



**Empowerment of Roma women and their children's early childhood development opportunities and school attendance**

E. van den Brink ~ 2011





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## Abstract

The current study investigated the differences between three Roma communities in Skopje regarding early childhood development opportunities and primary school attendance rate of children ( $n = 418$ ) and the degree of empowerment of women ( $n = 162$ ). Moreover, examined is if the degree of empowerment of women is associated with their children's early childhood development opportunities and school attendance. A questionnaire was administered to Roma women to investigate the early childhood development opportunities, school attendance rate and degree of empowerment. In addition, focus group discussions are held to assess the degree of empowerment of the women. Results showed that significant differences between the three communities exist concerning the degree of empowerment of women and the situation of the children. Additionally, the research showed an association between the degree of women empowerment and the situation of the children. Higher levels of empowerment of mothers are associated with a better situation of children. If the situation of children it to be improved, it is therefore required to invest in the situation of women as well.

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**Key words:** Roma, women empowerment, early childhood development opportunities, primary education

# Theoretical background

## Roma in Macedonia

### General information

According to the official census of 2002, 2.66 percent of the Macedonian population is Roma, which implies a number of 53.879 Roma inhabitants. Nevertheless, this is probably an underestimation of the actual size of the Roma community. It is believed that the actual Roma population in Macedonia is between 80.000 and 130.000 (Roma Education Fund, 2007). Indicating the exact percentage of the Roma population is problematic, because many Roma are not officially registered. They lack personal identity documents due to a number of reasons. The Balkan wars made it difficult to obtain personal documents as a result of family displacement and nowadays Roma often live in informal settlements, making it difficult to obtain residence permits and identity cards. In addition, Roma women who lack health insurance are not able to access health care during pregnancy and for their newborn children. These factors have as a consequence that many Roma children remain unregistered (Hoelscher, 2007). Macedonia contains 70 settlements with Roma inhabitants, of which 65 are located in towns and 5 in villages. In most of these settlements, Roma are the dominant majority of the population. A lot of Roma municipalities lack minimum infrastructural conditions, implying no access to water, electricity, sewage systems and paved roads. Almost half of the Roma live in poor suburban parts of Skopje, the capital town of the Former Yugoslav Republic of Macedonia<sup>1</sup> (Roma Education Fund, 2007). One of these municipalities near Skopje, Shuto Orizari, is the largest community in Europe in which Roma inhabitants are the vast majority (Lakinska-Popovska, 2000; Roma Education Fund, 2007). Shuto Orizari is inhabited by approximately 14.000 Roma inhabitants, living in 3122 families (Lakinska-Popovska, 2000). Dispersed Roma settlements in Skopje are isolated from the mainstream society and as a result are out of reach of public transport systems and far from healthcare services and schools (Hoelscher, 2007). About 80 percent of the Roma population in Macedonia speaks Romani and the other 20 percent mainly speaks Macedonian, Albanian or Turkish. Macedonian Roma are mostly Muslim (Roma Education Fund, 2007). Roma in Macedonia have traditionally been working as musicians or unskilled laborers in the cleaning sector and the black market sales. Currently, more people are relying on begging and social benefits, partly due to the economic crises (UNDP, 2005). Estimations of the unemployment rate among Roma are varying between 71 percent (UNICEF, 2007<sup>1</sup>) and more than 90 percent (Roma Education Fund, 2007). Low levels of education are contributing to this high unemployment rates. However, 65 percent of the educated Roma is still unemployed; indicating that the attitude of Roma towards wage employment and discrimination

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<sup>1</sup> Hereafter referred to as "Macedonia"

might also be a problem. The working ability of Roma is further decreased as a result of the high levels of experienced health problems (Hoelscher, 2007; Roma Education Fund, 2007). The situation of women is worst; compared to 99 percent of Macedonian and Albanian women, only 61 percent of Roma women is literate (State Statistical Office, 2007), 39 percent of Roma women have no or incomplete education and 83 percent of Roma women have never been employed (UNDP, 2005).

The Roma population is significantly poorer than the Macedonian population as a whole (Roma Education Fund, 2007; UNICEF, 2007<sup>1</sup>). The situation of Roma is even worse than the majority of the people living in the same neighborhood; based on income, 22 percent of Roma live under the poverty line of \$2.15 per day compared to 4 percent of non-Roma living in the same neighborhood (UNDP, 2005).

### **Poverty and social exclusion**

In every country in South East Europe, Roma people are exposed the most to poverty and social exclusion. Hence, these countries have adopted a Decade of Roma Inclusion for 2005 till 2015 in which they develop government plans to stimulate the inclusion of Roma in their country. The Roma Inclusion Decade is initiated by the World Bank, the Open Society Institute, the United Nations Development Program and several other partner organizations (Hoelscher, 2007). Children growing up in poor households are often trapped in an intergenerational cycle of poverty and exclusion, mainly due to limited access to education. As a consequence, they do not have many opportunities for employment and a basic income and therefore no chances to break the poverty cycle (UNICEF, 2007<sup>1</sup>; UNICEF, 2007<sup>2</sup>). The impact of poverty and social exclusion on Roma children starts even before they are born, with the influence it has on their opportunities for a healthy early childhood development (UNICEF, 2006). In comparison with the general population, the access of Roma mothers to basic health care services is far lower. As a consequence, mothers do not have access to pre-natal and infant health care. They lack information about promoting healthy pregnancies and some of them give birth without the company of a health professional. Once born, children are often not registered, which denies them citizenship and access to important development services like education, health care and social protection. Preschool is in many Roma communities not available and if children attend schools, they may be subject to discrimination by teachers and classmates. Completion rates of primary and secondary education of Roma children is much lower than the mainstream population (OSE & UNICEF, 2010). Each of these exclusion factors and their consequences for Roma children in Macedonia will be discussed in more detail in the continuation of this theoretical background.

### **Health insurance, birth registration and immunization**

Inclusion in the health insurance system enables entry into the public health system and provides economic security in the access to health services (Janeva, 2010). In Shuto Orizari, 4.1 percent of the Roma families is partially health insured and 18.4 percent is not insured at all (Lakinska-Popovska, 2000). A high value is placed on increasing the opportunities for pregnant Roma women to access adequate healthcare. Physical check up's during pregnancies, also called antenatal care, are important for ensuring the health and well-being of pregnant women and their (unborn) children (Hoelscher, 2007). The World Health Organization recommends a minimum of four antenatal visits. According to the Macedonia Multiple Indicator Cluster Survey (MICS) results, 79 percent of the pregnant Roma women receive antenatal care from a doctor, compared to 98 percent of the Macedonian women (State Statistical Office, 2007).

Antenatal care is also essential for ensuring the registration of newborn children, their immunization and the possibility for regular medical check-ups (Hoelscher, 2007). Birth registration is the official recording of the birth of a child by the government. It is important for a child to be registered, because it is an essential means of protecting a child's right to an identity. Furthermore, birth registration is required for an optimal developmental trajectory, because it is a key to ensuring the fulfillment of other rights, like the rights to protection, health care and education (Roma Education Fund, 2004; UNICEF, 2005; UNICEF, 2007<sup>1</sup>). Children without a birth registration tend to be poor, have limited access to health care services and are not attending early childhood education. Birth registration serves also a statistical purpose. Demographic data provided by civil registrations allows countries to investigate its own population statistics so policies and programs can be accurately planned and implemented (UNICEF, 2005). When children are not registered, they are invisible for policy makers which make it difficult for their needs to be fully met (UNICEF, 2007<sup>1</sup>). Since the children do not appear in official records, they fall through the prescribed procedures like vaccinations and school attendance (Hoelscher, 2007). Whether parents register the birth of their child or not depends on the awareness of the process and its importance by the parents, their opportunity and ability to access registration services and their willingness to have contact with state authorities. High costs, long distances to registration services and lack of knowledge of the importance of birth registration seem to be the most common reasons for non-registration in many countries. The educational level of a mother is associated with birth registration of her children. Children whose mothers attended primary education are significantly more often registered at birth as compared to illiterate mothers (UNICEF, 2005). The Roma communities have the highest percentage of unregistered children in Macedonia (Roma Education Fund, 2004). Results of the MICS show that the birth of 91.9 percent of the Roma children is registered (State Statistical Office, 2007). Of the registered children in Macedonia, 10 percent is not vaccinated and the percentage of non-

vaccination among unregistered children is probably even higher (UNICEF, 2007<sup>2</sup>). Estimations regarding the vaccination coverage rate among Roma in Macedonia vary between 50 (UNICEF, 2007<sup>1</sup>) and 66 percent (State Statistical Office, 2007) compared to national rates between 88 and 94 percent. Results of the MICS further show that the vaccination coverage is highest among children whose mothers have at least attended secondary education (State Statistical Office, 2007). Lack of awareness of Roma parents about the importance of vaccination for the health of children contributes to the low vaccination coverage of Roma children (UNICEF, 2007<sup>1</sup>). Immunization is however a key instrument in achieving the fourth Millennium Development Goal to reduce child mortality by two thirds by 2015 and it is essential for stimulating a healthy early child development (State Statistical Office, 2007).

### **Early childhood development**

To break the intergenerational transmission of poverty and social exclusion, it is important that children's capabilities and skills are developed from their early childhood onwards. This is essential, because the development and experiences during the first years of a child's life lay an important ground for their chances at school (UNICEF, 2007<sup>1</sup>). Early childhood development interventions aim to promote a healthy development of children aged zero till six and ameliorate the negative effects of the risks of growing up in poor households. The interventions encompass support to families by means of parent education, improvement of the home environment, health care services and pre-school, early childhood centers or kindergartens (UNICEF, 2006). Access to high-quality early childhood development interventions is seen as an important step towards poverty reduction and empowerment of communities (Young and Richardson, 2007). Education of parents is essential in this part and it is especially important for mothers to have access to information so they are able to support their children in their development and learning process (UNICEF, 2007<sup>1</sup>). The main objective of parent education is to make parents aware of the importance of the caregivers' role to support the child's development and empower parents in ways that improve the care and interaction with their children. Parent education should provide parents information and support in their parenting role and their own development. Programs should provide parents knowledge and skills to support the child's development (Evans, 2006). Meta-analyses show that the most effective parent education programs start in the first years of a child's life, have a minimum duration of two years and encompass informing parents about health care and child development, enrichment of the immediate environment of the child, as well as active stimulation of parenting skills (Engle, Black, Behrman, Cabral de Mello, Gertler, Kapirir, Martorell, & Young, 2007; Evans, 2006). Early childhood development centers in Macedonia encompass support to parents in the form of home-visits and group sessions. Parents are empowered to claim good child services and they are being educated in

order to care better for their children. Illiterate mothers are empowered by means of literacy courses so they have better access to child rearing information and they can read with their children. This also makes them more aware of the opportunities and rights they have (Ravens, 2010).

The environment characterized by poverty and parents with low educational levels in which Roma children live, leads to a disadvantage when they enter school (Hoelscher, 2007). Scientific research confirms the effectiveness of early childhood education in improving school readiness and giving children an equal starting point as they enter primary school (Engle et al., 2007; OSE & UNICEF, 2010; Young & Richardson, 2007). When starting primary education, those minority children who have attended some kind of pre-school education have an advantage over those who have not, because language and other learning barriers are overcome earlier. Though, the limited information that is available, shows that the participation rate of Roma children in South-East Europe is very limited (UNICEF, 2007<sup>1</sup>) due to the low social and economic status of the Roma in Macedonia. It costs approximately 25 euro per child to be enrolled in a kindergarten, which is impossible to afford for families when their monthly revenues are less than 94 euros (Janeva, 2010). Results of the MICS indicate a percentage of 4 percent of the Roma children attending pre-school education (State Statistical Office, 2007). In the municipality Shuto Orizari this percentage is higher; 13.7 percent of the pre-school aged Roma children are involved in any form of early childhood education (Lakinska-Popovska, 2000). The educational level of the mother is a strong predictor of the likelihood that a child will attend early childhood education. As the mother's educational level increases from primary to secondary education, the attending rate of children increases from less than 2 to 23 percent (State Statistical Office, 2007).

### **Education**

Scientific research confirms that investments in early childhood education and improving primary and secondary school attendance and completion are the most promising interventions to break the intergenerational transmission of poverty and social exclusion (Grantham-McGregor, Cheung, Cueto, Gleww, Richter, & Strupp, 2007; OSE & UNICEF, 2010). Access to education will influence a child's level of social inclusion and gives possibilities for the future (UNICEF, 2007<sup>1</sup>). There exists a positive relation between the educational level of a mother and the socioeconomic status of the family and the school attendance of children. Of children age seven whose mothers have at least secondary school, 98 percent are attending first grade, compared to 83 percent of children whose mothers have no education. In the richest households in Macedonia, 98 percent of the children is attending first grade, compared to 86 percent of the children of the poorest households. These relations partly explain the low school attendance rates of Roma children, since the socioeconomic status of the family and the educational level of their mothers are low. Of the seven years old Roma children in

Macedonia, 63 percent is attending first grade and only 45 percent make it to the last grade of primary school. 27 percent of them make the transition from primary to secondary school, compared to 87 percent of the other Macedonian children (State Statistical Office, 2007). Yet again, the percentages in Shuto Orizari are slightly higher; 80.1 percent of the children are attending primary education, but at age 15 only 35.5 percent of the children are still attending school. The percentage of children over 18 years of age having only primary education is 50.4 percent and 34.1 percent of the children in this age range is illiterate and has not completed primary education. As a consequence, their future chances to find an employment is considerably low (Lakinska-Popovsak, 2000). Reasons for the high drop-out rates of Roma children in education are the too high costs of textbooks and other school equipment, insufficient mastery of the Macedonian language, feelings of discrimination, the need for participation in earning money and the perceived lack of future job opportunities. Girls are more likely to leave school than boys (Hoelscher, 2007; Roma Education Fund, 2004; Roma Education Fund, 2007).

## **Empowerment**

### **Definition**

As can be concluded from the data of the Roma community in Macedonia, the problems faced by people living in poverty are multidimensional with strong connections and influences of poverty on access to health care, education and employment, resulting in social exclusion and reduced development opportunities. The poverty cycle of Roma can be broken through the strengthening of their own capacities which will increase their opportunities to participate in society (Roma Education Fund, 2004). This strengthening of people's capacities is also often called empowerment and is frequently the main goal of non-governmental organizations or other organizations giving developmental aid to people living in poverty (Van 't Rood, as cited in Anger, Van 't Rood, & Gestakovska, 2010).

However, what precisely is meant by empowerment? Although there is not a single model for empowerment, all models share certain characteristics of empowerment. Firstly, empowerment is always about having power. This power can be seen as an influence in social relations; dyadic interactions as well as interactions between an individual and a system. By means of this power, a person has control over his or her own life. Secondly, empowerment is always seen as related to well-being, implying that high levels of empowerment result in high levels of well-being (Bennett Cattaneo & Chapman, 2010). Empowerment is of value at the individual and collective level (World Bank, 2002). At the individual level, empowerment can be defined as *'the capacity of people to direct and control their own lives and resources: the ability to take their lives into their own hands'* (Alsop,

Bertselsen, & Holland, 2006; Van 't Rood, as cited in Anger et al., 2010; World Bank, 2002). This definition implies that individuals need to be able to organize themselves on self-identified challenges or problems (Van 't Rood, as cited in Anger et al., 2010) and corresponds to the term agency, which refers to the capacity of individuals to act independently by defining goals, choosing between different options to reach those goals and therefore making free choices (Alsop et al., 2006; Bennett Cattaneo & Chapman, 2010; Luttrell, Quiroz, Scrutton, & Bird, 2009). To be able to make purposeful choices and by this means control your life, one needs to have assets and the opportunity to choose. Assets can be defined as the provided resources individuals have to use opportunities, to be productive and to protect themselves from shocks. Assets are needed in different domains; psychological, economic, informational, organizational, material, social, human and financial. Education, employment and income are examples of assets. Having the assets and the ability to make choices alone is not enough to be empowered. Empowerment is restricted by the opportunity structure, defined as these parts of the institutional context within which an individual lives and works, which influences the ability to translate agency into actions which can create the desired outcomes. Opportunity structures therefore determine the effectiveness of empowerment, because institutions govern people's behavior and influence the success or failure of the choices they make (Alsop et al., 2006; World Bank, 2002). Individuals can be empowered in the social, economic and political domain of their lives, and the degree of experienced empowerment can vary within these domains (Alsop et al., 2006).

At the collective level, empowerment is defined as *'a process through which oppressed groups gain greater control over their lives and environment, acquire valued resources and basic rights, and achieve important life goals and reduced societal marginalization'* (Maton, 2008). Poor and oppressed people lack the power, assets and opportunities to increase their wellbeing and to have freedom of choice and action (World Bank, 2002). Empowering individuals is seen as an effective intervention for poor or oppressed communities to improve their quality of life (Maton, 2008; Perking & Zimmerman, 1995). Through empowerment, people acquire their basic rights and resources and therefore obtain greater control over their lives. It will make communities able to participate actively in the process of shaping society and making decisions through which they achieve important life goals and reduced societal marginalization (Luttrell et al., 2009; Maton, 2008). Empowerment will lead to the expansion of assets and opportunities of people to negotiate with, control and hold accountable institutions that affect their lives. For this to happen, the collective capacity to organize and mobilize community members is critical (Speer & Hughey, 1995; World Bank, 2002). The World Bank (2002) distinguishes four factors that are important for poor people to increase their degree of empowerment. These factors are (1) having access to information, (2) having opportunities to participate, (3) communities having the capacity to organize and (4) government

agencies to be accountable. Alsop and colleagues (2006) distinguish three indicators to measure empowerment, namely (1) the existence of an opportunity to make a choice, (2) the extent to which one makes use of the opportunity to choose and (3) whether the choice brings about the desired result.

### **Women empowerment**

Currently, the empowerment of women in particular is a main goal within official policies and programs of international development agencies (Campbell & Tegtsoonian, 2010). Improving the situation of women is very efficient; several studies show that the situation of the whole community and in particular the situation of the children improves consequently (Corsi, Crepaldi, Lodovici, Boccagni, & Vasilescu, 2010). The eight Millennium Development Goals provide a set of benchmarks to measure progress towards the eradication of global poverty (UNDP, 2010). The third Millennium Development Goal (MDG), promoting gender equality and women's empowerment, is not solely considered as an important independent goal, but also as instrumental in achieving all other Millennium Development Goals. This implies that the empowerment of women is, among other things, seen as essential to ensure that poverty is eradicated and all children achieve primary education (Malik & Courtney, 2011). The indicators of MDG 3 are the ratios of girls in primary, secondary and tertiary education, the share of women in wage employment in the non-agricultural sector and the proportion of seats held by women in national parliament (UNDP, 2010).

For women to be empowered, they need the opportunity to access resources like health care services, education and paid employment (Grown, Gupta, & Kes, 2005; Malik & Courtney, 2011). Not solely the attendance of education, but mainly the ensuring of completion of education is essential. Education is regarded as key to giving women more control over their lives (Malik & Courtney, 2011). The lack of education is, in fact, one of the main factors behind the social exclusion and poverty of Roma women, due to its influence on the employment status and the quality of work, on the housing conditions, and also on access to healthcare (Corsi et al., 2010). Higher education levels increase the opportunities for women to have a paid employment. Paid employment of women then is essential for households to escape poverty, to improve women's mobility and enable women to seek and access for example health services. Early marriage and childbearing, as well as low education levels are barriers to the entry of women in the labor market (Grown, Gupta, & Kes, 2005). The Macedonian Survey on the situation of women and children confirms the relation between the educational level of women and the school attendance rate of their children. The higher the educational level of the mother, the higher the attending rate of children in pre-school and primary education. Likewise, mothers with secondary education have more often received antenatal care during their pregnancies than mother with no education or solely primary education and additionally

birth registration- and immunization rates of their children are higher (State Statistical Office, 2007). Assets and opportunities are essential in ensuring women's empowerment, though having this is not sufficient. Women have to recognize that they can control their lives and have to utilize the available resources and opportunities in their own interest to bring about empowerment (Malhotra, Schuler, & Boender, 2002).

## Current research

### Objectives

The first objective of the current research is to assess the degree of empowerment of Roma women in Skopje and to assess the early childhood development opportunities and school attendance rate of their children. The second objective is to examine if the degree of empowerment of Roma women in Skopje is related to their children's early childhood development opportunities and school attendance. The third objective is to make a comparison between the situation of Roma women and children in the municipalities Topaana, Zlokukjani and four small dispersed Roma communities.

### Main research question

The main research question of this study is: *'Is the degree of empowerment of Roma women in Skopje related to their children's early childhood development opportunities and school attendance?'*

### Sub-questions

To be able to answer the main research question, several sub-questions need to be answered:

- ∞ How many children have early childhood development opportunities?
  - ~ How many children are registered at birth?
  - ~ How many children have a health insurance?
  - ~ How many children are vaccinated for BCG, polio 1/2/3, DPT 1/2/3, Hep. B 1/2/3 and MMR?
  - ~ How many children are attending or attended early childhood education?
- ∞ How many children are attending primary education?
- ∞ What is the degree of empowerment of Roma women?
  - ~ To what extent do Roma women have the assets identity documents, health insurance, education and employment?
  - ~ To what extent do Roma women have opportunities regarding stimulating the early childhood development of their children and sending their children to primary school?
  - ~ To what extent do Roma women utilize the opportunities they have regarding early childhood development and school attendance of their children?
  - ~ To what extent do Roma women acknowledge the importance of early childhood development opportunities and school attendance?
  - ~ To what extent do Roma women have the ability to define goals, have the feeling they can reach those goals and feel they have control over their lives and the lives of their children?
- ∞ Is the availability of the assets identity documents, health insurance, education and employment associated with the degree in which children are registered at birth, have a health insurance, are fully vaccinated, are attending early childhood education and are attending primary education?

- ∞ Is the ability to define goals and the feeling they can reach those goals and the feeling of having control over one's own life and the life of their children associated with the degree in which children are registered at birth, have a health insurance, are fully vaccinated, are attending early childhood education and are attending primary education?

## Methodology

### Research group

The target population of the research is Roma women with children aged 0-15 years living in Skopje, in the communities Topaana, Zlokukjani and four small dispersed communities at Momin Potok, Pod Kale and near the bus station and the railway. In total, 162 women and 418 children are included in the research.

A representative sample of the total amount of Roma women with children aged 0-15 years in the community Topaana participate in this research; 102 women with 247 children. The women are aged between 19 and 54 years with a mean age of 29.4 ( $sd = 5.0$ ). Of this women, 80.4 percent is formally married ( $n = 82$ ), 16.7 percent is consensually married ( $n = 17$ ), 2 percent is divorced ( $n = 2$ ) and 1 percent is single mother ( $n = 1$ ). The main source of income of the family is for 56.9 percent of the women social help or unemployment benefits ( $n = 58$ ), for 36.9 percent an occasional or seasonal wage job ( $n = 38$ ), for 2 percent the money earned by collecting garbage or selling old goods ( $n = 2$ ) and 3.9 percent has another main source of income ( $n = 4$ ). The average number of children of Roma women in Topaana is 2.4 ( $sd = 0.8$ ). The mean age of the children is 7.8 ( $sd = 2.7$ ). 56.3 percent of the children is male ( $n = 139$ ) and 43.7 percent is female ( $n = 108$ ).

In the community Zlokukjani, all available women with children aged 0-15 years are included in the research; 38 women with 110 children. The women are aged between 17 and 43 years with a mean age of 28.3 ( $sd = 7.1$ ). In Zlokukjani, 55.3 percent of the women is formally married ( $n = 82$ ) and the other 44.7 percent is consensually married ( $n = 17$ ). The main source of income of the families of the women is for 44.7 percent collecting garbage or selling old goods ( $n = 17$ ), for 23.7 percent an occasional or seasonal wage job ( $n = 9$ ), for 10.5 percent social help or unemployment benefits ( $n = 4$ ), for 5.3 percent begging ( $n = 2$ ), for 2.6 percent a regular wage job ( $n = 1$ ) and 13.2 percent has another main source of income ( $n = 5$ ). The average number of children of Roma women in Zlokukjani is 3.5 ( $sd = 1.9$ ). The mean age of the children is 6.8 ( $sd = 4.2$ ). 47.3 percent of the children is male ( $n = 52$ ) and 52.7 percent is female ( $n = 58$ ).

All available women in the above mentioned dispersed communities are included in the research as well; 24 women with 61 children. The women are aged between 16 and 46 years with a mean age of 30.1 ( $sd = 9.5$ ). In the dispersed communities, 25.0 percent of the women is formally married ( $n = 6$ ), 70.8 percent is consensually married ( $n = 17$ ) and 4.2 percent is single mother ( $n = 1$ ). The main source of income of families of the women is for 83.3 percent collecting garbage or selling old goods ( $n = 20$ ), for 12.5 percent social help or unemployment benefits ( $n = 3$ ) and 4.2 percent has another main source of income ( $n = 1$ ). The average number of children of women in the dispersed

communities is 3.2 ( $sd = 2.3$ ). The mean age of the children is 5.9 ( $sd = 4.0$ ). 55.7 percent of the children is male ( $n = 34$ ) and 44.3 percent of the children is female ( $n = 27$ ).

### **Operationalization of the concepts**

To obtain data, a questionnaire for Roma women was constructed containing questions to measure the degree of empowerment of Roma women and the degree to which their children receive early childhood development services as well as the degree to which their children are enrolled in primary education (see Appendix A for the questionnaire).

Early childhood development opportunities are operationalized in the following factors: birth registration, health insurance, immunization and attending an early childhood development center. To investigate the degree to which Roma children receive these early childhood development services, questions of the Macedonia Multiple Indicator Cluster Survey (MICS) are used. The MICS is designed 'to provide up-to-date information for assessing the situation of children and women in the Republic of Macedonia, to furnish data needed for monitoring progress towards goals established by the Millennium Declaration and to contribute to the improvement of data and monitoring systems in Macedonia'. The survey contains three questionnaires, namely The Household Questionnaire, The Questionnaire for Individual Women and The Questionnaire for Children under-5 (State Statistical Office, 2007). For this research, questions 2 and 2A of the 'Maternal and Newborn health' module of The Questionnaire of Individual Women are used (see Appendix A questions 2.3, 2.4 and 2.5 about antenatal care). Questions 2, 3 and 4 of the module 'Birth Registration and Early Learning' of The Questionnaire under-5 are used (see Appendix A question 2.9 about birth registration). The Macedonian guidelines proscribe a BCG vaccination to protect against tuberculosis, three doses of DPT vaccine to protect against diphtheria, pertussis and tetanus, three doses of polio vaccine, three doses of hepatitis B vaccine and a measles vaccination. These vaccinations should be given within the first few months of life, with the exception of the measles vaccination which has to be given at 13 months of age (State Statistical Office, 2007). In line with the MICS, questions about the above mentioned vaccinations are incorporated in the questionnaire for Roma women (see Appendix A questions 2.12 to 2.15). Women are asked if their children are vaccinated, if yes how many times they are vaccinated and if no why their children are not (fully) vaccinated. Additionally, women are asked if their children have a vaccination card. If women are able to show the vaccination card, the received vaccinations are filled in in the table in order to check if the children received all the proscribed vaccinations. In the analyses of whether or not children are fully vaccinated, all children aged two and older are included. A child is indicated as fully vaccinated when the vaccination card shows that the child has received all the vaccinations included in this research or when a mother is not able to show the vaccination card but states that her child had received all vaccinations.

Based on the theoretical research, the degree of empowerment of Roma women is operationalized and measured in four interrelated factors, namely (1) assets, (2) opportunities, (3) acknowledgment of importance and (4) ability to define goals, feelings of ability to reach those goals and feelings of having control. For the first factor, the assets 'identity documents', 'health insurance', 'educational level' and 'employment' of Roma women are investigated. The second factor encompasses the opportunities of Roma women and the utilization of these opportunities to access health care, opportunities regarding stimulating a healthy early childhood development and the opportunities for and support of their children to attend primary education. This information is obtained by observations in the Roma communities and by investigating the reasons of non-stimulation of a healthy early childhood development and non-attendance of primary education. The degree to which Roma women acknowledge the importance of early childhood development opportunities and school attendance is examined for the third factor. The questions about the importance are open-ended questions. Afterwards the answers are categorized. The last factor encompasses the extent to which Roma women have the ability to define goals and the degree to which they feel they can reach those goals and have control over their lives and the lives of their children. Questions measuring this factor are obtained of the questionnaire of Grootaert, Narayan, Jones and Woolcock (2003) (see Appendix A questions 4.1 and 4.2) and the questionnaire of Alsop, Bertelsen and Holland (2005) (see Appendix A questions 4.3 to 4.7).

### **Procedure**

The research started with a short pilot study in which the questionnaire is tested by ten women in the communities Topaana and Zlokukjani. Based on the results of the pilot study, the Macedonian translation of the first two questions of the control questions was revised. Structured interviews were held with the women to fill in the questionnaire. The women in Topaana were approached by a non-governmental organization working in this Roma community. The women in Zlokukjani and the dispersed communities were visited in their communities. The researchers went to the communities and approached all the available women with children between six and fifteen years old. Zlokukjani and one of the dispersed communities are visited several times to make sure all women are encompassed in the research. During the field work it became clear that women in the dispersed communities did not understand the first two questions of the control questions. Therefore, the results of these questions of the women in the dispersed communities are not included in the research. In each community a small focus group discussion is held with around five women to discuss these two questions in more depth and to still be able to say something about the degree of control of the women in the dispersed communities (see Appendix B for the questions of the focus groups).

## Analysis

The statistical Pearson's chi square test in SPSS (Statistical Package for the Social Science) is used to analyze the differences between the three communities with regard to the situation of children and the situation of women. This test analyzes whether there is a significant relation between two categorical variables in a contingency table. Two assumptions have to be met in order to be able to conduct the Pearson chi square test. At first, it is imperative that each item, in this case each person, contributes to only one cell of the contingency table. Secondly, the expected frequencies should be greater than five. In larger contingency tables it is acceptable to have up to 20 percent of expected frequencies below five, but no expected frequency should be below one. If one or both of the assumptions are not met in the case of a 2 x 2 contingency table, the Fisher's exact test is used. This test computes whether there is a relation between two variables with two categories (Field, 2005). If one or both of the assumptions are not met in the case of a contingency table with variables with more than two categories, no statistical test is executed. In some situations, the assumption of expected frequencies is not met, because almost none of the children or women contribute to one of the categories of a variable. In that case, this category is not included in the test and the relation between the variables is calculated without this category. This solution results in loss of information, but the number of children or women not included in the analyses are no more than two. The number of children or women contributing to the deleted category is mentioned in the text.

The Pearson chi square test is used here as well to analyze whether there is a relation between the degree of empowerment of Roma women and the situation of children. If the relation between two variables is significant, Cramer's V is used to measure the strength of this association (Field, 2005). Table 1 gives directives to interpret Cramer's V (de Vocht, 2006).

Table 1

### *Interpretation of Cramer's V*

Cramer's V	Interpretation
0.75 – 1	Perfect association
0.50 – 0.75	Strong association
0.25 – 0.50	Moderately strong association
0 – 0.25	Weak association
0	No association

The following categories are not included in the analyzes, as a consequence of the small numbers of children or women contributing to this categories resulting in violation of the assumption that 80 percent of the expected frequencies have to be above 5 and no expected frequencies may be lower

than one: (1) the category 'partial' of the variable 'health insurance', (2) the category 'yes irregularly' of the variable 'ECD- center', (3) the category 'yes irregularly' of the variable 'primary education', (4) the category 'secondary education completed' of the variable 'educational level', (5) the category 'do not know' of the variable 'do you think this things will ever change?' and (6) the categories 'yes, very easily' and 'yes fairly easily' of the variable 'do you feel that people like yourself can generally change things in your community if they want?'. The analyses between these variables and the other variables are conducted without the above mentioned categories.

In the following cases, the Fisher exact test is executed instead of the Pearson chi square test, because the assumptions are not met and the contingency table is 2 x 2: (1) 'women health insurance' and 'ECD-center', (2) 'identity documents women' and 'birth registration', (3) 'identity documents women' and 'health insurance women', (4) 'identity documents women' and 'primary education' and (4) 'identity documents women' and 'ECD-center'.

Between the following variables no analyzes are conducted by any test, because the assumptions are not met: (1) 'vaccinated' and any other variable, (2) 'community in which women live' and 'identity documents' (3) 'how much control do you feel you have in making decisions that affect your everyday activities?' and any variable relating to the situation of children, (4) 'do you feel you have the power to make important decisions that change the course of your children's lives?' and any variable relating to the situation of children, (5) 'do you think these things will ever change?' and 'fully vaccinated' and (6) 'do you feel that people like yourself can generally change things in your community if they want?' and 'ECD- center'.

## Results

### Early childhood development opportunities and primary education

There are significant differences between the three Roma communities regarding the situation of the children. Table 2 shows the differences between Topaana, Zlokukjani and the dispersed communities in percentages of children who are registered at birth and the percentages of children having a health insurance. As can be seen, all children in Topaana are registered at birth and are having a health insurance. In Zlokukjani a significant amount of children have no birth certificate (11.8 percent) and no health insurance (18.5 percent) and the percentages of children without birth registration and health insurance in the dispersed communities is even higher (34.4 percent and 62.3 percent respectively). All children with a health insurance have a full health insurance, except for two children in Zlokukjani who have a partial health insurance. The difference between the communities regarding birth registration is statistically significant ( $\chi^2(2) = 80.30, p < .001$ ) as well as the difference regarding the percentages of children having a health insurance ( $\chi^2(2) = 160.8, p < .001$ ). A significant, strong association is found between whether or not a child is registered at birth and whether or not a child has a health insurance ( $\chi^2(1) = 103.23, p < .001$ ; Cramer's  $V = .50$ ). 91.1 percent of the children who are registered at birth have a health insurance, compared to 27.3 percent of the children who are not registered at birth.

Table 2

*Number and percentage of children being registered at birth and having a health insurance, disaggregated by Roma community*

	Topaana		Zlokukjani		Dispersed communities	
<b>Birth registration</b>						
Yes	247	100%	97	88.2%	40	65.6%
No	0	0%	13	11.8%	21	34.4%
Total	247	100%	110	100%	61	100%
<b>Health insurance</b>						
Yes	247	100%	88	81.5%	23	37.7%
No	0	0%	20	18.5%	38	62.3%
Total	247	100%	108	100%	61	100%

In Topaana, all women state that their children are vaccinated and of 98.7 percent of the children the vaccination card is seen. The vaccination cards point out that 77.8 percent of the children are fully

vaccinated. In Zlokukjani, 97.9 percent of the children are vaccinated according to the women. However, of only 7.4 percent of the children are vaccination cards seen and 73.4 percent of the children's mother say their children have a vaccination card, but this card is not seen. 61.7 percent of the children in Zlokukjani are fully vaccinated. In the dispersed communities, 76.5 percent of the children are vaccinated according to their mothers. The vaccination card is seen of 9.8 percent of the children and 66.7 percent of the children also have a vaccination card but this card is not seen. 58.8 percent of the children are fully vaccinated (table 3). The difference between the communities regarding whether a child has a vaccination card or not and whether this card is seen or not is significant ( $\chi^2(4) = 324.2, p < .001$ ). The difference between communities regarding whether a child is fully vaccinated or not is significant as well ( $\chi^2(4) = 38.1, p < .001$ ). A significant but weak association is found between whether or not a child is registered at birth and whether or not a child is fully vaccinated ( $\chi^2(2) = 12.39, p < .05$ ; Cramer's V = .18). 71.9 percent of the children who are registered at birth are fully vaccinated, compared to 46.4 percent of the non-registered children.

Table 3

*Number and percentage of children being vaccinated, having a vaccination card and being fully vaccinated, disaggregated by Roma community*

	Topaana		Zlokukjani		Dispersed communities	
<b>Vaccinated</b>						
Yes	239	100%	92	97.9%	39	76.5%
No	0	0%	2	2.1%	12	23.5%
Total	239	100%	94	100%	51	100%
<b>Vaccination card</b>						
Yes (card is seen)	236	98.7%	7	7.4%	5	9.8%
Yes (card is not seen)	3	1.3%	69	73.4%	34	66.7%
No	0	0%	18	19.1%	12	23.5%
Total	239	100%	94	100%	51	100%
<b>Fully vaccinated</b>						
Yes	186	77.8%	58	61.7%	30	58.8%
No	50	20.9%	18	19.1%	15	29.4%
Unknown	3	1.3%	18	19.1%	6	11.8%
Total	239	100%	94	100%	51	100%

Significant differences are apparent between the three communities in enrollment percentages in early childhood development (ECD-) centers ( $\chi^2(2) = 45.5, p < .001$ ) and primary education ( $\chi^2(2) = 105.2, p < .001$ ). In Topaana, 95.3 percent of the four and five years old children are enrolled in ECD-centers, compared to 25 percent in Zlokukjani and 8.3 percent in the dispersed communities. All these children attend the ECD-center regularly, except for one child in Topaana who attends the ECD-center irregularly. Of the children aged six till fifteen years old in Topaana, 95.9 percent attends primary education regularly, compared to 44.8 percent in Zlokukjani and 31 percent in the dispersed communities (table 4). One child in Topaana attends primary education irregularly. No significant difference is found between boys and girls regarding primary school attendance ( $\chi^2(1) = 1.49, p = .22$ ), yet 78.9 percent of the boys and 72.5 percent of the girls are attending primary education. Significant, moderately strong associations are found between whether or not a child is registered at birth and whether or not a child is attending an ECD-center ( $p < .05$  by Fisher's exact test ; Cramer's V = .38) and whether or not a child attends primary education ( $p < .001$  by Fisher's exact test ; Cramer's V = .46). Of the children who are registered at birth, 70.8 percent is attending an ECD-center and 81.2 percent is attending primary education, while none of the children who are not registered at birth are attending either an ECD-center or primary education.

Table 4

*Number and percentage of children aged 4 and 5 attending an ECD-center and number and percentage of children aged 6 till 15 attending primary education, disaggregated by community*

	Topaana		Zlokukjani		Dispersed communities	
<b>ECD- center</b>						
Yes, regularly	41	95.3%	4	25%	1	8.3%
No	2	4.7%	12	75%	11	91.7%
Total	43	100%	16	100%	12	100%
<b>Primary education</b>						
Yes, regularly	164	95.9%	30	44.8%	9	31%
No	7	4.1%	37	55.2%	20	69%
Total	171	100%	67	100%	29	100%

## Empowerment of Roma women

### Assets

Table 5 shows that the overall level of education of the Roma women is low. Notwithstanding, significant differences occur between the educational level of the women in the three communities ( $\chi^2(6) = 60.8, p < .001$ ). The educational level in Topaana is highest, with 2 percent of the women having completed secondary education, 11.8 percent of the women having been enrolled in secondary education but not completed it and 59.8 percent of the women having completed primary education. In Zlokukjani, 47.4 percent of the women are illiterate and none of the women have a higher educational level than completed primary education. The educational level in the dispersed communities is the lowest with 62.5 percent being illiterate and the other 37.5 percent having attended primary education but none of them having completed it.

Table 5

*Educational level of women in Topaana, Zlokukjani and the dispersed communities.*

Educational level	Topaana		Zlokukjani		Dispersed communities	
Illiterate	12	11.8%	18	47.4%	15	62.5%
Primary education (not completed)	15	14.7%	12	31.6%	9	37.5%
Primary education (completed)	61	59.8%	8	21%	0	0%
Secondary education (not completed)	12	11.8%	0	0%	0	0%
Secondary education (completed)	2	2%	0	0%	0	0%
Total	100	100%	38	100%	24	100%

No differences are found between the communities with regard to the employment rate of the Roma women. With the exception of one woman in Zlokukjani, none of the Roma women have an employment. Apart from one woman, all women in Topaana have identity documents, compared to 89.5 percent of the women in Zlokukjani and 83.3 percent of the women in the dispersed communities. Significant differences are found between the communities with regard to the percentages of women having a health insurance ( $\chi^2(2) = 48.1, p < .001$ ), having received antenatal care during their pregnancies ( $\chi^2(2) = 34.2, p < .001$ ) and having received information about

childrearing and/ or health care ( $\chi^2(2) = 65.9, p < .001$ ). The percentages in Topaana are highest; 98 percent of the women have a health insurance, 94.1 percent has received antenatal care and 93.1 percent has ever received information about childrearing and/ or health care. The percentages in Zlokukjani are a little lower with 78.9 percent of the women having a health insurance, 81.6 percent having received antenatal care and 45.9 percent having received information about childrearing and/ or health care. In the dispersed communities not even half of women have a health insurance (43.5 percent) and have received antenatal care (45.8 percent) and an even lower percentage has received information about childrearing and/ or antenatal care (20.8 percent) (table 6).

Table 6

*Number and percentage of women having identity documents, a health insurance, having received antenatal care and having received information about childrearing and/or health care, disaggregated by community*

	Topaana		Zlokukjani		Dispersed communities	
<b>Identity documents</b>						
Yes	101	99%	34	89.5%	20	83.3%
No	1	1%	4	10.5%	4	16.7%
Total	102	100%	38	100%	23	100%
<b>Health insurance</b>						
Yes	100	98%	30	78.9%	10	43.5%
No	2	2%	8	21.1%	13	56.5%
Total	102	100%	38	100%	23	100%
<b>Antenatal care</b>						
Yes	96	94.1%	31	81.6%	11	45.8%
No	6	5.9%	7	18.4%	13	54.2%
Total	102	100%	38	100%	24	100%
<b>Received information</b>						
Yes	95	93.1%	17	45.9%	5	20.8%
No	7	6.9%	20	54.1%	19	79.2%
Total	102	100%	37	100%	24	100%

A significant, moderately strong association is found between whether or not women have a health insurance and whether or not women have received antenatal care during their pregnancies ( $\chi^2(1) = 68.2, p < .001$ ; Cramer's  $V = .41$ ). Only 50 percent of the women without a health insurance have received antenatal care, while 90.5 percent of the women with a health insurance have received antenatal care.

### **Opportunities**

The neighborhood Topaana has paved roads, boarding areas for the bus and shops on walking distance. The houses are provided with electricity, running safe water and a sewage system. An organization focusing on improving the lives and living standards of the Roma families is located in Topaana. This organization provides services for adults as well as children, ranging from adult literacy to stimulating citizen registration, vaccinations and attaining public services. Moreover, the organization provides services for pre-school children and afterschool services for primary and secondary school children. The center is open every workday and people are free to drop by anytime with questions or requests for help. The organization frequently organizes lectures on topics related to health care and education. A primary school and ECD-center are located in Topaana. Some children in Topaana are not attending an ECD-center because women ( $n = 7$ ) do not know there is an ECD-center available. All women with children who are not fully vaccinated ( $n = 32$ ) in Topaana claim that their children are too young to be fully vaccinated.

The community Zlokukjani is located outside the city and suburbs of Skopje and public transport is not on walking distance. Consequently, ECD- centers, primary schools, health care services and shops are not easy accessible for the people living in Zlokukjani. With the exception of a little shop, these services are not available and no organization is located in this community. The majority of the houses are provided with electricity, running safe water and a sewage system. Reasons for non-registration of children given by women in Zlokukjani are '*child was not born in the hospital*' ( $n = 2$ ), '*birth registration costs too much*' ( $n = 1$ ) and '*registration is not possible due to lack of ID-documents of parents*' ( $n = 1$ ). Four women in Zlokukjani claim that their children are too young to be fully vaccinated; another four women say their children are not fully vaccinated because the children were sick at the moment they had to be vaccinated. Women give as reasons for the non-attendance of an ECD-center of their children '*I do not work so my child can stay at home*' ( $n = 9$ ), '*it costs too much*' ( $n = 6$ ), '*must travel too far to an ECD-center*' ( $n = 2$ ), '*child does not have a birth certificate*' ( $n = 1$ ) and '*child has to work*' ( $n = 1$ ). Women give two different reasons for the non-attendance of primary education of their children, namely '*textbooks and other school equipment are too expensive*' ( $n = 5$ ) and '*child has to be engaged in earning money for the household*' ( $n = 1$ ).

The dispersed communities are very small (ranging from 5 families to 8 families living together) and are situated on locations not intended for living; by the riverside, under or close by the railway and on an industrial zone. The housing of the people living in these communities is very small, impermanent and made out of garbage. No electricity, running safe water or sewage system is available. The people living in these communities do not have a permanent living place; they are living on different places in and out of the city. ECD-centers, primary schools and health care services are not easy accessible for the people living in these communities, due to the fact that they have no permanent living place and are not living in neighborhoods. In the dispersed communities, two reasons for non-registration of children are given, that is *'registration is not possible due to lack of ID-documents of parents'* (n = 5) and *'must travel too far to register the child'* (n = 1). Reasons for the fact that children are not fully vaccinated are *'child has no identity documents'* (n = 2), *'child has no health insurance'* (n = 2) and *'family has no permanent living place'* (n = 1). Reasons for non-attendance of an ECD-center of their children are *'it costs too much'* (n = 5), *'did not know there is an ECD-center available'* (n = 3), *'attending kindergarten is not important'* (n = 3), *'child has no identity documents'* (n = 3), *'family has no permanent living place'* (n = 3) and *'must travel too far'* (n = 1.) The women state that children are not attending primary education because *'the child has no identity documents'* (n = 4), *'the family has no permanent living place'* (n = 4), *'the family is not informed of education'* (n = 2), *'there is no school nearby'* (n = 1) and *'textbooks and other school equipment are too expensive'* (n = 1).

### **Acknowledgement of importance**

The majority of the women acknowledge the importance of birth registration; 100 percent of the women in Topaana, 86.8 percent of the women in Zlokukjani and 95.8 percent of the women in the dispersed communities. None of the women do not acknowledged the importance of birth registration, but 13.2 percent of the women in Zlokukjani and 4.2 percent of the women in the dispersed communities are not able to say if it is important or not. The majority of the women in Topaana (61.9 percent) and Zlokukjani (51.5 percent) say birth registration is important, because a child has the documents he or she needs in life if it is registered at birth. The majority of the women in the dispersed communities (43.5 percent) say birth registration is important, because you need the documents for health care and/or education (see Appendix C for a complete overview of the given reasons).

The importance of vaccinations is acknowledged by all women in Topaana. The majority of women in Zlokukjani (97.4 percent) and the dispersed communities (87.5 percent) acknowledge the importance as well, but several women are not able to say whether or not vaccinations are important (2.6 percent in Zlokukjani and 12.5 percent in the dispersed communities). Largely all

women give one of the following two reasons for the importance of vaccination; *'because vaccination is prevention for diseases'* or *'because a child will be healthy when it is vaccinated'* (see Appendix C for a complete overview of the numbers and percentages).

In Topaana all women acknowledge the importance of ECD-centers, while 11.4 percent of the women in Zlokukjani and 4.2 percent in the dispersed communities say attending an ECD-center is not important. Another 5.7 percent of the women in Zlokukjani and 25 percent of the women in the dispersed communities are not able to say whether or not attending an ECD-center is important. The most given reasons for the importance of attending an ECD-center are *'because a child develops and learns at an ECD-center'* and *'because a child prepares for school in an ECD-center'* (see Appendix C for a complete overview of the given reasons). All women in Topaana and Zlokukjani and 91.7 percent of the women in the dispersed communities acknowledge the importance of primary education. One woman in the dispersed communities is not able to say whether or not primary education is important. The most given reasons for the importance of education in the three communities are *'because you will have a better future/ life with education'* and *'because it is easier to find an employment when you have finished education'*. In Zlokukjani and the dispersed communities the reason *'because it is important to be literate'* is frequently given as well (see Appendix C for a complete overview of the given reasons).

### **Feelings of having control, ability to define goals and feelings of ability to reach those goals**

Table 7 shows the answers on the question *'How much control do you feel you have in making decisions that affect your everyday activities?'* The majority of women in Topaana and Zlokukjani state they have control over most decisions that affect their everyday activities. However, in Zlokukjani, women (34.2 percent) frequently state as well that they have no control in making decisions that affect their everyday activities. The diversity in answers is confirmed by the results of the focus group discussion. Some women say they have control over their everyday activities, because there is no one who tells them what they need to do. They can decide for themselves what they will be doing. Other women though say they have no control to make decisions that affect their everyday activities, because certain things just need to be done. The activities they do during the day, like doing the laundry and cooking, are necessary and they have no control to decide if they want to do it or not. The answers of the women in Topaana are confirmed in the focus group discussion as well. All women in Topaana feel they have control to make decisions about their everyday activities. Sometimes their mother in law decides what the women need to do, but they have control over most decisions.

In the focus group discussion with women in the dispersed communities emerges that the women do not feel they have control to make decisions that affect their everyday activities. They are

able to decide what they do during the day, but this is no free choice. If they really had control over their everyday activities, they would not do the things they do now. The fact that they do not have opportunities (they do not have a permanent living place, no house, no employment and no money) makes that they have no control and are forced to do the things they do every day, like collecting bottles and begging.

Table 7  
*Answers of women on the question ‘How much control do you feel you have in making decisions that affect your everyday activities?’ disaggregated by Roma community*

	Degree of control women feel they have to make decisions that affect their everyday activities									
	No control		Control over few decisions		Control over some decisions		Control over most decisions		Total	
Topaana	2	2.0%	1	1.0%	39	38.2%	60	58.8%	102	100%
Zlokukjani	13	34.2%	3	7.9%	6	15.8%	16	42.1%	38	100%

The vast majority of the women in Topaana feel they are mostly able (40.2 percent) or totally able (57.8 percent) to make important decisions that change the course of their children’s lives (table 8). Good life according to women in Topaana is having an employment and having money so their children are able to go to school. One woman says it is also important to give your child love and security and another woman says in a good life children have their own bedrooms. The women do not have an employment, but they are able to give their children a good life because their husbands work, they receive money from the government or the parents in law are financing education.

The percentages in Zlokukjani are more diverse with both 23.7 percent of the women feeling totally able and 26.3 percent feeling totally unable (table 8). Good life according to the six women in Zlokukjani is to have an employment and to be able to buy food and clothes for their children. Two of the women add that having a good life implies that children are going to school. These two women feel they are able to give their children a good life at this moment, but they are not sure if the situation will stay the same. The other four women feel they are not able to give their children a good life, because the adults in the family have no employment and hence no money to give their children enough food and good clothes. Additionally, the families live in very small houses, some with more than one family and some without a bathroom and none with separate sleeping rooms for the children. Women state that the living conditions need to be improved to be able to give their children a good life.

Table 8

Answers of women on the question 'Do you feel you have the power to make important decisions that change the course of your children's live?' disaggregated by Roma community

	Degree to which women feel they have the power to make important decisions that change the course of their children's lives											
	Totally unable		Mostly unable		Neither able nor unable		Mostly able		Totally able		Total	
	Topaana	1	1.0%	0	0%	1	1.0%	41	40.2%	59	57.8%	102
Zlokukjani	9	23.7%	5	13.2%	3	7.9%	11	28.9%	10	26.3%	38	100%

For the women in the dispersed communities a good life implies having a house and having basic supplies like running safe water. The women state they do know what they have to do to give their children a good life; giving them enough food and clothes and sending them to school. They sound rather desperate and say they are not able to give their children what they need, because they do not have a permanent living place, no house and no money to buy food and clothes. The women say they are not able to give their children a good life in the current situation. They need help and money.

Significant differences are found between the communities in the answers of women to the question 'Is there anything in your life that you would like to change?' ( $\chi^2(2) = 34.9, p < .001$ ). More than half of the women in Topaana (57.8 percent) do not have anything that they would like to change in their lives, while the vast majority of women in Zlokukjani (78.9 percent) and all the women in the dispersed communities (100 percent) do have anything in their lives that they would like to change (table 9).

Table 9

Answers of women on the question 'Is there anything in your life that you would like to change?' disaggregated by Roma community

	Is there anything in your life that you would like to change?					
	Yes		No		Total	
Topaana	43	42.2%	59	57.8%	102	100%
Zlokukjani	30	78.9%	8	21.1%	38	100%
Dispersed communities	24	100%	0	0%	24	100%

The most given answers regarding what thing(s) women would most like to change differ between the women in the different communities. The women in Topaana would most like to have a higher educational level (32.1 percent) and/ or an employment (24.5 percent). In Zlokukjani, women would most like to have better living conditions (17.9 percent), a higher educational level (17.9 percent), their own house (15.4 percent) and/ or everything to be better (15.4 percent). The women in the dispersed communities would most like to have a (better) house and a permanent living place (40 percent), everything to be better (13.9 percent) and/ or a higher educational level (11.1 percent).

Significant differences between the communities are found in the answers of the question ‘Do you think these things will ever change?’ ( $\chi^2(2) = 7.8, p < .05$ ). The vast majority of the women in Topaana (81.4 percent) and Zlokukjani (83.3 percent) do think that these things will ever change, while in Zlokukjani as well the majority (46.7 percent) thinks it will change but another 13.3 percent is not able to say if it will ever change or not (table 10).

Table 10  
*Answers of women on the question ‘Do you think these things will ever change?’ disaggregated by Roma community*

	Do you think these things will ever change?							
	Yes	No	I don’t know		Total			
Topaana	35	81.4%	8	18.6%	0	0%	43	100%
Zlokukjani	14	46.7%	12	40%	4	13.3%	30	100%
Dispersed communities	20	83.3%	4	16.7%	0	0%	24	100%

In Topaana and Zlokukjani most women believe that their family (44.4 percent and 50 percent respectively) or the national government (25 percent and 35.7 percent) will contribute most to any change. In the dispersed communities women believe that they (45 percent) or the national government (35 percent) will contribute most to any change (table 11).

Table 11

Answers of women on the question 'Who do you think will contribute most to any change?' disaggregated by Roma community

	Who do you think will contribute most to any change?											
	Myself		My family		Our community		The local government		The national government		Total	
Topaana	7	19.4%	16	44.4%	1	2.8%	3	8.3%	9	25%	36	100%
Zlokukjani	0	0%	7	50%	0	0%	2	14.3%	5	35.7%	14	100%
Dispersed communities	9	45%	3	15%	0	0%	1	5%	7	35%	20	100%

Significant differences are found between the communities in the answers given to the question 'Do you feel that people like yourself can generally change things in your community if they want?' ( $\chi^2(4) = 41, p < .001$ ). The majority of women in Topaana (68.3 percent) believe they can generally change things in their community if they want, but with a great deal of difficulty. Women in Zlokukjani believe they can generally change things in their community with a great deal of difficulty (47.1 percent) or not at all (44.1 percent). The majority of women in the dispersed communities believe they can generally not change things at all in their communities (54.2 percent) or with a great deal of difficulty (33.3 percent) (table 12). None of the women in either community feel that people like themselves can generally change things in their community very easily or fairly easily.

Table 12

Answers of women on the question 'Do you feel that people like yourself can generally change things in your community if they want?' disaggregated by Roma community

	Do you feel that people like yourself can generally change things in your community if they want?							
	Yes, but with a little difficulty		Yes, but with a great deal of difficulty		No not at all		Total	
Topaana	26	25.7%	69	68.3%	6	5.9%	101	100%
Zlokukjani	3	8.8%	16	47.1%	15	44.1%	34	100%
Dispersed communities	3	12.5%	8	33.3%	13	54.2%	24	100%

## Relation between women empowerment and the situation of children

Significant associations are found between whether or not a woman has a health insurance and whether or not a child is registered at birth ( $\chi^2(1) = 133.2, p < .001$ ), has a health insurance ( $\chi^2(1) = 201.6, p < .001$ ), is fully vaccinated ( $\chi^2(2) = 6.58, p < .05$ ), is attending an ECD- center ( $p = .001$  by Fisher's exact test) and is attending primary education ( $\chi^2(1) = 81.4, p < .001$ ).

Of children with a mother with a health insurance, 98.6 percent is registered at birth, compared to 56.1 percent of the children with mothers without a health insurance. This association is strong (Cramer's  $V = .57$ ). Children of women with a health insurance are also more likely to have a health insurance than children of women without a health insurance. This association is strong as well (Cramer's  $V = .70$ ). The association between whether or not a woman has a health insurance and whether or not a child is fully vaccinated is weak (Cramer's  $V = .13$ ). The majority of children of both groups are fully vaccinated, but the children of women with a health insurance are more likely to be fully vaccinated (74.2 percent compared to 58.2 percent). Children aged 4 and 5 of mothers with a health insurance more often attend an ECD- center than children of mothers without a health insurance (73.3 percent and 18.2 percent respectively). This association is moderately strong (Cramer's  $V = .42$ ). Children aged six till fifteen years old are more likely to attend primary education if their mothers have a health insurance (86.3 percent) than if mothers do not have a health insurance (18.9 percent). This association is strong (Cramer's  $V = .56$ ) (table 14).

Significant, moderately strong associations are found between whether or not women have received antenatal care and whether or not a child is registered at birth ( $\chi^2(1) = 70.23, p < .001$ ; Cramer's  $V = .41$ ) and whether or not a child is fully vaccinated ( $\chi^2(2) = 35.68, p < .001$ ; Cramer's  $V = .31$ ). If a mother has received antenatal care during her pregnancies, chances are higher that a child is registered at birth and is fully vaccinated (table 13).

Table 13  
*Received antenatal care of woman in relation to birth registration and vaccination of child*

	Woman received antenatal care			
	Yes		No	
<b>Birth registration</b>				
Yes	338	96.8%	46	66.7%
No	11	3.2%	23	33.3%
Total	349	100%	69	100%
<b>Fully vaccinated</b>				
Yes	249	77.1%	25	41%
No	53	16.4%	30	49.1%
Unknown	21	6.5%	6	9.8%
Total	323	100%	61	100%

Table 14

*Health insurance of women in relation to birth registration, health insurance, vaccination, ECD-center attendance and primary education attendance of children*

	Health insurance woman			
	Yes		No	
<b>Birth registration</b>				
Yes	344	98.6%	37	56.1%
No	5	1.4%	29	43.9%
Total	349	100%	66	100%
<b>Health insurance child</b>				
Yes	335	96.5%	20	30.3%
No	12	3.5%	46	69.7%
Total	347	100%	66	100%
<b>Fully vaccinated</b>				
Yes	242	74.2%	32	58.2%
No	64	19.6%	16	29.1%
Unknown	20	6.1%	7	12.7%
Total	326	100%	55	100%
<b>ECD- center</b>				
Yes, regularly	44	73.3%	2	18.2%
No	16	26.7%	9	81.8%
Total	60	100%	11	100%
<b>Primary education</b>				
Yes, regularly	196	86.3%	7	18.9%
No	31	13.6%	30	81.9%
Total	227	100%	37	100%

Significant associations are found between whether or not a woman has identity documents and whether or not a child is registered at birth ( $p < .001$ , Fisher's exact test), has a health insurance ( $p < .001$ , Fisher's exact test) and whether or not a child attends primary education ( $p < .001$ , Fisher's exact test).

If a woman has identity documents, her child is more likely to be registered at birth (95.3 percent of the children are registered) than if a woman has no identity documents (16.7 percent of the children are registered). This association is strong (Cramer's  $V = .58$ ). The association between whether or not a woman has identity documents and whether or not a child has a health insurance is moderately strong (Cramer's  $V = .29$ ). The probability that a child has a health insurance is higher when the mother has identity documents. The association between whether or not a woman has identity documents and whether or not a child aged six till fifteen attends primary education is moderately strong (Cramer's  $V = .31$ ). None of the children of women without identity documents attends primary education, compared to 78.4 percent of the children of women with identity documents (table 15).

The percentage of fully vaccinated children is higher if mothers have identity documents (72 percent) than if mother have

Table 15

*Identity documents of women in relation to birth registration, health insurance, vaccination, ECD-center attendance and primary education attendance of children*

	Identity document women			
	Yes		No	
<b>Birth registration</b>				
Yes	381	95.3%	3	16.7%
No	19	4.7%	15	83.3%
Total	400	100%	18	100%
<b>Health insurance</b>				
Yes	351	88.2%	7	38.9%
No	47	11.8%	11	61.1%
Total	398	100%	18	100%
<b>Fully vaccinated</b>				
Yes	267	72%	7	53.8%
No	78	21%	5	38.5%
Unknown	26	7%	1	7.7%
Total	371	100%	13	100%
<b>ECD- center</b>				
Yes, regularly	45	65.2%	1	50%
No	24	34.8%	1	50%
Total	69	100%	2	100%
<b>Primary education</b>				
Yes, regularly	203	78.4%	0	0%
No	56	21.6%	8	100%
Total	259	100%	8	100%

no identity documents (53.8 percent) (table 15). However, this difference is not significant ( $p = .12$ , Fisher's exact test), therefore there is no association. No association occur as well between whether or not a woman has identity documents and whether or not children aged 4 and 5 attend an ECD-center ( $p = .58$ , Fisher's exact test).

Significant associations are found between the educational level of the mother and whether or not her child is registered at birth ( $\chi^2(3) = 44.60, p < .001$ ) and has a health insurance ( $\chi^2(3) = 67.51, p < .001$ ). As table 16 points out, all children of mother with completed primary education or not completed secondary education are registered at birth and have a health insurance. The percentages of non-registered children and children without a health insurance are highest among children of illiterate mothers (21.6 percent and 32.8 percent respectively). The association between the educational level of the mother and whether or not a child is registered at birth is moderately strong (Cramer's  $V = .33$ ) as well as the association between the educational level of the mother and whether or not a child has a health insurance (Cramer's  $V = .40$ ).

Moreover, a significant but weak association is found between the educational level of the mother and whether or not a child is fully vaccinated ( $\chi^2(3) = 26.95, p < .001$ ; Cramer's  $V = .19$ ). Still, percentages of fully vaccinated children are higher among children of mothers with a higher educational level. The significant association between the educational level of the mother and whether or not a child attends an ECD- center ( $\chi^2(2) = 21.24, p < .001$ ) and attends primary education ( $\chi^2(3) = 73.15, p < .001$ ) are strong (Cramer's  $V = .56$  and Cramer's  $V = .52$  respectively). All four and five years' old children of mothers with not completed primary education are attending an ECD-center, while only 27.3 percent of children of illiterate mothers are attending an ECD- center. Likewise, all children aged six till fifteen years of mother with no completed secondary education are regularly attending primary education, compared to 43.3 percent of children of illiterate mothers (table 16).

Table 16

*Educational level of women in relation to birth registration, health insurance, vaccination, ECD-center attendance and primary education attendance of children*

	Educational level women							
	Illiterate		Primary education (not completed)		Primary education (completed)		Secondary education (not completed)	
<b>Birth registration</b>								
Yes	91	78.4%	97	91.5%	163	100%	30	100%
No	25	21.6%	9	8.5%	0	0%	0	0%
Total	116	100%	106	100%	163	100%	30	100%
<b>Health insurance</b>								
Yes	78	67.2%	84	80.8%	163	100%	30	100%
No	38	32.8%	20	19.2%	0	0%	0	0%
Total	116	100%	104	100%	163	100%	30	100%
<b>Fully vaccinated</b>								
Yes	61	61%	65	67%	124	80.5%	23	76.7%
No	30	30%	17	17.5%	27	17.5%	7	23.3%
Unknown	9	9%	15	15.5%	3	2%	0	0%
Total	100	100%	97	100%	154	100%	30	100%
<b>ECD- center</b>								
Yes, regularly	6	27.3%	14	66.7%	23	92%	3	100%
No	16	72.7%	7	33.3%	2	8%	0	0%
Total	22	100%	21	100%	25	100%	3	100%
<b>Primary education</b>								
Yes, regularly	29	43.3%	38	65.5%	108	94.7%	27	100%
No	38	56.7%	20	34.5%	6	5.3%	0	0%
Total	67	100%	58	100%	114	100%	27	100%

Significant associations are found between the answer of women on the question *'Is there anything in your life that you would like to change?'* and whether or not a child is registered at birth ( $\chi^2(1) = 7.68, p < .01$ ) and whether or not a child has a health insurance ( $\chi^2(1) = 45.20, p < .001$ ). These associations are weak (Cramer's  $V = .14$ ) and moderately strong (Cramer's  $V = .33$ ) respectively. Children of mothers who do have anything in their lives they would like to change are more often not registered at birth (11.2 percent) than children of mothers who do not have anything in their lives they would like to change (3.6 percent). Likewise, all children of mothers who do not have anything in their lives they would like to change have a health insurance, compared to 76.6 percent of children of mothers who do have anything in their lives they would like to change (table 17). There is no significant association between the answer of women on the question *'Is there anything in your life that you would like to change?'* and whether or not a child is fully vaccinated ( $\chi^2(2) = 2.86, p = .24$ ). Moderately strong associations are found between the answer of women on the question *'Is there anything in your life that you would like to change?'* and whether or not a child is attending an ECD-center ( $\chi^2(1) = 14.8, p < .001$ ; Cramer's  $V = .47$ ) and is attending primary education ( $\chi^2(1) = 34.7, p < .001$ ; Cramer's  $V = .36$ ). If a mother does not have anything in her life she would like to change, the probability that a four and five years old child is attending an ECD- center and a child aged six till fifteen is attending primary education, is much higher than if a mother does have anything in her life she wants to change (table 17).

Table 17

*Answers women on the question 'Is there anything in your life that you would like to change?' in relation to birth registration, health insurance, vaccination, ECD-center attendance and primary education attendance of children*

	Is there anything in your life that you would like to change?			
	Yes		No	
<b>Birth registration</b>				
Yes	223	88.8%	161	96.4%
No	28	11.2%	6	3.6%
Total	251	100%	167	100%
<b>Health insurance</b>				
Yes	191	76.7%	167	100%
No	58	23.3%	0	0%
Total	249	100%	167	100%
<b>Fully vaccinated</b>				
Yes	157	69.5%	117	74.1%
No	49	21.7%	34	21.5%
Unknown	20	8.9%	7	4.4%
Total	226	100%	158	100%
<b>ECD- center</b>				
Yes, regularly	21	47.7%	25	92.6%
No	23	52.3%	2	7.4%
Total	44	100%	27	100%
<b>Primary education</b>				
Yes, regularly	96	62.7%	107	93.9%
No	57	37.3%	7	6.1%
Total	153	100%	114	100%

No significant associations are found between the answer of mothers on the question ‘Do you think these things will ever change?’ and whether or not a child is registered at birth ( $\chi^2(2) = 2.41, p = .30$ ), has a health insurance ( $\chi^2(2) = .43, p = .81$ ) and attends an ECD- center ( $\chi^2(1) = 1.91, p = .17$ ). The significant association between the answer of mothers on the question ‘Do you think these things will ever change?’ and whether or not a child attends primary education ( $\chi^2(1) > 9.53, p < .01$ ) is moderately strong (Cramer’s V = .29). The majority of children of women who think these things will ever change are regularly attending primary education (69.2 percent), while the majority of children of mothers who do not think these things will ever change are not attending primary education (59 percent) (table 18).

Table 18  
*Answers on the question ‘Do you think these things will ever change?’ in relation to primary education attendance of children*

	Do you think these things will ever change?			
	Yes		No	
Primary education				
Yes, regularly	72	69.2%	16	41%
No	32	30.8%	23	59%
Total	104	100%	39	100%

Significant associations are found between the answer of women on the question ‘Do you feel that people like yourself can generally change things in your community if they want?’ and whether or not a child is registered at birth ( $\chi^2(2) = 18.04, p < .001$ ), has a health insurance ( $\chi^2(2) = 85.1, p < .001$ ) and attends primary education ( $\chi^2(2) = 32.52, p < .001$ ). The more women feel they are not able to change things in their community if they want, the higher the probability that a child is not registered at birth, has no health insurance and is not attending primary education. The association between the extent to which a woman feels she can change things in her community and whether or not a child is registered at birth is weak (Cramer’s V = .21). The associations between the extent to which a woman feels she can change things in her community and whether or not a child has a health insurance and is attending primary education are moderately strong (Cramer’s V = .46 and Cramer’s V = .35 respectively).

The association between the answer of women on the question ‘Do you feel that people like yourself can generally change things in your community if they want?’ and whether or not a child is fully vaccinated is not significant ( $\chi^2(4) = 8.61, p = .07$ ). Albeit no statistical test can be done to

analyze if there is an association between the extent to which a woman feels she can change things in her community and whether or not four and five years old children attend an ECD-center, the percentages in table 19 indicates that there is an association. The more women feel they are able to change things in their community if they want, the more likely it is that a child attends an ECD- center and the more women feel they are not able to change things in their community, the less likely it is that a child attends an ECD-center.

Table 19

*Answers on the question 'Do you feel that people like yourself can generally change things in your community if they want?' in relation to birth registration, health insurance, vaccination, ECD-center attendance and primary education attendance of children*

	Do you feel that people like yourself can generally change things in your community if they want?					
	Yes, but with a little difficulty		Yes, but with a great deal of difficulty		No, not at all	
<b>Birth registration</b>						
Yes	80	98.8%	219	93.6%	73	82%
No	1	1.2%	15	6.4%	16	18%
Total	81	100%	234	100%	89	100%
<b>Health insurance</b>						
Yes	80	98.8%	216	92.3%	48	55.2%
No	1	1.2%	18	7.7%	39	44.8%
Total	81	100%	234	100%	87	100%
<b>Fully vaccinated</b>						
Yes	60	80%	150	68.5%	53	68.8%
No	12	16%	55	25.1%	14	18.2%
Unknown	3	4%	14	6.4%	10	13%
Total	75	100%	219	100%	77	100%
<b>ECD- center</b>						
Yes, regularly	8	80%	34	75.6%	3	23.1%
No	2	20%	11	24.4%	10	76.9%
Total	10	100%	45	100%	13	100%
<b>Primary education</b>						
Yes, regularly	54	90%	118	80.8%	25	47.2%
No	6	10%	28	19.2%	28	52.8%
Total	60	100%	146	100%	53	100%

## **Summary and discussion of the results**

### **Situation of the children**

Significant differences are found concerning the situation of Roma children in Topaana, Zlokukjani and the dispersed community. Overall it can be concluded that the situation of the children in Topaana is best, followed by the situation of the children in Zlokukjani and the situation of children in the dispersed communities is the worst.

All children in Topaana have a health insurance, while a significant amount of children in Zlokukjani and the majority of the children in the dispersed communities do not have a health insurance. Likewise, all children in Topaana are registered at birth, while a significant percentage of children in Zlokukjani and the dispersed communities are not registered. These numbers are worrisome, because birth registration is required for an optimal developmental trajectory since it is a key to ensuring the fulfillment of other rights, like the rights to protection, health care and education (Roma Education Fund, 2004; UNICEF, 2005; UNICEF, 2007<sup>1</sup>). These consequences of non-registration become apparent in the results of this research. If children have no identity documents, they are more likely to have no health insurance, to be not fully vaccinated and to not attend an ECD-center or primary education. High costs, long distances to registration services and lack of knowledge of the importance of birth registration seem to be the most common reasons for non-registration in many countries (UNICEF, 2005). These first two reasons are also given by women in Zlokukjani and the dispersed communities. Another reason is often given as well, that is women indicate that birth registration is not possible due to lack of identity documents of parents. The importance of birth registration is acknowledged by the majority of the women in all communities. However, several women in Zlokukjani and the dispersed communities are not able to say whether or not birth registration is important. This points out that the women in this communities are not informed enough of the importance of birth registration.

It is difficult to interpret the percentages concerning the vaccinations of children and to make statements about the rate of fully vaccinated children in Zlokukjani and the dispersed communities, because hardly any mother was able to show vaccination cards of the children. Judgments about whether or not a child is fully vaccinated are based on the mothers, which is not reliable because mothers could possibly lie or could be not informed of the exact number of vaccinations a child needs to receive on certain times. This last possibility is confirmed by the situation in Zlokukjani where several and in Topaana where all mothers of children aged two or older whom are not fully vaccinated claim that their child is not old enough to be fully vaccinated. This indicates that the women are not completely informed of the immunization procedure. It is highly reasonable that the women in Zlokukjani and the dispersed communities are not completely informed as well of the

immunization procedure and are consequently not able to determine whether or not their children are fully vaccinated (Corsi et al., 2010). Meaningful is however the known fact that almost all of the women in Topaana are able to show the vaccination cards of the children compared to almost none of the women in Zlokukjani and the dispersed communities. Some women say they have vaccination cards of the children, but they were not able to show these cards because they could not find them or they claimed that the doctors in the hospital have the cards. Certain is, that despite the differences between the communities, the number of children who are not vaccinated at all or are not fully vaccinated is unacceptably high in all communities. Literature elucidates that lack of awareness of Roma parents about the importance of vaccination for the health of children contributes to the low vaccination coverage of Roma children (UNICEF, 2007<sup>1</sup>). The current research shows that most of the women in the three communities acknowledge the importance of vaccinations and are able to explain that vaccinations are prevention for diseases and children will be healthy when they are vaccinated. The literature could nevertheless be confirmed by the results of women in Zlokukjani and the dispersed communities who do not directly deny the importance of immunization, but who are not able to say whether or not it is important.

The high number of children enrolled in an ECD-center in Topaana can be explained by the availability of two centers in this neighborhood providing activities for pre-school children. With this study, no conclusions can be made regarding the quality of these ECD-centers and the time spend at the centers. The significant larger number of pre-school children in Zlokukjani and the dispersed communities not enrolled in an ECD-center can be explained by the location of these communities. Women themselves give as explanations for the none attendance that it is too expensive and that it is too far away. Literature shows as well that the limited information that is available, shows that the participation rate of Roma children in South-East Europe in early childhood education is very limited (UNICEF, 2007<sup>1</sup>) due to the low social and economic status of the Roma in Macedonia. It costs approximately 25 euro per child to be enrolled in a kindergarten, which is impossible to afford for families when their monthly revenues are less than 94 euros (Janeva, 2010). Furthermore, women in Zlokukjani clarify that the child does not have to go to an ECD-center because she is at home and can take care of him. This highlights that women are not informed enough of the importance of ECD-centers, as can be confirmed by the data showing that a significant amount of women in Zlokukjani did never receive any information about topics related to childrearing.

More than half of the children in Zlokukjani and the dispersed communities are not enrolled in primary education and even in Topaana not all children are regularly attending primary education. Reasons for the non-attendance of primary education given by mothers are the too high costs of textbooks and other school equipment and the need for participation in earning money, which is in accordance with reasons given in the literature (Hoelscher, 2007; Roma Education Fund, 2004; Roma

Education Fund, 2007). In the dispersed communities reasons are furthermore that the child has no identity documents, the family has no permanent living place and the family is not informed of education. No differences in attendance rate are found between boys and girls.

### **Empowerment of the Roma women**

In this research the degree of empowerment of Roma women in Skopje is analyzed. A comparison is made between the women in Topaana, Zlokukjani and the dispersed communities. The degree of empowerment of Roma women is operationalized and measured in the four interrelated factors; (1) assets, (2) opportunities, (3) acknowledgment of importance and (4) ability to define goals, feelings of ability to reach those goals and feelings of having control.

With the exception of one woman, all women in Topaana have identity documents, which is not the case in Zlokukjani and the dispersed communities. This could be explained by the fact that some women living in these communities are refugees. Almost all of the women in Topaana have a health insurance, while a significant number of women in Zlokukjani and more than half of the women in the dispersed communities have not got a health insurance. Roma women who lack health insurance are not able to access health care during pregnancy. Receiving antenatal care during pregnancies is however essential for ensuring the registration of newborn children, their immunization and the possibility for regular medical check-ups (Hoelscher, 2007). The results of this research show that almost all of the women in Topaana and the majority of the women in Zlokukjani have received antenatal care, while more than half of the women in the dispersed communities have not received antenatal care. This possibly results from the fact that more than half of the women in the dispersed communities do not have a health insurance, which makes it very expensive to regularly visit a doctor during pregnancies. Results of this study show indeed that women without a health insurance are far less likely to have received antenatal care than women with a health insurance. Moreover, cultural barriers and lack of information frequently result in visiting a doctor solely when something is going wrong (Corsi et al., 2010). This lack of information is confirmed by the data showing that most of the women in Zlokukjani and the dispersed communities did not ever received information about childrearing and/ or health care whereas the vast majority of the women in Topaana do. The fact that a non-governmental organization is active in Topaana which frequently organizes lectures about topics related to childrearing and health care could account for this difference. The relation between whether or not a woman has received antenatal care and whether or not a child is fully vaccinated is confirmed in this research. If a mother has received antenatal care during her pregnancies, chances are higher that a child is registered at birth and is fully vaccinated.

The overall level of education of the Roma women included in this research is low, with only two women having completed secondary education. The educational level in Topaana is highest with

the majority of the women having completed primary education or more. In Zlokukjani almost half of the women are illiterate and none of the women has started secondary education. The majority of the women in the dispersed communities are illiterate and the other women did attend primary education but did not complete it. In the Roma culture girls are more likely to leave school, due to among other things the young age at which girls get married and the need for participation in earning money (Hoelscher, 2007; Roma Education Fund, 2004; Roma Education Fund, 2007). These factors could explain the low levels of education of the women in this research. With the exception of two women in Zlokukjani, none of the women have an employment. Yet, the main source of income differs between the communities. In Topaana the main source of income is mostly social help or unemployment benefits, while in Zlokukjani and the dispersed communities the money earned by collecting garbage and selling old goods are the main source of income.

All the above discussed differences between the three communities indicate that the women in Topaana have the most assets and consequently the most opportunities to stimulate a healthy early childhood development and to stimulate education for their children. The greater part of the women has identity documents and a health insurance and received antenatal care and information about relevant topics. Although the level of education of the women in Topaana is not high, most of the women attended at least primary education. And even though none of the women have an employment, the main source of income is mostly social help or unemployment benefits which give them the security of a regular income and the possibility to spent money on education. The location of the community furthermore gives the women opportunities because ECD-centers and a school is close by and other parts of the town are easy accessible. The importance of early childhood development opportunities and primary education is acknowledged by roughly all women in Topaana and they utilize the opportunities they have, evident from the data of the children.

Women in Zlokukjani and the dispersed communities have fewer opportunities to stimulate the early childhood development and education of their children, because a lot of them do not have identity documents and a health insurance. Women state that it is not possible for them to register or vaccinate a child due to their lack of these assets. The majority of the women are illiterate which makes it extremely difficult to obtain information about health care, childrearing and educational issues. As a consequence, women are less able to support children in their development and learning process (UNICEF, 2007<sup>1</sup>). The families have generally no steady income but are dependent on money earned by collecting garbage and selling old goods. This makes it difficult to continuously invest in early childhood development and education. The location of the communities additionally decreases the opportunities women have regarding stimulating a health early childhood development and education, because health centers, ECD-centers and schools are not close to the communities. Access to services is also obstructed by language barriers, with the Roma language lacking many specific

words in the fields of health and social care (Corsi et al., 2010). Opportunities of the women in the dispersed communities are further decreased due to the fact that they have no permanent living place. All the indicators of the lack of possibilities discussed in this paragraph are also given by women as reasons for non-registration, lack of health insurance, non-immunization and non-attendance of ECD-centers and primary education of their children.

The majority of the women acknowledge the importance of early childhood development opportunities and education, but also significant percentages of women in Zlokukjani and especially in the dispersed communities are not able to say whether it is important or not. This could be explained by the fact that they are not informed enough of the importance of these issues, bear out by the fact that a significant percentage of women have never received information about childrearing and/or health care and most of the women are illiterate which makes it difficult to obtain information. Another possibility is that women in particularly the dispersed communities are not busy with things like stimulating a healthy development and education, because their basic needs are not met. The theory of Maslow (Maslow, 1970 as cited in Gray, 2007) argues that a person can solely focus on higher needs when basic physiological needs, like food and water, and safety needs are met. The impermanent living place and lack of assets have as a result that women need their full attention and energy to sufficiently satisfy their basic needs which makes it very difficult for them to focus on higher needs like stimulating early childhood development and education.

More than half of the women in Topaana do not have anything they would like to change in their lives, while the vast majority of women in Zlokukjani and all the women in the dispersed communities do have anything they would like to change. To be empowered, individuals need the ability to act independently by defining goals and choosing between different options to reach those goals (Alsop et al., 2006; Bennett Cattaneo & Chapman, 2010). This could imply that women in Topaana are less empowered than the other women, because they were not able to define a goal in their lives. More likely is however that women in Topaana are more empowered, because they are able to organize themselves on self-identified challenges, which is an indicator of empowerment (Van 't Rood, as cited in Anger et al., 2010). These self-identified challenges include making sure children are registered, children are having a health insurance and being vaccinated and children are attending and ECD-center or primary education. The results of this research show that women in Topaana have succeeded better in achieve these challenges than the women in Zlokukjani and the dispersed communities. Consequently, women in Topaana are in all probability more satisfied with their lives which is reflected in the things women would mostly like to change in their lives. Women in Zlokukjani and the dispersed communities would like to have better basic living conditions and their own house or a permanent living place. On the other hand, the women in Topaana who do have anything they would like to change would largely like to have a higher education and an

employment. This corresponds to the previously discussed theory of Maslow (Maslow, 1970 as cited in Gray, 2007); women in Zlokukjani and the dispersed communities are not, like the women in Topaana, able to set higher goals like higher education and an employment, because their basic needs are not yet met. The vast majority of women in Topaana and Zlokukjani do think that the changes will ever be achieved by their families or the national government. The women in the dispersed communities are less empowered with the majority thinking it will never change or not being able to say whether or not it will ever change.

The direct questions about the perceived degree of control of the women show that women in Topaana generally feel they have control over their lives. Most women feel they have control over some or most decisions that affect their everyday activities and they feel they are mostly or totally able to make important decisions that change the course of their children's lives. The women in the dispersed communities do not feel they have control over these things, primarily due to their lack of opportunities. Diversity occurs in Zlokukjani, with women feeling they have no control as well as control over most decisions and women feeling they are totally unable as well as feeling totally able. Concerning the feeling that people like themselves can generally change things in their communities, women in Topaana are slightly more empowered with most of them feeling they can but with a great deal of difficulty compared to the majority of women in Zlokukjani and the dispersed communities feeling they are not able at all to change things.

### **Women empowerment and the situation of children**

Promoting women's empowerment is considered as instrumental in achieving all Millennium Development Goals. This implies that the empowerment of women is, among other things, seen as essential to ensure that the situation of children is improved (Malik & Courtney, 2011). In this research is analyzed whether or not the degree of women empowerment is related to the situation of children.

At first, relations are found between whether or not women have assets and the situation of their children. Moderately strong and strong relations are found between whether or not a woman has identity documents and whether or not a child is registered at birth, has a health insurance and is attending primary education. Children of women without identity documents are often not registered, have no health insurance and are not attending primary education. These relations are understandable, because it is more difficult for women without identity documents to arrange these things for their children. No relation is found between whether or not a woman has a health insurance and whether or not a child is attending an ECD-center, probably due to the small number of women without identity documents in this analysis which makes it impossible to find significant differences between groups (Field, 2005).

Roma women who lack a health insurance are not able to access health care during pregnancy and for their newborn children. These factors have as a consequence that many Roma children remain unregistered (Hoelscher, 2007). The current research confirms the strong relation between health insurance of a women and birth registration as well as with health insurance of the child and enrollment in an ECD-center and education. The situation of children regarding these issues is better when women have a health insurance.

The educational level of the mother is a predictor of the likelihood that a child is registered at birth and will attend and ECD-center and primary education. As the mother's educational level increases from illiterate to primary to secondary education, the number of registered children and the attending rate of children increases dramatically (State Statistical Office, 2007; UNICEF, 2005). The current research shows indeed the moderately strong to strong relation between the educational level and the situation of children. The higher the educational level of the mother, the higher the probability that a child is registered, has a health insurance and is enrolled in early childhood education and primary education. Differences occur even between illiterate women and women with uncompleted primary education.

If women do have anything in their lives they would like to change, children are more often not registered at birth, do not have a health insurance and are not attending an ECD-center and primary education. Women who do not have anything in their lives they would like to change are probably in a better situation and as the above mentioned results show, the situation of children is strongly related to the situation of their mothers. No relations are found between whether or not a woman thinks these things will ever change and the situation of children, with the exception of the enrollment in primary education. If a woman is convinced that the things will ever change, the probability that a child attends primary education is higher. It can be reasoned that women who think these things will ever change are more empowered and the situation of children of more empowered women is better. Therefore it is unexpected that no relation occurs between the other variables. Possible is however as well that no relations are found because the things women would like to change are mostly not related to early childhood development topics.

Significant associations are found between whether or not women feel that people like themselves can generally change things in their community if they want and whether or not a child is registered at birth, has a health insurance and is attending primary education. The more women feel they are not able to change things in their community, the more likely it is that children are not registered, do not have a health insurance and are not enrolled in primary education. Women feeling they are not able to change things are less empowered than women who do feel they are able to change things. These results confirm that the situation of children of more empowered women is better than the situation of children of less empowered women.

Weak or no relations are found between the above described variables regarding women empowerment and whether or not a child is fully vaccinated. This could be explained by the earlier mentioned probability that the data about the vaccination rate of children is not totally reliable. Relations do probably exist, but this research is not able to show these relations as a result of the unreliability of the data concerning vaccination of the children.

## Main conclusions and recommendations

- ❖ The current research clearly shows that differences exist regarding the situation of women and children in the different Roma communities in Skopje, which signifies the importance of disaggregated data on Roma. Results show the differences between more settled communities like Topaana, less settled communities like Zlokukjani and real dispersed communities. As the results show; the more settled a community is, the better the situation of women and children is as well. This points out to the need of more targeted support of especially the most marginalized communities.
- ❖ Concerning the situation of the Roma children, the results indicate the need for improvement of their situation. It is required to make sure all children are registered at birth, all children have a health insurance and receive the proscribed vaccinations, all children aged four and five years are enrolled in early childhood education and children aged six till fifteen attend primary education. School support activities should be provided to ensure completion of education.
- ❖ Significant relations are found between the situation of women and the situation of children. If the situation of children is to be improved, it is therefore required to invest in the situation of women as well. Roma women should be more empowered, which can be achieved through ensuring they have identity documents and making health services and social services available for them. Moreover, women should get literacy courses and information regarding health issues, early childhood development and educational topics should be provided. Projects in the Netherlands and Romania (see Corsi et al., 2010) are examples of empowerment programs for women by means of enhancing the mediating role of Roma women between their community and social services and health services. Women are trained to identify health problems and associated social problems in the community, to promote healthcare, to prepare registration with doctors, prepare vaccination campaigns and to deal with issues like the lack of birth registrations. Specific training should be provided to Roma women in order to enable them to access an employment. Providing micro-finance to women is an example of an effective way to improve women's empowerment and access to the labor market. It enables women to start their own small business, to be independent and to earn money (Pitt, Khandker, & Cartwright, 2006)<sup>2</sup>.

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<sup>2</sup> See [www.microfinancegateway.org](http://www.microfinancegateway.org) for more publications on this topic

- ❖ To be able to improve the health and educational situation of the women and children, it is essential to start with the basic needs. As women point out themselves as well, in Zlokukjani the living conditions and housing needs to be improved and the families in the dispersed communities need a permanent and solid living place.
  
- ❖ In Zlokukjani, a center can be established that aims at improving the living standard in the community by means of investing in the situation of women and children. A similar center can be established in the center of Skopje which will be reaching out to the Roma families living in dispersed communities. Outreach work to support these communities is needed, taking into consideration the lack of facilities for a possible center (like paved roads, electricity, running safe water and a sewage system) in these communities and the lack of a permanent living place of the families. Possible is as well to extend the existing center in Topaana with outreach activities in Zlokukjani and dispersed communities. Projects of the center should encompass the just described activities aiming at stimulating a health early childhood development and attending and completing primary education of children and empowerment of women.

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## Appendix A

### Questionnaire Roma women

#### 1. Questions about the respondent

1.1. How old are you?

.....

1.2. Do you have an identity document or a birth registration document of yourself?

- 1) Yes
- 2) No

1.3. What is your marital status?

- 1) Single
- 2) Married (consensual)
- 3) Married (legal/formal)
- 4) Divorced
- 5) Widowed

1.4. What is your educational level?

- 1) Illiterate
- 2) Primary education (not completed)
- 3) Primary education (completed)
- 4) Secondary education (not completed)
- 5) Secondary education (completed)
- 6) Higher education (not completed)
- 7) Higher education (completed)

1.5. Do you have an employment?

- 1) Yes
- 2) No

1.6. What is your main source of income?

- 1) Regular wage job
- 2) Occasional/seasonal wage job
- 3) Collecting garbage/selling old goods
- 4) Begging
- 5) Social help/unemployment benefits
- 6) Other (*specify*) .....

1.7. Do you have legal documents of your house?

- 1) Yes
- 2) No

1.8. Do you have a health insurance?

- 1) Yes
- 2) No
- 3) Partial

## 2. Questions about the health of the children

2.1. How many children do you have?

.....

2.2. What are the ages and gender of the children? *(Fill in for each child)*

	Age	Gender	Antenatal care			Postnatal care		
			M/F	Yes/No	Whom	Times	Yes/No	Whom
1.								
2.								
3.								
4.								
5.								
6.								

2.3. Did you see anyone for antenatal care during your pregnancies? *(Fill in for each pregnancy)*

1) Yes (.....)

2) No (.....)

*(If No, go to question 2.6)*

2.4. Whom did you see for antenatal care? *(Fill in for each pregnancy)*

1) Doctor

2) Nurse/ midwife

3) Auxiliary midwife

4) Traditional birth attendant

5) Community health worker

6) Relative/friend

2.5. How many times did you see anyone for antenatal care? *(Fill in for each pregnancy)*

On average ..... times

2.6. Did you see anyone for post-natal care after your pregnancies? *(Fill in for each pregnancy)*

1) Yes (.....)

2) No (.....)

*(If No, go to question 2.9)*

2.7. Whom did you see for post-natal care? *(Fill in for each pregnancy)*

1) Doctor

2) Nurse/midwife

3) Auxiliary midwife

4) Traditional birth attendant

5) Community health worker

6) Relative/friend

2.8. How many times did you see anyone for post-natal care? *(Fill in for each pregnancy)*

On average ..... times

2.9. Were your children registered at birth?*(Fill in for each child)*

- 1) Yes (.....)
- 2) No (.....) → Why were your children not registered at birth?
  - a) Costs too much
  - b) Must travel too far
  - c) Registration not possible due to lack of ID-documents of parents
  - d) Did not know they should be registered
  - e) Did not know where to register
  - f) Did not know how to register the child
  - g) Other reason (*specify*).....

	Birth registration yes or no	Health insurance yes, no or partial	Vaccinated yes or no	Number of vaccinations
1.				
2.				
3.				
4.				
5.				
6.				

2.10. Is birth registration important according to you? Why or why not?

- 1) Yes, because.....
- 2) No, because.....

2.11. Do your children have a health insurance (*Fill in for each child*)?

- 1) Yes (.....)
- 2) No (.....)
- 3) Partial (.....)

2.12. Are your children vaccinated? (*Fill in for each child*)

- 1) Yes (.....) (*Fill in how many times each child is vaccinated*)
- 2) No (.....)

2.13. Where are your children vaccinated?

- 1) In a hospital
- 2) In a health clinic
- 3) In a community center
- 4) At home
- 5) Somewhere else (*specify*).....

- 2.14. Do your children have a vaccination card? *(Fill in for each child)*
- 1) Yes (card is seen) (.....)*(Fill in which vaccinations each child received)*
  - 2) Yes (card is not seen) (.....)
  - 3) No (.....)

	Vaccination card no, seen or not seen	BCG	Polio 1 OPV1	Polio 2 OPV2	Polio 3 OPV3	DTP 1	DTP 2	DTP 3	HepB1 (DPT)H1	HepB2 (DPT)H2	HepB3 (DPT)H3	MMR Measles
1												
2												
3												
4												
5												
6												

- 2.15. In case the children are not (fully) vaccinated; Why are your children not (fully) vaccinated?

- 1) Costs too much
- 2) Must travel too far
- 3) Did not know they should be vaccinated
- 4) Did not know where to vaccinate
- 5) Other reason *(specify)*.....

- 2.16. Is vaccination important according to you? Why or why not?

- 1) Yes, because.....
- 2) No, because.....

- 2.17. Have you ever received any information about childrearing and/or health care?

- 1) Yes
- 2) No

### 3. Questions about the education of the children

- 3.1. Do/did your children attend kindergarten or an early childhood development center?*(Fill in for each child)*

- 1) Yes → a) Regularly (.....)      b) Irregularly (.....)
- 2) No (.....) → Why do/did your children not attend kindergarten or an early childhood development center?
  - a) Costs too much
  - b) Must travel too far
  - c) Did not know there is a kindergarten available
  - d) Attending kindergarten is not important
  - e) Other reason *(specify)*.....

- 3.2. Is attending kindergarten or an early childhood development center important according to you? Why or why not?

- 1) Yes, because.....
- 2) No, because.....

	Attend(ed) kindergarten		Attend(ed) primary school	
	Regularly	Irregularly	Regularly	Irregularly
1.				
2.				
3.				
4.				
5.				
6.				

3.3. Do your children attend primary school? *(Fill in for each child)*

- 1) Yes → a) Regularly (.....) b) Irregularly (.....)  
 3) No (.....)

*(If No, go to question 3.5)*

3.4. Why do your children not attend primary school?

- 1) Education is not important
- 2) Textbooks and other school equipment are too expensive
- 3) Feelings of discomfort and discrimination
- 4) Low success of the children, for example caused by language and knowledge barriers
- 5) Child has to be engaged in earning money for the household
- 6) There are no employment perspectives so there is no need for education
- 7) Other reason *(specify)*.....

#### 4. Control

4.1. How much control do you feel you have in making decisions that affect your everyday activities?

- 1) No control
- 2) Control over few decisions
- 3) Control over some decisions
- 4) Control over most decisions

4.2. Do you feel that you have the power to make important decisions that change the course of your children's lives? I am...

- 1) Totally unable to change the course of their lives
- 2) Mostly unable to change the course of their lives
- 3) Neither able nor unable to change the course of their lives
- 4) Mostly able to change the course of their lives
- 5) Totally able to change the course of their lives

4.3. Is there anything in your life that you would like to change?

- 1) Yes
- 2) No

*(If No, go to question 4.7)*

4.4. What thing(s) would you most like to change?

.....  
 .....

4.5. Do you think these things will ever change?

- 1) Yes
- 2) No

*(If No, go to question 4.7)*

4.6. Who do you think will contribute most to any change?

- 1) Myself
- 2) My family
- 3) Our community
- 4) The local government
- 5) The national government

4.7. Do you feel that people like yourself can generally change things in your community if they want?

- 1) Yes, very easily
- 2) Yes, fairly easily
- 3) Yes, but with a little difficulty
- 4) Yes, but with a great deal of difficulty
- 5) No, not at all

## **Appendix B**

### **Questions focus group discussions**

1. How much control do you feel you have in making decisions that affect your everyday activities?  
→ Do you feel that you are able to choose what you will do during the day? If no, why not?
  
2. Do you feel that you have the power to make important decisions that change the course of your children's lives?  
→ Do you feel that you are able to give your children a good life? Why or why not?  
→ Can you give examples of decisions you can make to give your children a good life?  
→ Are you able to make these decisions? (E.g. are you able to bring your children to the doctor when they are ill / are you able to send your children to school?) If not, why not?

## Appendix C

### Results acknowledgement of importance

Table 1

*Acknowledgment of the importance of birth registration*

	Topaana		Zlokukjani		Dispersed communities	
Birth registration important						
Yes	100	100%	33	86.8%	23	95.8%
No	0	0%	0	0%	0	0%
I do not know	0	0%	5	13.2%	1	4.2%

Table 2

*Reasons of the importance of birth registration*

	Topaana		Zlokukjani		Dispersed communities	
Reasons importance birth registration						
A child has the documents he/she needs in life if it is registered at birth	60	61.9%	17	51.5%	9	39.1%
You need the documents for health care and/or education	8	8.2%	5	15.2%	10	43.5%
A child will have its own identity if it is registered at birth	7	7.2%	0	0%	2	8.7%
A child will be in the system when registered at birth	7	7.2%	1	3%	0	0%
A child will have protection if it is registered at birth	2	2.1%	4	12.1%	0	0%
Without documents it is like you do not exist	2	2.1%	1	3%	1	4.3%
You need documents for the future/ you cannot do anything without documents	8	8.2%	3	9.1%	1	4.3%
Other reason	3	3.1%	2	6.1%	0	0%

Table 3

*Acknowledgment of the importance of vaccination*

	Topaana		Zlokukjani		Dispersed communities	
<i>Vaccination is important</i>						
Yes	102	100%	37	97.4%	21	87.5%
No	0	0%	0	0%	0	0%
I do not know	0	0%	1	2.6%	3	12.5%

Table 4

*Reasons of the importance of birth registration*

	Topaana		Zlokukjani		Dispersed communities	
<i>Reasons importance vaccinations</i>						
Vaccination is a prevention for diseases	98	96.1%	16	43.2%	14	66.7%
A child will be healthy when it is vaccinated	3	2.9%	20	54.1%	5	23.8%
Other reason	1	1%	1	2.7%	2	9.5%

Table 5

*Acknowledgment of the importance of an early childhood development center*

	Topaana		Zlokukjani		Dispersed communities	
<i>An ECD-center is important</i>						
Yes	102	100%	29	82.9%	17	70.8%
No	0	0%	4	11.4%	1	4.2%
I do not know	0	0%	2	5.7%	6	25%

Table 6

*Reasons of the importance of an early childhood development center*

	Topaana		Zlokukjani		Dispersed communities	
<b>Reasons importance ECD-center</b>						
A child develops and learns at an ECD-center	33	33.3%	20	52.6%	9	52.9%
A child prepares for school at an ECD-center	30	30.3%	1	3.6%	3	17.6%
I cannot learn my child the things they learn at an ECD-center	4	4%	0	0%	0	0%
A child learns the Macedonian language at an ECD-center	7	7.1%	1	3.6%	1	5.9%
A child socializes at an ECD-center	9	9.1%	1	3.6%	0	0%
Other reason	16	16.2%	5	17.9%	4	23.5%

Table 7

*Acknowledgment of the importance of primary education*

	Topaana		Zlokukjani		Dispersed communities	
<b>Primary education is important</b>						
Yes	102	100%	37	100%	22	95.7%
No	0	0%	0	0%	0	0%
I do not know	0	0%	0	0%	1	4.3%

Table 8

*Reasons of the importance of primary education*

	Topaana		Zlokukjani		Dispersed communities	
<b>Reasons importance primary education</b>						
You will have a better future/life with education	39	38.6%	4	11.4%	2	9.1%
It is easier to find an employment when you have finished education	17	16.8%	13	37.1%	6	27.3%
It is important to be literate	2	2%	10	28.6%	10	45.5%
An educated child is a more positive person	4	4%	1	2.9%	1	4.5%
Education gives more opportunities for the future	6	5.9%	0	0%	0	0%
Without education you are nobody	6	5.9%	0	0%	0	0%
Only with education you can achieve something in life	15	14.9%	3	8.6%	2	9.1%
Other reason	12	11.9%	4	11.4%	1	4.5%

