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Descriptions of health by EU citizens begging abroad

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ABSTRACT

Poor citizens from European Union (EU) member countries begging to support themselves are now common in affluent EU countries. Their lack of basic amenities, such as access to a shelter and sanitation is not in line with human rights and also implies a risk for health issues. Despite this, we know little about how these vulnerable EU citizens, themselves, perceive their health situation. The aim of this study was to explore vulnerable EU citizens’ descriptions of their health. Eight females and 12 males from Romania, 19–64 years of age, participated in individual interviews that included health issues. Qualitative content analysis was used, identifying the main category “Begging abroad and health - for better and for worse” together with two categories and five subcategories. It is concluded that EU citizens begging abroad risk poorer health as a consequence of their attempts to improve their situation, both their own health and that of their relatives. Therefore, they need access to affordable health care as this may decrease the need for unwanted travelling abroad to beg.

Introduction

Many people in the European Union (EU) are at risk of poverty, but their number varies among different member countries. Sweden has one of the lowest percentages of poor inhabitants (Weziak-Bialowolska & Dijkstra, 2014) and, as well as in other Scandinavian countries, it is now common to see people from other EU countries begging to make their living. These so called vulnerable EU citizens belong to another EU country, and have no residence permit in Sweden and therefore limited access to benefits from society (SOU 2016:6 [Official Government reports], 2016). They often come from Bulgaria and Romania, EU countries with the highest proportions of poor inhabitants (Weziak-Bialowolska & Dijkstra, 2014) and therefore temporarily travel abroad to earn money (Djuve, Friberg, Tyldum, & Zhang, 2015). Many of them are Roma, an ethnic group who live in extreme poverty, with poorer health and lower life expectancy than EU members on average (European Union, 2014). In Sweden, it has been estimated that the number of vulnerable EU citizens was about 4700–5000 in 2015 (SOU 2016:6 [Official Government reports], 2016). However, warnings have been raised that it is not possible to estimate their number based on how visible they are in society (Djuve et al., 2015).

Members of the EU have the right to apply for work in other countries in the union (Socialstyrelsen, 2013). Vulnerable EU citizens would also prefer to work instead of beg (Djuve et al., 2015; Engebrigtsten, Fraenkel, & Pop, 2014; Gaga, 2015) and when away from home they have an everyday life abroad that is full of hardships (Djuve et al., 2015; Gaga, 2015; Potrache, 2016). For instance, abroad they often lack access to a shelter (Djuve et al., 2015; Gaga, 2015; Potrache, 2016) which, in turn, affects their hygiene and cooking options (Gaga, 2015). Sometimes, they also lack enough food (Gaga, 2015; Midtsund Nordbø, 2014). Altogether, their situation demonstrates a lack of human rights (United Nations, 1948) both in their home countries and abroad. In Sweden, their need for access to the human right of water and sanitation also has been highlighted (Davis & Ryan, 2016). Their descriptions also show that vulnerable EU citizens abroad lack access to some of the “fundamental conditions and resources for health” (World Health Organization [WHO], 1986, p. 1.) such as food, shelter and income. This may adversely affect their health and the health aspect is the focus for the present article.

Health conditions and differing health care needs have been described previously in this population (Carlsson & Ekblad, 2014; Engebrigtsten et al., 2014; Gaga, 2015). Their tough situation abroad also necessitates additional health care (Djuve et al., 2015). Another issue for this group is that they often are requested to pay the non-subsidized cost of their health care abroad (Engebrigtsten et al., 2014; Mosskin, 2015; SOU 2016:6 [Official Government reports], 2016). Therefore, some of them cannot use these services (Carlsson & Ekblad, 2014) although access to affordable health care is considered a human right that should be distributed equally.

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(WHO, 2015) and EU citizens have a fundamental right to health care (European Union Agency for Fundamental Rights). Another finding related to health in this population is that vulnerable EU citizens beg to collect money to pay for treatment at home, either for themselves or for a relative (Djuve et al., 2015; Engebretsen et al., 2014; Gaga, 2015).

The challenging health situation for this population is evident. Despite this, little research has been conducted on this topic. Only a single master’s thesis, which included seven participants’ perceptions, has been identified as focusing on health in vulnerable EU citizens begging abroad (Gaga, 2015). Another study included 11 females, but not all of them engaged in begging (Carlsson & Ekblad, 2014). Thus, more knowledge is needed about health in this population, and more insights from the participants’ own perspectives. This is also in line with the earlier highlighted need of further information as to how they perceive their situation (Uliczka, 2015). Therefore, the aim of the present study was to explore vulnerable EU citizens’ descriptions of their health.

**Methods**

**Design and procedure**

This article presents the health-related results of the project “Perceptions of everyday life, health and future in vulnerable EU citizens” that has a descriptive qualitative design. The project was conducted as a collaboration with a non-governmental organization (NGO) that meets and supports this population on a regular basis. Participants were considered eligible if they were at least 18 years old, were EU citizens, had engaged in begging in Sweden and could communicate in Romanian or in Swedish and/or English. The project was approved by the Regional Ethics Committee in Linköping (2015/270–31).

The target group was informed about the project at an introductory meeting at the NGO’s premises by two of their members, together with a third member who served as a translator to Romanian. Those who showed interest to participate were included. The NGO members later conducted individual interviews with those who had agreed to participate.

**Participants**

Eight females and 12 males, 19–64 years old, participated in individual interviews that took place in the NGO’s premises during December to June 2015–2016. For some participants, this was the first stay in Sweden. However, most of them had been to Sweden several times before. It was most common to be together with relatives in Sweden but some were alone. All participants had contact with the NGO, but only about half of them (nine participants) had access to the NGO shelter for sleeping at the time they were interviewed. The reason for this was that some participants were interviewed during spring and summer and the opportunity to use the shelter finished in April. However, all participants had access to the other NGO support (clothes, warm food some days a week, shower and washing opportunities). Table 1 provides some information about the participants.

**Data gathering**

The interviews were based on an interview guide that included questions about their health, and were carried out in Swedish and translated to Romanian during the interview by a native Romanian NGO member. Each interview was conducted in a separate room at the premises of the NGO. The participants were informed, orally and in writing, about the study. This information included the voluntary nature of the participation: the confidential handling of the data, and that the presentation of the results would be at group level (Kjellström, 2012). The participants signed an informed consent form before the interview began. The audiotaped interviews generally lasted about one and a half hours.

**Data analysis**

The interviews were transcribed by two of the authors. Relevant text with respect to the aim of the present study was extracted and analyzed by qualitative content analysis (Graneheim & Lundman, 2004). This was an iterative process where preliminary codes and categories were expanded or collapsed and continuously controlled against the whole interviews. Example of the procedure for analysis is seen in Table 2. The analysis was conducted by the first

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**Table 1. Participant characteristics (n = 20).**

| Participants | |
|-------------|--|
| **Gender**  | |
| Women n     | 8 |
| Men n       | 12 |
| **Age (in year)** | |
| 19–28       | 6 |
| 29–38       | 10 |
| 39–48       | 2 |
| 49–58       | 1 |
| 59–64       | 1 |
| **Education (in year)** | |
| 0–4         | 6 |
| 5–8         | 10 |
| >8          | 4 |
| **Family situation in Sweden this visit** | |
| Alone       | 3 |
| With spouse* | 11 |
| With parents | 1 |
| With other relatives | 5 |

* Three of these were also here together with other relatives.
author in collaboration with the others who provided feedback during the process.

Results

The main category “Begging abroad and health - for better and for worse” was identified as well as the two categories “personal health” and “health conditions as a reason to beg” together with their five subcategories (Figure 1). Each category is described and illustrated by quotations that elucidate the findings. The translation of the quotations, from Swedish to English, attempts to capture their meaning rather than always being a verbatim translation (Nikander, 2002).

Personal health

The category “personal health” includes three subcategories. These are: various health conditions; situational risks for their health; and strategies for handling health risks and poor health.

Various health conditions

The participants’ description of their health differed. A few of them said that they were in good health: “Yes I thank God, I’m fine, nothing hurts”. However, the majority described various health conditions regarding their back, stomach and internal organs: “I have problems with a kidney and the liver”. They also described stress, diabetes and need for treatment and surgeries (e.g. gynaecology).

Situational risks for their health

Regardless of whether the participants said that they had good health or a health condition, they reported the health risks of their situation. They developed pain by sitting still: “It’s not very comfortable to sit outside the store; every bone in my body hurts”. The weather could also be a serious problem, especially in the winter: “[I get] pain in my back. When it’s windy I feel it here [neck and back] and my feet get cold”.

Stress was commonly described and the participants were stressed for reasons such as being away from their home and family, and worrying about them: “I think all the time that I’m not at home with my family”; not collecting sufficient money; and for not having access to shelter in Sweden. The fact that the participants wanted to work instead of

Dental problems such as toothache was one of the problems commonly mentioned: “I had a toothache yesterday. I have problems with my teeth”, and so was pain: “My leg hurts...and my stomach. If I don’t eat regularly, I get a stomach ache”. Headache was one commonly described type of pain, and sometimes related to stress – another common problem. Some participants also described mental and emotional conditions: “I laugh sometimes but only God knows how I feel”. Finally, a couple of the participants described conditions related to previous work experiences that had caused injuries. “When my back hurts it’s not possible to be still; it really hurts. I lifted something very heavy...I visited a doctor and they said that they can’t do anything for me but give me pills”.

| Table 2. An example of how the analysis was conducted. |
| Meaning unit | Condensed meaning unit | Code | Sub category | Category | Main category |
|---------------|------------------------|------|--------------|----------|---------------|
| When it comes to my body, I don’t feel well. I have pain in my back and headache every day. It has gotten worse during the years I have traveled between Romania and Sweden. | I don’t feel well...have pain...it has gotten worse | Pain | Various health conditions | Personal health | Begging abroad and health - for better and for worse |
| I don’t sit all the time. I stand up, walk a little and come back because my legs are sleeping. I need to stand up, otherwise my leg will fall asleep. | I stand up, walk a little and come back | Move around | Strategies for handling health risks and poor health | -II- | -II- |

Figure 1. The categories identified.
begging also contributed to stress as described by a participant. The quotation also exemplifies the physical and mental demands associated with begging and affecting health.

“I sit from 8:30 to 12:30 and I don’t move, except perhaps only my leg a little. My back collapses all the time. If you work, you’re moving all the time. There’s no work where you’re just sitting... If I didn’t sit all the time, I wouldn’t have problems with my health. If I was working, I wouldn’t feel stressed. You don’t think of other things [when working], you concentrate on the work”.

Strategies for handling health risks and poor health.
The participants described strategies for handling health risks or poor health. It was common to move around and not sit all the time. This was considered helpful, both physically and mentally.

“I try to move around and take a walk when the pain in my leg and back gets too bad”.

“I’m stressed... I can’t sit still, I need to move... if the stress grows, I move around ... It helps a lot”.

Another strategy mentioned was to eat in a certain way so as not to risk developing or exacerbating a health condition.

“When I’m here, I used to eat hot dogs and bread, so perhaps the reason I developed [the health condition] was that I didn’t eat properly. So now, I only eat bread. Perhaps that’s better”.

“There are sandwiches to buy in the store, but they are with meatballs and minced meat, which is not so good for my stomach so I buy French fries”.

Health conditions as a reason to beg

The second category focuses on various relations between begging and health and includes two subcategories: the initial decision to start begging and personal and relatives’ health care needs.

The initial decision to start begging
For some participants, the initial decision to start begging abroad was related to a health condition – either their own: “[I came to Sweden because] I was ill and had no money” or that of a relative:

“One of my children... is the biggest reason [to begin to beg] here... Our situation at home was very bad, we don’t have much... I knew that we needed money for her surgery. My relative [who had been abroad several times] suggested... that I should go to Sweden for two months and beg for money for the surgery. This would also be better for the family, with clothes and food to the older children if we got more money, but it was very difficult to take this decision”.

Personal and relatives’ health care needs
To get money to pay for costs related to their own or relatives’ health conditions was commonly reported as one of the reasons why the participants were begging currently.

“I need help with my health. My body is very weak, and I lose a lot of blood. I need money for a surgery in Romania for my problems”.

 “[I need to] focus on not losing my child... I need the money to get a surgery for my child”.

One participant also reported a continuous need for money to pay for different persons’ health care: “something is always happening”. Finally, some of the participants reported that money collected had contributed to improving the health of their relatives.

“I think it was a very good decision [to begin to beg]. The best was that some things changed. My child ... had a surgery”.

“It was good [to come here] because I can send money to [my relative] for food and medicine”.

Discussion

The present study focused on exploring vulnerable EU citizens’ descriptions of their health, which was one of the aims of the project. The discussion will therefore be restricted to this aspect although it should be recognized that health is only one of the relevant issues for this group.

Our results show that the participants faced health-related challenges. As in earlier studies (Carlsson & Ekblad, 2014; Gaga, 2015), the majority of our participants described health issues, need for treatments and stress caused by their situation (Carlsson & Ekblad, 2014; Gaga, 2015). Some of them also described a condition that worsened during the period they were begging in Sweden (Gaga, 2015).

Finally, our finding that their own or a relative’s health condition was one reason to beg also supports earlier research (Djuve et al., 2015; Engebrigtsen et al., 2014; Gaga, 2015).

Taken together, our results show that an individual’s health may be adversely affected by begging abroad – a finding that is clearly reflected in the title of a previous study, “This money begged here is paid with blood” (Gaga, 2015). However, as indicated by our main category “Begging abroad and health - for better and for worse”, it is too simple to say that begging is solely negatively related to health, considering the limited opportunities for this group. Our results also show that the money, collected by begging, had contributed to pay for health-related expenses, and, for some participants it was described as the way out of a severe health condition for a relative. This latter result emphasizes the importance of getting access to the human right of affordable health care (WHO, 2015) both abroad and at home.
as this may contribute to reducing the need to leave home to beg abroad.

The need for affordable health care abroad and in the home country is further underscored by the fact that even the minority of our participants who stated that they were in good health described situations that risked damaging their health in a long-term perspective. For instance, sitting outside for many hours, day after day, regardless of weather is an example of a sedentary behaviour identified as a health risk (Thorp, Owen, Neuhau, & Dunstan, 2011). Similarly, long-term stress has, for instance, been associated with depression (Rönnlund, Sundström, Eriksson Sörman, & Nilsson, 2013). Moreover, these findings also support Djuve et al. (2015) who describe that although many of their participants were in good health, their situation was so rough that it caused problems and required health care (Djuve et al., 2015). Overall, spending long days in undesired activities (such as begging) is not considered beneficial to health and well-being (Wagman, Håkansson, & Björklund, 2012).

However, our participants used strategies for not exacerbating their health conditions, such as eating in certain ways and alternating their sitting by taking walks. Only the latter had been described earlier (Gaga, 2015). Both these are examples of health promotional strategies, but health promotion implies having "access to information, life skills and opportunities for making healthy choices" (WHO, 1986, p. 1). It can be questioned whether this group has sufficient resources considering both their current situation and their low level of education. They may therefore benefit from health-promoting interventions while abroad. For example, a health promoting program could address dental care, exercise, healthy food and stress management since these were problems commonly described.

Such a program is a short-term solution for those vulnerable EU citizens that already are away from their home and would neither address the root cause of their situation, nor be sufficient for changing the difficult life that they live abroad. It may, however, be a complementary intervention for a NGO to ease their health situation and contribute to preventing it from deteriorating.

Methodological considerations

The present study has several methodological issues that need to be considered when interpreting its results. Being qualitative in design and with a limited number of participants, it makes no claim of serving as a basis for generalization. Nevertheless, the results may contribute to insights about the relation between begging and health in this population. However, further research is needed regarding the different relationships between begging and health. Furthermore, this study does not focus on the participants’ life at home, which may have provided a broader perspective. Finally, the participants’ health was only one of several aspects included in the interviews, and this may have limited the material and, consequently, the results. Potentially, more in-depth descriptions would have resulted from interviews focusing solely on their health and begging. On the other hand, the broad focus in the interviews gave the participants the opportunity to describe their health in relation to other aspects, such as their everyday life, and to focus on it as much as they felt was needed. It should be considered, though, that solely one interview was conducted with each participant. Repeated interviews may have resulted in further valuable information and given an opportunity to validate the preliminary results by member checking.

Conclusion

EU citizens begging abroad risk deteriorated health as a result of their attempts to improve their situation, although the money collected also may contribute to better health by paying for health-related expenses. However, health care is a fundamental right for EU citizens, which is not met for this group. Access to affordable health care may reduce the need for unwanted travelling abroad to beg.

Disclosure statement

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References

Carlsson, J., & Ekblad, S. (2014). Självupplevd psykisk och reproduktiv hälsa samt självupplevt vårdbehov bland kvinnliga EU-migranter. En kvalitativ studie på Crossroads och Bällsta boende i Stockholm [Self-perceived psychological and reproductive health and perceived care needs in female EU migrants. A qualitative study in Crossroads and Bällsta]. Socialmedicinsk tidsskrift, 4, 66–83.

Davis, M., & Ryan, N. (2016). Inconvenient human rights: Access to water and sanitation in Sweden’s informal Roma settlements. Raoul Wallenberg Institute for Human Rights and Humanitarian Law, Södertörn University, and the NuLawLab of Northeastern University School of Law.

Djuve, A., Friberg, J., Tyldum, G., & Zhang, H. (2015). Migrants from Romania on the streets of the...
Scandinavian capitals. Retrieved from http://www.fao.no/index.php/nb/zoopolitical/andre-fao-utgivelser/item/when-poverty-meets-affluence

Engebrigtson, A., Fraenkel, J., & Pop, D. (2014). Gateliv. Kartlegging av situasjonen til utenlandske personer som tigger [Street life. Survey of the situation for foreign people who beg] (Norsk institutt for forskning om oppvekst velferd, og aldring [Norwegian Institute for growing, welfare and ageing] NOVA Rapport 7 (2014). Oslo. Retrieved from http://www.hioa.no/om/HIOA/Senter-for-velferds-og-arbeidslivsforskning/NOVA/Publikasjonar/Rapporter/2014/Gateliv

European Union. (2014). Action on health inequalities in the European Union. Final version. The EU health programme’s contribution to fostering solidarity in health and reducing health inequalities in the European Union 2003-13. Retrieved from http://ec.europa.eu/chafea/documents/health/health-inequality-brochure_en.pdf

European Union Agency for Fundamental Rights. EU charter of fundamental rights. Article 35 – Health care. Retrieved from http://fra.europa.eu/en/charterpedia/article/35-health-care

Gaga, F. (2015). “This money begged here is paid with blood”. A qualitative study of the Romanian beggars’ perceptions on their health status before and during begging, and their health maintaining strategies in Uppsala, Sweden. Uppsala. Retrieved from http://www.diva-portal.org/smash/get/diva2:857977/FULLTEXT01.pdf

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. Nurse Education Today, 24, 105–112. doi:10.1016/j.nedt.2003.10.001

Kjellström, S. (2012). Forskningsethik [Research ethics]. In M. Henricsson (Ed.), Vetenskaplig teori och metod. Från idé till examination inom omvårdnad [Scientific theory and method. From idea to examination in nursing]. Lund, Sweden: Studentlitteratur.

Midtsund Nordbø, T. (2014). Rom i Tiggerstaden: Rapport om rumenske Rom i Oslo [Romans in Tiger City, Report on Romanian Roma in Oslo]. Retrieved from http://www.frelsesarneen.no/no/vart_arbeid/rusomsorgen/hoyre_kolonne/rapporter/Rapporter+fra+Frelsesarneens+rusomsorg.d25-SwRDI3M.ips

Mosskin, J. (2015). EU-migranternas världs situation [The care situation of EU migrants]. Socialmedicinsk tidskrift, 3, 366–368.

Nikander, P. (2002). Age in action: Membership work and stage of life categories in talk. Helsinki: The Finnish academy of science and lette.

Potrache, I. (2016). Romanian street beggars in Stockholm. A conflict between global city aspirations and informal livelihoods. Stockholm University, Department of Human Geography. Retrieved from www.humangeo.su.se

Rönnlund, M., Sundström, A., Eriksson Sörman, D., & Nilsson, L.-G. (2013). Effects of perceived long-term stress on subjective and objective aspects of memory and cognitive functioning in a middle-aged population-based sample. The Journal of Genetic Psychology, 174(1), 25–41. doi:10.1080/00221235.2011.635725

Socialstyrelsen. (2013). Summary: Homelessness among EU citizens in Sweden. Retrieved from http://www.socialstyrelsen.se/publikationer2013/2013-5-3/2013-5-3-summary.

SOU 2016:6 [Official Government reports]. (2016). Framtid sökes - Slutredovisning från den nationella samordnaren för utsatta EU-medborgare [Future wanted - Final report from the national coordinator for vulnerable EU citizens]. Retrieved from http://www.regeringen.se/contentassets/b9ca59958b5f43f681b8ec6dba5b5ca3/framtid-sokesslutredovisning-fran-den-nationella-samordnaren-for-utsatta-eu-medborgare-sou-2016_6.pdf

Thorp, A., Owen, N., Neuhaus, M., & Dunstan, D. (2011). Sedentary behaviors and subsequent health outcomes in adults. A Systematic review of longitudinal studies, 1996–2011. American Journal of Preventive Medicine, 41(2), 207–215. doi:10.1016/j.amepre.2011.05.004

Uliczka, H. (2015). Inventering av forskning och kunskap rörande FEADs: Smålgrupper - resultat och reflektioner [Inventorying the research and knowledge about FEADs target groups - results and reflections]. European Union. Retrieved from www.esf.se.

United Nations. (1948). Universal declaration of human rights. Retrieved from http://www.un.org/en/universal-declaration-human-rights/

Wagman, P., Håkansson, C., & Björklund, A. (2012). Occupational balance as used in occupational therapy: A concept analysis. Scandinavian Journal of Occupational Therapy, 19(4), 322–327. doi:10.3109/108382812.2011.596219

Weziak-Bialowolska, D., & Dijkstra, L. (2014). Monitoring multidimensional poverty in the regions of the European Union. Analysis of situation in 2012 and 2007. European Commission: JRC science and policy reports. Retrieved from https://ec.europa.eu/jrc/sites/default/files/final_report_22082014_version_online.pdf

World Health Organization. (1986). Ottawa charter for health promotion: First international conference on health promotion. Retrieved from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

World Health Organization. (2015). Health and human rights. Fact sheet no. 323. Retrieved from http://www.who.int/mediacentre/factsheets/fs323/en/