

Marginalized Groups and their Health in Society

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Abstract:

Introduction: Health has its own social determinants (www.schulich.uwo.ca, 2022) which considerably affect the quality of provided healthcare (Baah, 2019). Chronic diseases place a significant burden on people in vulnerable social classes, races, and lower socio-economical positions and also on other groups of minorities (Havranek *et al.*, 2015).

Methods: The essence of our research was the comparison of the results of preventive medical examinations between marginalized and non-marginalized groups of patients. The chi-squared test, T-test and the Chi-squared Independence Test for the contingency table were used in the processing of the data obtained.

Results: In the overall evaluation of particular groups, we confirmed the significantly worse results of preventive medical examinations among marginalized patients compared to the majority population.

Conclusion: The results of our research clearly confirmed a significantly higher incidence of cardiovascular risk factors among patients living in a marginalized group. Simultaneously, the results predict a higher prevalence of colon cancer in this group. Social justice is a challenge for public health and social work.

Introduction

Marginalized groups have been characterized as the outermost groups in society (Alexander *et al.*, 2003). Health has its own social determinants (www.schulich.uwo.ca, 2022), which considerably affect the quality of provided healthcare (Baah, 2019). Chronic diseases place a significant burden on people in vulnerable social classes, races, and lower socio-economical positions and also on other groups of minorities (Havranek *et al.*, 2015). People are born, live, work and deal with illnesses under certain conditions. These conditions define the social determinants of health (WHO, 2010). Social determinants such as deprivation, inequitable availability, illiterateness, stigma, and racism significantly influence health equity (CDC, 2019). Systematic differences among people lead to health inequities (Braveman, 2006). Social justice is the most crucial part of social work (Payne, 2005). In nursing research, marginalization was first suggested as a theory by Hall *et al.* (1994). 7 essential factors were defined in this theory, namely "*intermediacy, differentiation, power, secrecy, reflectiveness, voice, and liminality*" (Hall *et al.*, 1994). Intermediacy relates to human borders and works as walls and links.

Differentiation or diversity means "*physical and social distance from the center*". Power is associated with the influence of those in the center (Hall *et al.*, 1994 In Havrilla, 2017). Secrecy is another property of marginalized because the information is encompassed to create interpersonal bonds, hold trust, and bypass disloyalty. Reflectiveness is also the critical element of marginalized because marginalized persons have experiences that contrast them with better centrally encountered society members. If we talk about the voice as a condition of marginalized, we want to reflect on ways of communicating that distinguish marginalized groups from those at the center. Marginalized persons have altered perceptions of the time and self-image because of the consequences of the marginalizing experiences;

it is the reason why liminality was classified as one of the 7 mentioned factors (Hall *et al.*, 1994 In Havrilla, 2017) Many ethnical minorities have walls to valuable access to healthcare. The multicultural society is one of the examples where marginalized groups feel boundaries and injustice in the way to gain appropriate healthcare. "For example, In the UK, the expansion of myriad ethnic residents and linguistic groups, each with its cultural characteristics and health shapes, shows a problematic challenge to healthcare providers and policymakers to achieve fair access (Szczepura, 2005)."

Chauhan *et al.* (2020) analyzed 45 studies from 5 databases, namely MEDLINE, PUBMED, PsycINFO, EMBASE and CINAHL. The conclusion of this meta-analysis pointed to a "higher rate of hospital-acquired infections, complications, adverse drug events and dosing errors compared to the broader population (Chauhan *et al.* 2020)"; language proficiency was also the essential key factor (Chauhan *et al.* 2020)."017).

International Labor Office (2011) focused on the social determinants of health equity such as income, employment, social and health protection, the level of education, gender, age, and ethnicity in the West, Central and East Europe. Moreover, the authors highlighted that Roma women are the most vulnerable because of the lack of social protection. The frequently mentioned problem among the Roma population was drug addiction and high-risk sexual behavior. Also, according to the authors, unemployment was the most severe matter impacting the Roma population, namely in countries such as the Czech Republic, Greece, Portugal, Spain, and Slovakia, unemployment among the Roma population varied from 60 to 80%, and reached 100% in certain isolated areas (International Labor Organization, 2011).

The Roma population are notable ethnicity in the EU territory, with roughly 6 million (Dicka, 2021). The number of the Roma ethnicity in-

creased tenfold during the last 120 years in the Slovakia territory (Dicka, 2021). It was approximately 20,000 Roma communities in 1770, and the estimated forecast is 508,000 Roma citizens in 2020 in the Slovak Republic (Dicka, 2021). According to data in the Atlas of Roma Communities (2019), just 81.7% of the Roma population in the Slovak republic are non-integrated, and slightly more than half of them live on the edge and outside of settlements, namely 36.3% and 14%, respectively (Dicka, 2021).

WHO highlighted that the poor living conditions of Roma citizens in the EU have fatal consequences on their health (2022). The European Economic and Social Committee noticed the effects of the dire conditions in which Roma citizens live; the Committee showed that Roma's life expectancy is tenfold lower compared to non-Roma citizens (/www.eesc.europa.eu, 2014). Moreover, a higher incidence of long term illnesses is observable among Roma (European Commission, 2014).

Prejudice is often experienced by Roma patients, and this is the reason why their distrust of healthcare services is so high (de Graaf P, 2016). The level of education has huge impact on the level of their health status (de Graaf P, 2016).

The major policy impact should be focused on the integration and economic inclusion of the Roma population in Europe (Fesus, 2012). These initiatives have to lead to better quality healthcare for Roma citizens and their social equity (Fesus, 2012). Barriers for the Roma in many countries to healthcare insurance have to be exceeded to gain better social benefits for this minority (Kuhlbrandt, 2014). The literature also described difficulties in finding a GP for the registration by Roma people (Delescluse, 2020).

Methods

Comparison of the results of preventive medical examinations between marginalized and non-marginalized groups of patients was the essence of our research. The Chi-squared test, T-test and the Chi-squared Independence Test for the contingency table were used in processing of data obtained.

Results

In the overall evaluation of particular groups, we confirmed the significant prevalence of dys-

lipidemia, hyperuricemia, hepatopathy of higher SCORE rate, and higher incidence of a positive iFOB test result ($p < 0.005$) in the marginalized population group. In the case of pre-diabetes ($p = 0.455$) and diabetes ($p = 0.391$) prevalence, we did not find a significant difference among the compared groups. While analyzing the male part of compared groups, we did not observe a considerable difference in the incidence of dyslipidemia ($p = 0.056$), hyperuricemia ($p = 0.705$) and arrhythmia ($p = 0.113$), whereas, in other monitored parameters the distinction was a detriment to the marginalized group ($p < 0.05$).

When we compared the female results in both of the monitored groups, we found a higher prevalence of pathological effects in the marginalized group ($p < 0.05$) except for the occurrence of glucose metabolism disorder where no significant difference was found ($p = 0.243$). While we compared the incidence of pathological outcomes in the monitored groups based on the age parameter, we did not observe any significant difference in the age population under 40 years in both of the monitored groups ($p > 0.05$), with the exception of the positive iFOB test with a higher prevalence of positive results in the marginalized group ($p = 0.029$). In the 40 to 50 age group, we confirmed a higher incidence of pre-diabetes in the marginalized group ($p = 0.034$). In addition, the same result was reached in the over 50 age group ($p = 0.021$). Overall, a higher cardiovascular risk was affirmed among patients who were included in the marginalized group compared to patients who did not belong to the marginalized group ($p < 0.0001$).

Discussion

A higher prediction of a 10-year risk of fatal CVD (higher SCORE) was confirmed among patients from the marginalized group. Similar results are described in scientific literature. Schultz *et al.* (2018) mention that socio-economic level has a measurable and vital impact on cardiovascular health. The authors also defined socio-economic aspects that can lead to a higher prevalence of cardiovascular disease: earnings level, academic achievement, environmental factors, and employment status (Schultz, 2018). Dyslipidemia was more prevalent among marginalized groups of patients. Bartos & Badila (2011) measured cardiovascular risk factors among the Gypsy

population from Romania, and the authors surveyed 511 Gypsies. The research showed that studied patients had several cardiovascular risk factors, namely obesity (50.8%), diabetes mellitus (10.3%) and smoking (25,8 %). Elevated activity of the hepatic enzymes was noticeably more prevalent among the marginalized group of patients by several causalities such as viral hepatitis infections (Macejova *et al.*, 2020) or alcohol consumption (Babinská *et al.*, 2014). Prevalence of positive stool test for occult bleeding was higher among the marginalized group of patients than in the majority population. The results may be due to a decreased diet quality because of socioeconomic status.

Conclusion

The results of our research confirmed a significantly higher incidence of cardiovascular risk factors among patients living in a marginalized group. Simultaneously, the results predict a higher prevalence of colon cancer in this group. Social justice is a challenge for public health and social work.

References

- ALEXANDER G L, EDWARD L K, LOUISE C M, TIMOTHY B P (2003) Marginalized and health geomatics. *Journal of Biomedical Informatics* [online]. 2003, 36(4-5), 400-407 [cit. 2022-03-22]. ISSN 15320464. Available: doi:10.1016/j.jbi.2003.09.021.
- BAAH FO, TEITELMAN AM, RIEGEL B (2019) Marginalization: Conceptualizing patient vulnerabilities in the framework of social determinants of health - An integrative review. *Nurs Inq*. 2019 Jan;26(1):e12268. doi: 10.1111/nin.12268. Epub 2018 Nov 29. PMID: 30488635; PMCID: PMC6342665.
- BABINSKA I, GECKOVA AM, JAR-CUSKA P, PELLA D, MAREKOVA M, STEFKOVA G, VESELSKA ZD (2014) HepaMeta Team. Does the population living in Roma settlements differ in physical activity, smoking and alcohol consumption from the majority population in Slovakia? *Cent Eur J Public Health*. 2014 Mar;22 Suppl:S22-7. doi: 10.21101/cejph.a3897. PMID: 24847610.
- BARTOS D, BADILA E (2011) Prevalence of arterial hypertension and other cardiovascular risk factors in an adult Gypsy population from Romania. *Romanian Journal of Cardiology*. 2011;21doi:10.1161/CIRCULATIONAHA.117.029652
- BRAVEMAN P (2006) Health disparities and health equity: Concepts and measurement. *Annual Review of Public Health*. 2006;27: 167–194.
- DE GRAAF P, ROTAR PAVLIC D, ZELKO E, VINTGES M, WILLEMS S, HANSSSENS L. Primary Care for the Roma in Europe: Position paper of the European forum for primary care. *Zdr Varst*. 2016 May 10;55(3):218-224. doi: 10.1515/sjph-2016-0030. PMID: 27703542; PMCID: PMC5031074.
- DELESCLUSE J *et al.* (2020) Within, with and for Roma community, 2020. <https://medecinsdumonde.be/>. https://medecinsdumonde.be/system/files/publications/downloads/PRO%20HEALTH%20for%20Roma%20-%20Within%20With%20and%20For%20Roma%20-%20publication%20March%202021%20-%20web_1.pdf#health#downloads (accessed May 19, 2022).
- EUROPEAN ECONOMIC AND SOCIAL COMMITTEE, NAYDENOVA V (2014) Open Society Institute Roma Health Mediators: Advancing the Health and Rights of Roma Communities, 2014. www.eesc.europa.eu. <https://www.eesc.europa.eu/en/news-media/presentations/roma-health#downloads> (accessed May 19, 2022).
- EUROPEAN COMMISSION (2014) Roma health report: health status of the Roma population: data collection in the Member States of the European Union, 2014. Available March 30, 2016 from. [http:// ec.europa.eu/health/social_determinants/docs/2014_roma_health_report_en.pdf](http://ec.europa.eu/health/social_determinants/docs/2014_roma_health_report_en.pdf).
- FESUS G, PIROSKA O, MARTIN M, ROZA ADANY (2012) Policies to improve the health and well-being of Roma people: The European experience. *Health Policy* [online]. 2012, 105(1), 25-32 [cit. 2022-05-19]. ISSN 01688510. Available: doi:10.1016/j.healthpol.2011.12.003.
- KUHLBRANDT C, K. FOOTMAN B R, MCKEE M (2014) An examination of Roma

- health insurance status in Central and Eastern Europe. *The European Journal of Public Health* [online]. 2014, 24(5), 707-712 [cit. 2022-05-19]. ISSN 1101-1262. Available z: doi:10.1093/eurpub/cku004.
12. NESTOROVA D J (2021) Demographic Changes in Slovak Roma Communities in the New Millennium. *Sustainability* 2021, 13, 3735. <https://doi.org/10.3390/su13073735>.
 13. HALL JM, STEVENS PE, MELEIS AI (1994) Marginalization: A guiding concept for valuing diversity in nursing knowledge development. *Advances in Nursing Science*, 16(4), 23–41.
 14. HAVRANEK EP, MUJAHID MS, BARR DA, BLAIR IV, COHEN MS, CRUZ-FLORES S, DAVEY-SMITH G, DENNISON-HIMMELFARB CR, LAUER MS, LOCKWOOD DW, ROSAL M, YANCY CW American Heart Association Council on Quality of Care and Outcomes Research, Council on Epidemiology and Prevention, Council on Cardiovascular and Stroke Nursing, Council on Lifestyle and Cardiometabolic Health, and Stroke Council.
 15. HAVRILLA E (2017) Defining Vulnerability. *Madridge Journal of Nursing* [online]. 2017, 2(1), 63-68 [cit. 2022-05-18]. ISSN 26381605. Available: doi:10.18689/mjn-1000111 Chauhan, A., Walton, M., Manias, E. *et al.* The safety of health care for ethnic minority patients: a systematic review. *Int J Equity Health* 19, 118 (2020). <https://doi.org/10.1186/s12939-020-01223-2>.
 16. MACEJOVA Z, KRISTIAN P, JANICKO M, HALANOVA M, DRAZILOVA S, ANTOLOVA D, MAREKOVA M, PELLA D, MADARASOVA-GECKOVA A, JARCUSKA P, TEAM H (2020) The Roma Population Living in Segregated Settlements in Eastern Slovakia Has a Higher Prevalence of Metabolic Syndrome, Kidney Disease, Viral Hepatitis B & E, and Some Parasitic Diseases Compared to the Majority Population. *Int J Environ Res Public Health*. 2020 Apr 29;17(9):3112. doi: 10.3390/ijerph17093112. PMID: 32365672; PMCID: PMC7246595.
 17. MARGINALIZED POPULATIONS & SOCIAL DETERMINANTS OF HEALTH (2022) www.schulich.uwo.ca/. https://www.schulich.uwo.ca/epibio/research/research_clusters/areas_of_substantive_expertise/marginalized_pop_social_determinants.html (accessed Jan 23, 2022).
 18. MELEIS AI, IM E (1999) Transcending marginalization in knowledge development. *Nursing Inquiry*, 6(2), 94–102.
 19. NCHHSTP (2019) Social Determinants of Health, Frequently Asked Questions, 2019. CDC. <https://www.cdc.gov/nchhstp/socialdeterminants/faq.html>.
 20. PAYNE M (2005) *Modern social work theory*. Basingstoke: Palgrave Macmillan.
 21. SCHULTZ WILLIAM M., HEVAL M KELLI, JOHN C LISKO, *et al.* (2018) Socioeconomic Status and Cardiovascular Outcomes. *Circulation* [online]. 2018, 137(20), 2166-2178 [cit. 2022-03-23]. ISSN 0009-7322. Available: doi:10.1161/CIRCULATIONAHA.117.029652
 22. SCHULTZ, WILLIAM M, HEVAL M. KELLI, JOHN C LISKO *et al.* (2018) Socioeconomic Status and Cardiovascular Outcomes. *Circulation* [online]. 2018, 137(20), 2166-2178 [cit. 2022-03-23]. ISSN 0009-7322. Available: Szczepura, A. Access to health care for ethnic minority populations. *Postgraduate Medical Journal* [online]. 2005, 81(953), 141-147 [cit. 2022-05-19]. ISSN 0032-5473. Available: doi:10.1136/pgmj.2004.026237.
 23. WORLD HEALTH ORGANIZATION (2010) *A conceptual framework for action on the social determinants of health* Retrieved from http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf
 24. SCHEI X, ADLUNG, KUHL C (2011) Social Security Policy Briefing Paper 8 Social Security for All Addressing inequities in access to health care for vulnerable groups in countries of Europe and Central Asia, 1st ed.; *International Labor Office*: ISBN: 9789221254591; 9789221254607 (pdf), 2011.
 25. WHO (2022) *Roma Health in the European Region, 2022*. [www.who.int. https://www.euro.who.int/en/health-topics/health-determinants/roma-health/roma-health-in-the-european-region](http://www.euro.who.int/en/health-topics/health-determinants/roma-health/roma-health-in-the-european-region) (accessed May 19, 2022).