Poverty and social exclusion in the WHO European Region: health systems respond

WORLD HEALTH ORGANIZATION

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Poverty and social exclusion in the WHO European Region: health systems respond

Edited by Theadora Koller
WHO European Office for Investment for Health and Development

WORLD HEALTH ORGANIZATION
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ISBN 978 92 890 4203 1

Keywords
POVERTY
SOCIAL ISOLATION
SOCIOECONOMIC FACTORS
CHILD
MIGRATION
MINORITY GROUPS
HEALTH STATUS DISPARITIES
NATIONAL HEALTH PROGRAMS – organization and administration
HEALTH SERVICES ACCESSIBILITY
EUROPE

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Citation advice
Whole text: *Poverty and social exclusion in the WHO European Region: health systems respond*. Copenhagen, WHO Regional Office for Europe, 2010.
Chapter in text [example]: Marek M. Poland: Poverty and health. In: *Poverty and social exclusion in the WHO European Region: health systems respond*. Copenhagen, WHO Regional Office for Europe, 2010.

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The WHO European Office for Investment for Health and Development was set up by the WHO Regional Office for Europe, with cooperation and support from the Ministry of Health and the Veneto Region of Italy. Its key responsibility is to provide evidence on, and support Member States in acting upon, the socioeconomic determinants of health. Follow-up to resolution EUR/RC52/R7 on poverty and health corresponds to the WHO Medium-Term Strategic Plan (2008-2013) Strategic Objective 7, which is "to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches". For more information please write to info@ihd.euro.who.int.

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Cover photo credit: A doctor holding an elderly woman's hand - part of a series © Sandor Kacso/fotolia.com.

WHO wishes to thank the Italian National Institute for Health, Poverty and Migration for the financial support for the editing, design, printing, and dissemination of this publication, as well as the Federal Ministry of Health of Germany for its financial contribution to the commissioning of the background papers. See the annexes for information on collaborators in the case study and background paper production and review process.

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Acronym list

ACEC	Association for Culture, Education and Communication (Slovakia)
AISBL	European Federation of National Associations Working with the Homeless
BHC	Building Healthy Communities (Ireland)
BKK Bundesverband	Federal Association of Company Health Insurance Funds (Germany)
BOSPO	Bosnian Committee for Help (Bosnia and Herzegovina)
CAHD	child and adolescent health and development
CCEE	countries of central and eastern Europe
CE	Council of Europe
CHF	Swiss Franc, currency
CLES	Centre for Local Economic Strategies (Ireland)
CRISS	Centrul Romilor pentru Interventie Sociala si Studii (Roma Center for Social Intervention and Studies; Romania)
CUAMM	Collegio universitario aspiranti e medici missionari (University College for Aspiring Missionary Doctors; Italy)
DEPBiH	Bosnia and Herzegovina Medium-term Development Strategy (Bosnia and Herzegovina)
DH	Department of Health (United Kingdom)
DWP	Department for Work and Pensions (United Kingdom)
EC	European Commission
ECLAC	Economic Commission for Latin America and the Caribbean
ECMI	European Centre for Minority Issues
ECRI	European Commission against Racism and Intolerance
EDIS	Sociological Investigation Team
ERRC	European Roma Rights Centre
EU	European Union
EU27	countries belonging to the EU after January 2007
FAROS	Förnyad Arbetslivsinriktad Rehabilitering, Organisation och Samverkan (Renewed Work-oriented Rehabilitation, Organization and Collaboration; Sweden)
FEM	Frauen Eltern Mädchen (Women Parents Girls; Austria)
FRISK	Förenade Regionala Initiativtagare Startar Kampen (United Regional Initiators Start the Fight; Sweden)
FSG	Fundación Secretariado General Gitano (Roma Secretariat Foundation; Spain)
FSW	Fonds Soziales Wien (Viennese Social Fund; Austria)

GBP	guaranteed benefit package
GDP	gross domestic product
HM Treasury	Her Majesty's Treasury (United Kingdom)
HSE	Health Service Executive (Ireland)
IDP	internally displaced person
ILO	International Labour Organization
IMAS	Institutul de Marketing si Sondaje (Marketing and Studies Institute; Republic of Moldova)
IMF	International Monetary Fund
INAIL	Italian National Insurance Institute for Work-related Accidents
IOM	International Organization for Migration
IQ	intelligence quotient
ISTAT	Italian National Institute of Statistics
LVL	Latvian Lat, currency
MDGs	Millennium Development Goals
MDL	Moldovan Leu, currency
MEN	Männer Väter Burschen (Men Fathers Boys; Austria)
MICS	Multiple Indicator Cluster Survey
MiMi	Mit Migranten für Migranten (With Migrants for Migrants, Germany)
MONSTAT	Statistical Office of the Republic of Montenegro
NA	not available
NATO	North Atlantic Treaty Organization
NGO	nongovernmental organization
NHIC	National Health Insurance Company (Republic of Moldova)
NHS	National Health Service (United Kingdom)
NIHMP	National Institute for Health, Migration and Poverty
NIS	newly independent states
OECD	Organisation for Economic Co-operation and Development
OHCHR	Office of the United Nations High Commissioner for Human Rights
OPEN	One Parent Exchange and Network (Ireland)
OSAGI	Office of the Special Adviser on Gender Issues
OSCE	Organization for Security and Co-operation in Europe
OSI	Open Society Institute

PDCA	plan – do – check – act cycle
PICUM	Platform for International Cooperation on Undocumented Migrants
PHE	peer health educators
PPP	purchasing power parity
RSD	Serbian Dinar, currency
SAESA	State Agency for Employment and Social Assistance (Georgia)
SKDS	Marketing and Public Opinion Research Centre (Latvia)
SM	Tajik Somoni, currency
SPACE	The Social Policy Analysis Centre
SUSIF	State United Social Insurance Fund (Georgia)
TB	tuberculosis
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
USSR	Union of Soviet Socialist Republics
WGKK	Wiener Gebietskrankenkasse (Vienna District Health Insurance Fund; Austria)
WHA	World Health Assembly
WWII	Second World War
Zl	Polish Zloty, currency

Foreword

Much about poverty is obvious enough, particularly the relationship between poverty and ill health. So evident are the links that extreme poverty is listed in the International Classification of Diseases. Far more controversial are the answers to the following questions: How is poverty caused? How can it be measured? How can it be tackled? What are the health status and access to health systems of people experiencing poverty and social exclusion, and how do they compare to people experiencing greater wellbeing and inclusion in society? What can health systems do to meet the needs of people in poverty and thus ensure the right to health for all? What can be done at cross-government levels (by the health sector together with others) to address poverty and social exclusion as determinants of health?

These questions are at the centre of a longstanding European and worldwide debate. Today, in the context of the current financial crisis and economic downturn, scaling up focus by all stakeholders on these issues is critical.

The past decade began with an unprecedented global commitment to tackle poverty. This was embodied by the Millennium Declaration, endorsed by 189 nation, which led to the creation of the eight Millennium Development Goals (MDGs) addressing multidimensional poverty. At the regional level, United Nations agencies work to support national governments to reinforce actions in these areas. In the WHO European Region, in 2001 and 2002, the WHO Regional Committee for Europe passed resolutions EUR/RC51/R6 and EUR/RC52/R7, calling for increased action on the links between poverty and health. These resolutions emphasized the need for a rights-based approach to tackling the impacts of poverty on health. They stressed that all European Member States are affected by poverty, albeit to different degrees, and urged governments to formulate and further develop actions to combat the harmful effects of poverty on health.

One of the actions resolution EUR/RC52/R7 required of WHO was to continue the process of developing, analysing and disseminating knowledge on the relationship between poverty and health, including through the use of case study research methodology. The resolution specified that the WHO European Office for Investment for Health and Development, in Venice, was to have a key role in supporting follow-up. The Venice Office – set up by WHO with the cooperation of the Italian Ministry of Health and the Veneto Region of Italy – supports European Member States in addressing the socioeconomic determinants of health and reducing health inequities. As adverse daily living conditions and related health inequities disproportionately affect populations experiencing poverty and social exclusion, the follow-up to resolution EUR/RC52/R7, the work of the WHO Commission on Social Determinants of Health and the more recent World Health Assembly resolution WHA62.14 on reducing health inequities through action on the social determinants of health, have become an important part of its activities.

I hope that this publication, through both its development and its dissemination to a wider European audience, contributes to a further scaling-up of research and action to address the impact of poverty on health. Reducing health inequities across the social gradient, with proportionate attention to the most vulnerable populations, is of great importance in the new European health policy, which is one of my priorities as Regional Director at the WHO Regional Office for Europe. The policy will promote regional values and aims for health, provide a coherent and integrated framework and roadmap for health action, and specify ways in which health systems can be strengthened and the wider determinants of health and health inequities can be tackled. The release of this publication supports the Regional Office's collective efforts towards the MDGs and uptake of the findings of the WHO Commission on Social Determinants of Health. It also synergizes with 2010 as the European Year for Combating Poverty and Social Exclusion, as well as with the follow-up to the 2009 European Commission communication *Solidarity in health: reducing health inequalities in the European Union*.

Zsuzsanna Jakab
WHO Regional Director for Europe

Introduction

Populations experiencing multidimensional poverty and social exclusion are at heightened risk of being deprived of their right to health. This includes the social, economic and environmental conditions required for health.

In keeping with WHO Regional Committee for Europe resolution EUR/RC52/R7 on poverty and health, this book focuses on how health systems can meet the needs of populations experiencing poverty and social exclusion. It explores these issues using case study research methodology. It is the second in a series of publications responding to the resolution's call for case studies.

The first book in the series, published in 2004, included ten case studies. One was a study on the Department of Preventive Medicine for Migration, Tourism and Tropical Dermatology at the Istituto di Ricovero e Cura a Carattere Scientifico San Gallicano (San Gallicano Institute for Hospitalization and Cure with a Scientific Approach) in Rome, Italy. The Department – which has since become the Italian National Institute for Health, Migration and Poverty (NIHMP) – works to safeguard the health of populations experiencing social exclusion, including disadvantaged migrants, Roma, and homeless people. Building on its engagement in the first round of case studies, NIHMP supported the production of this second book, together with other partners (see Annex 2).

With 22 case studies and 3 background papers written between 2007 and 2009, this book reflects the engagement of a wide range of European Member State representatives and other stakeholders in an analysis of the efforts made by health systems to confront poverty and health. Unlike the approach taken in the first book, where consultants researched and wrote the studies, the present case studies were produced by focal points nominated by their governments.

To help them in the drafting process, WHO provided general guidance based on the then-emerging work of the Commission on Social Determinants of Health; on Article 12 of the United Nations International Covenant on Economic, Social and Cultural Rights on the right to health; and on previous work on addressing health inequities (including the "Levelling Up" series on tackling social inequities in health by Whitehead and Dahlgren).

The authors were asked to consider how multifaceted social exclusion processes render some groups (such as Roma and migrants living in poverty, the under-employed and children living in poverty) particularly vulnerable, as evidenced in multiple national plans for social inclusion and in progress updates on poverty reduction strategies. They were asked to describe interventions designed to improve the accessibility, availability, acceptability and quality of health services for populations living in poverty and social exclusion. They were invited to reflect on both the proximate and distal determinants of health, and how the health sector works with other sectors to address them. The authors were also encouraged to explore other aspects of health system strengthening including financing, sustainability, service delivery networks, human resource requirements, community empowerment and political leadership.

Outlines of the studies were reviewed by a task force and, to create a space for shared learning, early drafts or outlines were presented at a European consultation on follow-up to resolution EUR/RC52/R7 in December 2007 in Venice, Italy. The consultation brought together representatives from Roma and migrant civil society groups, intergovernmental bodies, academia, and multilateral system agencies, in addition to Member State focal points, to contribute to the debate and analysis.

The focal points and the editorial team finalized the studies at different periods during 2008–2009. As such, the data and references for each study do not necessarily reflect the most recent situation nationally. The three background papers reflect data available up to early 2008. Readers should bear these time considerations in mind.

The value of the case studies is to show what it is going on in countries; it is not to highlight "best practices". This would have entailed a systematic evaluation of interventions against a tested criteria and the subsequent identification of best practices. The purpose, therefore, is to use the case studies for qualitative research, in which they can be analysed singularly, as a set, and in relation to other comparable case studies. They have an intrinsic value as a vehicle for fostering further reflection on lessons learnt about meeting the health needs of people living in poverty and social exclusion: on challenges faced, on enabling factors, and on areas where increased investment may be required. Some of the interventions highlighted in this publication have been evaluated nevertheless and, in these cases, the authors were asked to briefly describe the evaluation aim, methodology and results. Nor do we wish to say that the interventions contained herewithin do not apply multiple promising or "best" practices; we wish to simply emphasize that this was not the scope of the exercise.

A cross-gradient approach, based on the principles and values of primary health care including universalism, is acknowledged to be the key to reducing health inequities and this book contributes to current discussions on universal coverage. It documents how Member States are responding to complex questions such as: what to do when population groups, due to multidimensional poverty and exclusion, fall through the cracks of universal services; how to move towards what the Strategic Review of Health Inequalities in England post-2010 (The Marmot Review) recently termed "proportionate universalism"; and what to do in resource-scarce transition situations, in which a targeted approach is currently applied in the absence of fully universal services.

Further, the book provides examples of how health systems can work simultaneously across four functions (stewardship, service delivery, financing and resource generation) to address the relationship between poverty and health. It demonstrates how Member States have taken action to strengthen cross-sectoral mechanisms for addressing poverty and social exclusion as determinants of health; improve information systems to monitor health inequities; increase awareness among public and private health providers of how to take account of social determinants of health when delivering services; and achieve better distribution of funding according to people's ability to pay, thus avoiding impoverishment as a consequence of ill health or service usage. The case studies illustrate the clear need to move beyond a project/ad hoc approach towards integrated system-wide and sustainable measures to reduce health inequities, paying due attention to the needs of vulnerable groups (as called for by the Tallinn Charter: Health Systems for Health and Wealth).

In reading this book, it is opportune to reflect on the findings of the Commission on Social Determinants of Health. The Commission calls for the universal provision of social protection (which includes health services as well as rights and entitlements to the conditions required for health). It states that targeted measures should only be used for those who fall through the cracks of universal services. In transition and resource-scarce environments, the progressive realization of universal services may be necessary. It recommends public sector leadership in health-care systems financing, ensuring universal coverage of health care regardless of ability to pay, and minimizing out-of-pocket health spending. The Social Exclusion Knowledge Network of the Commission calls for further action to address how exclusion – across the social, cultural, political and economic dimensions – has an impact on health. These and other recommendations of the Commission are highly relevant to improving the health of populations experiencing poverty and social exclusion, as called for by resolution EUR/RC52/R7.

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Resolution EUR/RC52/R7

Poverty and health – Evidence and action in WHO's European Region

The Regional Committee,

Having considered the contents and recommendations of document EUR/RC52/8 (Poverty and health – Evidence and action in WHO's European Region);

Recognizing the overwhelming evidence of the close relations between poverty, both absolute and relative, and ill health;

Being aware of the responsibility of the health system to improve the health of the poor and to contribute to the reduction of poverty, as part of comprehensive multisectoral efforts;

Recognizing that health is an integral part of social development;

1. THANKS the Regional Director for the action taken to implement the provisions of its resolution EUR/RC51/R6 and for including the subject of poverty and health on the agenda of the present session;

2. EMPHASIZES that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being;

3. ACKNOWLEDGES that the issue of poverty and health is a central concern both of WHO and of its Member States, which are all affected, although to different degrees;

4. URGES Member States:

   (a) to accelerate the formulation and further development of actions to combat the harmful effects of poverty on health;

   (b) to develop a minimum guaranteed package of free medical services for the poor, and to ask donor countries to consider supporting these efforts;

5. REQUESTS the Regional Director:

   (a) to impress upon the international community the need for political commitment in order to place health at the centre of sustainable development, and consider the socioeconomic and political implications of failure to address poverty and ill health;

   (b) to review the criteria used for defining absolute and relative poverty, considering the specificity of each country;

   (c) to continue the process of developing, analysing and disseminating knowledge on the relationship between poverty and health, and in particular the systematic collection, validation and dissemination of case studies on the practical role of the health system in addressing issues of poverty and health;

   (d) to establish a data bank at the WHO Regional Office for Europe on the effective actions taken by the health systems of Member States in the European Region to promote the health and wellbeing of the poor and the most vulnerable groups;

   (e) to assist Member States by providing evidence-based information on best practices to improve policy-making in addressing issues of poverty and health;

   (f) to utilize the resources available within the Regional Office, including the recently established European Office for Investment for Health and Development in Venice, to develop activities related to poverty and health and provide technical assistance to Member States;

   (g) to work closely with other relevant agencies active in the field, with the aims of producing regular comprehensive reports on the poverty and health situation in the European Region and monitoring progress.

Part I. Case studies of actions by health systems to address poverty and social exclusion

1. Austria: neunerHAUSARZT – demand-oriented health-care services for the homeless

Michael Fuchs, Christine Reidl and Gabriele Schmied
European Centre for Social Welfare Policy and Research

Summary

This case study focuses on underemployed and unemployed people and, in particular, on a measure to increase health system performance among homeless people: neunerHAUSARZT.

Austria has several socioeconomic strengths. In an international comparison, where wealth is measured in gross domestic product (GDP) per person and social protection expenditure in per cent GDP, Austria appears to be a high-income country that provides high social standards. Also, the country's overall employment rates are above (and unemployment rates are below) the average for the 25 countries of the European Union (EU) before January 2007. The country's health insurance, which is organized as statutory insurance, covers the gainfully employed and also covers recipients of social transfers and certain co-insured relatives. In 2006, taking into account medical assistance (within the social assistance systems) and other provisions, about 99% of the population had coverage for the cost of health services.

Both people who are acutely roofless and people who are homeless and living in welfare institutions were estimated to be about 0.2% of the population in 1999. The majority of them are affected by income poverty and vulnerable health. Even if the coverage of costs is secured, in practice they still face several barriers to health care. Among these barriers is their tendency to ignore symptoms, because their main challenges are to find a place to sleep and money for something to eat. Also, when they finally get in touch with the medical system, they are often critically ill and need inpatient treatment. As this is difficult to bear for many of them, they try to avoid subsequent medical examinations. Additional barriers result from organizational and bureaucratic requirements of outpatient clinics and general practitioners; for the homeless, such barriers often include the lack of necessary documents, difficulties in keeping appointments and finding waiting intolerable. Thus, in terms of health policies, low-threshold services are important and should be linked to other care and integration services.

The overall aim of the programme neunerHAUSARZT, based in Vienna, is to safeguard and improve homeless peoples' access to standard health services. It also tries to influence other sectors, such as special medicine, hospital care and home care. Currently, four physicians provide regular low-threshold health services at 10 of 24 Viennese hostels for homeless people. From March to December 2006, 661 hostel occupants visited a general practitioner at the hostels. In September 2007, the pilot phase was completed and the programme gained permanence, with the Vienna District Health Insurance Fund and the Viennese Social Fund agreeing to cover 100% of the costs.

To ensure that different services complement each other, the physicians in the programme practise case management, favouring an interdisciplinary and holistic approach. They cooperate closely with the staff of the homeless shelters, as well as with other health care providers that offer their services at the shelters. Among the services for these homeless people are regular meetings

with the psychiatrists of the Psychosocial Service of the City of Vienna as well as with specialists from the women's health centre FEM, which provides counseling for women. Starting in 2008, comparable support will be available for men. Offering such gender-sensitive support for homeless people is new in Austria.

Establishing such a programme, which enters uncharted terrain, was quite challenging. For example, at times it was difficult to negotiate funding and support with the different partner institutions. The programme, however, did manage to receive broad acceptance, and it received positive feedback from patients, partner organizations and social workers at the shelters. Also, the programme closed a gap in health care for the target population. Moreover, in the services provided, the different partners complement each other: health care providers contribute medical expertise and social services play an important role in reaching the homeless.

To establish a similar programme in other regions, the local structures have to be taken into account, as stakeholders, political contexts and social systems differ from place to place. Also, detailed knowledge of existing services and structures is of utmost importance to successful project planning and implementation.

Socioeconomic and policy context

In 2006, Austria's total population was 8.3 million people, of which 15.7% were younger than 15 years of age and 16.7% were older than 65 years of age. The GDP per person reached €29 770 in 2005. It was highest in Vienna and lowest in the states of Lower Austria and Burgenland, suggesting a gap between urban and rural areas. Income inequality and at-risk-for-poverty rates were relatively low. In a 2005 survey of people in private households, the Gini coefficient for disposable equivalized income (weighted for returns of scale in households with more than one person) was 26% (1995: 27%) and the at-risk-for-poverty rate (below 60% of median disposable equivalized income) was 12% (1995: 13%) (Statistik Austria, 2007). Also, the overall employment rate (15–64 years of age: 70.2% in 2006) was clearly above the average for the 25 countries belonging to the EU before January 2007, but the low employment rate among the elderly (55–64 years of age: 35.5% in 2006) is still a problem. Unemployment rates are traditionally low (4.7% in 2006). However, although the employment rate for women is also above the EU average for the same 25 countries, women (especially those with children) are underemployed. In an international comparison for 2004, Austria's educational level showed high rates, around International Standard Classification of Educational levels 3 and 4 (62%), which correspond to upper secondary and post-secondary, non-tertiary education, but a low share for tertiary education (18%) (Statistik Austria, 2006; Eurostat, 2007).

In 2005, the expenditure on social protection amounted to 28.8% of the GDP. The major part was spent on benefits related to social insurance and (universal) family benefits, and only a small share went to means-tested benefits. Recent measures that affect population well-being include an increase of low unemployment benefits (in terms of the replacement rate of the previous employment income) in 2001 and the introduction of the universal child care benefit in 2002, which extended the group of receivers to non-active people. In 2001, however, entitlement conditions for unemployment benefits were tightened and family supplements were reduced at the same time.

Current political debates are focused on the introduction of a basic security benefit in 2009, which should harmonize and basically increase present monetary social assistance benefits provided by the nine Austrian federal states. A first step, in 2007, consisted of a considerable increase in the topping up of very low pensions. In the area of taxes, a tax-free zone was introduced in 2000 and was enlarged significantly in the course of the tax reform for 2004/2005. Also, tax credits (including a negative tax) for single parents and single earners were extended.

Although public health services are a federal matter, in terms of legislation and execution, the responsibilities do not lie exclusively in the hands of the Federal Ministry for Health, Family and Youth. Important responsibilities are also administrated by various ministries at the federal level, federal states and municipalities, and the social insurance institutions. For example, within the hospital system, legislation and implementation laws, including the provision of hospital health care, is under the authority of the federal states. The distribution of authority and the variety of means of financing within the health care system require a significant amount of coordination among the various decision-making sectors (Federal Ministry of Health and Women, 2006).

Access to individual services of the public health care system is governed by social insurance law. The country's health insurance is organized as statutory insurance that, besides the gainfully employed, also covers recipients of cash benefits (such as pensions and unemployment benefits) and certain co-insured relatives. Furthermore, there are several possibilities for

voluntary insurance. Since May 2004, so-called foreigners in need have also been included (Grundsicherung für hilfsbedürftige Fremde).

For people who lack of health insurance, this should in principle be absorbed by medical assistance provided within the social assistance systems. On the whole, the services provided correspond to the spectrum of benefits in kind for insured people (Pfeil, 2001) and, for a fairly long time, there has been a discussion of concrete steps to include those receiving medical assistance in the health insurance system. If there is no entitlement to medical assistance, basically uninsured patients have to pay so-called self-pay rates. However, there are several ambulatory facilities (such as Amber-med and Marienambulanz ambulance services) and stationary facilities (such as Barmherzige Brüder hospital), which are concentrated in larger cities, as well as some individual physicians who cooperate in some cases with charitable organizations, which offer treatments free of charge to the uninsured.

Although health insurance protection is relatively broad, people in exceptional circumstances or transitions in status drop out of the protection net (Dimmel, 2001). Examples of these situations are unemployment without entitlement to unemployment benefits or loss of co-insurance after divorce. Generally, people become uninsured because they lack information on entitlement rules (Fuchs, Schmied & Oberzaucher, 2003). In 2006, the number of people not covered by social health insurance amounted to 1.5% of the population (120 000 people) (Hauptverband der österreichischen Sozialversicherungsträger, 2007). Taking into account medical assistance and other provisions, about 1% had no registered cost coverage. As a rule, people with low income and without (official) employment are of concern, as are those among them who are also homeless.

Following the definition of the United Nations (Springer, 2000), homelessness is a much broader term than acute rooflessness and, among other things, includes accommodation in welfare institutions, hidden homelessness and potential homelessness. Related to the target group of neunerHAUSARZT, the focus in the present case study is on people living in welfare institutions. However, some of the figures reported also relate to acute roofless people.

In Austria, there are no uniform standards for documenting homelessness and the services that target it (Schoibl, 2005). For the country as a whole, the latest figures relate to 1999[1]: the number of people living on the street then was estimated to be about 1000–2000. During that year, about 12 000 people were accommodated in stationary facilities for the homeless. Vienna has a high concentration of homeless people, although from 1997 to 2002 the number of acute roofless people decreased from 800–1000 to 300–500 and the number of those living in welfare institutions decreased from 5000 to 3700.

An extrapolation of the 1999 figures for the stationary sector showed that 3500 people – about 2000 children and 300 juveniles below 19 years of age – belonged to families with children. However, the majority of homeless people consisted of single adult males and, in Vienna alone, about 75% of the homeless were estimated to be male. Also, there is evidence that homeless people are often affected by separation and divorce, a partial cause of homelessness. Moreover, the socioeconomic conditions faced by the homeless coincide with factors that lead to homelessness: the main factor is income poverty caused by indebtedness, long-term unemployment or precarious employment. Furthermore, the educational level of the homeless is usually low (Eitel & Schoibl, 1999; Republic of Austria, 2006).

Chronic diseases, mental illnesses and drug abuse may also lead to homelessness. Once homeless, people may experience many additional health problems, such as exposure to infectious illnesses, increased mental health problems and drug addiction. Also, the homeless are impaired by the living conditions connected with homelessness.

In the majority of cases, the homeless are covered by health insurance or medical assistance; for Vienna, it is reported that about 70% are covered by health insurance, the majority of the remaining 30% receiving medical assistance. If they are not insured, it is mainly because they are unemployed without entitlement to unemployment benefits. The access to medical

[1] The figures for 1999 on homelessness in Austria are derived from an investigation conducted by the Federal Consortium for the Assistance of Homeless People, which was funded by several Austrian federal ministries. A questionnaire on sociodemographic characteristics of homeless people was sent to all institutions that provided substantial support for the target group. Results were extrapolated for Austria as a whole. Although it was originally planned to make the investigation the starting point for a documentary system on homeless people, it turned out that many facilities did not give the project a high priority. Furthermore, essential travel by the organizers, to guarantee a high and comparable level of data collection, could not be arranged (Eitel & Schoibl, 1999). These difficulties accumulated and led to the initial investigation being delayed until a second round of field research at the end of 2007 and beginning of 2008.

This second round will use more-standardized definitions for data collection, will have better direct access to facilities and will involve the nine Austrian federal states. Thus, for the stationary sector, it appears that no extrapolations will be needed; for the non-stationary sector, it appears that valuable information can also be gathered. Although, the vast majority of initiatives and supporting programmes are based at the local level, this detailed and up-to-date data for Austria as a whole will help greatly to evaluate the quantitative and qualitative demand of the homeless and to ease the planning and integration of future support programmes and measures.

assistance usually works only with the support of institutions that target homelessness, as there are complicated administrative procedures.

Even if the coverage of costs is secured, there are still barriers that hinder the utilization of health care. For example, homeless people often ignore their health problems – as they face many other problems – and seek medical treatment only when symptoms are severe or when there is an emergency. Also, in rural areas, only a few low-threshold institutions are available and medical treatment usually is available only from general practitioners with high barriers to access.

A special problem for the homeless is long-term treatment and treatment of mental problems, as follow-up treatment outside the inpatient sector does not work well. This is partly due to the lack of capacity in supervised housing (Eitel & Schoibl, 1999; Fuchs, Schmied & Oberzaucher, 2003; Perl, Schoibl & Zuschnig, 2006).

Thus, health services should be linked holistically to other care and integration services, which need to be supported by institutions working with the homeless. Such integrated systems of support, including housing, health and employment, are still under development. Also, each of the Austrian federal states has its own system of services and, in many cases, a comprehensive approach to preventing homelessness, taking acute measures and reintegrating the homeless is restricted to larger cities (Schoibl, 2005; Perl, Schoibl & Zuschnig, 2006). In larger cities, systematic prevention of eviction notices, through support from organizations for the homeless and through charitable organizations, is on the way. A successful measure to prevent eviction is the short-term takeover of outstanding rent debts through social assistance (Republic of Austria, 2006).

For the already homeless, there is emergency relief. In 1998 (the most recent figures), the homeless were cared for in 95 day-care facilities and 177 facilities with accommodations, which contained 7328 sleeping berths and makeshift beds, of which about half of these were located in Vienna. Among the available facilities with accommodations, there are homeless shelters, asylums, hostels and supervised housing. Among other things, each of these facility types shows significant differences in its legal framework, financial resources, quality, capacity, psychosocial care and advisory services.

Continuing support for a range of accommodations, from temporary to assisted living and welfare housing, is being expanded. In Vienna, a target is to provide housing for all homeless people outside of care facilities, where people can stay up to two years. For the elderly, specialized nursing homes with unlimited residence are foreseen. Recently two hostels were made available for women exclusively. In other Austrian federal states, such measures as specific long-term accommodations for homeless women and the reduction of accommodations in large facilities in favour of an enlargement of the supply of assisted housing and flats are being developed.

Among the tasks remaining are the improvement of coordinated action for effective maintenance of the homeless and their reintegration into society. Also, existing support should be extended to a chain of interventions, from advice centres and makeshift beds to assisted living and welfare housing. Two needs, in particular, are the area-wide extension of preventing eviction notices and improving the quality of the facilities that accommodate the homeless (Eitel & Schoibl, 1999; Republic of Austria, 2003; Schoibl, 2005).

In the realm of health policies, low-threshold services are important. Besides general facilities, which also provide medical care for the uninsured, there are a number of health care programmes established especially for the homeless. In Vienna, in a participatory approach that involves relevant stakeholders and nongovernmental organizations (NGOs), the Viennese Social Fund (Fonds Soziales Wien, FSW) started pilot projects to offer special medical treatment. In the westernmost state of Austria, Vorarlberg, there is regular networking between social psychiatry and the homeless sector. Among specific NGO programmes, Caritas Vienna provides the Luise-Bus, a structure for mobile treatment of people living on the streets, and also provides medical care for elderly homeless in the Haus Allerheiligen. Moreover, the non-profit-making organization B 37 offers a wide range of low-barrier psychological services for the homeless in Linz, the third largest city in Austria and capital of the state of Upper Austria. Furthermore, neunerHaus, in Vienna – whose project neunerHAUSARZT is the focus of the present case study – practises a low-barrier approach, providing consultation hours by general practitioners. In the future, allocating more resources for people with mental health problems would be highly beneficial (Perl, Schoibl & Zuschnig, 2006).

Health care for occupants of homeless shelters: neunerHAUSARZT

This section covers the following topics: settings, aims and first results; human resource requirements, networking and funding; why homeless people in Vienna need neunerHAUSARZT; and accessibility, acceptability and quality control.

Settings, aims and first results

Situated in Vienna, neunerHaus is an incorporated, non-profit-making association. It was set up in 2001 to establish and manage housing for homeless people, according to their needs. In early 2005, the project expanded, from offering only lodging for 60 (today 100) people to providing access to medical treatment for occupants of several homeless shelters in Vienna. Planning and scheduling for the project required a year, during which the project initiators visited similar projects abroad, especially in Germany, and learned from their experiences. Also during this period, a detailed review of already existing services and structures was undertaken. The concept was then presented to key stakeholders – the Vienna District Health Insurance Fund (Wiener Gebietskrankenkasse, WGKK), the Viennese municipality (MA 15), FSW, hospitals, and several organizations that support the homeless by offering housing or health care – whose support and/or collaboration were needed. Round tables with experts were held to adjust and adapt the concept and to define requirements for establishing an on-site place where a medical practitioner could treat or advise patients at a homeless shelter. Also, cooperation with other health care providers was established and is constantly being extended.

The pilot project started in January 2006, and the first medical consultations were carried out in March 2006. In September 2007, the pilot phase was completed and the project gained permanence. Today, neunerHAUSARZT provides health care at 10 (of 24) Viennese hostels for the homeless, offering 1202 accommodations, and the inclusion of more shelters in the programme is part of plans for the future. From March to December 2006 (statistics for 2007 were not available when the present case study was prepared), 661 occupants visited a general practitioner at the hostels, and a total of 3392 medical consultations were carried out. Analysis of the patients' medical documentation emphasized the importance of improving access to medical treatment for the homeless. About 70% were multi-morbid, some with up to 15 diagnosed health problems. Also, more than 45% suffered from such mental disorders as depression, addiction-related disorders or personality disorders (Anonymous, 2007).

The all-embracing mission and objective of neunerHAUSARZT is to safeguard access for the homeless living in hostels to all medical services available to the public. It focuses on measures that build confidence, which reduces the threshold at which members of the target groups become afraid and thus makes medical treatment available to them. The following measures help reduce that threshold.

- Medical treatment is offered on site at homeless shelters interested in this service, so that physicians are within easy reach of homeless residents.
- Services are offered regularly, and physicians set up fixed weekly hours for consultations.
- Access to medical treatment is non-bureaucratic.
- Patient's needs decide the duration of a consultation.
- Physicians use their professional contacts, whenever possible, to refer patients to specialists or health care providers (such as laboratories, pharmacies and hospitals) familiar with the target groups' needs.
- Patients with severe impairments who need to visit a specialist are accompanied by a social worker or an alternatively suitable person.
- Psychotherapeutic and psychosocial support for women, as well as gynaecological attendance, is available on site through the partner organization FEM (Frauen Eltern Mädchen – Women Parents Girls), a women's health centre. In 2008, as a result of cooperation with a men's health centre called MEN (Männer Väter Burschen – Men Fathers Boys), comparable support will be available for men.

Human resource requirements, networking and funding

The project manager of neunerHAUSARZT, Barbara Zuschnig, was interviewed for this case study. She is in charge of project planning and coordination, networking, public relations, and fund raising. Her work is supported by staff members of neunerHaus and by volunteers. The group of four physicians that work for the project puts in 40 hours a week, with one of the group acting as the medical director. The doctors can use premises in the shelters to treat and advise homeless patients. According to Barbara Zuschnig (personal communication, September 2007), "We provide everything which is available in the ordinary medical system. There is no quality difference. We prescribe the same pharmaceuticals; we carry out the same medical examinations every other patient can get at the general practitioner."

When working with groups of disadvantaged people, skills in social medicine are essential. The four doctors that work with neunerHAUSARZT are experts in social medicine, and some have worked with drug addicts or in social work concerned with individuals and their personal circumstances. The project includes training young doctors in this field to complement the team. They are supervised by the experienced physicians – additional input is provided by staff members of neunerHaus – and are introduced to:

- the living conditions and lifestyles of the homeless and poor (how social marginalization effects their state of health and help-seeking behaviour);
- training in the soft skills and communication necessary to establish a reliable patient–doctor relationship;
- effectively medicating multi-morbid patients, thereby considering possible existing addiction problems and adverse drug effects;
- possibilities and limitations of homeless people's cooperation or compliance during treatment, resulting from their difficult personal circumstances, and how to deal with this; and
- available social and health services for the homeless and how to access them.

Homeless patients need more time for a consultation than do average patients, and health care for them has to take this into account. Also, the longer the period of homelessness, the more time is needed for a consultation. On average, a consultation lasts 16 minutes, whereas in a general practitioner's ordinary practice the average time spent with one patient is 1–5 minutes. This greater investment of time is not only because of the poorer health of the patients, but is also because of communication problems and a different perception of health.

Physicians for the homeless practise interdisciplinary and holistic case management, to ensure that the different services complement each other. They participate in case-oriented meetings with the staff of the homeless shelters or at least are regularly informed by a social worker. They cooperate closely with other health care providers and initiatives in the health care area (such as FEM) and offer their services on site.

This close cooperation is particularly important because nearly all homeless women have had violent experiences with men. The counselors of FEM understand the situation of marginalized women and address their fears and needs, as well as female health concerns. By ensuring their homeless clients that they can rely on them, counselors establish a trustful relationship that helps the homeless accept offers by social services or health care providers. One reason for giving assurance is the negative experiences of some women that lead them to reject psychiatric treatment, even though it would be helpful. In such cases, counselors cooperate with the psychiatrists of the Psychosocial Service of the City of Vienna to carefully prepare a consultation, avoiding circumstances that cause anxiety. FEM also provides gynaecological treatment by a specialized female doctor.

Within neunerHAUSARZT, there are also regular meetings with psychiatrists of the Psychosocial Service of the City of Vienna – part of the programme's basic multidisciplinarity principle. According to particular requirements, contacts with the homeless are made at day centres, day-care providers or other health care facilities. According to Barbara Zuschnig (neunerHAUSARZT, personal communication, September 2007), networking activities are very important.

> We benefit from the projects' high degree of awareness and are establishing network ties with every institution relating to our patients. Often I just phone a health care institution and request their cooperation. Sometimes they are taken by surprise; however, in the majority of cases, they are willing to help.

In a concrete case of care management, a round table was organized at a psychiatric hospital, where nurses and physicians were informed about the services available at homeless shelters during the week. This raised their awareness – for example, that there was no support available for psychiatric patients discharged during weekends, which might result in patients' being re-admitted only a few hours later.

Physicians of neunerHAUSARZT also know which pharmacies cooperate in servicing their patients. For example, if a patient has to take several medications a day, the pharmacies put them into special boxes, sorted by day of the week and time of day, which helps multi-morbid patients to take the right drug at the right time. Physicians also arrange with pharmacies, by phone, if any bureaucratic problems arise, instead of leaving it to the patient to gather missing information.

At the moment, networks are based on personal contacts and the work experiences of the doctors. For the future, there are plans to establish networks on a formal level.

The total cost of the pilot phase was €400 000 (Anonymous, 2007), of which 50% was funded by WGKK, 30% by FSW and 20% by neunerHAUSARZT. After completion of the pilot phase, WGKK and FSW agreed to cover 100% of the costs (50% each), which guaranteed long-term, sustainable funding for health care provision for homeless people. Also, private sponsorships are granted frequently – for example, for publicity campaigns. Moreover, the programme is supported further at the municipal level in Vienna.

Why do homeless people in Vienna need neunerHAUSARZT?

The programme aims to make standard health services available to homeless people, covering the area of general medicine and also trying to influence other sectors, such as special medicine, hospital care and home care. Basically, the homeless have access to the same medical services as others, but several hindrances keep them from such access (see the section on "Socioeconomic and policy context"). Also, the homeless often feel unwelcome in hospitals, doctor's offices or outpatient clinics, because they are perceived as *difficult*.

To tackle this problem, neunerHAUSARZT established a network of trusted medical specialists, such as gynaecologists, ophthalmologists, specialists in internal medicine and pharmacies in the neighborhood of the shelters. To lend support to the mentally ill homeless, social workers escort them to the medical specialists.

Besides addressing the lack of access to quality health services, the project also addresses a variety of risk factors that influence the health of the target groups. Homeless people, especially those who have lived on the streets for several years, face multiple health problems. Often they have not taken care of their health for a long period of time, because their main challenges are to find a place to sleep and to get money for something to eat. Also, they lack health literacy. Also, their sensitivity to pain and illness differs from that of the general population. They often tend to ignore (or not even notice) symptoms. They are often ill-nourished, because of poor quality food or because of addictive behavior – replacing eating by drinking alcohol and/or consuming illegal drugs. Most homeless people smoke cigarettes, and many of them suffer from depression and other mental illnesses. Anxiety and stress is a side-effect of their living conditions. Often, they have experienced violent social environments, leading in the worst cases to psychic trauma.

When they finally get in touch with the medical system, they are often critically ill and inpatient treatment is necessary. As a consequence, homeless people, who often experience being ordered to stay in hospital after consulting with a doctor, tend to avoid subsequent medical examinations. Also, economic and organizational requirements of outpatient clinics and general practitioners constrain access to treatment for the homeless. Moreover, homeless patients often lack necessary documents, have difficulties keeping appointments and (many of them) are not able to bear waiting.

To counter these drawbacks, project neunerHAUSARZT provides a regular low-threshold service in an environment familiar to the client, which raises the acceptance of the services and compliance with them. According to Barbara Zuschnig (NeunerHAUSARZT, personal communication, September 2007), "We had clients at the hostels who kept an eye on the health service for a year before they were ready for a consultation."

Preventing the problems faced by the homeless is very difficult. Instead neunerHAUSARZT focuses on traditional medical practice and social medicine. It is necessary to stabilize the health of the patients before specific illness prevention and health promotion initiatives can be considered.

Accessibility, acceptability and quality control

The programme is accessible because it is user-friendly and not bureaucratic, and it is acceptable because it is a low-threshold service, with the doctors providing their services in the facilities for the homeless at regular hours. Moreover, it is acceptable to the homeless because it is unnecessary to make an appointment and waiting times are appropriate.

The programme is also acceptable to the homeless because it takes into account their special needs. Furthermore, within the programme, the homeless are accepted as they are, thus avoiding discrimination, and their treatment costs are generally covered either by health insurance or medical assistance. Even where expenditures are not covered by health insurance or medical assistance, the patients are not charged for the services. If they are charged, the costs are covered by the project itself.

As already mentioned, the programme is sensitive to gender requirements, taking into account the special needs of women living on the streets, such as experiences of violence and rape. Also, the health of the homeless is much worse than that of other people the same age. Thus, they need more medical services at a younger age and need care earlier in life.

Confidentiality is a basic principle of the programme. Although doctors exchange information about the patients among themselves, they pass on information – for example, to social workers at the shelter – only if they get the patient's consent. Exceptions are made for patients that might endanger themselves or others, but these cases are very rare.

Besides carrying out medical documentation, the programme regularly carries out self-evaluations, although no funds are available for evaluation. For such evaluations, programme partners (such as F.E.M, Psychosocial Service of the City of Vienna and social workers) are consulted by questionnaire. Also, programme clients are interviewed personally, because questionnaires are too difficult to use for many in the target group, due to poor reading and writing skills. Results from the evaluations showed broad acceptance of the health care services provided for the target group. Social workers running homeless shelters, as well as psychiatrists from Psychosocial Service of the City of Vienna, experienced the assistance of neunerHAUSARZT as an important additional resource that made their work easier. Thus, the evaluations proved that nearly all stakeholders were very satisfied with the service.

The results of the evaluations strongly supported the necessity of interdisciplinary cooperation among physicians, social workers, psychiatrists and psychologists. As a result of the self-evaluations' aim of improving the quality of care, treatment of inhabitants' psychiatric disorders increased considerably, which also led to a more conflict-free atmosphere at the shelters. Also, analysis of medical data resulted in a rearrangement of health care provision by the physicians of neunerHAUSARZT. Moreover, because occupants of hostels for long-term homeless people showed the poorest health status, more service capacity was shifted to them.

Lessons learned

Cautious planning and implementation of the programme neunerHAUSARZT – a concept that was a complete novelty within the existing health care system – contributed to its success. This included the examination of similar projects abroad, especially in Germany, and a detailed review of existing local services and structures. Its success can also be attributed to the early involvement of key stakeholders – such as WGKK, MA 15, FSW, and hospitals and several organizations that support homeless people by offering housing or health care – whose support and/or collaboration had to be achieved. Moreover, publicity and the professionalism of the non-profit-making association neunerHaus were instrumental in convincing powerful partners to support the ideas behind project neunerHAUSARZT, which in the long run ensured sustainable funding from WGKK and FSW.

The programme closed a gap in health care for the target population, making it possible to provide care for people without coverage from health insurance or medical assistance. According to Barbara Zuschnig (neunerHAUSARZT, personal communication, September 2007), "They are only few, but they need not fear getting a bill they cannot pay." Based on its interdisciplinary approach, neunerHAUSARZT fosters cooperation between social and health services, where health care providers contribute medical expertise and social services – in this case, mainly the homeless shelters – play an important role in reaching the homeless.

The programmes' greatest success is its broad acceptance. The project received positive feedback from patients, partner organizations and social workers at the shelters. The success is "that we exist [and] that we could persuade people that we are necessary" (Barbara Zuschnig, neunerHAUSARZT, personal communication, September 2007).

Establishing a programme that enters uncharted terrain in Vienna (and Austria) was quite challenging, especially in negotiating with different partner institutions for funding and support. Social workers in charge at the different shelters, for example, had to be convinced that their target group would profit from a regular on-site health service, which was not obvious to them at the beginning.

When the project's first summer approached and the project manager, Barbara Zuschnig, addressed the organization of holiday replacements for physicians, the feedback from the hostels indicated that this was not needed. Although she disagreed with them, she accepted the social workers' decision. In the programme's second summer, however, each physician was asked to organize a holiday replacement because the social workers did not want to continue without on-site health service. According to Ms Zuschnig (neunerHAUSARZT, personal communication, September 2007), "You have to be patient, you have to be able to even endure developments you dislike and act flexibly when trying to match the aims of the programme with realities."

When starting the project, its initiators were confronted with several administrative problems. Because each physician was practising medicine at several shelters and no mobile e-card readers were available, it was necessary to develop (with WGKK) a suitable administrative method for keeping track of the patients and for accounting for services. Also, a completely new model for remunerating physicians' work had to be established, because four physicians shared one full-time position.

The initial programme concept envisioned establishing an outpatient clinic for the homeless, in addition to the medical care in the hostels. Because of insufficient funding, this idea could not be realized until now. Also, a dental practice is planned. Moreover, a gynaecologist is being sought. Starting in 2008, male occupants will be able to make use of psychosocial counselling for men, carried out by MEN.

The programme also reaches target groups that formerly did not seek assistance. Three quarters of the patients accessing the health service at the shelters did not have a family practitioner. Therefore, physicians expect a growing demand. Right now, although the four physicians cope with the number of patients, there is a plan to enlarge the team by two physicians. This was expected, because the programme concept already included the possibility of training physicians how to treat the homeless according to their needs.

Evaluation is important for quality control of the project's health services. Funding for evaluation, however, is still lacking.

To establish a similar programme in other Austrian federal states or in another region, the local structures have to be taken in account, because stakeholders, political contexts and social systems differ from country to country, and even from region to region. For the programme to be adapted to other places, profound knowledge of existing services and structures of the health care system is of utmost importance for successful planning and implementation.

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2. Bosnia and Herzegovina (Federation of Bosnia and Herzegovina): Roma strategy and action plan for health

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Summary

Bosnia and Herzegovina was recognized by the international community in 1992 as a newly independent country. A war followed from 1992 to 1995 and was ended by the Dayton Peace Accords. Today, Bosnia and Herzegovina is comprised of two entities: the Federation of Bosnia and Herzegovina and Republika Srpska, as well as Brčko District – which is independently administered and over which neither Republika Srpska nor the Federation of Bosnia and Herzegovina have jurisdiction. The Federation of Bosnia and Herzegovina is further decentralized into 10 cantons. The central government is run by the three-member presidency and the Council of Ministers. As with the political system, the health system is decentralized, and the Federation of Bosnia and Herzegovina and Republika Srpska each have their own system. This case study focuses on the Federation of Bosnia and Herzegovina.

The recent war negatively effected the demographic and socioeconomic situation in the Federation of Bosnia and Herzegovina: the economy is weak, and refugees and internally displaced persons continue to live with few economic resources. The international community supports an ongoing process of reconstruction, democratization and political stabilization, but widespread poverty and governance issues pose challenges. An estimated 19.5% of the population lives below the general poverty line, which is defined as the minimum income required for food, clothing and other essentials. Every second inhabitant is classified as socially excluded in some way, according to the general social exclusion index.

According to some estimates, the Roma population in Bosnia and Herzegovina is currently 8.5 times the number reported in the most recent prewar census of 1991. Some of these Roma have been in Bosnia and Herzegovina since independence; others have returned from other countries where they had been refugees; and still others came to Bosnia and Herzegovina seeking refuge. In general, poverty deeper than that in the general population, marginalization, low educational attainment, and poor living conditions shape Roma status in Bosnia and Herzegovina, as in many other countries in the Region. Indicators bear this out: the unemployment rate is high, at about 97.7%; 5% receive social assistance and only a third have health insurance. Of those with health insurance, 75% are covered by the Unemployment Bureau. Most Roma in Bosnia and Herzegovina, however, lack personal identification documents, which exacerbates their marginalization.

Lack of health insurance, inadequate living conditions, poor sexual health, low rates of immunization, and the use of tobacco, drugs and alcohol have been identified as problems within the Roma community in Bosnia and Herzegovina.

In July 2005, the Council of Ministers adopted the Roma Strategy of Bosnia and Herzegovina. In conjunction with the Strategy, the Ministry of Human Rights and Refugees has coordinated the development of different working groups charged with producing sectoral action plans. Sectoral priorities include health, housing, employment and education. Bosnia and

Herzegovina has also expressed its intent to join the Decade Roma of Inclusion 2005–2015. In July 2008, in Sarajevo, the Council of Ministers adopted Decade action plans, as well as a decision establishing a Coordination Board to monitor the implementation of the action plans. The Council of Ministers also officially agreed to join the Decade.

This case study summarizes the process used to develop the Roma health action plan, while identifying synergies with other health strategies and policies. The study is based on communications with stakeholders and secondary analyses of existing data from both completed and ongoing national programmes. Based on these analyses, the study briefly presents some of the lessons learned and some considerations for policy-makers, practitioners and Roma civil society.

Socioeconomic and policy context

Bosnia and Herzegovina was recognized by the international community in 1992 as a newly independent country. A war followed from 1992 to 1995 and was ended by the Dayton Peace Accords. Today, Bosnia and Herzegovina is comprised of two entities: the Federation of Bosnia and Herzegovina and Republika Srpska, as well as Brčko District – which is independently administered and over which neither Republika Srpska nor the Federation of Bosnia and Herzegovina have jurisdiction. The Federation of Bosnia and Herzegovina is further decentralized into 10 cantons. Also, Bosnia and Herzegovina has a total of 142 municipalities, 79 of which are in the Federation of Bosnia and Herzegovina, 62 of which are in Republika Srpska, one of which is the municipality of Brčko District. The central government is run by a three-member presidency and the Council of Ministers. As with the political system, the health system is decentralized, and the Federation of Bosnia and Herzegovina and Republika Srpska each have their own system. This case study focuses on the Federation of Bosnia and Herzegovina.

All population data are estimates, as there were large demographic changes and population movements during and after the war, and there has not been a national census since 1991. The 1991 census showed a total population of 4.3 million people (Bosnjovic & Smajkic, 1997:3). The total population is now estimated to be 4 million people. An estimated 45% live in urban areas. Many people had their homes destroyed during the war, and thus living standards have declined for a large percentage of the population (Ministry for Human Rights and Refugees, 2006).

According to the *National Human Development Report 2007* for Bosnia and Herzegovina (UNDP in Bosnia and Herzegovina, 2007), 50.3% of the population is socially excluded in some way (based on the general social exclusion index, which has seven proxy indicators that reflect living standards, health, education, participation in society and access to services). The first postwar socioeconomic research was a living standards measurement survey, carried out in 2001 to guide the development of the Poverty Reduction Strategy. Data from the survey show that 19.5% of the population of Bosnia and Herzegovina lived under the poverty line, defined as the minimum income required for food, clothing and other essentials. Broken down by entity, the respective rates were 16.3% in the Federation of Bosnia and Herzegovina and 24.8% in Republika Srpska (UNDP in Bosnia and Herzegovina, 2007). The most recent Living in Bosnia and Herzegovina Survey (conducted 2004/2005) shows that poverty had decreased since 2001 to 17.8% for Bosnia and Herzegovina, and 15.4% for the Federation of Bosnia and Herzegovina and 20.8% in Republika Srpska (UNDP in Bosnia and Herzegovina, 2007). The groups at the highest risk of income poverty and unemployment are minority returnees, Roma, the elderly, youth, children and people with disabilities, and they also have far more difficulty accessing public services and participating in political life (UNDP in Bosnia and Herzegovina, 2007).

Health care financing, management, organization and provision in Bosnia and Herzegovina are the responsibility of each entity (Cain et al., 2002). This implies that there are three health care systems. Cantonal governments in the Federation of Bosnia and Herzegovina deal with health through 10 cantonal health ministries. According to a March 2003 Law of the Ministries, the Ministry of Civil Affairs of Bosnia and Herzegovina is charged with overall coordination of health issues at the state level.

The population experiences inequities in access to health care and in distribution of health outcomes. Between 17% and 35% of the population, depending on the part of the country, are not covered by health insurance. Rural–urban discrepancies in coverage and lack of transferability of health insurance benefits across the country further contribute to inequity in access to health care (WHO, 2007).

Socioeconomic status of Roma

Roma, an ethnic minority group, live throughout Europe, but there is no country in which they are the majority population. In general, there is a serious lack of data for this population. The Statistical Yearbook of 1992, based on the last census, reported 8864 people, or 0.2% of the total population, as having declared themselves as Roma in Bosnia and Herzegovina (Statistics Bureau of Bosnia and Herzegovina, 1992:44). The Council of Europe (CE) estimated that between 50 000 and 60 000 Roma lived in Bosnia and Herzegovina (CE, 1996).

The Roma Council[1] coordinated a census undertaken by Roma NGOs and supported by World Vision in both the Federation and Republika Srpska in 2007. They estimated that 76 251 Roma live in Bosnia and Herzegovina (Roma Council, 2007). Because the census was done by a Roma entity and was considered "unofficial", it is likely that it may be more representative than an official census. The reason for this is that Roma who generally do not self-identify as such in official censuses (due to fears of stigmatization) may be more willing to do so in an unofficial census. Based on the above census, the population figure used for activities related to the Decade for Roma Inclusion 2005–2015 is 75 000 Roma citizens, making Roma (de facto) the largest national minority in Bosnia and Herzegovina (Decade of Roma Inclusion 2005–2015, 2008a).

This represents a large increase (8.5 times) over the population reported in the prewar census. In part, this is likely because some Roma have moved to Bosnia and Herzegovina from elsewhere. Among those interviewed as part of a recent survey undertaken by the Roma Council, 19% were internally displaced due to the war. Unfortunately, only 8.6% (of the total) were registered as a refugee or displaced person (Roma Council, 2007). Studies suggest that the fertility rate among Roma is higher than that among other populations, and this has also contributed to the increase (UNICEF, 2007). Additional data on the Roma population are needed. Collecting disaggregated quantitative data is a precondition for developing national policies for sustainable inclusion of such vulnerable groups as Roma, internally displaced persons and refugees.

In April 2003, Bosnia and Herzegovina ratified the European Framework Convention on the Protection of National Minorities (CE, 2005) and adopted a national law on the protection of minority rights (Parliamentary Assembly, 2003). The law regulates the rights of 17 minority groups in the country, including the Roma. Among other things, the Convention covers the right to education, the use of minority languages, and the right to true participation in the work of the elected bodies and state administration.

Bosnia and Herzegovina has 44 registered Roma associations, although only about half of them are active (Sanela Bešić, Coordinator of the Roma Council, personal communication, November 2007). These NGOs often act under the umbrella of the Roma Council. They have increased the visibility of problems that affect the Roma community. Several key international organizations and NGOs, including the Organization for Security and Co-operation in Europe (OSCE), the Helsinki Committee for Human Rights, th Open Society Institute (OSI), the Soros Foundation and World Vision, also work on Roma issues. Their work is challenged by the lack of definitive data and information on Roma in Bosnia and Herzegovina before and after the war.

Despite the increase in Roma NGOs, Roma are in some ways even less integrated into the post-conflict society than they were before the conflict, as their interests are not represented by any of the existing political parties (OSCE, 2005; UNHCR, 2008). For this minority group, marginalization, discrimination, and overall lack of political and economic support networks mean that the high rates of unemployment and poor housing that affect many citizens in Bosnia and Herzegovina affect the Roma in particular (UNHCR, 2008). For a variety of reasons, including lack of knowledge about the process and inability to pay fees, Roma are less likely to register their children when they are born. Failure to register Roma at birth prevents access to social welfare benefits, as well as enrolment in school. Also, Roma refugees from Serbia and Kosovo[2] may lack documents as well.

Roma marginalization is also characterized by low rates of formal employment, low enrolment in formal education, and unhealthy accommodations. Only about 1% of the Roma are formally employed in the public or private sector (OSCE, 2007), and half of Roma of working age were registered at the Unemployment Bureau (Roma Council, 2007). Accommodation conditions are more precisely illustrated in research undertaken by the international NGO World Vision in the Federation of Bosnia and Herzegovina and Republika Srpska, which showed that every third Roma person lives in a house without a bathroom,

[1] The Roma Council is the body responsible for presenting and advocating the interests and needs of the Roma community in Bosnia and Herzegovina to the Council of Ministers. It is the main entity for Roma issues. It comprises nine elected representatives of Roma NGOs from all of Bosnia and Herzegovina.

[2] Reference to Kosovo in this publication, including in the bibliography, should be interpreted as: Kosovo (in accordance with Security Council resolution 1244 (1999)).

every sixth without water and every tenth without electricity. About 75% of Roma lack a safe, adequate accommodation, as compared with about 11% of the overall population (World Vision, unpublished data, 2006).

Between 30% and 35% of Roma children are estimated to be enrolled in school. These levels reflect the need for efforts to increase enrolment – by Roma civil society groups, the international community, and domestic and international NGOs dealing with Roma issues – and to implement an action plan on educational needs of Roma and other ethnic minorities (OSCE, 2007). Schools and universities employ positive discrimination measures for admission and, depending on the financial resources of the school and canton, Roma and other poor children are given school books and supplies and food (Samir Šlaku, the Ministry of Human Rights and Refugees, personal communications, November 2007 and July 2008).

Inequities in health status and health system access

A major challenge in producing this case study was the availability and quality of data on the health of the Roma population, as governmental health data is not disaggregated by ethnicity. The figures here should therefore be seen as indicative. The data available come from surveys and research conducted by the Roma Council, United Nations agencies and other intergovernmental bodies, international and Roma NGOs, personal observations, and communications with representatives of the targeted population.

Research undertaken by the Roma Council in 2007 showed that about 34.3% of the Roma have health insurance. Among these, 74.3% are insured via the Unemployment Bureau (Roma Council, 2007). Of the Roma surveyed by World Vision, 25% stated that their family was not covered by health insurance. Of the families that are covered, many actually only have coverage for some, but not all, members of the family (World Vision, unpublished observations, 2006). Of the families with health insurance, 42% have coverage for only one person. The reasons given covered primarily administrative obstacles (World Vision, unpublished observations, 2006). Lack of identity documents and municipal registration further limits access to health insurance (OSCE, 2005).

Of those surveyed by the Roma Council, 8.1% stated that they have children with special needs. Among children with special needs, 55.6% were born with a disability, 24% have problems due to illness, 10% had been injured, and the rest did not provide a response (Roma Council, 2007)

Although data on vaccination rates among the Roma population are lacking, existing indicators suggest that they are low. In 2004, the NGO Budimo Aktivni, supported by the United Nations Children's Found (UNICEF) and the European Commission (EC), undertook research for the project Inclusion of Roma Children in the Education System. The project found that 40% of Roma parents reported they did not know for which illnesses their children had been vaccinated (UNICEF & EC, 2005). The majority of these parents responded that vaccination had occurred immediately after the birth of their child and never again. This result is similar to that found in World Vision research, where 90% of parents stated that their child had been vaccinated at birth, but probably not again (World Vision, unpublished data, 2006). It thus appears that Roma children may not be receiving the full continuum of vaccines required in Bosnia and Herzegovina. Data reported in *National Human Development Report 2007* show that Roma surveyed were 5–6 times less likely to be vaccinated than refugees and internally displaced persons, two groups that are also very vulnerable (UNDP in Bosnia and Herzegovina, 2007). During an Institute of Public Health vaccination investigation in 2003, authorities had trouble finding Roma parents. This highlights the difficulties associated with improved vaccination rates and follow-up. The health system began conducting vaccination campaigns after the war, targeting also Roma children.

Women's NGOs that address domestic violence and trafficking in women state that the percentage of their clients who are Roma has been increasing, as has the number of Roma drug users (Fadila Hadžić, National Coordinator, Foundation La Strada (NGO), personal communication, October 2007; Samir Ibišević, president, and Amer Rastoder, vice president, Citizen's Association for the Support, Treatment, Resocialization of Drug Addicted and Recovered Persons (NGO UGProi), personal communication, October 2007); Hajrudin Hasečić, MD, Head of Department for Drug Addiction Public Institute for Alcoholism and Substance Abuse of Canton Sarajevo, personal communication, October 2007). The research conducted by World Vision suggests that expenditures for legal drugs and alcohol are also significant; alcohol and cigarettes appeared at the end of a list of top ten expenditures. Among 50% of the Roma surveyed, expenditures for tobacco equalled those for medicine (World Vision, unpublished data, 2006).

Among Roma, data on HIV/AIDS and knowledge about it are scant. The International Organization for Migration (IOM) conducted a HIV/AIDS knowledge, attitudes, and practices survey at its medical centre in Sarajevo in 2006. Of the centre

clients, 35% were Roma. The survey report concluded that the following mobile groups were potentially at increased risk of HIV infection: Roma, international transport drivers, refugees/asylum seekers and irregular migrants. These groups were identified based on their significantly low knowledge of some or all of the basic details of HIV/AIDS and HIV-infection routes. The majority of those surveyed (except for trafficking victims) could not name a place where one could get an HIV test (IOM, 2006). IOM also recommended that preventive action be targeted at vulnerable groups. World Vision research showed similar results and suggested that the stigma associated with having HIV is widely prevalent.

Cross-sectoral policies/strategies to improve Roma inclusion

International and national NGOs, in cooperation with OSCE, CE, EC, the United Nations High Commissioner for Refugees (UNHCR), UNICEF and others, have been a driving force behind growing recognition that Roma are among the most discriminated against and socially marginalized population in Bosnia and Herzegovina. As a step towards remedying this, OSCE maintains a strong partnership with Roma NGOs on the implementation of projects leading to the integration of Roma in society (OSCE, 2005).

During the writing of this case study and in conjunction with the Roma Strategy of Bosnia and Herzegovina (see the following section), the government developed action plans for health, employment and housing for the Roma population. These were accepted and adopted by the Council of Ministers in July 2008. An action plan for education for Roma and other minorities had previously been developed and adopted in 2004. By adopting these action plans, Bosnia and Herzegovina achieved the preconditions for applying to participate in the Decade of Roma Inclusion 2005–2015. In September 2008, the Chairman of the Council of Ministers signed the Declaration of the Decade of Roma Inclusion, officially making Bosnia and Herzegovina the 11th member of the Decade of Roma Inclusion (Decade of Roma Inclusion 2005–2015, 2008b).

Roma Strategy of Bosnia and Herzegovina

The Roma Strategy of Bosnia and Herzegovina (Ministry for Human Rights and Refugees of Bosnia and Herzegovina, 2005), which is an official document, provides the framework needed to address the status of Roma. The Ministry for Human Rights and Refugees of Bosnia and Herzegovina, in conjunction with representatives of Roma communities, discussed elements of the Strategy at sessions of the Council of Ministers and the Parliamentary Assembly (CE, 2005). The Council of National Minorities is charged with monitoring and evaluating the Roma Strategy and respective action plans.

Several working groups are advancing components of the Roma Strategy of Bosnia and Herzegovina. The health, employment and housing working groups each developed their respective action plans. Two senior health experts (one from the Federation of Bosnia and Herzegovina and one from Republika Srpska) evaluated the work of the health working group. The health action plan was adopted by the Council of Ministers in July 2008.

The Health Working Group consists of 21 members, seven of whom are Roma. Members include governmental health and social welfare representatives, as well as NGO representatives. Key governmental sectors, such as health insurance, are represented. Members were nominated by the Ministry of Human Rights and Refugees, which also delegated some nominations to an entity (Federation of Bosnia and Herzegovina or Republika Srpska) and municipal level.

There is also a Monitoring and Evaluation Working Group for the health action plan (as well as separate similar groups for the employment and housing action plans). Members of this group represent different stakeholders: four work for the Ministry of Health or Institute of Public Health in their respective entity, five are Roma NGO representatives, and the others represent local political authorities. None of the health professionals work specifically with Roma people directly – except for one, who is involved with a UNICEF-funded project, Responsible Parenthood. The members of the Monitoring and Evaluation Working Group and Health Working Group overlap, as has been pointed out by representatives of CE and OSCE.

In the formulation of the Roma health action plan, the Ministry of Human Rights and Refugees consulted a number of stakeholders (facilitated by the Bosnian Committee for Help (BOSPO) and World Vision), which resulted in many key points being raised. The Ministry of Human Rights and Refugees pointed out some key challenges to improving Roma health status, most notably low health insurance coverage and poor health literacy. Roma NGOs present at these meetings stressed the important role played by discrimination in shaping Roma access to health care. Other stakeholders pointed out positive examples from Republika Srpska, where Roma can have health insurance regardless of their employment status due to the

way the social assistance system is structured – that is, so long as the father is covered, women and children are not obligated to pay for insurance. Other frequently noted issues were the need for Roma to attend medical schools, the role of unhealthy housing in health, and the need for greater employment (and thus health coverage) among the Roma. The importance of birth certificates (and that Roma disproportionately do not have these) was also noted.

Some meeting attendees called for specific programmes that target Roma drug users, women and children. Activities proposed to improve health included locating health services in Roma communities. Also, many stressed the importance of raising the awareness of Roma and the general population about the work on the action plan.

In the Roma health action plan, activities to improve Roma health are broken down into several categories (Decade of Roma Inclusion 2005–2015, 2008c). The following objectives and measures are reflected in three key areas: (a) ensuring the right of Roma national minority members to health care; (b) raising awareness in the health care field; and (c) providing and implementing preventive measures aimed at improving Roma health.

Measures in the action plan to ensure the right of Roma national minority members to health care are:

- registering newborn children and other Roma who are not registered in birth records, in compliance with the law;
- developing a database of insured Roma health care beneficiaries, disaggregated by gender and age;
- aligning legislation to ensure Roma rights to health care are exercised uniformly in all of Bosnia and Herzegovina; and
- obliging governments at all levels of authority in Bosnia and Herzegovina to provide funds to ensure the right to health care for all Roma who are not insured on some other grounds.

Action plan activities for awareness in the health care field are:

- providing health professionals with additional training in fighting prejudice and preventing stereotypes about Roma;
- providing additional training in specific health risks faced by this population and specific health care programmes;
- having information campaigns on the right to health care and working on raising the awareness of the Roma national minority about the importance of health care (and prevention of diseases);
- educating Roma trainers within local communities in preventive health care measures, as proposed by the Bosnia and Herzegovina Roma Council;
- implementing health and educational activities on prevention of illness, through local trainers; and
- ensuring governmental and nongovernmental organizations financial support for education and training of Roma medical staff.

Preventive measures aimed at improving Roma health covered in the action plan are:

- conducting priority preventive health care programmes;
- ensuring proper health care provision for Roma, including immunization and complete medical check-ups for high-risk groups at the primary health care level; and
- ensuring integration of health-promoting measures, from strategies in other fields, into Roma programmes.

Funds for implementing all action plans will be provided by two main sources. First, they will be provided from the budgets of the authorities – those at the state, entity and Brčko District levels, and canton and municipal levels – in the amount of 70% of the total sum necessary and planned for implementation. Second, they will be provided through aid from various international organizations and institutions, in the amount of 30% of the total funds planned. The estimated total budget of the Roma health action plan is KM 347 million, until the end of 2015 (Decade of Roma Inclusion 2005–2015, 2008a). Funds for implementing the health action plan now come from different sources, generally through the Ministry of Human Rights and Refugees, in partnership with the Swedish International Development Agency (for action plans on housing), while the EC and World Vision financed health and employment action plans. Other agencies, such as CE, OSCE, the Spanish Development Agency, UNHCR and UNICEF, also supported the development of action plans.

A coordinating body for monitoring the implementation of (all) action plans was established in October 2008 (Albert Pančić, programme manager, World Vision, and Samir Šlaku, associate, Ministry of Human Rights and Refugees, personal communications, November 2008).

Lessons learned

While also facing challenges, the implementation of the Roma Strategy of Bosnia and Herzegovina and sectoral action plans has resulted in successes. The greatest success of the Strategy thus far has been the gathering of professionals to discuss the same topic: the inclusion of the Roma population. This process has resulted in increased awareness of Roma health issues, as well as the social and living conditions that affect their health. The most significant challenges in implementing the Strategy relate to organization/coordination and a lack of consensus among stakeholders on the best way to proceed to include the Roma minority.

Interviews by the author of the present case study with stakeholders involved in the process have revealed opportunities to address these challenges: by more clearly defining the roles of the different stakeholders involved in implementation; by ensuring sufficient human resources for coordination – for example, to facilitate participatory preparation and follow-up to coordination meetings; and by including measures to ensure that actors representing or working directly with the Roma population are included. To facilitate coordination and execution, specific operational documents with targets and indicators for competent authorities – also for branch ministries at the entity and cantonal levels – may help. Furthermore, to address the lack of human resources for coordination, a Coordination Board has been established by the Council of Ministers (Decade of Roma Inclusion 2005–2015, 2008d).

As stated above, the involvement of several different sectors (such as social, health insurance, NGOs, different ministries and international organizations) in this process has been positive. They have developed connections, reinforced each others' capacity and shared viewpoints. Much of the impetus for dealing with Roma exclusion came from international organizations. As a result of the ongoing discussions about the status of Roma, Roma have been identified as a distinct vulnerable group, which has resulted in NGOs undertaking special programmes that deal more broadly with social and health issues. For example, recent Global Fund Programme to Prevent HIV/AIDS activities included as an objective the introduction of HIV prevention in Roma communities and among formerly displaced persons.

Health providers and governmental representatives are reticent to focus on the right to health for just one national/ethnic category, especially in a country where there are 17 minority groups. Some professionals feel that programmes aimed at a particular group of people could create a backlash among providers and health service users in a country where many people are poor and vulnerable. Thus, despite the good intentions of Roma-specific programmes, there are fears that these activities could lead to even deeper discrimination. It would be opportune to raise the awareness of service providers of the increasing recognition at the European level of the need to address the specific needs of Roma populations through targeted measures within universal social service provision, measures that aim to reduce social and health inequities and ensure the inclusion of all vulnerable groups (EC, 2008).

The comprehensive primary health care approach influences determinants of health that arise in sectors other than health. It also permits health systems to be more responsive to the needs of people, including those facing adverse conditions, through delivery points located in their communities. Better coordination among sectors for improving Roma health and that of other disadvantaged groups could best be achieved through primary health care. As the country is currently pursuing health reform, the Ministry of Health has opportunities to start more collaborative efforts with other actors at the primary health care level, not just for the Roma population. Community-oriented mental and physical rehabilitation at the primary health care level are good models for such cooperation.

Opportunities for improved health may arise from health sector providers receiving further training (and capacity building) about Roma inclusion and addressing health inequities. They may also arise through further engagement of the Roma themselves. Training on Roma inclusion issues was conducted for members of the Health Working Group and the Monitoring and Evaluation Working Group in parallel with drafting the action plan. If the training had been conducted prior to the start of the drafting process, its effect could have been optimized. This is an important lesson to consider when producing further operational plans. Also, mechanisms to ensure participation should be built into the specific implementation plans of each component of the health action plan.

Social inclusion gained through more education, better employment and healthy living conditions could also (and perhaps to a greater extent) influence the health status of Roma people, in light of these being important determinants of health.

Finally, it is important that work to improve people's health moves beyond a project-by-project approach to a system approach, for Roma as well as other disadvantaged groups. Given ongoing reforms in the health sector, a family-doctor-based approach might be best. As a basis for action and monitoring its effect, further health surveys should allow for disaggregation of data by ethnicity and socioeconomic status.

Acknowledgements

For the input they provided, thanks go to: Mr Raif Alimanovic, of the NGO Roma and Friends; Mrs Sanela Bešić, coordinator of the Roma Council; Mrs Maja Grujić, of World Vision; Mr Rašid Milkunić, of the Municipality of Tuzla; Mr Albert Pančić, programme manager of World Vision; Mr Dervo Sejdić, OSCE monitor, of the Roma Council; and Mr Samir Šlaku, of the Ministry of Human Rights and Refugees.

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3. Bosnia and Herzegovina (Republika Srpska): poverty and protecting children from family violence

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Summary

The postwar years have seen growth, increased macroeconomic stability, and strengthened central monetary institutions in Bosnia and Herzegovina (Republika Srpska). Yet, much remains to be done to reduce economic insecurity. Growth in inequality and the worsening of the material well-being of some groups are exemplified in data provided by the 2005 revision of the Bosnia and Herzegovina Medium-term Development Strategy (DEPBiH).

Research consistently suggests that people with lower socioeconomic status are at greater risk of exposure to violence. Numerous studies of many countries have shown a strong association between poverty and child maltreatment. Communities with higher levels of unemployment, concentrated poverty, population turnover, less social capital, deteriorating physical and social infrastructures, and overcrowded housing have higher rates of child abuse. In Republika Srpska, domestic violence affects children disproportionately. Many factors lead to the rise in domestic violence and violence against children, and these include poverty, unemployment, social insecurity and changes in societal/cultural values.

The activities of institutions that protect children from violence in Republika Srpska are aimed at effective and cross-cutting systemic solutions. In recent years, a number of important legislative acts and regulations (by-laws), as well as policies, strategies and guidelines, have been developed and adopted with the aim of reducing domestic violence significantly, especially violence against children. Republika Srpska is also advancing policies and strategies that promote social equity and foster social capital.

Reforms in the health care system in Republika Srpska address the problem of unequal access to health care by: (a) reducing the number of people without health insurance; (b) ensuring better availability of health care through technical and allocation efficiency (including the primary health care level); and (c) enhancing the availability of health care to vulnerable groups. The introduction of the family medicine model has promoted continuous monitoring of the health status of all family members through early detection of risk factors, promotion of healthy lifestyles, treatment of disease and rehabilitation. The need to provide a more comprehensive service package to the beneficiaries, particularly to the more vulnerable groups, requires changes in the composition of the family medicine team and how it functions. To meet the additional responsibilities of family medicine, the Ministry of Health and Social Welfare of Republika Srpska decided to incorporate existing community nurses into the family medicine network.

Protecting children from domestic violence involves forming a network that aims to accomplish that goal. This network includes NGOs, schools and kindergartens, medical institutions, counselling centres and social institutions, the police, public prosecutors, and the courts. In this network, the Centres for Social Work have a primary role in detecting, evaluating

and treating child victims of violence and constitute the basic institution in charge of child protection. Community nurses and family medicine teams work with the Centres for Social Work and other stakeholders to protect children from child maltreatment. Child maltreatment refers to the physical and emotional mistreatment, sexual abuse, neglect and negligent treatment of children, as well as to their commercial or other exploitation.

Addressing domestic violence and its risk factors is an important objective in Republika Srpska, and it cuts across sectors and disciplines. Despite the progress already made in this area, challenges remain, including: introducing programmes for the primary prevention of child maltreatment; harmonizing and amending laws to protect children from domestic violence and to ensure their practical enforcement; improving mechanisms for an effective network for protecting children from violence; ensuring resources for building capacity and training multidisciplinary professionals; establishing mechanisms for including children in the creation and implementation of policies and measures related to violence against them; working for the reduction of the number of children in conflict with the law; and setting up a juvenile justice system adapted to children and in harmony with international standards. The risk factors for exposure to violence can also be addressed by ensuring the application in Republika Srpska of the United Nations Convention on the Rights of the Child and by providing a healthy start for all children, as recommended by the WHO Commission on Social Determinants of Health.

Socioeconomic and policy context

Bosnia and Herzegovina was recognized by the international community in 1992 as a newly independent country. A war followed from 1992 to 1995 and was ended by the Dayton Peace Accords. Today, Bosnia and Herzegovina is comprised of two entities: Republika Srpska and the Federation of Bosnia and Herzegovina, as well as Brčko District – which is independently administered and over which neither Republika Srpska nor the Federation of Bosnia and Herzegovina have jurisdiction. This case study focuses on Republika Srpska, which comprises 49% of the total territory of Bosnia and Herzegovina. Republika Srpska's current population is estimated to be 1 487 800 people (Republika Srpska Institute of Statistics, 2007a).

Poverty

The postwar years have seen growth, increased macroeconomic stability, and strengthened central monetary institutions. Yet, much remains to be done to reduce economic insecurity. In 2004, in Bosnia and Herzegovina, 17.8% of the population lived below the poverty threshold, and in Republika Srpska the percentage reached 20.8% that year. In the years between the last two authoritative poverty surveys (the 2001 living standards measurement survey and the 2004 Living in Bosnia survey), poverty fell by less than 4%, despite cumulate growth being estimated at 30% (UNDP, 2007).

Growth in inequality and the worsening of material well-being of some groups are exemplified in data provided by the 2005 revision of the DEPBiH (DEPBiH, 2006). In response to these downturns, making growth pro-poor and reaching out to the vulnerable, to enable them to participate in the positive economic dynamics, are now stated as key priorities for authorities (UNDP, 2007).

Economic growth is accepted as a precondition for reducing poverty, but it is not the only precondition. Poverty reduction must be complemented by measures that enable the disadvantaged members of society (including young people, women and other marginalized groups, such as Roma and the disabled) to participate in the labour market, health care, education and social protection. The government is attempting to bring about improvements in the labour market, but considerable challenges remain. Education also plays a key role in the poverty-reduction process and is thus a priority, as educated people are able to increase productivity in all sectors (Council of Ministers, 2006).

Poverty and violence against children

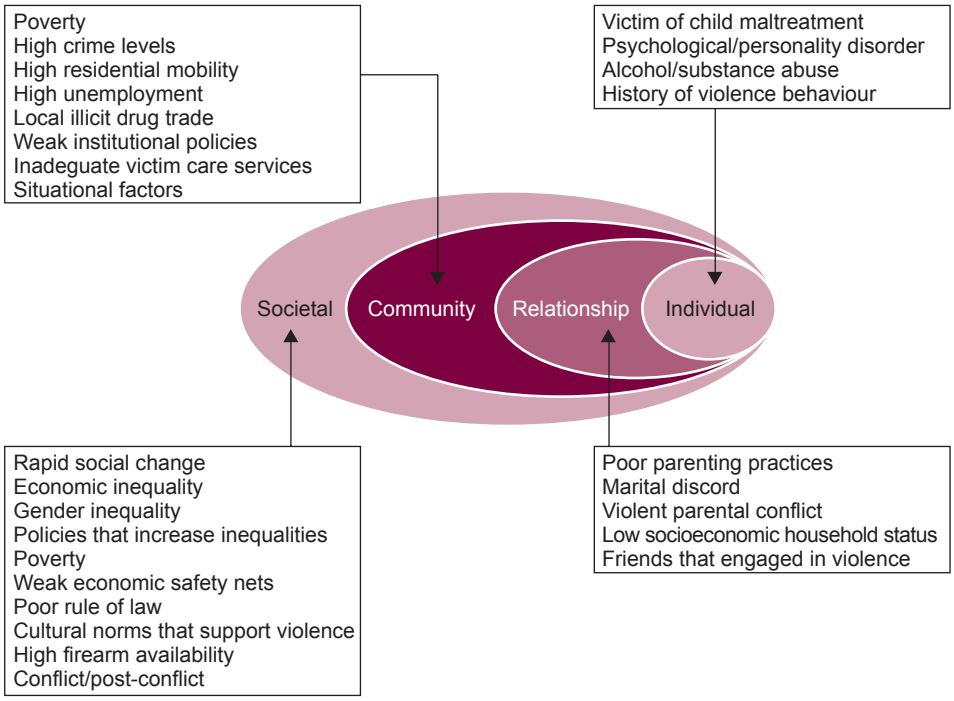
As highlighted in the *World report on violence and health* (Krug et al., 2002), research consistently suggests that people with lower socioeconomic status are at greater risk of exposure to violence. The report defines violence as, "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that results either in injury, death, psychological harm, maldevelopment or deprivation."

Multidimensional poverty and social inequity – including poor housing, lack of education, unemployment, gender inequity,

and other poverty-related and excluding conditions – place people at a heightened risk of violence. The rate at which people enter into poverty and the differential way in which they experience poverty – that is, relative deprivation within a particular setting, rather than absolute level of poverty – are also important. Because of the links established between such conditions and violence, the *World report on violence and health* suggests that governments should implement primary prevention programmes against child maltreatment, strive for effective social protection services and, if necessary, reorder the priorities in their national budgets.

With regard to children, numerous studies across many countries have shown a strong association between poverty and child maltreatment. Child maltreatment refers to the physical and emotional mistreatment, sexual abuse, neglect and negligent treatment of children, as well as to their commercial or other exploitation (Butchart et al., 2006). Communities with higher levels of unemployment, concentrated poverty, population turnover, less social capital, deteriorating physical and social infrastructures and overcrowded housing have higher rates of child abuse (Krug et al., 2002). Children in ethnic minority groups are often at high risk of violence because of a confluence of other risk factors associated with social exclusion (Pinheiro, 2006). Fig. 3.1 represents an ecological model of risk factors – at individual, relationship, community and societal levels – for interpersonal violence, including violence against children.

Fig. 3.1. Ecological model showing shared risk factors for subtypes of interpersonal violence



Source: Butchart et al. (2004:4).

There is evidence that social capital, such as social networks, is a protective factor for children, even for children exposed to a number of risk factors. Other protective factors include, but are not limited to: child and family policies that cover arrangements for parental leave, maternal employment and child care; preventive health care for infants and children, as an aid to identifying cases of abuse in children; the ability of the social welfare system to provide a safety net for children and families; and the nature and extent of social protection and the responsiveness of the criminal justice system (Krug et al., 2002).

As in most societies undergoing transition, Republika Srpska has serious social and economic challenges. One of the most pressing social problems is the rise in domestic violence, which puts children at risk of child maltreatment. Many factors lead to the rise in domestic violence and violence against children. In Republika Srpska, poverty, unemployment, social insecurity and changes in cultural/societal values directly and indirectly influence the increase in domestic violence. A broader discussion about domestic violence as a general public, social and health problem started about a decade ago, when a large number of scientific papers on this topic were published. During the postwar period, there was an increase in the incidence of

such cases, and society as a whole became more sensitive to this problem, which made it easier to recognize cases of domestic violence. Domestic violence is increasingly being considered a public problem, rather than a private and intimate matter of the family affected.

Data from 2007 show that in Republika Srpska about 87 900 people younger than 20 years of age are beneficiaries of social welfare services (Republika Srpska Institute of Statistics, 2008). Of these, 38 850 children live in disadvantaged families – that is, they are children without both parents, children of unknown parents, children abandoned by parents, children of parents prevented from performing parental duties (for example, due to imprisonment, sickness or chronic disease), children of parents deprived of parental rights (for example, due to the decision of a court), children from economically disadvantaged families, children from families with disturbed family relationships (such as molestation, domestic violence, drug abuse or criminal behaviour), children of divorced parents and others (such as children of single parents).

Data for the categories mentioned in the preceding paragraph reveal the numbers of children living under such conditions, as follows:

- children of parents with insufficient income: 32 538
- children without both parents: 290
- children of unknown parents: 11
- children abandoned by parents: 149
- children of parents prevented from performing parental duties: 258
- children of parents deprived of parental rights: 19
- child victims of domestic violence: 876
- children whose development is influenced by the family situation: 3382
- socially neglected and maladjusted children: 1327.

Of the 87 900 people younger than 20 years of age that are beneficiaries of social welfare services, 49 060 are:

- children with psychophysical disorders: 4042;
- children engaging in risky behaviour (such as prostitution, delinquency, criminal acts or alcoholism): 2895;
- children with a psychological disorder: 150;
- children living in difficult situations (such as no housing, returnees from a home for juvenile deliquents, and civil war victims): 36 638;
- others: 5335.

The data for children of parents with insufficient income was provided by the 2007 Household Budget Survey and corresponds to income below the general poverty line (Republika Srpska Institute of Statistics, 2007b).

The latest Multiple Indicator Cluster Survey (for 2006) funded by UNICEF found that attitudes towards domestic violence were linked to cultural habits, socioeconomic level (unemployment, social insecurity, criminal actions, and changes in societal/cultural values) and life experiences of marital partners (Jokić et al., 2007). A total of 4.8% of women aged 15–49 years (sample of 3225 women) believed that a husband/partner is justified in beating his wife/partner. The survey also revealed that in Republika Srpska 39.9% of children aged 2–14 years were punished psychologically or physically by their parents/caretakers or other household members, and 2.6% were severely punished physically. The number of parents/caretakers who professed believing that to raise their children properly, they needed to physically punish them (12.1%) is lower than the number of parents who actually did this (39.9%) (Lolić, Prodanović & Stijak, 2007).

The policy context for protecting children against domestic violence

The activities of institutions that protect children from violence in Republika Srpska are aimed at effective and cross-cutting systemic solutions. In recent years, a number of important legislative acts and regulations (by-laws), as well as policies and strategies and guidelines, have been developed and adopted with the aim of reducing domestic violence significantly, especially violence against children.

The Law on Protection from Domestic Violence (Ministry of Justice of Republika Srpska, 2005) defines the roles of all relevant

actors – such as police, public prosecutors, authorities in charge of custody, health care professionals, courts and others – in addressing domestic violence. Special emphasis is placed on the responsibility to report domestic violence and ensure prompt action. In line with the Law on Protection from Domestic Violence, the 2007/2008 Action Plan against Domestic Violence (Gender Centre of Republika Srpska, 2007) aims to: promote protection procedures and mechanisms provided for in the Law; strengthen the capacities of the relevant authorities under the Law; promote cooperation between courts, public prosecutors, police and the Centres for Social Work; and promote the development of the 2009–2013 Entity Strategy against Domestic Violence

Another tool against violence directed at children, the National Strategy for Protection of Child Maltreatment for 2007–2010 (Ministry of Human Rights and Refugees of Bosnia and Herzegovina, 2007), sets forth the national child policy in the field of combating violence. The National Strategy will enable further adoption of programmes and plans at the national, entity and local levels. Special aims and measures of the Strategy include:

- strengthening the role of the family in society;
- raising public awareness of the scope, types, characteristics and consequences of such violence;
- establishing permanent and sustainable capacity for promoting nonviolence through primary prevention programmes;
- establishing an effective network that protects children against violence; and
- winning the trust of the child victims of violence and their parents/caretakers in the work of professional services.

Multidisciplinary institutions and NGOs are involved in implementing rehabilitation and reintegration programmes, building human and technical resources, and strengthening the capacity of those who work with and for children.

In addition to the above-mentioned Action Plan and Strategy, other policies address domestic violence against children. These include, but are not limited to:

- the 2006–2010 Strategy against Juvenile Delinquency in Bosnia and Herzegovina
- the 2006–2012 Strategy for Protection of Children without Parental Care
- the 2006 Mental Health Policy for Republika Srpska
- the 2008–2012 Youth Health Policy in Republika Srpska
- the 2006–2009 Disability Policy
- the 2006–2010 Strategy against Juvenile Offenders for Bosnia and Herzegovina.

It is important to note that Republika Srpska is also advancing policies and strategies that promote social equity and foster social capital, with the following desired outcomes, which are particularly relevant to preventing violence in light of their bearing on cross-cutting risk factors (Krug et al., 2002; Pinheiro, 2006):

- increased access to, and quality of, early childhood education and care;
- implementation of primary prevention programmes, such as health visits by community nurses to high-risk families;
- improved (and equal) access to primary and secondary education, including adequate resource allocation for education;
- reduced unemployment rates;
- stronger systems for social-protection – for example, social security for the elderly and disabled, health insurance, child care, income and/or food supplements, and unemployment benefits; and
- increased gender equity.

The evidence base of what works in preventing the maltreatment of children has been summarized by WHO (Krug et al., 2002). The response is multisectoral, involving sectors such as health, social services, and education. Primary prevention programmes with evidence of effectiveness include those for home visitations, training for parents, improved access to prenatal and postnatal services, and preschool enrichment. The recent reforms in primary care and the onus of strengthening health systems provide an opportunity for mainstreaming these in Republika Srpska.

Efforts made towards the above outcomes include actions undertaken to achieve the MDGs and ensure social cohesion and

convergence with EU norms. In Republika Srpska, improvements of the social welfare system are provided for by the new Law on Social Welfare of Republika Srpska, which provides better and more efficient protection of the most vulnerable groups, including children. That new Law on Social Welfare of Republika Srpska will be in force in March or April 2009.

Health system

The Dayton Peace Accords and the Constitution of Bosnia and Herzegovina provide for social and health policies that fall within the direct remit of two entities – Republika Srpska and the Federation of Bosnia and Herzegovina – as constituent state-building units. Despite many similarities, the health care and social welfare systems in the two entities are structured differently. The health care system in Republika Srpska is defined in the Health Care and Health Strategy Programme by 2010 (Ministry of Health and Social Welfare of Republika Srpska, 2001). The main goals of the Programme are to:

- reduce differences in the health status of the population and in the availability of health care, in terms of geographical coverage and socioeconomic status of the beneficiaries;
- improve the health status of the population and increase the availability of health care to vulnerable groups;
- reorient overall health care to improve health and prevent diseases; and
- enhance the efficiency and quality of health care.

Reforms in the health care system in Republika Srpska address the problem of unequal access to health care by: (a) reducing the number of people without health insurance; (b) ensuring better availability of health care through technical and allocation efficiency (including the primary health care level); and (c) enhancing the availability of health care to vulnerable groups. In line with its health policy goals, the Ministry of Health and Social Welfare of Republika Srpska is committed to improving the delivery of community-based health care through community-based centres for mental health and community-based physical rehabilitation centres.

The backbone of the overall health care system and one of the most powerful levers for implementing reform in primary health care is the introduction of service according to the primary care model based on family medicine. This model is based on the delivery of available, effective, quality, and cost-effective services, interventions and programmes. Introduction of the model has promoted continuous monitoring of the health status of all family members, through early detection of risk factors, promotion of healthy lifestyles, treatment of disease and rehabilitation.

A typical family medicine team is composed of a family medicine doctor and two nurses who focus on community-based work. Family medicine nurses link the functions of primary health care to beneficiaries in their homes, workplaces and other community settings. The team organizes, coordinates and implements social health care measures and activities by cooperating closely with authorities and organizations involved in such areas as social welfare, health care, preschool and school education, and work.

The primary care model based on family medicine facilitates early detection of signs of asocial behaviour in a family and other risk factors for domestic violence. Families with infants and young children who routinely come in contact with the health and social services can be targeted for need by: (a) assessing the child's development needs in general; (b) assessing the capacity of a parent to respond appropriately to their child's needs; and (c) assessing the wider social and environmental factors that affect the capacity to parent (WHO Regional Office for Europe, 2007). At the primary care level in Republika Srpska, domestic violence may be prevented by networking the family medicine teams, Centres for Social Work, community-based centres for mental health and community-based rehabilitation centres. The following section expands on the role and function of the Centres for Social Work and, in particular, on their role in cooperating with primary health care services.

Centres for Social Work

Social welfare and child protection in Republika Srpska are organized at two levels: entity and local (municipal). A key role in child protection is played by the Centres for Social Work, which maintain a register of families in social need. The Law on Social Welfare (National Assembly of Republika Srpska, 1993, 1996, 2003) and the Law on Child Protection (National Assembly of Republika Srpska, 2002) specify the rights and entitlements of these families and children.

Protecting children from domestic violence involves forming a network that aims to accomplish that goal. In Republika Srpska, this network includes NGOs, schools and kindergartens, medical institutions, counseling centres and social institutions, police, public prosecutors, and the courts. In this network, the Centres for Social Work have a primary role in detecting, evaluating and treating child victims of violence and constitute the basic institution in charge of child protection. Larger and better staffed Centres for Social Work in Republika Srpska have mobile around-the-clock teams that intervene in cases of domestic violence.

In recent years, the activities of the Centres for Social Work have often enlisted the cooperation of local partners, which contributes to the overall quality of these activities. Local partners include health care and educational institutions, the judiciary, police and municipal authorities, as well as numerous governmental and nongovernmental humanitarian organizations and citizens' associations. Community nurses and family medicine teams also work with the Centres for Social Work and other stakeholders to protect children from violence. Such broad engagement of numerous social welfare actors requires that the Centres for Social Work coordinate professional and institutional efforts aimed at curbing violence against children.

Coordination between primary health care and social services and the role of community nurses

Collaboration with social services to share knowledge and build effective partnerships and teamwork is among the objectives of family medicine. Such collaboration is essential for protecting children from domestic violence. The need to provide a more comprehensive service package to beneficiaries, particularly to the more vulnerable groups, requires changes in the composition of the family medicine team and the way in which it functions. To meet the additional responsibilities of family medicine, the Ministry of Health and Social Welfare of Republika Srpska decided to incorporate the existing community nurses into the family medicine network. These nurses link family medicine with the community and coordinate the services for the vulnerable segments of the population. They focus on home care services, including palliative care, patient education, health promotion and illness prevention, treatment follow-up, early detection of diseases and risk factors, and referral.

Nurses in the community are key players in responding to the complex and changing demands on health and care services. To respond to these demands and work in new and different ways as part of multidisciplinary and multi-agency teams, nurses must continually adapt and improve their skill sets. The seven core elements of nursing in the community are:

1. working directly with individuals and their carers
2. adopting public health approaches to protecting the public
3. coordinating services
4. supporting self-care
5. working in multidisciplinary and multi-agency teams
6. meeting the health needs of the community
7. supporting anticipatory care.

As other professionals and networks are needed to complement family medicine in its work, new actors – such as social workers, mental health care providers and other specialists – work increasingly with these teams. Professionals from the social sector should be involved in the development of the curriculum for training community nurses. Other health providers should be actively involved in team building, coordination activities and their respective fields of work. These efforts will also help health providers to become familiar with the range of activities and services available in the social network and will improve collaboration among all partners, including on issues such as violence against children.

Lessons learned

As documented in the United Nations Secretary-General's *World report on violence against children* (Pinheiro, 2006), violence against children carries forward into their later childhood, adolescence and adult life and has immediate and long-term effects on health and development. Victims of such violence may lose trust in other human beings, since learning to trust through attachments in the family is an essential task of childhood and is closely related to the capacity to love, have empathy and develop future relationships. Violence thus stunts the potential for personal development and achievement in life and presents heavy costs to society through related economic effects. These effects include direct costs, such as the cost of medical care for victims, the cost of legal and social welfare services, and the cost of placing child victims in care. Indirect costs include: possible lasting injury or disability; psychological costs or other effects on a victim's quality of life; disrupted or discontinued education; and productivity losses in later life (Pinheiro, 2006).

In light of this, addressing domestic violence and its risk factors is an important intersectoral objective in Republika Srpska. The ultimate goals of entity activities are to maintain family health as the foundation of society, prevent violence and protect victims. Progress made towards these goals in recent years has included: the strategies noted in the section on "Socioeconomic and policy context"; the strengthening of primary health care (for example, through the family medicine model); and the raising of awareness about this issue through various media, including billboard displays, radio and TV shows, and music spots against domestic violence.

Despite the progress made so far, there is still much to do to protect children from domestic violence. Among the remaining challenges are the needs to:

- harmonize and amend all laws that aim to protect children from domestic violence, to ensure their practical enforcement;
- improve the network for protecting children from violence by making it more effective, which requires coordinating all institutions (including those involved in primary health care and the Centres for Social Work) and professionals (including family medicine teams) who work on preventing violence and protecting children from violence;
- ensure resources for building capacity and training multidisciplinary professionals on awareness of (and standards for) protecting children from violence;
- establish mechanisms for including children in the creation and implementation of policies and measures related to violence against them; and
- work on reducing the number of children in conflict with the law and set up a juvenile justice system that is adapted to children and is in harmony with international standards.

With regard to addressing risk factors for exposure to violence, such as poverty, there are opportunities for scaling up action to:

- ensure application in Republika Srpska of the United Nations Convention on the Rights of the Child, with the aim of improving and raising standards and strengthening the role of the child in the family and in society; and
- provide a healthy start for all children, as recommended by the WHO Commission on Social Determinants of Health, through an integrated policy framework for early child development (WHO, 2008).

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4. Czech Republic: information brochures about the health care system for foreigners

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Summary

Within the EU, migration (particularly from one Member State to another) is among the most important topics of common interest. It concerns the values of respect for human dignity, freedom, democracy, equality, the rule of law and human rights, including the rights of minorities. The EU aims to combat social exclusion and discrimination and to promote social justice and protection, gender equality, solidarity between generations, and the protection of children's rights.

This case study discusses the contribution of health care to the integration of immigrants into Czech society. Immigrants' access to health care was systematically studied during the period 2000–2006 by a research team headed by Karolína Dobiášová. The team found that the barriers immigrants encounter in accessing health care in the Czech Republic appear to be mainly administrative.

This case study focuses on two brochures – *Guide to the health care system in the Czech Republic: information guide for foreigners* and *Guide to children's health care in the Czech Republic: information guide for foreign nationals residing with children in the Czech Republic*. These brochures advise foreign nationals, whether permanently or temporarily residing in the Czech Republic, about the Czech health care system. The aim is to enable them to easily orient themselves and make use of the possibilities granted by relevant laws and health care services.

During the period 2002–2005, 20 000 brochures were printed and distributed to foreigners in the whole of the Czech Republic. These brochures were (and still are) available in Czech, English, German, Russian, Ukrainian and Vietnamese. Migrant communities were actively involved in the creation and yearly revision of the brochures.

The brochures are joint projects of the Ministry of Health, the Commission for the Integration of Foreign Nationals of the Ministry of the Interior, and the former Institute of Health Policy and Economics. Public funds paid for the work, and it was part of broader research on the health of migrants and foreigners and the determinants of their health in the Czech Republic. The brochures were distributed by all project partners and also by organizations for migrants and foreigners and NGOs working in this field. Feedback from these entities and results of project evaluations were positive; it suggested that the brochures contributed to the knowledge and social competence of migrants, reacted to the stated needs and problems, and addressed the need for information about the Czech health care system in immigrant communities.

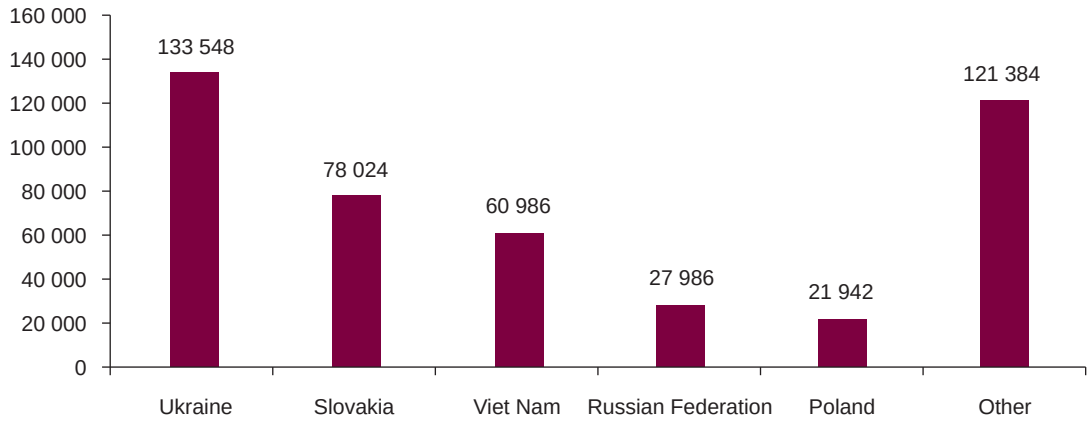
Socioeconomic and policy context

Since 1999, the gap between the economic level of the Czech Republic and the average economic level in the countries belonging to the EU after January 2007 (EU27) has been decreasing consistently. In 2007, the GDP per person (adjusted for purchasing power parity (PPP)) reached 82% of the EU27 level. With a population of 10 381 130 (as of December 2007), the current demographic situation in the Czech Republic is characterized by an overall ageing of the population – that is, by a decrease in the portion of the youngest age groups in the overall age composition of the population. Since 2002, despite a negative natural increase in the population, a slight growth in the number of inhabitants has been recorded, thanks to the positive contribution of migrants (Ministry of Labour and Social Affairs, 2008).

Between 2006 and 2009, there was an intense influx of foreigners into the Czech Republic. As of April 2009, 443 870 foreigners (255 847 men, 188 023 woman) were registered within the territory of the Czech Republic (Czech Statistical Office, 2009). In comparison with 2006, this represents more than a 40% increase. In 2005, foreigners made up 4.7% (5.6% in 2006) of the country's overall labour force. The influx of foreigners in recent years has contributed significantly to increasing the number of inhabitants in the Czech Republic. Migration temporarily balances the population losses caused by the low birth rate in recent years. Because of the continually low birth rate and the growing prosperity of the Czech Republic, the country may lack sufficient sources of domestic labour. The shortfall in labour will, most likely, be reinforced somewhat by migrant workers. Thus, a growing interest among foreigners in work and residence in the Czech Republic should continue in the future. In connection with this interest, the integration of foreigners who have legally settled in the Czech Republic for the long term has become increasingly important (Ministry of Labour and Social Affairs, 2008).

According to data available as of April 2009 (Czech Statistical Office, 2009), the largest groups of migrants are Ukrainians, Slovaks (which are EU citizens) and Vietnamese (see Fig. 4.1). The attention of public health professionals to the migration phenomena is related to the health status of migrants (which is influenced by living and working conditions in the countries of origin, transit and destination) and to access to the health system in the Czech Republic.

Fig. 4.1. Foreigners in the Czech Republic by nationality, as of 30 April 2009



Source: Adapted from Czech Statistical Office (2009); Directorate of Alien Police (2009).

The three main features of the health care system in the Czech Republic are as follows: (a) social health insurance with universal membership, funded through contributions by individuals, employers and the State; (b) diversity of provision, with mainly private ambulatory care providers and public hospitals that have contractual arrangements with the insurance fund; and (c) joint negotiations by key players on coverage and reimbursement issues (Rokosová et al., 2005).

Health care in the Czech Republic is provided primarily on the basis of statutory health insurance. People with permanent residence in the Czech Republic are entitled to health insurance, as are those residing in the country who do not have their permanent residence but are employed by an employer whose registered base is in the country. Each health insurance fund is obligated to accept any client meeting the conditions for participating in statutory health insurance (Rokosová et al., 2005).

Anyone who does not meet these conditions may take out contractual health insurance. Depending on the term and scope of care paid for by that insurance, a person may obtain a short-term or long-term health insurance policy. Short-term policies (under 365 days) are suitable for short-term stays in the country – that is, for tourism or business. Long-term health insurance policies (in cases of stays over 365 days) may be taken out by foreigners who are staying in the country on the basis of a visa exceeding 90 days (with the exception of foreigners with a visa exceeding 90 days, granted for employment, if their employer's registered base is in the Czech Republic – since they participate in the statutory health insurance system) (Rokosová et al., 2005). In the case of families of employed migrants from countries outside the EU, the members of the family are also insured: by employers, if they work; or by short- or long-term private health insurance, if they are not involved in the labour market. There is no institution of co-insurance in the Czech Republic. Also, unemployed migrants from third countries lose the insurance paid by employers and become uninsured, so their only options are to buy private health insurance or (de facto) leave the country.

Migrants (especially those from third countries) face administrative, cultural, communication and economic barriers in accessing the health care system. Migrant health and access to health care for migrants were studied during the period 2000–2006 – for example, by Dobiášová et al. (2003a,b; 2004; 2006). These studies included the health of regular Ukrainian migrants and their use of health care in the Czech Republic in 2002 and covered a representative sample (n = 645) (Dobiášová, 2003b). This particular study was based on a three-part questionnaire that covered health status, health care utilization, and social and economic determinants of health. The questionnaire was in Czech, Russian and Ukrainian. Research assistants helped (when needed) migrants surveyed to fill in the questionnaire. Questionnaire preparation was preceded by a small qualitative survey.

Among other things, the research focused on Ukrainian migrants found that only about half the respondents had undergone an initial medical examination, which is compulsory for extended stays in the Czech Republic. The researchers, therefore, assumed this obligation is not always fulfilled. A quarter of surveyed Ukrainians living in the Czech Republic for more than a year were medically uninsured, with the high cost of health insurance reported as the most common reason for not obtaining such insurance. Of the Ukrainians surveyed, a large percentage had not been informed of their obligations for (and entitlements to) using and paying for health care services in the Czech Republic. Unfortunately, some respondents also reported being victims of so-called false health insurance companies, which do not have licences to operate and which do not give the patients reimbursement for services.

Of the Ukrainians surveyed, 28% reported being afraid to visit a doctor or hospital. These fears, however, lessen with the length of their stay. The most frequent concern about using health care services is the fear of losing employment, followed by concerns about the inability to pay for it. With regard to payment for health care, about 65% of the Ukrainians surveyed stated this was covered by health insurance, while 45% indicated they paid in cash. Significant barriers to access to health care appear to be communication, being understood by health care providers and perceived negative views of Ukrainians as a migrant group. Of questionnaire respondents, 40% also stated they could not orient themselves in the Czech health care system, while 2% said they had a bad experience with health care in the Czech Republic. The most frequent health problems noted subjectively among Ukrainians surveyed are fatigue, exhaustion, back pain and headaches.

Other work by Dobiášová et al. includes a study on health care of the children of foreigners, entitled *Health care for children of foreigners: reality and experience* (Dobiášová et al., 2006). The research was based on a standardized interview (30–90 minutes long), with foreigners selected by using the snowball sampling method, where referrals from initial subjects were used to generate additional subjects. The shortcoming of this method is that it introduces bias, because the method itself reduces the likelihood that the sample will represent a good cross-section of the population. The research sample, n, was 21. This number needs to be taken into consideration when drawing conclusions from this study.

The main hypothesis of the study – *Health care for children of foreigners: reality and experience* (Dobiášová et al., 2006) – was that barriers restrict access to health care for the children of foreigners living long term with their parents in the Czech Republic. The study findings confirmed the hypothesis and demonstrated the presence of these barriers. These findings showed that children of foreigners who are not participants in public health insurance are at greatest risk of not receiving care, and those with private health insurance face risks and other problems (barriers), including:

- the risk of not being insured;
- the risk of the contract for health insurance not being renewed if there are any medical problems;
- a limited choice of physicians;
- a restricted range of dental care covered;

- the need to pay the full price for prescribed medications, where costs are subsequently reimbursed by the health insurance company; and
- the risk of an excessive financial burden on the family.

According to study findings, language is another barrier children of foreigners encounter, although it is one that decreases with the length of their stay, as they become more fluent in speaking and understanding Czech. This can be a problem for children who live with their parents outside of Prague, because they often do not have access to specialized centres designated solely for foreigners or they have difficulty in finding a physician who can communicate with them in their language. Study findings also indicate that while the language barrier is not the most significant problem for children of foreigners who need access to health care in the Czech Republic, it is one of them.

With regard to how well foreigners are informed of health care for children, study findings indicate that most foreigners came to the Czech Republic without any information on how the health care system works. Moreover, the majority of respondents reported feeling that information was not readily available.

According to the study, foreigners staying long term in the Czech Republic with their children have no particular criticism of their treatment by medical personnel or of the competence of Czech doctors.

Information brochures about the health care system

The brochures *Guide to the health care system in the Czech Republic: information guide for foreigners* and *Guide to children's health care in the Czech Republic: information guide for foreign nationals residing with children in the Czech Republic* are joint projects of the Ministry of Health, the Commission for the Integration of Foreign Nationals of the Ministry of the Interior, and the former Institute of Health Policy and Economics. The aim of these brochures is to advise foreign nationals, whether residing permanently or temporarily in the Czech Republic, about the health care system, so they can easily orient themselves and make use of the possibilities granted by relevant laws and existing health care services.

The brochures provide information that helps foreigners better understand Czech laws on health care – for example, that almost all health care facilities, both private and public, have a contract with health insurance companies and provide health care to patients insured by those companies without direct payment. The brochures aim to increase the health literacy of immigrants and foreigners (and decrease fear and apprehension) about the health care system. The brochures explain to them what they should do and expect, their legal entitlements, and where they can send complaints.

The brochures were (and still are) available in Czech, English, German and the languages of the two largest migrant groups (with the exception of Slovaks, for whom no language barrier exists) living in the Czech Republic: Ukrainian and Vietnamese. The approach taken to the content of the brochures was culturally sensitive. The questions that appear in the brochures were derived from the questions most frequently asked by members of the target communities.

The first part of the *Guide to the health care system in the Czech Republic: information guide for foreigners* contains a brief and user-friendly description of the health care system. The second part of the brochure is designed to assist foreign nationals in various situations they may encounter in the Czech health system. This part is divided into the following sections, with a question and answer format.

- **Health insurance.** This section contains information that responds to such problems and questions as: I have come to the Czech Republic and I have no health insurance. How should I proceed? Who can I turn to and what are my options? What does health insurance cover and what do I have to pay for in cash?
- **Receiving health care.** This section answers such questions as: What should I do if I feel the need to seek medical care? How do I find a doctor who speaks my language?
- **Employed foreign nationals.** This section can help with such problems as: I am changing my job in the Czech Republic. How does that affect insurance? Where should I go? Where should I report? What problems am I faced with if my employer does not pay my insurance?"
- **Foreign nationals as entrepreneurs and self-employed persons.** This section answers such questions as: If I want to do business in the Czech Republic, how can I get insured? What do I have to do to get insurance?

- **Foreign national employees and self-employed people, and health insurance for foreign nationals' children born in the territory of the Czech Republic.** This information's was published in 2005 in the brochure *Guide to children's health care in the Czech Republic: information guide for foreign nationals residing with children in the Czech Republic*.

The third part of the guide focuses on the type of health insurance (such as public health insurance, health insurers and contractual health insurance). The fourth part helps people from abroad understand what it means to be a payer of insurance premiums. The fifth part informs the reader about the rights and obligations of foreign nationals receiving health care in the Czech Republic. This is followed by information about the extent of health insurance coverage. There are also parts dedicated to the following subjects: the free provision of health care on the basis of international agreements; the organization of health care provision in the Czech Republic, with contacts for institutions; an overview of the most important legal regulations in force in the area of health care provision; and further information available in Czech publications. *The Guide to the health care system in the Czech Republic: information guide for foreigners* was first published in 2002 and was revised yearly until 2005. During the period 2002–2005, 20 000 copies of the brochure were printed and distributed to foreigners in the whole of the Czech Republic.

In 2005, the second brochure – the *Guide to children's health care in the Czech Republic: information guide for foreign nationals residing with children in the Czech Republic* – was published, because until that year the issue of the health care of children of foreign nationals had only been outlined superficially. The need for a special guide for children arose from the feedback of users of the first brochure. The aim of the second brochure was to inform foreign nationals about living with children permanently or temporarily in the Czech Republic and about the Czech health care system. The brochure gives information about legally defined obligations. It pays special attention to gender issues, as it was designed to consider the needs of mothers caring for small children. Taking a life-cycle approach, it addresses such important issues as nutrition and vaccinations. It provides parents with information on recommended portions of food and the vaccination calendar (starting with vaccinations on the fourth to sixth day after birth and ending with a vaccination for tetanus in the fourteenth year). The table of contents of this brochure appears in Box 4.1.

The project arose from the programme Conception of the Integration of Foreigners in the Czech Republic, which is under the authority of the Ministry of Interior. The brochures were free of charge and, thus, more accessible to both the organizations working with foreigners and foreigners themselves. Funding for the project came from the Ministry of Health and the Ministry of Interior, and the project activities were designed to be time-limited.

The *Guide to the health care system in the Czech Republic: information guide for foreigners* was revised yearly until 2005. The yearly revision entailed evaluation by the target group, with an evaluation sheet being part of the brochure. The sheet contained questions such as: What did you miss in the brochure? Was the information in the brochure useful for your contact with the health system? Further revision of the guide – to update the contents if necessary – may be possible in the future and may be funded from public sources.

During the revision process, foreigners had the opportunity to comment and make suggestions, based on the use of the brochures in everyday life. The comments, suggestions and also new legislation, among other things, were monitored by the team of brochure authors, headed by Karolína Dobiášová, and were used in revisions. The efficiency and effectiveness of the project were also evaluated by the Ministry of Health and the Ministry of Interior. Moreover, the associations of foreigners and NGOs made several useful comments to improve the user friendliness of the content and design of both brochures.

The brochures were distributed by all project partners, by associations of immigrants and foreigners and by NGOs working to support the integration of foreigners into various components of society. This also enabled these helper groups to improve their ability to give advice on access to health care. Not surprisingly, the Czech language version of the brochure was appreciated by social service providers, teachers, scholars and others; they found that it described the Czech health care system in a user-friendly format. There was also positive feedback from the Austrian Embassy; it expressed its appreciation for the German language version of the brochure, which was useful to Austrian citizens coming to the Czech Republic – also for shorter (tourist) stays.

Box. 4.1. Table of contents for Guide to children's health care in the Czech Republic

I. Introduction

II. Health insurance
- Health insurance for children of foreign nationals born in the territory of the Czech Republic
  - A child born to parents resident in the territory of the Czech Republic on the basis of a residence permit
  - A child born to parents who are staying in the Czech Republic temporarily, on the basis of a long-term visa (that is, for a visa for residence over 90 days)
  - A child born to parents temporarily residing in the Czech Republic, on the basis of a short-term visa (that is, exit visa, transit visa, airport visa and visa for residence up to 90 days)
  - A child born to parents or citizens of a EU Member State residing long-term in the Czech Republic
  - A child born to a mother who is applying for asylum or has a residence visa for the purpose of sufferance according to asylum law
  - A child borne to a mother who has gained asylum
- Health insurance for children of foreign nationals residing with their parents in the Czech Republic
- Types of health insurance
  - Public health insurance
  - Private health insurance
- The extent of children's health care covered by health insurers
  - The extent of coverage from public health insurance
  - The extent of coverage from private health insurance
- Possibilities for insurance for children that a private insurer refuses to insure

III. Organization of the system of Czech health care provision
- Introduction
- Outpatient care
- Institutional care
- Accident and emergency services
- Special paediatric services (nursery institutions, children's homes, crèches)
- Pharmacy services in the Czech Republic
- Complaints

IV. Preventative health care for children and young people
- Preventative examinations
- Screening
- Vaccination
  - Payment for vaccination
- Child nutrition
- Dental care
- Injuries

V. Contacts for important institutions

VI. Overview of the most important applicable legal regulations in the area of health care

VII. Annex 1. Vaccination calendar of regular child vaccinations

VIII. Annex 2. Nutrition pyramid

Note. Some minor changes, which do not alter the content, have been made.

Source: Dobiášová et al. (2005:4).

Lessons learned

According to the feedback received from users, the research project and its outcomes helped to improve foreigners' knowledge of the health care system. Feedback suggests that the brochures have had both empowering and reactive importance: they contributed to the knowledge and social competence of migrants and reacted to the stated needs and problems.

The most significant challenge in implementing the brochure projects was to understand the information needs of the target group – needs that may not be apparent to authorities, insurance company administrators and academics. For this reason, it is important to cooperate with the target group itself and NGOs and migrant associations who may have, due to the nature of their work with these communities, more insight. Furthermore, these entities are also important partners for disseminating information to the target group and advocating the use of project brochures among group members.

The process of designing the brochures and compiling their contents also produced its own results. It built human resource capacity and cooperation among researchers, civil servants, health insurance professionals, NGOs and immigrant communities. The community mediators, advocates and brochure distributors were selected in light of the particular needs of each community.

The author of this case study would recommend similar brochures for other countries. From the experience of the Czech Republic, a lesson learned is to include the production of this type of informative material in a broader research programme on the migrant community (as a whole and with attention to specific groups of migrants). The brochures discussed in this case study were written in accordance with findings of the studies about migrant health status and its determinants in the Czech Republic.

Regarding the financial sustainability of such projects, it is recommended that long-term public sources of funding be allocated. The yearly revisions of the brochures are expensive, and this cost could be included in the yearly budget of a public administrative body or provided through sustained donations from other public sources (such as EU structural funds) or private organizations (both profit-making and non-profit-making organizations).

Migration is a complex phenomenon and needs to be considered in the broader societal and individual contexts. In the Czech Republic, the barriers to accessing health care for this group are most often administrative and related to health professional–patient communication.

In the case of the Czech Republic, cooperation between sectors is crucial. Such cooperation is highly recommended for fostering the contribution of all relevant stakeholders.

To further improve target-group access to health services, the author of this study suggests that it may be useful to:

- establish an information system to systematically monitor trends in migrant health conditions and health service access by migrant communities and take concrete measures aimed at improving the situation;
- focus on ensuring migrant access to services in individual regions of the Czech Republic – both locally and by type of service;
- create health policies that consider migrant health and its determinants;
- consider the adoption of measures aimed at advancing the flow of information to the target group about entitlements, obligations and opportunities in health and health services and about the newest changes in this field; and
- support the development of multidisciplinary cooperation for migrant health, such as inter-departmental cooperation and cooperation with NGOs.

Goals related to migrant health are incorporated into such strategic documents as *Strategy of integration of the foreigners into Czech society* (Ministry of Interior, 2000). The biggest challenge in addressing migrant health is the implementation of the strategic goals and existing legal framework in the everyday activity of health care providers.

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5. Georgia: the Medical Assistance Programme for the Population below the Poverty Line

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Summary

Since 1991, conflict and economic hardships have had a significant effect on the welfare of the population of Georgia, including its access to health care. Between 1990 and 1994, public spending on health care decreased 13 times, causing a significant increase in out-of-pocket expenditures for medical services. The utilization of essential health care services has incurred an extremely heavy financial burden on the poorest segment of the population and increased its vulnerability. Responding to this challenge, wide-ranging reforms are underway, which include health care and social protection. This is in keeping with the objective of the health system to ensure financial access to essential health services and to protect the population from the financial risks associated with illness.

The Medical Assistance Programme for the Population below the Poverty Line, launched in 2006, is an important tool for implementing government policy in the social and health sectors. The Programme provides about 650 000 people identified in the database as the poorest with a health care package that consists of outpatient and inpatient services. The Programme is the first explicit comprehensive measure designed to improve the health care conditions of Georgia's poorest segment.

This case study describes and analyses various aspects of the Programme until October 2007. It draws from a number of documents and resources, including Programme reports and interviews with several government officials actively involved in both designing and implementing the Programme. This case study also highlights major positive developments and suggests further improvements.

The outputs of the Programme during the first 11 months include the funding of 30 062 urgent hospital services, 17 828 planned hospital care services and 31 249 baby deliveries. During six months in 2006, the Programme expenditure amounted to 15.3 million lari[1] (1 lari ≈ US$ 0.6), which was only 6.1% of the total government expenditure on health. Also, the reduced expenditure on health care by poor households has enabled them to spend more on other essential necessities, especially on nutritional needs.

While implementing the Programme, a number of challenges were encountered. The case study analyses these and makes several recommendations. Also, it stresses the need for: including the cost of prescribed medication in the Programme; systematic monitoring and evaluation, to make necessary adjustments in the Programme; improving public relations; and making administration of the Programme simpler, through annual reassessment of beneficiaries' socioeconomic conditions.

[1] Georgian currency

Socioeconomic and policy context

Socioeconomic context

With a population of 4.4 million people, Georgia occupies an area of 69 700 km^2 and borders Armenia, Azerbaijan, the Russian Federation, Turkey and the Black Sea. Since 1991, conflict and economic hardships have had a significant effect on the welfare of the population of Georgia, including access to health care. Responding to this challenge, wide-ranging reforms are underway in health care and social protection.

The Economic Development and Poverty Reduction Programme, developed in 2003, has provided a comprehensive, all-embracing strategic framework and planning process targeted at raising the welfare of the population through improvement of the quality of life of each person and the sustainable socioeconomic development of the country (Government of Georgia, 2003).

The Economic Development and Poverty Reduction Programme sets forth two main strategic objectives.

1. **Fast and sustainable economic development.** The average growth rate of the real GDP is 5–8% a year, which should ensure a twofold to threefold growth of real GDP by 2015, in comparison with 2001.

2. **Reduced poverty.** This would occur by reducing extreme poverty (in relation to the *alternative minimum poverty line*) from 14% to 4–5% and reducing poverty in relation to the *official poverty line* (or subsistence minimum) from 52% to 20–25% by 2015.

As of October 2007, progress towards the first objective has been substantial, and measures designed to tackle poverty have been significant. Between 2003 and 2007, state pensions increased by a factor of 3.0, and funds allocated for social assistance increased by a factor of 6.5. In addition to increased financing, the government introduced means testing, which will gradually replace category-based social assistance. For means testing, a new proxy system was established, which by March 2007 had assessed 464 800 applications and granted social assistance to 95 900 households (State Agency for Employment and Social Assistance, unpublished data on recipients of means-tested social assistance, 2007). This allowed the government to channel more resources to those in greatest need.

Georgian health care system

The health care system clearly reflects tough socioeconomic conditions. During conflicts, the majority of medical facilities were used as shelters for refugees. For example, in 1994, between 80% and 90% of the existing hospital capacity was occupied by refugees (Gamkrelidze et al., 2002). Because of chronic fuel shortages in the country, hospitals were often without electricity, even during winters. More importantly, however, the drastic reduction in public funds meant that the health system, which had previously depended completely on public financing, was unaffordable – between 1990 and 1994, real per person public expenditure on health declined from about US$ 13 to less than US$ 1 in 1994 (Gamkrelidze et al., 2002).

Georgia's health care system is centralized and financed by state, private and international sources. The state health care responsibilities, according to type of service, are grouped in the health care programmes as main directions. In 2007, these state programmes were as follows:

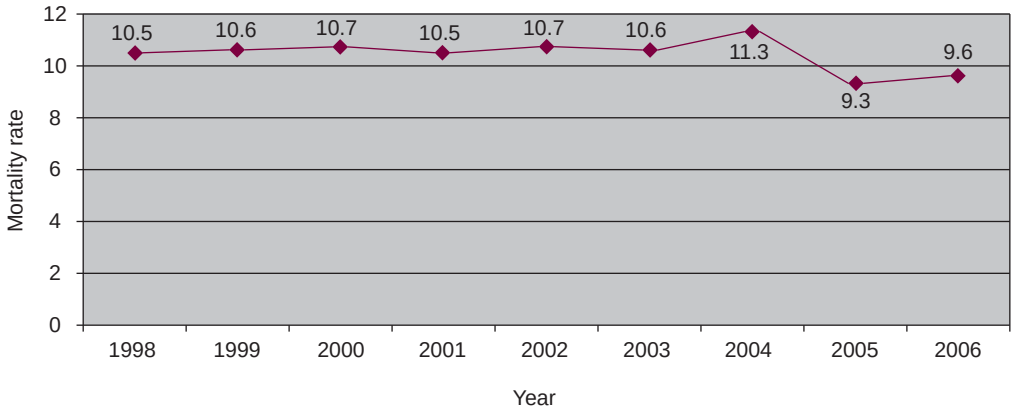
- a programme for financing health care for the population below the poverty line
- a programme for primary health care
- a programme for emergency health care
- a programme for inpatient care
- a programme to supply the population with specific drugs
- a prophylactic programme for select communicable diseases and epidemiological surveillance
- a health care programme for veterans.

Apart from programmes oriented towards ensuring medical service implementation, other state programmes work on institutional development of equipment and human resources for the health care system. These include: a programme for institutional and functional development of the health care system; a rehabilitation and equipment programme for buildings in the medical sector, including the health care ministry; and a programme for training medical staff. These programmes are financed through the state budget and are purchased primarily by state purchasers.

According to National Health Accounts of Georgia, in 2006 total expenditures on health amounted to 1.159 billion lari, 8.4% of the GDP (Ministry of Labour, Health and Social Affairs, 2007a). Of this amount spent on health, 21.6% was public expenditure (250 million lari), 5.2% came from international aid (60 million lari) and the rest (849 million lari), 73.6% , came from mostly out-of-pocket payments (Ministry of Labour, Health and Social Affairs, 2007a). The share of private health insurance expenditures in total health expenditures is only 1.1% (12.8 million lari), and less than 1.5% of the population is covered by private or employer-financed insurance. Consequently, the amount of out-of-pocket payments reached about 72.5% of total health expenditures (both formal and informal) (Ministry of Labour, Health and Social Affairs, 2007a). The amount of out-of-pocket payments has increased vulnerability to extreme poverty and possible bankruptcy in case of an incident of illness or disability.

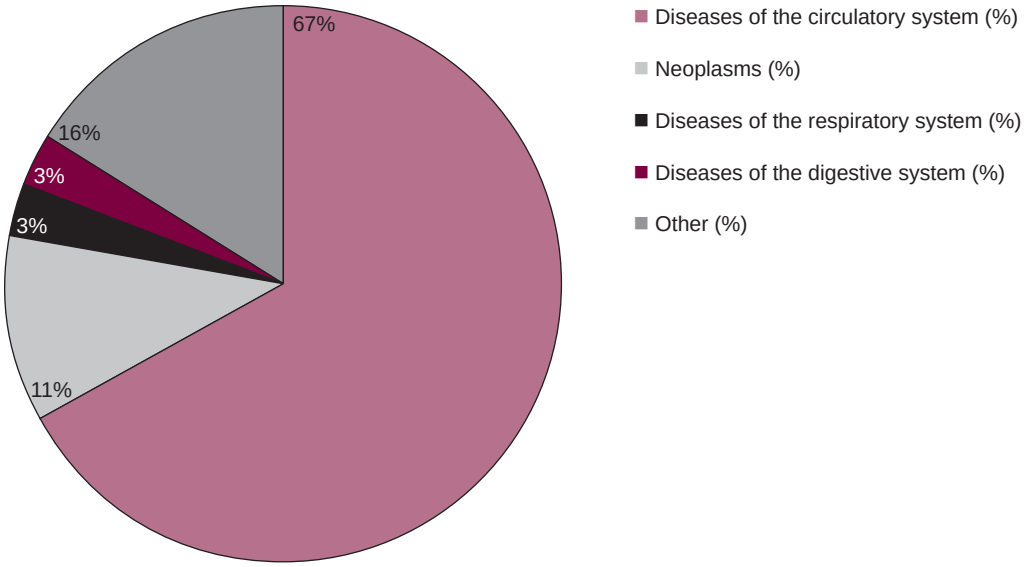
The high level of out-of-pocket payments underscores the weak capacity of both the public and private sector to organize pooled forms of funding. Given the population's limited resources, the utilization of health services fell radically. Also, the physical condition of medical facilities deteriorated severely, as did their medical technology and equipment and, to a certain extent, the skills of their medical staff.

Fig. 5.1. Total mortality rate (per 1000 people), 1998–2006



Source: Ministry of Labour, Health and Social Affairs (2007b:8).

Fig. 5.2. Mortality structure by main causes of death



Source: Ministry of Labour, Health and Social Affairs (2007b:9).

According to the *National health report*, the average life expectancy in Georgia is 73.8 years (69.9 years for males and 77.4 years for females), the morbidity rate is 37 980.2 cases per 100 000 population and the mortality rate is 9.6 deaths per 1000 population (Ministry of Labour, Health and Social Affairs, 2007b:6, 8). Fig. 5.1 shows the mortality rates for 1998–2006, and Fig. 5.2 shows the mortality structure by the main causes of death. The main causes of death are diseases of the circulatory system (coronary disease and hypertension), respiratory system and digestive system, and neoplasms. Of these causes of death, diseases of the circulatory system accounted for the major share (67.1%) of deaths in 2006, followed by neoplasms (11.4%). The mortality rate decreased significantly from 11.3 deaths per 1000 population in 2005 to 9.3 deaths per 1000 population in 2005 and then increased slightly to 9.6 deaths per 1000 population in 2006.

Current government priorities in health

The government's current priorities for the health of Georgia's people were formulated in the document *Basic data and directions for 2007–2010* (Government of Georgia, 2006). The main goal of the health care system is to improve the health of the population, as measured by increasing life expectancy and quality of life, decreasing burden of noncommunicable and infectious diseases, increasing immunization rate, and decreasing mother and child mortality. These goals are reflected in obligations guaranteed by the Constitution of Georgia and international declarations endorsed by Georgia, with the latter including the MDGs to be achieved by 2015.

To make progress towards the above-mentioned goals of the health care system, the following intermediary objectives and directions (to be achieved by 2011) were identified:

- ensuring financial access to essential health services and protection of the population from the financial risks associated with illness;
- ensuring a high-quality health service through the creation and enforcement of a proper regulatory environment;
- ensuring physical access to quality health services through sustainable development of the medical infrastructure and competent human resources; and
- improving the effectiveness of the health care system by developing the capacity of the Ministry of Labour, Health and Social Affairs and its affiliated organizations and by promulgating good principles of governance.

To achieve these objectives, the government is cooperating closely with international donor organizations, which have been providing substantial support. United Nations agencies have shown a major interest in supporting the reform, and WHO has taken a leading role by providing technical support on a broad range of issues, including health policy, health system performance evaluation, health information systems, hospital management, health financing (including access to drugs), HIV/AIDS surveillance, food safety, tuberculosis (TB), substance abuse and nutrition. The United Nations Population Fund (UNFPA) has focused on reproductive health, and UNICEF has provided support for immunizing children, by supplying vaccinations, syringes, essential cold-chain equipment (such as refrigerators and transport boxes) and training for health workers.

Medical Assistance Programme for the Population below the Poverty Line

The Programme in brief

The Medical Assistance Programme for the Population below the Poverty Line was launched in July 2006, as part of the State Hospital Care Programme, and continued as a separate programme in January 2007. At the time of writing of this case study (October 2007), it provided about 650 000 beneficiaries with a package that includes:

- urgent outpatient and hospital care;
- planned hospital care services;
- outpatient diagnostic services upon referral from a primary health care physician – with a financial limit of 200 lari a year per beneficiary set for this type of service; and
- reimbursement of costs incurred during pregnancy and delivery.

In addition, the Programme of Medical Assistance for the Population below the Poverty Line covers the beneficiaries' share of co-funding in various disease-specific state programmes.

Programme rationale

Out-of-pocket expenditure for utilization of essential health care services incurred an extremely heavy financial burden on the poorest segment of the population and increased its vulnerability: in 2005, the average expenditure on hospitalization of a poor person was 2.8 times greater than their average monthly household income (Government of Georgia, 2006). Thus, most poor households had to either refrain from using health care services, leading to further deterioration of their health, or face the medical poverty trap. This problem was acknowledged by the government and emphasized in the problem description of the Programme, which pointed out that "at the current stage of economic development a significant part of the population experiences severe economic hardships and consequently does not have access to elementary health care services" (Ministry of Labour, Health and Social Affairs, 2007c). Thus, increasing financial access to health care for the population below the poverty line was the avowed objective of the Programme.

Eligibility

Beneficiaries of the Programme are determined by proxy means testing. To target social assistance most effectively in 2005, the government created a database of socially vulnerable families. This database assessed the socioeconomic conditions of more than 460 000 families and ascribed scores that ranked the severity of poverty. This enables the identification of those with the highest need, as well as appropriate levels of social assistance for different households. As of October 2007, households that rank below 70 000 are eligible for participation in the Programme, and households below 57 000 also receive cash benefits.

Administrating agency

The Ministry of Labour, Health and Social Affairs is the central government unit responsible for developing and implementing state policy in labour, health and social spheres. The Ministry holds the second largest budget of all government agencies: its share in 2007, 919 million lari, was a fourth of the total, planned state budget. From this budget, 255 million lari were allocated to the health care sector, which includes the provision of services and institutional development (Ministry of Finance, 2007).

During recent years, the Ministry of Labour, Health and Social Affairs underwent considerable structural changes. At present, its structure consists of functional departments, such as sectoral policy, administration, health care and disaster management, social security, and regulation. Policies are executed by state agencies – the Georgia State Agency for Employment and Social Assistance (SAESA) and the Georgia State United Social Insurance Fund (SUSIF) – which operate under the Ministry's umbrella. SAESA is responsible for administration of means-tested benefits and various state social programmes, and SUSIF administers pensions and state purchases of health and social services. Both agencies have regional and *rayon* (district) branches.

Planning

The Government of Georgia uses the medium-term expenditure framework method of planning. Within this framework, the sectoral priorities and resources required are determined (on an annual basis) by sectoral ministries and agreed upon by Georgia's President and the Cabinet of Ministers. At the next stage, the government submits for discussion a *Basic data and directions* document to respective parliamentary committees. After receiving amendments made by the committees, the Ministry of Finance uses the *Basic data and directions* document to draft the state budget, which has to be approved by Parliament.

Within the Ministry of Labour, Health and Social Affairs, the main sectoral priorities are determined by each sector's policy department. At the next stage, the priorities are transformed into programmes by the departments responsible for developing the tools for policy implementation. Health care programmes (including the Programme of this case study) are designed by the Department of Health Care and Disaster Management. After the programme has been designed, its implementation is delegated to either SUSIF or SAESA.

Funding

In 2006, the Medical Assistance Programme for the Population below the Poverty Line was allocated 18 million lari, of which 15.3 million lari were spent. This was 6.1% of the total public expenditure on health: 250 million lari (Ministry of Finance, 2007)). In 2007, the Programme's budget was increased to 44 million lari. The funds were transferred to SUSIF, which purchases medical services directly from providers at prices agreed on beforehand or from insurance companies in two locations (Tbilisi and the Imereti Region). To support the private health insurance market, the state purchaser (SUSIF) will gradually increase the purchase of the insurance package from private insurance companies with resources mobilized for health care. It will give a stimulus to the private insurance companies to inform and offer the population their insurance products (including nonmedical products). Along with building capacity in the private insurance market, purchasing services directly from health service providers will be decreased while the scope of insurance products purchased by SUSIF will be increased. Beneficiaries may choose between contracted service providers (or insurance companies). In line with the principle of geographical accessibility, SUSIF also finances urgent cases of medical treatment from non-contracted service providers.

Major actions

The initial stage of the Programme included informing providers about it, negotiating and determining prices for different services and making contracts with providers. Given the time constraint, the main challenge was to carry out these tasks in a short period of time. Due to its experience purchasing various medical services and long-term relationship with providers, SUSIF successfully managed to carry out all these tasks within a month. Prices were set at market levels and several hundred providers were given contracts (see Table 5.1).

Table 5.1. Medical service providers with contracts, by components and regions, from July 2006 to May 2007

Territorial Unit	Medical service component			
	Outpatient service	Urgent hospital care	Planned hospital care	Obstetric care
Tbilisi	64	19	57	11
Imereti	141	19	6	15
Samegrelo and Zemo Svaneti	23	10	3	11
Adjara	16	9	1	7
Guria	6	3	1	3
Racha-Lechkhumi – Kvemo Svaneti	15	4	1	4
Kvemo Kartli	33	7	2	11
Shida Kartli	22	7	1	5
Kakheti	18	8	1	10
Mtskheta-Mtianeti	34	5	--	6
Samtskhe-Javakheti	23	6	2	9
Total	395	97	75	92

Source: SUSIF, unpublished data, 2007. Reproduced with the permission of the copyright holder.

In parallel with this activity, the Ministry of Labour, Health and Social Affairs launched an information campaign in July. The campaign included commercials on TV and the distribution of leaflets.

Another major action was printing and distributing medical cards. As noted above (see the section on "Eligibility"), the beneficiaries of the Programme were determined by using the SAESA database. SUSIF printed medical cards and SAESA delivered them to beneficiaries through its social agents. To accelerate this process, however, SUSIF also engaged family doctors who made at least one mandatory visit to registered families; during such visits, the doctors evaluated the health needs of the target population. The data served as a basis for future planning of Programme activities. In 2007, paper cards were replaced by electronic cards, which allow providers to obtain more information about the beneficiary. Also, cards are delivered now by primary health care providers.

Procedure

The procedure for receiving outpatient, urgent and pregnancy treatment is fairly simple, with the treatment beneficiary receiving it immediately at any provider with a contract. Receiving planned hospital service, however, is related to certain formalities. If the outpatient unit or family doctor decides that the patient needs hospital treatment (including surgery), a note is sent to SUSIF's regional branch, which in turn forwards this information to the central branch. SUSIF's central branch examines the request, places the patient on a waiting list and then finds a provider for the treatment. Finally, the patient is notified by mail about the dates of hospital service and the provider of treatment. Waiting time usually ranges from one to three months.

Control mechanisms

To avoid Programme abuse, both by beneficiaries and providers, SUSIF carries out random inspections. The beneficiaries are warned that, if another person attempts to use their medical card, they will lose eligibility for the Programme. To avoid Programme abuse, the compatibility of the medical card with other documents that identify the beneficiary is examined.

As for providers, they are strongly advised not to charge beneficiaries any additional fees for the services covered by the Programme. SUSIF monitors it by distributing questionnaires to each beneficiary, to measure their satisfaction with the services received. In cases where beneficiaries are charged an additional fee, providers are obliged to refund the full amount paid for the service. If a service provider repeats this malpractice and is discovered, the contract between the provider and SUSIF is annulled. So far, SUSIF has reclaimed about 60 000 lari from service providers, and several contracts have been annulled.

Quality assurance

Assuring the quality of the Programme involves several elements. First, in randomly chosen providers, SUSIF checks the compatibility of service provided with the state standard adopted for a particular diagnosis. Second, as noted in the preceding section, all beneficiaries are given questionnaires, where they can express their level of satisfaction with the services received, as well as any complaints. SUSIF uses these questionnaires to measure the performance of particular providers. Providers with a low level of customer satisfaction are likely to lose their contract for the next year. Third, in cases where there are serious problems with the quality of medical services provided, beneficiaries are advised to contact either SUSIF or the Georgia State Agency of Medical Regulations (an agency affiliated with the Ministry of Labour, Health and Social Affairs). The Agency will investigate these cases and will then advise the Ministry if sanctions are to be used and the type of sanction to use.

Challenges

The Programme encountered two substantial challenges. First, beneficiaries frequently required services not covered by the Programme. While this can be attributed partly to shortcomings in the information campaign, the major factor is more likely to be the asymmetry between patient and provider in understanding information about the health care system – that is, for system beneficiaries it is rather difficult for patients to understand and differentiate between different kinds of services and treatments, and also particular diseases.

Second, on an irregular basis, SAESA conducts evaluations of households several times a year. Consequently, the database changes several times a year, since some households lose eligibility and some new ones are added. These continuous changes entail extra administrative work for SUSIF staff and, in some cases, increase beneficiary waiting time.

Outputs

The data collected show that beneficiaries have been actively using health care services provided by the Programme. In 2006 only, the Programme covered the costs of 17 200 urgent outpatient and hospital care services (see Table 5.2). In the same year, 13 101 people received planned hospital care services, and the costs of pregnancy and delivering babies were covered for 16 450 women. Also, a household survey on health service utilization and expenditure showed that the level of satisfaction with health services was quite high among the Programme beneficiaries and did not differ from that of the rest of the population (Georgia Department of Statistics et al., 2007). Most importantly, the survey showed that Programme beneficiaries constitute 90% of all people with any type of medical insurance – 14.1% of the total population has some kind of medical insurance, out of which less than 1.5% is private.

Table 5.2. Number of services provided, 2006/2007

Type of care	July–December 2006							January–May 2007					
	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total	Jan.	Feb.	Mar.	Apr.	May	Total
Urgent outpatient and hospital care	1 763	2 117	3 002	2 880	3 294	4 144	17 200	2 009	1 878	2 460	2 264	4 251	12 862
Planned hospital care service	0	147	2 327	2 592	4 394	3 641	13 101	1 039	1 193	1 288	1 047	160	4 727
Obstetric care	1 913	2 505	2 709	3 253	3 007	3 063	16 450	3 613	2 891	2 943	3 043	2 309	14 799

Source: SUSIF, unpublished data, 2007. Reproduced with the permission of the copyright holder.

Administration costs

Additional costs for administering the Programme appear to be very low, because part of the administrative costs is covered by the general administrative budget of SUSIF and SAESA. In 2006, the total expenditure on administration amounted to 265 921 lari, which was only 1.5% of the total cost of the Programme (see Table 5.3). Low administrative costs can be explained by the absence of means-testing costs, which were incurred by SAESA, and by most of the other tasks being carried out by existing staff that administer all state health care programmes and receive their salary straight from the administrative budget of SUSIF. Most of the money was spent on printing medical cards. In 2007, direct administrative costs were estimated to be even lower, since the staff was already trained and technical equipment was already purchased.

Table 5.3. Direct administrative costs, July – December 2006

Type of expenditure	Amount (lari)
Additional employees	28 813
Explanatory work with patients and medical staff	5 184
Information bulletins	18 340
Training of SUSIF staff	17 220
Administrative costs of the branches	26 722
Technical provision	17 900
Printing	151 742
Total	265 921

Source: SUSIF, unpublished data, 2007. Reproduced with the permission of the copyright holder.

Monitoring and evaluation

Monitoring and evaluation of the Programme were included as an essential element for measuring its effectiveness. Effectiveness was measured by a number of indicators and other sources of necessary information. The timetable for conducting monitoring and evaluation, however, was not defined, though it had to be carried out by the end of 2007. Also, the Ministry of Labour, Health and Social Affairs made an agreement with one of its main donors – the World Bank – to conduct, in November 2007, an evaluation of new social assistance benefits.

Political support

The development of the Programme has been influenced significantly by the wide political support given by the highest-ranking government officials. The President, Prime Minister and other members of the Cabinet of Ministers have expressed their support for the Programme on several occasions; in his annual report to Parliament, the President identified the Programme as one of the major measures for improving the welfare of the socially disadvantaged population (President of Georgia, 2007). Support from Parliament has also been substantial. To begin with, the Programme was initiated in June 2006, which required amendments to the state budget to fund it. The amendments passed all three hearings without serious objections and were

adopted by a large majority. At the time of writing this case study (October 2007), the Ministry of Labour, Health and Social Affairs is initiating a proposal that mandates that coverage of the Programme be extended to 1.1 million people in 2008. So far, consultations with other government units and the Parliamentary Commission on Health and Social Issues indicate that this proposal is very likely to be adopted.

Lessons learned

The Medical Assistance Programme for the Population below the Poverty Line is an important element of both social reform aimed at providing more resources for the neediest and health care reform aimed at increasing financial and geographical access to health care services.

Positive developments

At the time of writing (October 2007), it is very difficult (if not impossible) to assess its effect on the health conditions of the target group, because the Programme has been in existence for such a short time. Nevertheless, some positive developments can be noted. First, the Programme is the first measure targeted explicitly at poor households. Unlike health programmes that are disease or function specific, this programme provides a comprehensive package of services (including ambulatory treatment, and urgent and planned hospital and specialized care) for the most vulnerable segment of the population. This package means that households that previously had limited or no access to health care services can now get comprehensive medical treatment.

Second, provision of free health care has a large positive effect on the amount of income available to poor households, which means that poor households can spend more money on other essential necessities, especially on nutrition. Also, improved health enables more poor individuals to increase their productivity.

Third, embedding the principle of ensuring geographical access in the Programme has contributed to developing and/or sustaining a number of medical centres. This is especially true for regions with a high incidence of poverty. In these regions, the Programme is the main source of income for most health service providers, since the majority of the population cannot even afford to pay for basic treatment.

Factors contributing to positive developments

A number of factors have contributed positively to Programme development. Political support has undoubtedly played a key role in developing and implementing the Programme. Continued support from the executive branch of government and Parliament has been reflected in the swift allocation of funds, and such support is highly likely to continue for the coming years.

Also, the database of socially vulnerable families and the targeting method deployed by SAESA have been extremely useful for identifying the Programme beneficiaries. They have ensured that the Programme encompassed the segment of the population that faces the most difficult socioeconomic conditions.

Another beneficial factor has been the administrative capacity of the implementing government unit (SUSIF). Close links between SUSIF and SAESA and the former's long-term experience in carrying out the administration of social and health programmes and purchasing medical services – combined with a sufficient number of staff in countrywide *rayon* branches – have enabled fast and smooth implementation of the Programme without significant additional expenditure.

Shortfalls and suggestions

Despite these achievements, the Programme still experiences certain shortcomings, which have not been dealt with properly until now. As the household survey on health service utilization and expenditure showed, 24% of Programme beneficiaries could not afford to purchase the medications prescribed for them, which makes the effectiveness of the medical treatment provided questionable (Georgia Department of Statistics et al., 2007). To avoid this problem, the Programme should also cover the costs of medications prescribed.

To identify existing deficiencies and make necessary adjustments, defining an exact timetable for conducting Programme monitoring and evaluation should be a priority. While the World Bank November 2007 evaluation of new social assistance benefits will certainly be useful for assessing Programme outcomes, the Ministry of Labour, Health and Social Affairs monitoring and evaluation efforts would benefit from focusing on assessing performance and immediate outputs.

While the use of SAESA databases has been immensely useful for SUSIF in determining the Programme beneficiaries, there have been problems. To remedy them, a change of scores that rank the severity of poverty and, consequently, of status should be carried out on annually. Also, households should be given fixed identification numbers.

Last, but not least, the Programme's public relations component needs to be improved. Many entitled beneficiaries still have an obscure understanding of the Programme, and some of those who have not used it are skeptical about the quality of the services. Well-designed commercials on TV that highlight particular successful cases and stress the simplicity of the procedure and the satisfaction with treatment received might help encourage greater participation in the Programme. Also, each beneficiary should be provided with a leaflet that indicates precisely the types of services offered and other relevant information about the Programme.

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6. Germany: MiMi Project - With Migrants for Migrants

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Summary

In Germany, 18.6% of the people are immigrants. When compared with the host population, immigrants face higher risks of poverty and ill health. These risks stem from the immigration process, which can entail adverse living and working conditions, as well as social exclusion.

Recent policy initiatives in Germany have sought to improve the health and social inclusion of immigrant populations. The German National Framework for Prevention Strategies, the National Integration Plan, the Immigration Act of January 2005, and the German National Action Plan against Poverty and Social Exclusion support the integration of immigrants and the reduction of health inequities.

This case study focuses on an initiative that formed within this social and political context: the *With Migrants for Migrants – Intercultural Health in Germany* programme, henceforth referred to as MiMi. Developed at the Ethno-Medical Centre in Hanover, MiMi was launched, in cooperation with the Federal Association of Company Health Insurance Funds (BKK Bundesverband), in 2003 as a pilot programme in four cities. MiMi's goal is to recruit, train and support intercultural mediators and enable them to teach the German health system and related health topics to their respective immigrant communities. These mediators are well-integrated immigrants with a sense of civic commitment; they are 20–60 years of age, with legal residence in Germany. The majority of them (80%) are women. Programme participants for the community group sessions organized by mediators are usually immigrants with lower levels of social integration. During these events, information on health and health system access is delivered in diverse languages within a culturally specific context.

The programme applies the following mechanisms:

- standardized training of intercultural health mediators from immigrant communities;
- community group sessions to inform immigrants about health issues and access to the health system;
- a health guide to explain the health system (available in 15 languages), in addition to educational materials on specific health-related topics;
- a network of intersectoral partners and activities, including project conferences and training health professionals, to increase the capacity of partners to meet the needs of migrant communities; and
- a monitoring and evaluation system, to ensure sustainability and effectiveness.

Since the programme's inception, MiMi has expanded to 46 cities in 10 federal states. MiMi now cooperates with more than 100 partners across Germany. Municipal health services and social service providers are key partners. The programme has facilitated important links between immigrant communities and the health system, enabling increased comprehension of their respective needs.

As of December 2008, MiMi had trained 781 mediators from 65 different countries, involved over 17 700 immigrant attendees at community group sessions (reporting high satisfaction rates for usefulness of activities), and helped to diffuse health knowledge to more than 41 500 family members, according to a centralized data-pool at the Ethno-Medical Centre. The health system itself has also benefited from the programme. Service professionals have become more aware of (and attuned to) the needs of the immigrant population, which allows them to better address this population's needs in culturally appropriate ways.

Socioeconomic and policy context

In 2007, 15.3 million people with an immigrant background lived in Germany. About half of them are non-German citizens (7.3 million *Ausländer* or foreigners), while the other half (about 8 million) have become German citizens or are Germans living abroad. Immigrants account for 18.6% of the German population. Altogether, just under a third of all children younger than 5 years of age in Germany have an immigrant background. Turkish immigrants constitute the largest group of immigrants (1.8 million), followed by people from the former Yugoslavia, Italy and Greece (Federal Statistical Office of Germany, 2007, 2008).

The structure and process of immigration to Germany has been changing. In the 1960s and 1970s, so-called guest workers and their families constituted the immigrant population, while refugees and asylum seekers dominated the 1980s and 1990s. Since the 1990s, resettlers (Germans from the newly independent states (NIS)) constitute the third group that has increasingly migrated to Germany (Federal Statistical Office of Germany, 2008).

Overall, the percentage of immigrant women and children is growing, and the demographic structure comprises more and more elderly immigrants. Also, the number of illegal immigrants is increasing, which poses a challenge to German society and government. Overall, Germany has become a so-called migration country (Hornung, 2004).

In terms of their socioeconomic status, immigrants are generally disadvantaged. The chance of getting a well-paid job depends to a large extent on educational attainment. Although the prospects for education have improved for the second generation, it must be noted that children with an immigrant background still have a lower educational status. Also, the first generation of parents is still working under precarious circumstances – that is, they are working in manual, unskilled and semi-skilled jobs, with little social security and poor prospects of promotion. Moreover, immigrants run a higher risk of unemployment (Hradil, 2001).

With regard to inequities in the health status of immigrants, compared with the host population, we find the paradox of the healthy-migrant effect. This means that the health status of immigrants is good at the time of settlement, since they belong to a selected sample of healthy people. This advantage, however, diminishes with time. Socioeconomic disadvantage and insufficient access to the local health system worsens their health status, as compared with that of the host population. Interestingly, though, health inequities do not show a consistent pattern. Older guest workers, for instance, have a lower total mortality than their German peer group – for example, cardiovascular mortality is lower among Turkish men. Maternal death among immigrants, however, is 1.7 times higher than among of their German peer group (Razum, 2006).

Notwithstanding this inconsistent pattern, it is obvious that immigrants lack sufficient access to the German health system. They face a number of problems: insufficient information on existing structures and measures; poor communication between patients and professionals; and differing cultural concepts of health and disease. Together, these problems determine the perception, causation and presentation of symptoms. On the other hand, immigrants might possess a range of personal and social resources, such as transcultural competence, flexible coping strategies, perceptions of self-efficacy and control, and family networks (Hornung, 2004).

As a consequence, policies to improve the health status of immigrants include strategies to reduce stress and strengthen resources, both at an individual and structural level. Such strategies include (Hornung, 2004):

- trauma therapy;
- occupational health and safety;
- health promotion services that address the personal situation of immigrants without stigmatization;

- qualification of health professionals, to improve their intercultural competence;
- broadening health services transculturally, by incorporating and integrating professionals with immigrant backgrounds, introducing interpreter services, and linking health and psychosocial services;
- improving knowledge of health and personal responsibility in immigrant patients; and
- strengthening social networks and self-help groups in immigrant communities.

Since 1997, the Federal Commissioner for Migration Issues has coordinated the German cross-sectoral working group on migration and public health (Arbeitskreis Migration und öffentliche Gesundheit). The working group is a professional network of 41 members, each representing different authorities of the public health services. Their concern and aim is to improve public health services for immigrants.

The health-related measures mentioned above should be embedded in a general strategy to promote social inclusion of immigrants. This currently happens within the framework of the National Integration Plan. For the first time, all those dealing with integration in politics and in society work hand in hand: the federal government; federal states (Länder); local authorities; immigrants; institutions and organizations from science, media, culture, sports, trade and industry; trade unions; and religious groups. The most important aims of the National Integration Plan (Bundesregierung, 2007) are:

- improving integration measures, such as training;
- promoting the German language from the start of migration;
- ensuring good education and vocational training, to improve opportunities in the labour market;
- improving the life situation of women and girls, to achieve gender equality;
- supporting integration in the communities;
- recognizing cultural diversity;
- using sports for integration;
- using the various kinds of media available to support integration/social inclusion;
- strengthening integration through civic commitment and equal participation; and
- ensuring that the knowledge of immigrant populations is incorporated into the scientific and learning culture in Germany and that immigrants also are integrated into the scientific community.

Programme benefiting the target population

Overview of the With Migrants for Migrants programme

Language and cultural barriers, as well as adverse socioeconomic living conditions, make access to health services difficult for immigrants and their families. To address this situation, the With Migrants for Migrants – Intercultural Health in Germany programme (henceforth referred to as MiMi) aims to make the health system more accessible to immigrants, to increase their health literacy and to empower them through a participatory process. MiMi does this by recruiting, training and supporting intercultural mediators, to enable them to teach the German health system and related health topics to their migrant communities. It also builds the capacity of all partners involved in this process to improve migrant health.

Originally developed at the Ethno-Medical Centre (Ethno-Medizinisches Zentrum), with financial support from the BKK Bundesverband, MiMi was launched in 2003 as a pilot programme in four cities in the federal states of Lower Saxony and North Rhine-Westphalia. It has since expanded to 37 cities in Lower Saxony, Hessen, North Rhine-Westphalia, Brandenburg, Baden-Württemberg, Rhineland-Palatinate, Bavaria, Hamburg, Bremen and Schleswig-Holstein.

Each city's implementation phase lasts about 18 months. Implementation entails the use of the following core mechanisms: training of intercultural health mediators from immigrant communities; community group sessions – delivered by the trained mediators – to inform immigrants about health issues and health system access; a health guide to explain the health system and educational materials on specific health-related topics; a network of intersectoral partners and activities to increase the partners' capacity to meet the needs of immigrant communities, including project conferences and the training of health professionals; and a monitoring and evaluation system. The following subsections will elaborate on these mechanisms, providing relevant background and explaining how they evolve in each of the phases of implementation.

Pre-implementation: designing tools and methodologies for mediators

To reach its goal, the Ethno-Medical Centre considered that the mediators, once trained, would need tools, platforms, and approaches that helped reach the aim of improving immigrant access to the German health system. Thus, during the project formulation stage, it designed a methodology of interrelated and synergistic mechanisms. This methodology encompassed community group sessions, a health guide, and intersectoral collaboration, explained below.

Community group sessions are designed to address the following core topics:

- the German health system (as a mandatory topic for all information sessions)
- unhealthy eating habits and lack of physical activity
- smoking, alcohol and substance abuse/medication dependency
- mental health
- accidents/injuries and children's health
- health of the elderly.

In developing the programme methodology and curricula, MiMi determined that immigrants should be provided with language and culturally appropriate information in accessible locations. Sessions were to be held in easy-to-reach local arenas, such as municipal health service points, community centres, sports clubs, religious institutions, educational institutions (such as language schools) and private company offices.

The *Health guide* delivers complementary information (in the diverse native languages of immigrants in Germany) about: health insurance; issues related to visiting a doctor or dentist; issues related to the operations of pharmacies and hospitals; a description of the public health service; what to do in case of emergency; and useful contacts (BKK Bundesverband, 2008).

Under the topic of health insurance, the guide covers:

- German statutory health insurance, including its benefits, beneficiaries, private health insurance and the principle of free choice of insurance companies;
- additional payments, giving instances when personal contributions are necessary and when they are exempt; and
- the Asylum Seekers' Benefits Law (Asylbewerberleistungsgesetz), which covers benefits available to asylum seeker and refugees.

Under the topic of visits to a doctor or dentist, the guide covers:

- the issues of choosing a doctor, consultation and confidentiality;
- preparing for a doctor's appointment;
- information a doctor should deliver, regular medical check-ups for early diagnosis and recommended vaccinations;
- dental check-ups and the bonus booklet;
- dentures and dental treatment abroad; and
- the curative costing plan, personal contributions and private dental health insurance.

Under the topic of at the pharmacy and in the hospital, the guide covers:

- choice of hospital, contracts, referrals and discharge;

- information before operations, doctors' duties, what to bring for hospitalization and daily hospital routine; and
- tracking medical history and frequent examination requirements.

During the design phase, the network of partners was foreseen as a dynamic and essential component of the programme, as it enables intersectoral work to deliver the community sessions and design the health guide, while facilitating the reduction of ethnic discrimination in service delivery and making public health services more responsive to the needs of immigrant patients. The following four groups of professionals were identified as central to reach through the network:

1. health service employees not adequately prepared to work with the immigrant population;
2. integration officers unfamiliar with health provision matters that pertain to immigrants;
3. social and immigrant counselling services that maintain direct contact with the immigrants; and
4. immigrants who feel too inhibited to approach the health services and who are unaware of available health and social support.

Initial steps: from design to activating operations

This section covers forming and establishing partnerships, linking partnership resources to programme methodology and recruitment of intercultural mediators.

Forming and establishing partnerships

After developing the programme methodology and securing funding, MiMi set out to form partnerships with the local health and integration services. A first round of meetings took place with the heads of these services. The next step for MiMi was to recruit the cooperation of additional partners, such as local authorities, NGOs, insurance companies and educational institutions. Then, another round of meetings was set up to bring together: (a) the health services, (b) the integration offices and (c) the recently recruited partners.

This second round of meetings served two purposes. First, it allowed MiMi personnel to present partners with a unique opportunity to turn into practice the theory of engaging disadvantaged communities. Second, once partners committed to the programme, the meetings served as a forum to formulate and sign a contract that defined the role and responsibilities of each partner in the implementation process. For example, in one area, the health services would be responsible for providing training resources, and the integration office would be designated as the lead player in reaching the target population. All partners agreed to be part of the monitoring and evaluation process and to incorporate MiMi as the official programme name. This was to ensure standardization and maintenance of quality in the programme. Partners agreed to help identify opportunities for sustainable funding and agreed on the publication of programme materials and results. This contract would later develop and come to be known as the shared action plan.

The way in which partners are incorporated into the programme changed as the programme expanded. In the initial stages (2004–2005), MiMi looked for and contacted potential partner organizations. In the second phase of the programme, after the pilot phase, word of the programme became widespread. Then, potential partners and individuals who wanted to be involved with MiMi contacted headquarters directly. Word of mouth and television and newspaper coverage helped to promote the programme. Within the first year of the programme's launch, 96 newspaper articles were published on MiMi. This also helped to drive political support, as mayors of cities became aware of the benefits the programme offered.

In each of its sites, MiMi was invited to present the programme to local officials (such as mayors and city councillors), who then met with the local legislative body (parliament or other relevant body) to discuss and approve the programme's implementation. Parliament's approval is indispensable to the sustainability of the programme, as it allows the health and social services to take the vital next step, in their role as partners, of allocating part of their financial budget and human resources to the operation of MiMi.

Linking partnership resources to programme methodology

The role of each of the health system and other partners in the MiMi programme varies according to the programme area in which it is implemented and according to the availability of resources. Some partners are able to make monetary contributions,

while others offer the use of their existing physical infrastructure and human resources. Of all partners, 30% offer materials and rooms for both training and community group sessions.

In training courses for mediators, medical professionals provide technical and content-related training, so that mediators themselves can plan and conduct community group sessions on various health-related topics. Often, medical professionals set aside special so-called teaching hours during normal business hours to conduct additional training. In these sessions, medical professionals also help to facilitate the use of municipal health service points – that is, public health departments, medical specialists and advisory centres.

During community group sessions conducted by trained and certified mediators, doctors and nurses are present an average of 20% of the time to provide additional support, and they often remain connected to the immigrant community through the MiMi network. These medical professionals essentially become a steady source of health-related information, and mediators are encouraged to ask for their advice whenever needed.

For the health guide, 80 professionals from various organizations in different areas of implementation collaborated to determine the main health topics to be addressed. All partners – including the health and social services, insurance companies, and universities – contributed to the development of the guide and its publication process. Partners now use and help to distribute this guide among their clients.

Recruitment of intercultural mediators

After partners committed to the programme and established their roles within it, mediators were recruited. Advertising campaigns through newspapers, television and posters are among the methods used to recruit new mediators. These campaigns specify that the MiMi programme is looking for strong migrants and invite individuals to meetings about the programme. Word of mouth also helps to attract new mediators. Informative meetings then provide details about the MiMi programme and the role and responsibilities of intercultural mediators. When immigrants are interested in becoming mediators, they go through a formal application process.

A sufficiently high social index is the criteria used to select applicants to become mediators. This index is formed by evaluating the following criteria: educational attainment, level of social integration, language abilities, occupation, and the respect they enjoy among their communities. For example, to determine the level of an applicant's language abilities and ensure that he or she is endowed with the necessary skills to become a mediator, the applicant may be asked to translate a newspaper article from the German to his or her native language, and vice versa.

Building the programme and key operations

This section covers mediator training, medical professional training, co-ordination among partners and the improvement of financial sustainability.

Mediator training

Once the training mechanisms were established and the applicants selected, the recruits were ready to begin official mediator training. For a total of 50 hours, during evenings and on weekends, mediator recruits were trained on the following 17 health-related topics:

1. the German health system, including necessary vaccinations
2. risks of alcohol consumption
3. nutrition and exercise, such as risks of unhealthy eating habits and lack of physical activity
4. risks of smoking and how to quit
5. dealing with medication: when it is necessary and how to avoid addiction
6. pregnancy and family planning
7. children's health and preventing accidents
8. healthy teeth and oral hygiene
9. obesity
10. first aid for children
11. mental health: depression, anxiety and stress; recognizing a psychological illness; helpful services

12. care for the elderly
13. illness prevention services and early diagnosis examinations
14. breastfeeding
15. diabetes
16. the disease management programme
17. breast cancer: early diagnosis and therapies.

When recruits finish their training, they must pass a multiple-choice test on these topics to receive a certificate and become official intercultural mediators. MiMi mediators are paid €150 for each community group session they conduct, or €200 (€100 each) if two mediators opt to have a joint session. Sessions themselves usually last 3 hours, and preparation and post-session reports (to record information on demographics of attendees and questions asked) usually take another 6–9 hours.

Medical professional training

Additional research, observation and evaluation – through a joint effort of the Ethno-Medical Centre and the medical faculty at the Hannover Medical School – found that service professionals too required more formal assistance to learn how to better meet immigrant needs (see the section on "Monitoring and evaluation" for more details on the collaborative effort in evaluating programme efficiency and effectiveness). As a result of these efforts, the MiMi programme has recently begun to provide training courses for (health) service professionals, developed by the Ethno-Medical Centre. Though this was not part of the original MiMi programme and methodology, it has helped health professionals in more established implementation areas to better understand and work with immigrant clients.

Professional training has two levels. At the first level, health service managers undergo two days of training. This helps to ensure: (a) that they take on the responsibility of managing future staff training sessions and (b) that they have full knowledge of what their personnel will be learning. At the second level, training proceeds with personnel training which, depending on the size of the particular health service organization, can take up to a year. Each 2–3 hour session aims at promoting transcultural awareness and understanding. The entire training course includes:

- an overview of the immigration process and recent trends in immigration
- guidelines for effective communication and how to use interpreters
- advice on conflict management
- trading places and role playing.

Essentially, the course gives medical professionals historical background on migration, a theoretical understanding of transcultural patient–doctor relationships, and a practical toolkit to more effectively serve immigrant communities. The course focuses on overcoming barriers related to communication and cross-cultural understanding, which represent 90% of the access barriers facing migrants. The other 10% is comprised of German medical practitioners' limited knowledge about some diseases that may be more prevalent in the immigrant's country of origin, but which are less prevalent in Germany. Should a situation arise in which service staff is confronted with such an illness, this training also provides medical professionals with a network of other professionals they can contact. Finally, training courses have also resulted in the production of standard guidelines to help medical professionals work with immigrants.

Coordination among partners

The Ethno-Medical Centre, in cooperation with the BKK Bundesverband, conducts public relations activities through newsletters, various media and the MiMi project web site (MiMi, 2008), where multilingual MiMi guides and materials are available for download. These public relations activities ensure that both partners and the public are regularly informed about programme developments.

To facilitate cooperation among the growing number of partners, MiMi has developed a coordination scheme based on a contractual partnership between site-specific bodies, with central management from the Ethno-Medical Centre. The coordination scheme includes:

- meetings with representatives of the BKK Bundesverband (sponsors);
- meetings for project coordination;

- programme review conferences (MiMi Projektkonferenzen) every six months, which all partners attend; and
- ensuring operation of shared action plans and ongoing exchange through e-mail and telephone conversations among partners throughout implementation, to measure each partner's respective progress.

The biannual programme review conferences help facilitate the flow of information among policy-makers, mediators, and health and social workers. At the conferences, mediators meet policy-makers and partner agency representatives to suggest how to best advance the programme. Also at the conference, all partners exchange experiences and develop solutions to challenges.

Improving financial sustainability

The costs of operating the MiMi programme are mainly incurred through: recruitment campaigns, training and pay for mediators; staff salaries and daily operations; and programme evaluation. MiMi's funding and its distribution of funds have evolved with the expansion of the programme. During the first year of the programme, with four pilot cities, the BKK Bundesverband supported MiMi. After the first year, the Ethno-Medical Centre negotiated and allocated funds, according to the number of cities or regions and the phase in which the project was implemented (with cost reduction over time).

This finance model, however, became unsustainable as the programme expanded. The most recent funding model now incorporates three main funding sources, a step forward for MiMi in ensuring programme sustainability. The three funding sources of each project implementation are: (a) the city, (b) the county (such as the federal state of Lower Saxony) and (c) the insurance companies.

Monitoring and evaluation

This section covers questionnaires on training events and community health sessions, and the overall programme evaluation.

Questionnaires on training events and community health sessions

Evaluation of the MiMi programme is an ongoing process. After every training event or community group session, questionnaires are filled out to (better) monitor progress. During (or after) training events, the organizer of the event, trainees and trainers all fill out an evaluation form on the session's activities. A similar process occurs in community group sessions, but the participants currently also answer pre-session questions to note their preconceptions of health, their demographics and what they hope to learn. Some of the questions included are as follows.

- How did you hear about the MiMi programme and this information event?
- Whom do you usually contact when you are ill?
- Why did you decide to participate in this community group session?

Participant questionnaires are available in 15 different languages. Post-session questionnaires are six pages long and include such questions as the following.

- Did your opinion about this topic change?
- Did you learn anything new?
- Will you make use of this knowledge in the future?

In the first year of the programme, 70–80% of the questionnaires were completed. MiMi is now trying to improve the format of the post-session questionnaires (for more details, see "Changes and future steps" in the section on "Lessons learned").

Overall programme evaluation

A more systematic, overall programme evaluation is underway. This evaluation aims to expand the current concept of evaluating the health determinants of target populations and the capacities built during training and community group sessions – for example, health literacy, behaviour and attitudes. In addition, more innovative research approaches aim to qualitatively describe the use and benefits of MiMi to the actors involved through, for example, interviews and working groups with trainers, mediators, and participants. Also, research aims to determine the cost–effectiveness of the project in various settings. Partners at the Hannover Medical School, the Public Health Service, the Department of Social Psychiatry and the Ethno-Medical Centre are evaluating the

programme, and the evaluation is funded through research grants from the German government. Such cooperation allows MiMi to take advantage of the experiences these institutions have in research and evaluation of projects.

Annual evaluation reports covering state-wide programmes have been published since 2007. Preliminary quantitative findings from the monitoring process (see Table 6.1) have indicated that the programme has:

Table 6.1. Results of information campaign evaluations

Type of information		Year				
		2004	2005	2006	2007	2008
Immigrants accessed	Total per year	1 105	1 569	3 817	4 069	6 965
Gender [a]	Male	32.0	27.3	17.8	16.5	20.2
	Female	68.0	72.7	82.2	83.5	79.8
Age (in years) [a]	<20	9.6	5.8	3.9	3.0	4.8
	20–50	66.7	65.8	63.5	68.0	65.6
	>50	23.7	28.4	32.6	29.0	29.6
Origin [a]	No. of countries	34	64	92	79	98
	Europe	79.8	69.4	77.0	76.8	66.1
	Asia	18.9	18.4	15.2	18.3	29.1
	Africa	0.1	9.9	6.3	2.9	3.6
	North America	0.0	0.2	0.1	0.1	0.1
	Central America	0.6	0.4	0.2	0.4	0.2
	South America	0.6	1.8	1.2	1.5	0.9
German language skills – self concept	None	17.4	17.5	9.6	7.7	7.5
	Satisfactory	22.2	21.5	21.0	18.3	18.1
	Sufficient	29.2	28.2	34.0	30.2	32.5
	Good	17.0	20.0	21.2	26.3	25.2
	Very Good	14.3	12.8	14.2	17.5	16.8
Recruitment channels for campaign participants [b]	Personal invitation	78.1	73.9	64.5	54.1	55.9
	Brochures	4.5	10.3	5.7	6.9	5.9
	Posters	5.5	11.0	5.9	6.4	3.1
	Newspaper	4.2	3.8	3.3	5.7	2.0
	Phone	13.1	11.3	20.8	23.2	32.2
	Letter	9.0	8.4	15.4	14.5	10.8
	Home page	1.1	0.8	1.7	2.5	2.2
I have to review my attitude towards health [a]	Not true	5.5	3.1	4.4	2.9	2.8
	Not really true	8.9	7.9	4.8	4.5	6.1
	Neutral/ partly	30.3	23.5	28.1	26.4	28.2
	Quite true	25.8	27.8	28.2	33.2	33.9
	True	29.5	37.6	34.5	33.0	29.0
I will look after my health more in future [a]	Not true	2.1	2.3	1.9	1.3	1.3
	Not really true	3.2	5.0	2.7	2.4	2.8
	Neutral/ partly	22.0	13.6	17.0	15.7	16.3
	Quite true	31.5	35.0	33.8	37.4	37.9
	True	41.2	44.1	44.6	43.2	41.7
Did you learn anything new at the event? [a]	Nothing	1.1	2.7	2.2	1.1	1.4
	A little	6.3	5.6	7.1	6.0	5.3
	Partly	21.9	17.1	21.3	20.2	26.2
	A lot	49.0	48.4	57.8	56.2	52.7
	Everything	21.7	26.2	11.6	16.5	14.4

[a] Percentage of participants.

[b] Percentage of positive answers of participants; one participant can provide more than one answer.

- expanded, reaching a greater number of immigrant participants and spreading their newly found knowledge to family members;
- reached various immigrant communities, the programme having trained 781 mediators (originating from 65 countries) by December 2008; and
- empowered women, since the majority of intercultural mediators are women (80%).

In addition, there are also qualitative findings, which suggest the following.

- Current health systems do not necessarily need additional health services specifically created for immigrants; rather, most health needs can be addressed through: (a) supplementary services that help facilitate access to the health care system; and (b) increased capacity to meet increased demand. Examples of supplementary services and increased capacity include: the employment of more bilingual staff, including physicians; the creation of health information material available in different languages; and the increased availability of interpreters, all of which contributes to increasing immigrant access to health services.
- Guidelines are helpful for medical professionals who address in a culturally specific context such specific areas as drugs, HIV/AIDS, mental health and oral health. In the past few years, the use of such methods has increased participation of immigrants in drug rehabilitation centres in Hamburg from 3% to 20%.

Lessons learned

This section covers successes, challenges and areas of improvement, as well as changes and future steps.

Successes

Since its inception in 2004, the MiMi programme has had a number of successes. Evaluations indicate that the programme has facilitated the formation of important links between immigrant communities and the health system. Intercultural mediation coupled with (a) direct immigrant participation and (b) the involvement of local health and social services in accessible community settings have been critical in enabling these linkages. Health professionals have increasingly come to view the immigrant community as a vital partner in health promotion. Such links have fostered a mutual comprehension of respective needs and, through the engagement of social services, also enabled action on the socioeconomic determinants of health of the immigrant population.

The programme has mobilized not only its partners in a collaborative effort, but also political support. More local government authorities are making financial commitments to demonstrate their support. Moreover, the German Government Representative for Immigration, Refugees and Integration, Professor Dr Maria Böhmer, has acted as patron of MiMi. Such support was made possible by the key method of inviting policy-makers to share in the programme's experiences and achievements during press conferences.

Furthermore, MiMi has sought to promote intercultural collaboration at its headquarters. The personnel at the Ethno-Medical Centre are diverse, with 50% of programme staff being immigrants and the other half being native born. More recently, the programme improved gender balance in management by actively recruiting and hiring immigrant women for managerial positions. MiMi has found that its strongest teams have been multicultural, because they offer and discuss different viewpoints and because they address the most difficult cross-cultural issues.

Challenges and areas for improvement

MiMi faces continuous challenges and has found aspects of the programme that might be improved. First, though some local authorities have committed financially to the programme, local authorities in other areas still need to do so. Local governments need to take increased ownership of, and become more engaged in, the programme.

Second, in some communities, MiMi immigrant participants have become very active in requesting access to services. This has resulted in a backlash from some services, which complain that immigrants suddenly have too many needs and that the

health system does not have the capacity to serve them. For the majority of cases, the issue is not that immigrants have unique needs that the health system does not provide or that suddenly they have new needs; rather, the issue is that these needs have always existed and have now been brought to light. Essentially, after addressing the inequities present in immigrant access to health services, the capacity of the health and social services must be re-evaluated and increased where needed.

Third, MiMi has created a new evaluation standard in Germany. The cost–effectiveness of MiMi is monitored and evaluated using a method that is not only qualitative, but is also quantitative. This has created some tensions between MiMi and other interventions, which are now often asked to meet the same standard. MiMi believes that this dual approach is a step in the right direction and that it ultimately improves both the effectiveness and efficiency of interventions.

Fourth, due to the expansion and widespread media coverage of MiMi, some cities are attempting to duplicate the programme without the help, authorization or operational process and methodology of MiMi. This competition in recruiting intercultural mediators has reduced the supply of available and well-integrated immigrants to serve in the programme.

Fifth, two villages involved in the MiMi programme have been unsatisfied with the results. These villages found the programme did not adequately meet its aims. Further investigation revealed mistakes in the implementation and operation of the programme within these villages, such as the following.

- **Under-qualified intercultural mediators.** Training on health topics requires mediators to have a good grasp of the German language. Subsequently, the teaching of community group sessions requires mediators to have a good grasp of the respective language used by the particular immigrant community they address. Accepting immigrants who lack sufficient language abilities in both German and the immigrants' languages increases the risk of incorrect or incomplete information transfer.

- **Underpayment of intercultural mediators.** Mediators are a critical component of the programme's operation and should be treated as such. They require sufficient funds to deliver high-quality community group sessions, and underpaying them jeopardizes the quality of the programme and its endeavours. In addition, it may hinder the recruitment of the most integrated and talented immigrants for the job of mediator.

Finally, internal programme coordination might be enhanced through:

- decentralizing operation centres in each state, as the programme will soon include more than 30 cities and its programme operation is currently centrally coordinated at MiMi headquarters in the Ethno-Medical Centre;

- making a clearer division of tasks between partners and the organization that executes projects;

- holding more frequent regional conferences to exchange information and experiences between regional partners; and

- endowing mediators with more responsibility for decision-making, as they represent the core of the programme and may possess additional insights that can improve programme operations and methodology.

Changes and future steps

Continuous monitoring of the MiMi programme has helped catch mistakes early and discover areas for improvement, thus facilitating positive change. Some of these changes have already been made, and others are in progress.

To ensure the sustainability of the programme, requirements have changed for: (a) new partners wishing to join an existing implementation area and (b) new cities wishing to implement the programme. Each new MiMi partner must develop a concept for funding the project after initial funding from the BKK Bundesverband has ended, such as funding from charitable foundations or other health insurance funds. Also, each new implementation area must now have secured financial support for five years prior to programme initiation. The original requirement was two years.

In September 2007, the MiMi programme began the creation of a national network of mediators and a working group that consists of representative mediators from each city. Then, at a national convention, the delegates will elect one woman and one man to become the national spokespersons for the MiMi programme, to raise political support at the national level. The BKK Bundesverband provides funding for the national convention and the mediators' working group.

Changes have been made to the session questionnaires. MiMi is continuing to use pre- and post-session questionnaires. Previous post-session evaluation forms were lengthy, requiring about 30 minutes to complete. This usually resulted in

substandard response rates and incomplete or fewer completed questionnaires. As a result of this, the questionnaire was made more succinct (20% shorter) and less time-consuming to complete. Also, instead of *income, capacity to save* is now measured, leading to a higher rate of answers to this question. To enhance the overall programme evaluation, MiMi might aim to capture more demographic information, such as the status of migration (first-, second- or third-generation migrant), parents' country of birth and resident permit status.

Finally, the evaluation of MiMi demonstrates its capacity to serve immigrants best if used for: (a) health promotion and preventative care information sessions and (b) the reduction of communication and information barriers, to increase access to existing health services. To maintain this service capacity, the Ethno-Medical Centre has decided to keep this focus and limit its expansion to related activities. For example, when evaluations demonstrated the need for increased services for people with mental and physical disabilities, the Ethno-Medical Centre was able to outsource this need and form a new NGO dedicated to serving these people. This allows the Ethno-Medical Centre to maintain the quality of MiMi programme operations, while simultaneously addressing/respecting additional needs.

Acknowledgements

The authors would like to acknowledge the inputs provided by Fabrice Danjou and Lisa Chen, interns at the WHO European Office for Investment for Health and Development during 2007, and by Eva Schwarz, Katja Ngassa Djomo, Alexey Milstein, Björn Menkhaus, Dr Matthias Wienold, Ahmet Kimil and Elena Kromm-Kostjuk of the Ethno-Medical Centre.

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7. Hungary: Health Clubs for Elderly Roma

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Summary

This case study describes a 16-month project of the Sex Education Foundation, a Hungarian NGO. From 2003 to 2004, the Foundation implemented a project to improve the health of the Roma population. The project, the Establishment of a Network of Health Clubs for Elderly Roma People, entailed 66 Clubs set up in three counties in western Hungary. It involved 261 Roma settlements and more than 2000 Roma individuals born before 1945.

The goal of the project was to facilitate access to heath care services for elderly Roma. In Roma societies, elderly Roma are perceived as reference people and opinion leaders, so educating them about health could benefit the entire population. Within this goal, several specific objectives were pursued:

- **short-term objective:** strengthen linkages between the Roma population participating in the project and the health care system (including the primary care system) and its workers;
- **short-term objective:** teach project participants about a healthy lifestyle and increase their health-related knowledge;
- **short-term objective:** provide social and legal assistance to Health Club participants;
- **medium-term objective:** increase the use of health care services by Roma people;
- **medium-term objective:** prevent cardiovascular and respiratory diseases; and
- **long-term objective:** improve the health of the Roma population.

The Sex Education Foundation, together with Semmelweis University Medical School and the National Institute for Health Development (a government agency within the Ministry of Health that plans, coordinates, monitors and evaluates public health and health promotion at the national level), first organized a network that included local governments and minority local governing structures. Members of this network then selected leaders within the Roma community and employed them as health mediators. In cooperation with general practitioners and other project partners, these health mediators in turn recruited Health Club participants from Roma settlements.

The project started with a basic health status screening of participants and a general assessment of health behavior and needs. Participants then attended three Roma Health Club meetings. Local general practitioners also attended the meetings, during which important health issues, such as smoking, sexual health and nutrition, were discussed. The Clubs used didactic methods for particular health problems and broader discussions between Roma participants and general practitioners.

In addition to basic health care issues, the project addressed wider socioeconomic determinants of health. Participants discussed socioeconomic concerns both during Health Club meetings and with health mediators outside of meetings. Within the bounds of their knowledge, health mediators and other project staff directed participants to services that might help them resolve these issues. In some cases, health mediators accompanied Health Club participants to local administrative offices to resolve issues related to identification documents, social assistance and unemployment registration, among other concerns.

Overall, the project was successful and participants appreciated it. Communication between the Roma community and health providers improved, and the health screenings revealed several cases of hypertension and poor nutrition that were referred appropriately. The number of participants attending the meetings continued to increase, demonstrating participants' positive response to the project.

The long-term sustainability of project activities is doubtful, as no additional funds were available to cover costs on an ongoing basis. However, since the project improved relations between Roma communities and physicians, it is hoped that the benefits will be seen well into the future.

Socioeconomic and policy context

Hungary is located in central Europe. It covers 93 000 km^2 and has a total population of about 10 million people. A fifth of the population lives in the capital, Budapest, and almost 65% of the population lives in urban areas. The population has been shrinking since the 1980s; the proportion of the population aged 0–14 years fell from about 20% in 1990 to 16% in 2003. Since 1980, the percentage of the population above 65 years of age has increased; it is currently 15% and is expected to reach 22% by 2030. According to the 2007/2008 Human Development Report (UNDP, 2007), 6.7% of the population lives below 50% of the median income, and 15.9% lives on less than US$ 4 a day.

The Hungarian GDP has been steadily growing since the transition from communism. In 2000, it was US$ 4606 per person, and by 2004 it reached US$ 9962 per person. The average monthly gross income of economically active Hungarians is about €630, with manual workers earning about half of what skilled workers do. The unemployment rate was quite high in the mid-1990s, reaching more than 10% at one point, but it fell to 7.2% by 2005. Due to the population ageing, expenditure on allowances for old-age pensions stood at 10.5% of the GDP (Prime Minister's Office, 2006) in 2006.

Using the World Bank's recommended benchmarks for absolute poverty in Europe, the annual household survey in 2002 found that less than 2% of Hungary's population was living on US$ 2.15 per person a day. Eurostat reported that, in 2002, 10% of the Hungarian population lived in relative poverty – that is, below the risk-of-poverty threshold set at 60% of the national median equivalized disposable income (after social transfers) (WHO Regional Office for Europe, 2006).

Relevant national health indicators and changes over time are summarized in Table 7.1.

Table 7.1. Select national health indicators

Health indicator	Value and year
Crude death rate per 100 000 population	13.46 in 2005; 13.88 in 1996
Life expectancy at 1 year of age	72.4 in 2005; 70.4 in 1996
Hospital beds per 100 000 population	1.8 in 2005
General practitioners per 100 000 population	65 in 2005
UNDP Human Development Index	0.869 in 2004

Source: WHO Regional Office for Europe (2007).

As in other former communist countries, the health system in Hungary has changed drastically since 1989. The national government is still responsible for health policy and regulates the health system, but it is no longer the primary financer. The Health Insurance Fund now covers most health care costs in Hungary, with most capital costs covered through taxation. Voluntary health insurance schemes do exist, but few purchase these policies, and their importance in overall health expenditures in Hungary is fairly low. As the health care system has been decentralized, locally controlled public providers contract with the Health Insurance Fund to provide health care services. Private providers may also deliver services in public sector facilities and use public sector resources. This is the basic form of primary health service delivery (Gaal, 2004)

Within the Ministry of Health, the National Public Health and Medical Officer Services is responsible for overall public health, including disease control and health promotion (Gaal, 2004). In the past, this entity undertook Roma health programmes.

Demographic characteristics of the target group

The most recent census found that Roma comprised 2% of Hungary's total population. However, given the stigma that Roma may feel, it is likely that many Roma did not self-identify as such in the census. International agencies and NGOs estimate that Roma actually make up about 7% of Hungary's population, meaning that there were about 700 000 Roma in 2001 (Kemény, Ladányi & Szelényi, 2002). As can be seen in Table 7.2, Roma are concentrated in particular geographic areas.

According to the prevalence odds ratio, the values of limitation in well-being show significant differences among the Hungarian regions. Although the values are not too high in themselves, they do not make transparent the huge differences in standard deviations. The upper values in standard deviations, however, give clear evidence of existing excluded subpopulations within regions with good prevalence odds ratio values/averages, as shown in Table 7.2.

Table 7.2. Roma Health Clubs related to basic Hungarian demographic data

Hungarian regions, included in 3 counties	Percent of the total Hungarian population [a]	Roma population in Hungary as % of the whole population [a]	Limitation in well-being in Hungary [b]		Number of Health Clubs in region [c]
			Prevalence odds ratio	Standard deviation	
Western Transdanubia	10	0.83	1.0	(Reference)	21
Central Transdanubia	11	0.82	1.4	(0.6–3.6)	0
Southern Great Plain	13	1.07	2.0	(0.8–4.6)	0
Central Hungary	28	0.84	2.7	(1.2–3.6)	0
Southern Great Plain	15	3.24	3.0	(1.4–6.4)	0
Southern Transdanubia	10	2.41	3.0	(1.3–6.8)	45
Northern Hungary	13	5.10	4.4	(2.1–9.4)	0
Total					66

Source:

[a] Authors' calculations based on Hungarian Central Statistical Office population census data of 2001.

[b] Compiled from Melles & Vitrai (2003). Reproduced with the permission of the copyright holder.

[c] Data calculated by authors.

Socioeconomic conditions of Hungarian Roma

Regional surveys and sociological research confirm that the majority of Hungarian Roma experience poorer living conditions than the overall population (Kemény, Ladányi & Szelényi, 2002). Poverty among the Roma is deeper and longer lasting than among the ethnic Hungarian population (Horváth, 2006). This deep and widespread poverty is likely to be the primary cause of the very poor health status of the Roma population. Recent analyses also suggest that segregation and exclusion from social, economic, political and cultural life play an important role in shaping Roma health.

The health indicators for Hungary, including health behaviour, morbidity and mortality, compare unfavourably to both EU and other central and south-eastern European countries (Kopp, 2001), and Roma are disproportionately represented in these figures. Research indicates that Roma become ill more frequently, see physicians less frequently and die earlier than people in the overall population.

It is difficult to obtain specific national-level health data for Roma. Several non-representative surveys have been carried out. These surveys show that Roma have poorer health than the overall Hungarian population and that they suffer from higher infant mortality rates and lower life expectancy (Gaal, 2004). Roma and physicians also report that patient–doctor relationships are often poor or dysfunctional. This can make the situation even worse, as sick Roma seeking health care might be unable to communicate effectively with their physician. These communication challenges exacerbate Roma exclusion from the health system.

In short, measurably improving Roma health on a population level is an urgent, but difficult task. No national-level representative baseline data exists, so improvements are hard to discern. Moreover, the determinants of Roma health are diffuse and entrenched, so it is difficult to address them in short-term, specific projects.

Policies and strategies to improve the Roma inclusion

In 1995, the Hungarian government established the Roma Affairs Coordination Council and the Public Foundation for Roma in Hungary. The latter has the task of coordinating the work of various ministries involved in addressing Roma issues. Subsequently, the government issued a medium-term package of measures, which included primarily steps to promote Roma education and culture, while also including other measures, such as employment programmes, training Hungarian police in Roma culture, and the demolition of unhealthy Roma settlements. Since 1995, the government has decreed several similar packages of medium-term measures, with an ongoing focus on education and cultural preservation. In 2002, Roma affairs were placed under the Prime Minister's Office, with the appointment of a Political Undersecretary of Roma Affairs (Ministry of Foreign Affairs, 2004).

Hungary participates in the Decade of Roma Inclusion 2005–2015. As part of this, the Parliament issued the most recent Roma Health Action Plan in 2007. The Action Plan is particularly innovative, covering many activities to improve the geographic coverage and quality of health care services in Roma communities, rather than focusing almost exclusively on creating demand for health services within the Roma community. The Plan, however, does not specify timelines or how activities will be financed, though the Parliamentary Resolution issued when the Plan was adopted does state that the government shall provide sufficient budgetary resources to implement the activities foreseen (Decade of Roma Inclusion 2005–2015, 2008). It should be noted that the Parliament calls on non-profit-making organizations to assist in implementing some of the planned activities.

It is also important to describe the institutions given the task of integrating vulnerable groups. Numerous institutions exist that address the health of vulnerable populations in Hungary, including:

- the Institute of Representatives for Patients' Rights
- the Department of National and Ethnic Minorities, within the Office of the Prime Minister
- the Department for Roma Integration, within the Ministry of Social Affairs and Labour.

Also, several other ministries have staff charged with Roma issues. Moreover, the National Strategic Reference Framework 2007–2013 – a national document that lays out the strategy for the use of EU structural funds – describes several different programmes that aim to facilitate the social integration of Roma, including the activities foreseen in the Decade of Roma Inclusion 2005–2015 Health Action Plan.

The Hungarian National Public Health Programme includes 19 chapters (Ministry of Health, 2002). A specific chapter, "Equity for health", specifies means to reduce inequities between excluded groups and the overall Hungarian population. Several excluded groups are named, including Roma, the disabled and the homeless. The chapter elaborates several specific objectives to:

- address the socioeconomic determinants of health in the short run, ultimately improving the health status of these groups in the long run;
- ensure equal and discrimination-free access to health care and prevention services for socially excluded groups;
- reduce prejudices among the health staff, vis-à-vis socially excluded populations, and prevent false stereotyping of patients;
- supplement graduate and post-graduate training of health care workers with course work on the health status, socioeconomic situation and cultural features of socially excluded groups, especially Roma; and
- improve the screening and care of socially excluded populations.

This chapter did not have particular financial resources allocated to its realization, and it should be noted that – for all chapters – financial resources for the Public Health Programme were significantly reduced during the period 2003–2006.

The Roma Health Club Project

The government is the primary provider of health services in Hungary, but civil society initiatives can play an important role in facilitating access to these services. Also, NGOs may be especially well-placed to work in Roma communities, since in many cases they already have experience in community-based work and have contacts in Roma communities. IOM initiated the Roma Health Club Project, with the aim of creating links between excluded Roma settlements and the public health system. Funding was provided through IOM to support the elderly Roma population that had survived the Second World War.

IOM subsequently contracted with the Sex Education Foundation, which established the Network of Health Clubs for Roma born before 1945. In part, the Sex Education Foundation was selected because it had undertaken several projects related to Roma health and social status in the past – for example, a community-based HIV/AIDS prevention programme, oral cancer screening in Roma settlements, and Roma health assistant training – so it already possessed institutional knowledge about key Roma health priorities.

The Network operated from September 2003 to December 2004. An additional three months were required before the start, for preparation, and when the project ended 12 months were dedicated to evaluating it.

The goal of the project was to facilitate access to heath care services among elderly Roma. Within this goal, several specific objectives were pursued:

- **short-term objective:** strengthen linkages between the Roma population participating in the project and the health care system (including the primary care system) and its workers;
- **short-term objective:** teach project participants about a healthy lifestyle and increase their health-related knowledge;
- **short-term objective:** provide social and legal assistance to Health Club participants;
- **medium-term objective:** increase the use of health care services by Roma people;
- **medium-term objective:** prevent cardiovascular and respiratory diseases; and
- **long-term objective:** improve the health of the Roma population.

The following questions were formulated before the beginning of the programme.

- Is it possible to influence health-minded behaviour with information and orientational activities?
- Is it possible to promote the need for basic and specialist health care services in the Roma population?
- Is it possible to improve the relationship between health care providers in general practice and the Roma population?
- Is it possible to reduce discrimination and false stereotypes during personal meetings?

In Roma societies, elderly Roma are perceived as reference people and opinion leaders, so educating them about health could benefit the entire population.

As part of the three-month preparatory phase, the following tasks were carried out:

- a review of the literature
- an assessment of needs
- identification of the territorial distribution of elderly Roma.

The preparatory phase revealed that, as described in the literature, cardiovascular, respiratory and musculoskeletal illnesses posed major health problems for Roma. The budget for the project is shown in Table 7.3.

The Sex Education Foundation, together with collaborators Semmelweis University Medical School and the National Institute for Health Development (a government agency within the Ministry of Health that plans, coordinates, monitors and evaluates

public health and health promotion at the national level), first organized a network that included local governments and minority local governing structures. Minority local governing structures were created according to Hungary's 1993 Act on the Right of National and Ethnic Minorities. Thirteen minority groups have the right to develop such structures, which are allowed to maintain their own institutions for local education, media and cultural preservation (Decade of Roma Inclusion 2005–2015, 2008).

Table 7.3. Project budget

Item	Cost
Administrative costs (material and research costs, overhead and the like)	€20 000
Incentives for participants	€38 8000 (€80/person)
Incentives for mediators and county coordinators	€25 000 (€360/person)

Members of the network created through the project then selected health mediators. Mediators attended a two-day training session, which consisted of four main parts:

1. basic health issues that would be covered in the Health Clubs
2. strategies for effective communication with health workers
3. the functioning of the health and social assistance systems
4. project operations, including instructions for organizing project activities.

The health issues covered included nutrition, tobacco smoking and alcohol consumption, and safe sex. In part, the choice of these topics was based on the assumption that the older Roma could inform and influence younger Roma.

The Health Club Network consisted of 66 Clubs in 261 settlements of three western counties of Hungary. The Clubs were held in centrally located and important settlements, with transport provided for Roma from neighbouring villages. Each of the 66 Health Clubs met three times during the project and a total of 2184 Roma participated.

Before the Health Club meetings took place, area physicians provided a baseline cardiovascular and respiratory disease risk-factor screening for Health Club participants. During this screening, general practitioners and other health care professionals collected information about body mass index, blood pressure, health knowledge and risk factors. The health mediators collected data on the number of participants and their satisfaction. Where relevant, participants were referred for care.

The three Health Club meetings focused on transmitting information related to cardiovascular, respiratory and musculoskeletal disorders, and their risk factors, including smoking tobacco, alcohol consumption and nutrition. The Club meetings also provided an overview of available health services and how to access them. Moreover meeting participants could make personal contact with the health and social care professionals who provide services, which could improve interpersonal relationships between professionals and Roma. During the course of the meetings, participants received illustrated information leaflets on the topics covered. These leaflets had been pretested prior to the start of the project. The text in the leaflets was quite simple, and the illustrations made it easy to understand and read. Participants who were too sick to attend one or all of the Health Club meetings were visited at home and provided with at least the health education element of the meetings. As incentives for participating, Roma Health Club members received food tickets and physicians received basic medical supplies.

Partnership

As noted, the Sex Education Foundation collaborated with governmental and local governing structures in planning the project, including Semmelweis University Medical School, the local offices of the National Public Health and Medical Officer's Services, local governments, and local governing structures for minorities. Project managers acted as liaisons with the health care system, particularly the National Public Health Officer's Service and curative medical services. Over the life of the project, the Foundation had regular consultations with representatives of the National Public Health Officer's Service at both the county and city level, including chief medical officers and health promotion department heads. During these meetings, priority health issues that pertained to elderly Roma, as well as Roma access to the health care system, were discussed, and a high priority was given to risky behaviour and opportunities to prevent illness.

Also, the Sex Education Foundation employed public health experts, Roma health promotion experts and sociologists specifically for this project. Over 400 general practitioners and other health and social care professionals participated in the project. Most of them were provided with incentives to participate, such as material or non-material allowances – for example, leaflets, blood pressure instruments and social capital – and they provided important guidance on key health problems in the Roma community.

Human resources and management structure requirements

Forty-eight health mediators played a major role in recruiting Club participants, in implementing the Clubs, in facilitating Roma access to social and legal services and in the final evaluation. County coordinators managed them. The health mediators were paid in food tickets, phone cards and gasoline tickets.

Three county coordinators ensured that Health Club meetings ran smoothly. They undertook basic administrative tasks, distributed food tickets to the elderly attendees, wrote brief reports of the meetings, and liaised with the moderators and project leaders. They also supervised the health mediators, including paying them. The county coordinators were compensated in food tickets, phone cards and gasoline tickets.

Three moderators were responsible for coordinating project activities. They were in direct contact with the physicians, mediators and county coordinators.

The project leader was responsible for overall and financial management.

Linkages between the project and social and other complementary services

The project included a formal system of referral to social services. Also, during and outside the meetings, both county coordinators and the health mediators collected information about particular social and legal problems, focusing particularly on problems related to public administrative bodies: local government assistance departments, child welfare services, legal support services for minorities and patients' rights services. Mediators reported any complaint, request, or problem to county coordinators, who forwarded those in official form to the appropriate bodies on the local, county, or national level. Those making requests or complaints were informed of the results.

The most common problems identified and referred were about: taxation, custody, child and family care, family violence, marriage and divorce, inheritance, compensation, and social assistance and housing. In addition to these problems, specific cases of discrimination and other legal problems were addressed.

Evaluation

Formal and informal evaluations were conducted. The formal evaluation included a detailed analysis of the reports written by physicians, mediators and county coordinators. These evaluations focus mostly on participation (headcount) and satisfaction. The informal evaluation included discussions among moderators, physicians, mediators and county coordinators, as well as feedback from Health Club participants.

The results of the evaluations showed that the project was successful in the following three key areas.

1. It facilitated improved relationships between Roma and health care workers. This also entailed a wider knowledge of the Roma population, which made access to services easier.

2. As indicated in the previous subsection, the project helped Roma to solve specific social and legal problems.

3. It positively influenced the health behaviour and quality of life of the Roma participating in the project.

Both Roma and health care workers were enthusiastic about the project from the beginning. Health Club attendance rates show the commitment and satisfaction of Roma participants; there were a total of 2037, 2129 and 2184 participants at the first, second and third meetings, respectively. At the end of the project, both Health Club participants and health care workers explained that they felt that their relationship had been strengthened with the other party.

The Sex Education Foundation, partners, and participants felt that the project should have continued at the original sites. It would also be useful to extend the project to additional locations and to include other age groups. The Sex Education Foundation applied for funds for this on several occasions, but was unsuccessful.

Based on the data collected during the evaluation and the activity records kept during the project, the Sex Education Foundation identified some effects of the Roma Health Clubs on health determinants and health system functioning.

Effect on determinants of health and the health system at the local level

The project had a positive effect on the relationships between general practitioners and patients and on contacts among participants. Also, the use of the leaflets helped widen the Roma's knowledge of risk factors and related behaviour. Besides these effects, the project managed to change the Roma's attitude about using services: they understood they should not wait until their health became extremely serious and that primary health care also plays a preventive role. Moreover, health system quality was improved, in so far as physicians were more sensitive to Roma and, thus, better able to provide appropriate care.

Through the work of county coordinators and mediators, the content of the Club meetings, and links with social and other services, the project also addressed some of the wider determinants of health. These included health system access, discrimination, cultural norms of behaviour and attitudes, lack of identification, lack of employment, social isolation, and other social issues listed above. In particular, access was increased through education about services available; through increased trust in the health care system, gained through contact with physicians; and through assistance in resolving administrative issues, such as identity documents and health insurance coverage.

Lessons learned

Answers to key questions

The authors of the present case study believe that project implementation provides answers to some key questions. With regard to the question "Is it possible to increase demand among the Roma population for basic and specialized health services?" the project experience indicates that it is – through strengthened community-based primary health care. With regard to the question "Is it possible to improve the relationship between health care workers and the Roma community?" the emerging answer is yes, although it is essential that efforts do not try to treat the phenomenon globally, but work instead to treat it at the local and personal level. For reducing discrimination and false stereotypes during personal meetings, it is essential too that both parties come to the table motivated to cooperate. With this, personal meetings can weaken stereotypes and strengthen tolerance on both sides.

Improved acceptability and quality of health services

One of the key short-term objectives of the project was to improve the relationship between the Roma population and the health care system. Mutual distrust was a key impediment to Roma accessing health services. However, many projects seeking to improve Roma health are unable to affect meaningful improvements in this area, as they focus solely on the Roma community, rather than also focusing on the health system.

The accomplishments of the Health Clubs project can be seen through the respective lenses of the four interrelated components of the right to health: availability, accessibility, acceptability, and quality. Improved communication between Roma communities and the health system affected both the acceptability and quality of health services. Roma Health Club participants' trust in the health system improved, making health care services more acceptable to them. Also, participating health care workers likely changed their attitude towards Roma patients, as a result of the programme, thus increasing their acceptance of the Roma community and the quality of care they provided it.

Even more sustainable and widespread changes in health care acceptability and quality might be brought about by incorporating elements related to Roma culture and their specific health needs into health care worker curricula at the national level.

The need for improved cooperation between the local government and minority local governing structures

Project organizers found it particularly difficult to facilitate cooperation between local governments and minority local governing structures. In part, cooperation was difficult because some members of local governments were not interested in collaborating with Roma governing structures. For their part, Roma local governing structures might have been accustomed to being excluded by local governments. Better cooperation between these two entities could have significantly helped the project to build even more linkages between the Roma community and services provided by the state. As a result of this lack of cooperation, marginalization of the Roma local governing structures further enabled marginalization of Roma communities overall.

Preconditions for designing/adapting similar projects elsewhere

The authors of the present case study believe this project could be adapted in other parts of Hungary or even Europe. In addition to addressing issues related to the elements noted above, the authors suggest that organizers might want to consider: the time frame for the project, the beneficiary population, Roma involvement, physician involvement and potential contributions of civil society.

Time frame for the project

Fifteen months is likely to be the minimum amount of time required to have some effect on health behaviour and status. Two-year projects might be preferable, owing to the following.

- Better involvement of the local civil services and organizations is needed.
- Improved access to and involvement of the target population are needed.
- The realization of an evaluation with more viewpoints needs a minimum two years.
- From a human perspective, enough time is needed to halt the resistance that opposes the new information and attitudes.

The Health Club could be an adequate method to optimize access to health services for any socially excluded groups that cannot take advantage of the social and health care services equally.

Beneficiary population

Project planners might consider including (or even specifically targeting) younger populations, given that the overall Roma population is fairly young. When approaching Roma communities, planners should also take into account the important role of decision-maker played by community elders. The changed attitudes of the elders and their broader knowledge could have a very significant effect on Roma families.

Roma involvement

Roma were involved at almost all stages of the project. Also, having health mediators was particularly important, because non-health mediators would likely not be able to recruit so many Health Club participants or convince community leaders about the need for the project.

Physician involvement

The involvement of physicians was germane to project successes, particularly to improving communication and trust between Roma and the health system and to providing concrete medical assistance to those Roma identified during the initial screening.

Potential contributions of civil society

A NGO spearheaded the project; an intergovernmental organization that insured the financial background backed it; and it was executed in conjunction with the government. It is a good example of government–civil-society cooperation. Because the NGO had already gained the trust of the Roma community and medical professionals, it was a good bridge between two groups.

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8. Ireland: Building Healthy Communities Programme

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Summary

Despite Ireland's unprecedented levels of economic growth in recent years and despite a reduction in the number of people living in consistent poverty, the number of people who are at risk of poverty remains high. Health inequalities also remain a concern, with poorer people experiencing poor health and dying younger. To address this situation, the participation of those experiencing poverty and health inequalities is a commitment in health policy. A number of key policy documents, including the National Development Plan and the National Action Plan for Social Inclusion, state a commitment to tackling health inequalities and to introducing comprehensive primary care service to those in greatest need.

The Combat Poverty Agency is a statutory advisory body responsible for developing and promoting evidence-based proposals and measures to combat poverty in Ireland. Under its current strategic plan, Combat Poverty is undertaking a major programme of work that addresses health inequalities and poverty. As part of this programme, it hosted the Building Healthy Communities (BHC) Programme that directly supported community development organizations involved in tackling health inequalities. The Programme had the following key aims:

- to promote the principles and practice of community development in improving health and well-being outcomes for disadvantaged communities;
- to build the capacity of community health interests to extract practice and policy lessons from their work;
- to guide and support policy initiatives that relate to the links between poverty and health; and
- to explore mechanisms for effective, meaningful and sustainable community participation in making decisions about health.

The Programme supported projects that focused either on targeted geographic areas or on communities of interest that share common characteristics, such as asylum seekers and refugees, deaf people, Travellers[1], lone parents and women with mental health issues.

The projects are involved in three broad activities:

1. tackling the main social determinants of ill health
2. tackling the lack of infrastructure and evidence base for ill health and inequalities

[1] Travellers are members of various groups of traditionally nomadic people, living especially in Ireland and the United Kingdom.

3. tackling the ill health of a geographical area or vulnerable group.

The projects varied in size, some involving national organizations and others, at the other end of the scale, involving small local interventions. The work funded by the Programme is very often a small part of the overall workload of the group that hosts a project.

The Programme evaluators outlined the following direct effects to date on:

- how health services are delivered, so they include more vulnerable groups;
- the way health services interact with the community of a particular area and/or the way health services interact with a vulnerable group;
- the perception of community development as an approach to tackling health inequalities; and
- building capacity within communities and vulnerable groups.

The Programme concluded in December 2007, and a full evaluation will be available in 2008. The lessons emerging from these projects are used to influence the Combat Poverty Agency's policy positions on health. Combat Poverty will continue to work with the projects in 2008, to consolidate policy lessons emerging from the Programme. While the final evaluation of the Programme is currently being finalized, initial findings have indicated that the Programme has met it aims and objectives. The Programme was successful and had several positive outcomes, considering its size and budget, and also had significant strengths and a number of weaknesses.

Socioeconomic and policy context

Socioeconomic context

Over the past decade, Ireland has experienced an unprecedented level of economic growth. Although this growth has slowed down in the past few years, the economy is expected to continue to grow at a slower rate than previously (Barrett, Kearney & O'Brien, 2008). In 2006, Ireland had the second highest GDP per person, expressed in terms of purchasing power standards within the EU, at 45.4% above the EU average (Central Statistics Office Ireland, 2008b). Based on gross national income, however, Ireland was in fifth place, at 25.2% above the average of the 27 Member States of the EU on 1 January 2007 (Central Statistics Office Ireland, 2008b). With its economic development, Ireland has reduced significantly the numbers of people unemployed and living in poverty. The unemployment rate is currently 6.1%, (Central Statistics Office Ireland, 2008a), and while the number of people living in consistent poverty[2] has fallen to 6.9% of the population the number of people at risk of poverty or who are income poor (on an income of under €202.49 per week in 2006) remains high, at 17% of the population (Central Statistics Office Ireland, 2007, 2008b). During the period 1998–2007, the population of Ireland increased by 17.2%, to almost 4.34 million people, with about 10% of the current population being foreign born (Central Statistics Office Ireland, 2006).

Several particular groups are at risk of poverty. These include lone parents, the long-term unemployed, children, people with disabilities, ethnic minorities, including Travellers, and ethnic minority communities new to Ireland.

Data for Ireland from 2001 illustrate the link between social gradient and health (Balanda & Wilde, 2001). Some examples are as follows.

- The all-cause mortality rate in the lowest occupational class is 100–200% higher than the rate in the highest occupational class.

[2] Income poverty is a term that refers to an income that is less than that regarded as acceptable by general society and that gives a lower than normal standard of living. It is measured as the share of people with an equivalized income below 60% of the national median income. This is also known as relative income poverty or at risk of poverty. Consistent poverty is income poverty combined with the lack of two or more of 11 basic deprivation items: having to go without heating at any time in the past year; being unable to keep the home adequately warm; being unable to buy presents for friends or family at least once a year; being unable to replace worn out furniture; not having two pairs of strong shoes; not having a warm, waterproof coat; being unable to afford new (not second-hand) clothes; being unable to afford meat, chicken or fish (or vegetarian equivalent) every second day; being unable to afford a roast dinner once a week; not having friends or family for a drink or meal once a month; and not having a morning, evening or afternoon out in the last fortnight for entertainment. Equivalized income is defined as the household's total income divided by its equivalent size, to take account of the size and composition of the household, and it is attributed to each household member.

- For circulatory diseases, mortality is 120% higher in the lowest occupational classes; for cancer, 100% higher; for respiratory disease, 200% higher; and for injuries and poisoning, more than 150% higher.
- Mortality rates for Ireland were generally higher than the rates in the (combined) 15 countries that were Member States of the EU before expansion on 1 May 2004. In comparison with the same EU group of countries, the all-cause mortality rate for Ireland was 21% higher for females and 9% higher for males.

Research commissioned recently by the Combat Poverty Agency highlighted the links between lower social class, lower educational qualifications, lower incomes and poor health (Layte, Nolan & Nolan, 2007). Using data from a national household study, the research found that 38% of those at risk of poverty and 47% of those living in consistent poverty report having a chronic illness, compared with 23% of the general population. Of men in the highest income decile, 11% have a chronic illness; for men in the middle of the income range, the figure is 20%; and for men with the lowest incomes, it is 42%. Also, only 57% of those living in consistent poverty have good or very good health; the figure for the rest of the population is 84%.

Poverty and poor health are closely interrelated (Balanda & Wilde, 2001; Barrington, 2004). Reducing poverty is, therefore, a key to improving the health of people living in poverty. Poor social conditions, such as lack of income and inadequate housing, hugely increase the likelihood of premature death. Also, children with low birth weight are more likely to be born to mothers experiencing poverty (McAvoy et al., 2006). The stress of striving to make ends meet affects both the physical and mental health of people in poverty – women in particular (Daly & Leonard, 2002). Moreover, a recent study by the Women's Health Council highlighted the issue of debt as a major cause of ill health (The Women's Health Council & MABS ndl, 2007).

People living in disadvantaged urban areas or remote rural areas find it more difficult to access primary care services, such as doctors, even though they are often the most in need, as it can be very difficult to attract services to deprived areas (Crowley, 2005b). Also, general practitioner services are unevenly distributed by location, with poor areas having fewer general practitioners. Therefore, people in those areas are more likely to use out-of-hours services and accident and emergency services (Layte, Nolan & Nolan, 2007). Furthermore, the cost of going to a general practitioner for those with low incomes who do not have access to a medical card (which entitles free access to about 28% of the population) is a deterrent to accessing primary care services.

Policy context

Public policy and services have a powerful influence on the external conditions that lead to poverty and play an important role in creating a social environment that is conducive to good health. The Irish health services were restructured during the past three years, and there is increased investment to develop primary care services. The National Health Strategy document *Quality and fairness: a health system for you* (Department of Health and Children, 2001a) states that: "To develop an effective health system, the determinants of health, that is the social, economic, environmental and cultural factors which influence health, must be taken into account." There is a need for formulating and implementing, on a cross-departmental basis (preferably with strong interdepartmental coordination) policies that tackle the structural causes of ill health. The health services are subject to structural reform and, with the establishment of the Health Service Executive (HSE), there are opportunities to tackle health inequalities at a strategic level.

The importance of trying to narrow the gap between rich and poor in Ireland and to get at the root causes of poverty has been recognized in the National Action Plan for Social Inclusion for 2007–2016 (Department of the Taoiseach, 2007) managed by the Office for Social Inclusion in the Department of Social and Family Affairs. The Plan contains targets to improve access to primary care services, especially for medical card holders. In 2007, a national steering group on health inequalities was established within the HSE, and the current HSE National Service Plan (HSE, 2007) makes a commitment to developing a draft HSE framework to tackle health inequalities.

The Primary Care Strategy document *Primary care – a new direction* (Department of Health and Children, 2001b) acknowledges that Ireland's primary care infrastructure is poorly developed and that services are fragmented, with a focus on treatment at the expense of a more balanced emphasis on prevention, health promotion and well-being. The National Partnership Agreement document *Towards 2016* (Department of the Taoiseach, 2006b) commits to "ongoing investment to ensure integrated, accessible services for people within their own community", with the official launch of 500 primary care teams by 2011. This commitment is reinforced in the National Development Plan for 2007–2013 (Department of the Taoiseach, 2006a) and the National Action Plan for Social Inclusion for 2007–2016 (Department of the Taoiseach, 2007).

Community development supports communities to identify and address the underlying causes of poverty and inequalities, including health inequalities (Combat Poverty Agency, 2007b). It empowers people to participate in the decisions that affect their lives, to bring about positive change within their communities (Combat Poverty Agency, 2005b). It is a process that supports the empowerment of groups of people to become involved in social change. It is about widening participation in the development, planning and delivery of health services and about ensuring that the community is actively involved in these decisions. It seeks to fulfil the right to the highest attainable physical and mental health. There is increased awareness of the advantages of this approach in tackling poverty and health inequalities, as it supports the participation of those experiencing health inequalities. Participation can lead to an improvement in services, because then services are more relevant and are designed to meet the required needs of the community (Combat Poverty Agency, 2007b).

Public policy recognizes that communities should be involved centrally in shaping health services, including primary care services (Health Boards Executive, 2002; Department of Health and Children, 2005). The National Action Plan for Social Inclusion for 2007–2016 (Department of the Taoiseach, 2007) promotes the application of community development approaches in achieving more people-centred health services. Also, the National Health Strategy (Department of Health and Children, 2001a) and the Primary Care Strategy (Department of Health and Children, 2001b) make commitments to the participation of communities in policy and service development. Moreover, the National Development Plan for 2007–2013 (Department of the Taoiseach, 2006a) acknowledges the strong social class gradient in health status.

The Combat Poverty Agency recognizes the current commitments, particularly in primary care, to target resources to those most in need. The delivery of commitments in the National Development Plan for 2007–2013, the Social Partnership Agreement document *Towards 2016* (Department of the Taoiseach, 2006b) and the National Action Plan for Social Inclusion for 2007–2016 (Department of the Taoiseach, 2007) are key to tackling health inequalities.

Programme benefiting the target population

Building Healthy Communities Programme

The Combat Poverty Agency is a statutory advisory body responsible for developing and promoting evidence-based proposals and measures to combat poverty in Ireland (Combat Poverty Agency, 2005c). The Building Healthy Communities Programme was launched in May 2003 by the Combat Poverty Agency and the Department of Health and Children (Nexus Research Co-operative, 2004). The Programme supported disadvantaged communities in tackling poverty and health inequalities and is currently in its second phase. The BHC Programme has the following key aims:

- to promote the principles and practice of community development in improving health and well-being outcomes for disadvantaged communities;
- to build the capacity of community health interests to extract practice and policy lessons from their work;
- to guide and support policy initiatives that relate to the links between poverty and health; and
- to explore mechanisms for effective, meaningful and sustainable community participation in making decisions about health.

The BHC Programme had three interlinked strands. The first strand focused on the innovative actions of the projects. The second strand supported projects to network and share experience and practice across the Programme. The third strand was concerned with documenting lessons that arose from practice and evaluating the Programme.

The BHC Programme was a three-year demonstration intervention that provided resources and technical support to community development and health projects. It provided funding for projects to develop innovative approaches to tackle poverty and health inequalities, using community development approaches. Resources were provided to network and share lessons learned, with the main aim of influencing policy. The Combat Poverty Agency conducted research and documented its findings to guide its own policy advisory role. A formative evaluation of the Programme was conducted, and its findings are due in 2008.

The BHC Programme is one approach that aims to tackle the social determinants of health and, in particular, to help tackle poverty by focusing on those groups within society that are most likely to experience poverty and (consequently) ill health. The projects funded through the Programme support the effective interaction of communities with health services, through a

community development approach. This will help ensure that future health services appropriately meet the needs of people who need them the most.

Community development has an important role to play in helping to alleviate poverty and improve access to health services. The approach to tackling health inequalities focuses on helping to build community infrastructure that strengthens a community's interaction with state health bodies. This provides the opportunity for those most excluded in society to have a real voice within the health services in Ireland and to transform the way in which health services are delivered in the future.

Phase 1

In the first phase of the BHC Programme, from 2003 to 2004, seed funding was offered to 31 community development and health projects involved in tackling poverty and related health inequalities (Nexus Research Co-operative, 2004). The Programme was supported by the Department of Health and Children, which provided resources for a number of projects – in particular, those involved in primary care (Crowley, 2005a). An advisory committee was established and included representatives from the Department of Health and Children, the Office for Social Inclusion, the Institute of Public Health in Ireland, HSE staff, community development and health projects, and public health academicians.

Example phase 1 project: Lifford-Castlefinn Primary Care Project

The Lifford-Castlefinn area is a rural area in the south-east of Donegal, which is located in the north-west of Ireland and is one of the largest counties in Ireland. In turn, Donegal is close to the border of Tyrone in Northern Ireland. In 2002, Lifford-Castlefinn had a population of 7300 people, with 19% of the population unemployed. The area has a poor public transport infrastructure and an underdeveloped local economy. In 2003, the Lifford Resource Centre received support from the BHC Programme for employing a consultant to support the local community's interaction with health services (HSE, 2004).

The area was targeted to develop a pilot primary care team. The project established a local community health forum, consulted with the local community and developed representation mechanisms on the primary care team. The community health forum has three representatives; these people bring the community's interests to the team and provide feedback to the broader forum. The forum works hard to ensure the voices of people experiencing poverty are heard.

As a result of the work of the project and the work of the local community, service delivery in the area has improved significantly. This improvement includes the extension of general practitioner services, services for people with intellectual disabilities, and recruitment of new social workers, an occupational therapist and physiotherapists, as well as strengthening the social networks in the area (HSE, 2006).

Phase 2

The second phase of the Programme ran from 2005 to 2007 (Combat Poverty Agency, 2005a). In 2005, community development and health projects were invited to apply for funding for a three-year period and to participate in the Programme. Of 34 applicants, 10 were selected, as follows:

1. Cáirde: a national community development organization working with ethnic minority communities;
2. Irish Deaf Society: a national association of deaf people;
3. One Parent Exchange and Network (OPEN): a national network of lone parent self-help groups;
4. Schizophrenia Ireland: Women Together Network: a national network of women who have experienced mental health challenges;
5. Galway Traveller Movement: a local community development organization working with Travellers;
6. Galway Refugee Support Group: a local community development organization working with asylum seekers and refugees;
7. Fettercairn Community Health Project, based in Tallaght, Dublin: a local multisectoral project based in an urban community;
8. Fatima Groups United, based in Fatima, Dublin: a local family resource centre based in an urban community;

9. Community Action Network, based in Dublin, and Northside Community Health Initiative, in Cork City: a national project and a local project focused on community development approaches to health; and

10. West Offaly Partnership: a regional-area-based partnership, based in a rural area.

Both the Department of Health and Children and HSE provided funding for projects. In 2005, the Department of Heath and Children funded a project focused on widening community participation in primary care services, and HSE continued to fund this project. As noted earlier (in the section in "Policy context"), there are policy commitments to enhancing primary care services.

HSE also funded two projects that work with ethnic minority groups, including asylum seekers and refugees. These projects have been involved in the development of the National Intercultural Health Strategy, coordinated by HSE. Other projects work with deaf people, women living with mental health challenges, single parents, Travellers, and people living in both urban and rural disadvantaged areas.

The overall budget for the BHC Programme was about €400 000 a year over the three-year period, of which €300 000 went to funding projects. The Programme was supported by staff at the Combat Poverty Agency and was located in a larger programme of work on health, called the Health Programme. The Health Programme Advisory Committee, which includes the above-mentioned stakeholders, is a subcommittee of the Board of the Combat Poverty Agency and guides the Health Programme.

The projects received annual funding of about €30 000 a year over the three-year period and were expected to participate in networking events, which were usually two-day events three times each year. The networking events were planned by a steering committee that included staff and participants drawn from the projects.

Projects were expected to participate in a formative evaluation and were offered the support of the BHC Programme evaluators, to develop their own self-evaluation. A Programme consultant was contracted by the Combat Poverty Agency to directly advise and support projects on ways to promote policy lessons emerging from their work. The Combat Poverty Agency provided a range of technical support to projects, including training, policy briefings and opportunities for networking, and facilitated contact between projects and policy-makers.

At the end of the BHC Programme, the Combat Poverty Agency will seek to work with HSE and a number of other stakeholders to mainstream effective community development approaches to health.

Example phase 2 project: Cáirde

Cáirde is a NGO that works to reduce health inequalities among ethnic minorities. It has a national remit, and its central office is in Dublin. Cáirde received funding in both phases of the BHC Programme to develop an ethnic minority health forum (Cáirde, 2007).

Cáirde continues to support the development of the National Ethnic Minority Health Forum, which is a representative body open to all ethnic minority community organizations, groups and activists living in Ireland. The Forum encourages ethnic minorities, refugees and asylum seekers to participate in the Forum, to ensure their voices are heard in the planning of health services.

The Forum meets regularly and undergoes training on policy issues. It has been successful in building representative bodies for ethnic minority communities to influence policy issues in the health arena and to identify the broader social determinants of health for their communities. It was involved in the consultations for the National Intercultural Health Strategy.

The focus of project activity

The projects funded through the BHC Programme were designed to address the key objectives of the Programme as a whole. From an analysis of the projects, the evaluators of the Programme (CLES Consulting, 2006) suggested there were three broad activities in which the projects were involved: (a) tackling the main determinants of health; (b) tackling the lack of infrastructure and evidence for ill health and inequalities; and (c) tackling the ill health of excluded groups. The balance of these activities varies.

Tackling the main determinants of health

A number of the local projects based in geographic communities focused on the general determinants of ill health, such as socioeconomic conditions (cultural, social and community) and living and working conditions. Thus the emphasis was not solely on the symptoms and treatment of ill health, but was also on the factors that determine ill health, such as living in a particularly deprived area with few or inaccessible services.

Tackling the lack of infrastructure and evidence for ill health and inequalities

Some projects focused on the infrastructure and processes for ill health and placed emphasis on creating more social and community infrastructure activity. The infrastructure, however, was not developed to provide health services directly, but was developed to provide the means by which ill health could be aired and addressed. Examples of projects include the development of community infrastructure that helped to provide representation for ethnic communities in Ireland at local, regional and national levels.

A number of the projects were involved in gathering data about and doing research on the communities with which they worked. This research is valuable, as it gathered evidence of the health inequalities experienced by these communities. For instance the lone parent network, OPEN, conducted research on the stress experienced by lone parents living in isolation.

Tackling the ill health of excluded groups

The third category of broad activities focused on excluded groups likely to experience ill health, because (in some way) they are more likely to be excluded from health care services. The focus of activity was directly on ill health of a particular group, and it sought to directly address ill health, as well as address the causes and social determinants. The Irish Deaf Society, for example, focused on promoting Irish Sign Language interpretation in the health services, to address health inequalities experienced by deaf people. To a lesser or greater extent, each project had its own individual blend of emphases, reflecting the particular local, regional or national context and approach to be taken.

Project context

The projects supported through the BHC Programme varied according to the scale of the operation. Some operated at a very local, area-based level while others aimed to work at a more regional or even national level. The organization was often an important element in determining the scale at which the project worked.

The national organization

A project hosted by a national organization works closely with local regional partners to act locally and gather evidence about inequalities. In this instance, there are processes and systems in place within the parent organization for its local, targeted project to have national resonance. Examples of such projects include the Irish Deaf Society, OPEN, Cáirde, the Community Action Network and Schizophrenia Ireland.

The regional/city organization

In this instance, the project benefited from a regional perspective, with potential national resonance. The project, however, was also close to local issues. Examples of such projects include the Galway Traveller Movement, the Galway Refugee Support Group and the West Offaly Partnership.

The local organization

These projects had national resonance in that they sought national change, but campaigned for change through practical work. In this instance, the process of influencing national or regional change may be more difficult than in instances in which the parent organization is a national or regional organization. The local project is typically based around a particular area. Examples of such projects include Fatima Groups United and the Fettercairn Community Health Project.

Relationships with health services

It is evident that all the projects varied in their relationships with health authorities and their associated bodies. HSE was directly involved in some of the area-based projects, actively working as a partner, on project design and implementation.

For other groups, the process was about interacting directly with health authorities and putting an infrastructure in place that advanced the local/regional relationship between health authorities and a particular health issue or group. For still others, the goal was more distant, with the aim being to advance the awareness and recognition within the health authorities of a particular group, issue, or community development approach to health. Many of the projects focused on influencing the introduction of primary care services (Crowley, 2005a).

The Combat Poverty Agency's role

The BHC Programme was located in a larger programme on health within the Combat Poverty Agency. As the Agency is a statutory advisory body, it will continue to advise and liaise closely with the health services and other statutory bodies on Programme findings. In 2007, the Agency produced a health policy statement (Combat Poverty Agency, 2007b) that was guided strongly by the BHC Programme, and it will continue to draw lessons from the Programme. It has supported the Programme in a number of ways, by providing:

- technical assistance for projects, to promote the lessons learned;
- networking support, with three networking meetings of the Programme each year;
- support for projects, to develop relationships with National Health Service staff and other policy-makers; and
- additional resources, to support consultation for the development of the National Intercultural Health Strategy.

The Combat Poverty Agency also sought opportunities for the projects to provide input to its broader health programme in 2007, namely:

- a national conference held in June, targeting health service staff, on the theme of community participation in primary care (Combat Poverty Agency, 2007a);
- by using research and inputs from projects in its health policy statement published in June 2007; and
- by drawing on submissions from projects for the Combat Poverty Agency's submission to the National Strategy for Service User Involvement in the Irish Health Service (Department of Health and Children, HSE & Health Services National Partnership Forum, 2008) and the National Intercultural Health Strategy (HSE, 2008).

The BHC Programme demonstrated that it can add significant value to the delivery of health policy by interacting with vulnerable groups, tackling the determinants of health and gathering evidence.

Interacting with vulnerable groups

The Programme assisted organizations that work with those most excluded in Irish society. This work is crucial to enable the health services to understand the needs of these groups and to make service delivery of practical work inclusive and effective. The Programme also supported the development of new partnership arrangements with statutory organizations.

Tackling the determinants of health

The Programme targeted the socioeconomic, environmental, cultural, age-related, sex-related and hereditary determinants of health present in society. This gave the Programme a much broader scope for understanding the realities behind poor health and mortality in the country as a whole. This, however, needs to be complemented by a strong proactive policy that targets the causes and symptoms of disease – as the health services alone cannot tackle all of the determinants of health.

Gathering evidence

One of the crucial roles of the Programme was that it acted as a vehicle for gathering data and evidence about the state of health inequalities experienced by a number of communities. Nine of the projects in the Programme produced research about their communities. The information gathered through the Programme will be invaluable for government departments in planning and targeting health services in the future.

Lessons learned

The effect and range of the BHC Programme varied broadly from project to project. While all projects embraced the objectives of the Programme, the extent to which different projects focused on these aims varied. The work of the evaluators suggests that projects had a number of direct effects on: (a) how health services are delivered, so that they provide more of the expected and required services to vulnerable groups; (b) the way health services interact with the community of a particular area and/or the way health services interact with a vulnerable group; (c) the perception of community development as an approach to tackling health inequalities; and (d) building capacity within communities and vulnerable groups.

As to the first effect, on how health services are delivered, the projects did this by gathering evidence and working with health providers to influence the way in which services are planned and delivered, so that they are more accessible in the future. This could also be described as having a direct effect on making health services more accessible, perhaps shown very clearly by the work the Irish Deaf Society is doing to make health services more accessible to the deaf community.

The second effect – the way health services interact with the community of a particular area and/or the way health services interact with a vulnerable group – allowed a community and/or a vulnerable group to have a voice, so that they were empowered to represent their community in a range of policy forums. This was demonstrated by the work of the Galway Refugee Support Group, which worked with ethnic minorities to reduce health inequalities.

The third effect – the perception of community development as an approach to tackling health inequalities – is about developing a culture in which approaches to community development are recognized more readily and are seen to add real value to the work of statutory health providers. The Community Action Network worked on this issue in their action learning unit (Community Action Network, 2006). Evaluation will be crucial for this effect to be captured, so that it produces the desired result through practical work.

For the fourth effect – building capacity within communities and vulnerable groups – the projects in the Programme worked closely with communities and vulnerable groups to build up the capacity of a group, so that it could play a key role in articulating its health needs. This also involved developing the specific target group's relationship with local services, to influence service provision. This is a common feature of BHC projects. For example, the West Offaly Partnership worked on establishing a local and regional community health partnership.

To date, the analysis of projects demonstrates that people experiencing health inequalities are engaged in the work of the projects and the Programme. The common way in which projects are planned and delivered illustrates that community development provides a flexible and responsive mechanism for tackling health inequalities and influencing the delivery of health services, particularly for those communities and vulnerable groups that are most excluded.

Although the Programme concluded in December 2007, it is continuing into 2008 to network between the projects and gather policy lessons from the Programme. Although a full evaluation of the Programme will be available in 2008, preliminary findings from the draft evaluation indicate that the Programme has met its original aims (Combat Poverty Agency, 2008).

A number of outcomes for projects participating in the Programme were identified in the draft evaluation. Projects identified the following areas that the Programme supported:

- the development of new community representative infrastructure and effective community development approaches that work;
- the development of new partnership and interagency approaches to tackling health inequalities;
- support for new opportunities for sharing good practice;
- strengthening and understanding the role of a community heath worker;
- increased awareness of the role of the social determinates of health and of community development approaches;
- strengthening the collective voice of community projects; and
- new primary research that highlighted the health equalities faced by each of the communities.

The following strengths of the BHC Programme were identified.

- **It encouraged an evidence-based approach to community development.** The Programme has piloted new approaches to community development, to tackle health inequalities and poverty located in a social determinants model.
- **It supported networking.** The visits and learning within and between the projects has been incredibly beneficial to all participants of the Programme.
- **It provided value for the money spent**. The cost of the Programme was relatively low, but the outcomes achieved represents good value for the money spent, particularly as the Programme has supported national and local community projects and has worked with some of Ireland's most disadvantaged communities.
- **It influenced national policy formulation.** The Programme supported projects to participate in national policy formation and has increased awareness among policy-makers of issues that relate to poverty and ill health.
- **It provided its partners with credibility.** The Combat Poverty Agency's support for the Programme has been important for the projects, as it has given them credibility through their involvement in a national programme.
- **It built capacity within the community development sector.** The Programme has helped build and strengthen the capacity of the community development sector and has supported the growth of organizations.
- **It supported partnerships.** The Programme has also facilitated the dialogue between different organizations and supported interagency approaches to tackling health inequalities.
- **It provided flexibility.** Project managers considered the Programme to be flexible and adaptable, which is important for community development type projects. Projects could use the allocated funding to develop areas of work unforeseen at the outset of the project.
- **It provided professionalism and management.** Combat Poverty Agency staff and management have been supportive, accessible and interested.

The main weaknesses of the BHC Programme were as follows.

- **It was a pilot programme.** One of the main weaknesses identified by the projects was their limited time frame. Many felt there is a need for a long-term vision on how to approach this issue with mainstream funding, for both a programme of this nature and for individual projects.
- **It was resource intensive.** The community development approaches used in the Programme require a great deal of long-term activity for projects in disadvantaged communities, getting to know local people and working with disadvantaged communities on a long-term basis.
- **It needed more work on developing and establishing indicators.** In the future, the Programme could explore the development of more detailed indicators.
- **It lacked connectivity with other initiatives.** At a national government level, the activity supported through the Programme could be integrated with other work at a national level to support disadvantaged communities.

The Combat Poverty Agency will use the evidence and lessons learned from the Programme to guide its policy messages in the future. Combat Poverty will also employ a policy liaison strategy to disseminate the lessons learned and the evidence from the Programme to policy-makers charged with addressing health inequalities and poverty.

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9. Italy (Tuscany Region): the Community Health Partnership of the north-west zone of Florence

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Summary

The Community Health Partnership of the north-west zone of Florence is a public consortium that includes the eight municipalities of Calenzano, Campi Bisenzio, Fiesole, Lastra a Signa, Scandicci, Sesto Fiorentino, Signa and Vaglia. It was created in 2004, in response to the 2002 Tuscany Regional Health Plan, to better integrate social and health services and improve services for disadvantaged populations, including socially excluded immigrants. Since then, 17 other community health partnerships have been created within the Tuscany Region.

The legislative context of this public consortium was set by constitutional reform (Law 3 of 2001), regional laws 40 and 41 of 2005, the Regional Health Plan, and the Regional Integrated Social Service Plan. These outline a system of welfare, the objective of which is the right to health (defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"). Therefore, the 18 community health partnerships of the Tuscany Region government aim to improve integration of health and social services at the local level. These partnerships influence: health system programme activities and actions; the provision of social services; urban and rural development plans; transport plans; environmental policies; housing policies; cultural, sport and free-time policies; and education and training policies.

The first Health Profile of the north-west zone of Florence was produced by the Community Health Partnership in 2005, to base the design of services on evidence and to define objectives for the Integrated Health Plan (local plan for implementation, derived from the Regional Health Plan). The Profile, which analyses health outcomes based on the material deprivation index, shows that standardized mortality rates and hospitalization rates increase as socioeconomic status worsens.

During the period 2001–2005, immigrant populations in all municipalities in Tuscany increased continuously, from 2.80% to 5.65% of the overall population. The most recent number (for 2005) is above the national mean for immigrant populations (4.50% of the general population). In response to this increase, the Community Health Partnership of the north-west zone of Florence decided that one of the nine areas it addressed should be the health of immigrants. In an attempt to address the health of immigrants and its wider determinants, activities of the Community Health Partnership have aimed to:

- increase the access of migrant populations to general practitioners and paediatricians;
- provide education on maternity and paternity for migrant populations;
- prevent TB among migrant populations;
- promote and enhance culturally appropriate services for resident migrant populations, including services through the Plum

Flower Centre, which integrates traditional Chinese and Western medicine;

- ensure control of occupational health hazards to which immigrants are exposed;
- provide a referral desk for access to housing and work opportunities, thus acting on the upstream determinants of health;
- strengthen mechanisms to educate adult migrants about their rights and opportunities within the Italian system;
- provide educational support and sporting activities for immigrant children outside of school hours;
- provide courses for immigrants working as caretakers of the elderly;
- institute a multi-area agreement for supporting women in need, including women who have been trafficked and former sex workers – some of whom are immigrants; and
- provide training of cultural mediators.

Socioeconomic and policy context

Immigration in the north-west zone of Florence

In recent years, the north-west zone of Florence has experienced an overall decline in population growth and an increasingly large elderly population. In some of its municipalities, for some years, however, there have been more births than deaths, and the population is becoming increasingly younger. This is due in part to a greater number of inhabitants from non-EU countries.

In the area covered by the Community Health Partnership (Società della Salute) of the north-west zone of Florence, the number of registered immigrants doubled during the period 2001–2005, from 5908 to 11 744 (see Table 9.1), due mainly to regularization of 700 000 immigrants in Italy, of whom 17 000 were from Florence Province – concomitant to Law 189 of 13 July 2002, amending the Immigration and Asylum Act (Parliament, 2002). Of the registered immigrants, those from Member States belonging to the EU before 1 January 2007 are not considered here, while new Member States are, because citizens from these newly entered countries do not benefit from full rights of circulation and labour market access. Also, non-residents are also excluded from the present data.

All municipalities in the area have demonstrated a continuous increase in the influx of immigrants. This is particularly the case for immigrants from Romania – their number having increased fivefold during the period 2001–2005. Immigrant numbers in the area represent 5.65% of the population, which is above the national mean of 4.50% of the general population.[1]

More than 50% of the immigrant population of the north-west zone of Florence is between 19 and 40 years of age, while 24% is under 18 years of age. The largest part of the immigrant population consists of families with children who are mainly born in Italy (61%). Attention needs to be given to this second generation of immigrants, because of the conflict in identity this situation can create and because they are still considered foreigners, but will probably become Italian citizens in the future.

In general, immigrant populations are more exposed to adverse socioeconomic conditions – in particular, poverty and social exclusion – that can result in health inequities. For example, working conditions can be worse, as a higher percentage of immigrants work in factories and at manual labour, where the incidence of occupational health hazards can be higher. Also, they may not be fully aware of their rights as workers. Moreover, housing conditions can be worse. For instance, overcrowding is more common. Immigrant populations may also have higher incidences of infectious diseases, which reflect exposure in their countries of origin and/or unhealthy living conditions and inadequate access to services in Italy. Furthermore, nutrition and physical activity may be worse, due to culturally influenced nutritional transitions, lack of resources (time, knowledge and money) to partake in healthy lifestyles, and social exclusion that prevents participation in sporting opportunities.

[1] Figures on Chinese and other immigrants only consider resident foreign citizens regularly residing in one municipality. They do not include all foreign citizens with a residence permit but without a regular residence. Most importantly, they do not consider all foreign citizens with no residence permit who may nevertheless live in the municipalities of the north-west zone.

The aspect of inequity most important to the Community Health Partnership is immigrant's inferior access to health and social services, compared with that of the general population. This is a result of linguistic barriers, lack of awareness of services and inhibitions about seeking assistance, unless ill health has reached an advanced stage. Cultural norms of behaviour can also influence health, in light of health services being incompatible with customs.

Table 9.1. Number and percentage of resident immigrants from non-EU countries

Municipality	Resident immigrants in 2001		Resident immigrants in 2005	
	Number	Percentage of total population	Number	Percentage of total population
Campi Bisenzio	1 918	4.9	4 281	10.5
Sesto Fiorentino	1 159	3.1	2 048	7.4
Scandicci	1 036	2.9	1 923	4.9
Signa	559	2.4	1 261	4.3
Fiesole	442	2.2	926	3.9
Lastra a Signa	402	2.1	580	3.8
Calenzano	291	2.1	564	3.7
Vaglia	101	1.9	161	3.2
Total	5 908	2.8	11 744	5.6

Source: Unpublished data from registry offices and data processing centres in the municipalities of the north-west zone of Florence (updated June/July 2005). Reproduced with the permission of the copyright holder.

Health system organization and community health partnerships

In each region of Italy, public health services are structured and delivered by local health units (Azienda Sanitaria Locale) that cover from 100 000 to 500 000 inhabitants and include different municipalities, hospitals and primary health care services. These services are managed by a director named by the regional council member responsible for health. Since Legislative Decree 502 of 1992 (Ministry of Health, Health Planning Directorate General, 1992), which deals with the payment of health contributions, the directors of local health units can count on reinforced independence for their management. This has not always been the case since the creation of the Italian National Health System in 1978 (Parliament, 1978), and the history of the health system has been marked by alternation, between mayors and directors, of political control of the local health units.

The Community Health Partnership is an answer to alternating political control, in that it creates a platform for mayors and directors of local health units to share decisions about health and social planning. The community health partnerships legislative context was set by constitutional reform in Law 3 of 2001 (Parliament, 2001), by regional laws 40 and 41 of 2005 (Regional Council of the Tuscany Region, 2005a,b), by the Regional Health Plan 2002–2004 (Regional Council of the Tuscany Region, 2002), and by the Regional Integrated Social Service Plan (Regional Council of the Tuscany Region, 2001). This legislation outlines a system of welfare, the objective of which is the right to health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", reflecting the WHO Constitution (WHO, 2005). Their proper creation responded to regional laws 40 and 41 of 2005 (Regional Council of the Tuscany Region, 2005a,b) and Tuscany Region Committee Resolution No. 155 of 23 September 2003 (Regional Council of the Tuscany Region, 2003). Since the creation the Community Health Partnership of the north-west zone of Florence, in 2004, 17 other community health partnerships have been created within the Tuscany Region.

The aim of community health partnerships is to share with the municipal government and other local stakeholders the responsibilities for health, in an attempt to involve them and civil society in addressing the wider determinants of health. As in many countries, Italy delivers a high level of efficient services. Since public investments are no longer proportional to the improvement in health outcomes, action on the determinants of health and an increase in preventive measures are needed.

The community health partnerships were introduced as pilot programmes in the Tuscany Region through its Regional Health Plan 2002–2004 (Regional Council of the Tuscany Region, 2002). The piloting phase lasted 3–4 years, during which (on a

volunteer basis) the social-health zones of the Tuscany (34 in total) had the opportunity to create the public consortiums that are the community health partnerships. The Tuscany Region left the decision to the municipalities of whether to sign up as a community health partnership pilot programme. Now, with the new law, the community health partnerships are obligatory and are being regulated according with the lessons learned during the pilot phase. Currently, 18 zones implement community health partnerships, and the number is increasing.

Programme or intervention benefiting the target population

The Tuscany Region government's community health partnerships aim to strengthen the integration of health and social protection systems. The underlying principles of community health partnerships are as follows.

- Health is an outcome of biological, environmental, social and cultural influences.
- Territory – that is, the social, economic and environmental conditions under which a person lives – is central to the health and well-being of the population.
- Policies and interventions for health are not the exclusive responsibility of the health system.
- A new interdisciplinary service management model is necessary, and it should be based on health objectives and constructed with the involvement of the entire community.

The community health partnerships' aim is to improve integration of health and social services, by influencing:

- health system plans/programmes at the provincial, metropolitan and *area vasta*[2] levels
- local social service provision
- urban and rural development plans
- transport plans
- environmental policies
- housing policies
- cultural, sport and free-time policies
- education and training policies.

Organizational structure

The community health partnerships are public consortiums comprised of municipal and local health units. In the case of the north-west zone of Florence, the Partnership includes one local health unit (Azienda Sanitaria di Firenze) and eight municipal governments (the municipalities of Calenzano, Campi Bisenzio, Fiesole, Lastra a Signa, Scandicci, Sesto Fiorentino, Signa and Vaglia).

The input of various contributors is ensured through regular round-table consultations (Tavola/Consulta di Terza Settore). Participants in the round-table consultations include community members and beneficiaries, local service providers, intersectoral representatives (including those from the housing and education sectors), labour unions, and representatives from the voluntary sector and civil society (more than 200 volunteer associations, representatives of service user groups and NGOs). These consultations bring needs and requests to the governing body of the Partnership, the Committee (Giunta), which is comprised of municipal mayors or town councillors, the Director-General of the local health unit, the President of the Partnership (elected from among the municipal representatives), the Auditor and the Scientific Director.

It is compulsory for the round-table consultation to endorse the Committee's decisions before implementing them, making stakeholders true partners in the outputs of the Community Health Partnership. The Director of the Community Health Partnership is responsible for applying the Committee's decisions, for related management of the local health unit and the municipalities' social service professionals and for negotiating the budget. The round-table consultations also evaluate and monitor mechanisms for service provision and integration and the results of applying them.

[2] *Area vasta* refers to geographical groupings of local health units. They are used for consulting stakeholders, planning health service delivery and purchasing medical equipment and are part of the organizational structure of the Tuscany Region health system.

The activities of the Community Health Partnership of the north-west zone of Florence are determined by the strategic areas of work delineated in the Integrated Health Plan. These activities ensure the improvement of the health and well-being of the population, starting with its most vulnerable members. Activities of the Community Health Partnership of the north-west zone of Florence are grouped as follows:

- special projects, covering such topics as information counters that provide information on both health and social services, home care and intermediate care, reduced waiting list times, and palliative care;
- integrated care for the elderly;
- integrated care for people with disabilities;
- integrated care that promotes the well-being of families and children;
- mental health projects;
- substance abuse projects;
- immigrant projects;
- prevention projects; and
- reorganization of services.

To implement these integrated strategic activities that involve social services, the Tuscany Region distributes to municipalities, each year, financial resources from the National Fund for Social Policies. The Director of the Community Health Partnership is in charge of deciding related objectives and budgets for health sector services (the local health units) and social services of municipalities. These financial resources benefit the social services of the municipalities and also benefit specific projects elaborated jointly by the municipalities and voluntary associations on the basis of local needs.

As a public consortium, the community health partnerships are sustainable over time, because their financing does not come from – but rather is a proper part of – the health service fund of the local health unit and the budget of the municipalities. Their financing is discussed and decided yearly.

The Tuscany Region created a dedicated fund aimed at supporting the launch of the community health partnerships and specifically addressing and facilitating the piloting phase. The financial independence of local health units and the community health partnerships is crucial to ensure the economic stability of the regional health budget. Should a split-up occur, management responsibilities go back to the original stakeholders. Guidance on allocation and management of financial assets, split-up procedures following financial, managerial or outcome underperformance, as well as debt coverage responsibilities, is provided within the guidelines for the piloting phase.

The Community Health Partnership has become the entity that decides what integrated social and health strategies are to be taken. These strategies cover the assessment of needs, choice of projects to implement, coordination of such projects, allocation of resources and evaluation. The coordination of the programme for health and social services facilitates an operational overview of service offerings, thus enabling efforts to be streamlined, which eliminates duplication and concentrates actions where they are needed.

Monitoring and evaluation

The 2005 Health Profile of the north-west zone of Florence was the first assessment of needs produced by the Community Health Partnership of this area (Valdré, Zecchi & Galli, 2005). Its purpose was to analyse population needs, to steer the Integrated Health Plan and the design of services. It uses the material deprivation index – which takes into account the variables of unemployment, overcrowding, and non-car and non-home ownership – to include aspects of socioeconomic status, such as education level, unemployment and housing conditions. The Health Profile, in its section on health status, gives epidemiological data and data on the supply of social and health services. Such an assessment of the situation provides data that can be used to compare and evaluate the outcomes expected from Community Health Partnership implementation.

The work of the Community Health Partnership also includes developing and implementing projects aimed at effectively integrating and harmonizing social and health interventions. During 2006, 62 projects were implemented, each with its own measurable indicators of process and outcome. These projects are under evaluation at the moment.

Improving the health of migrants

The Community Health Partnership of the north-west zone of Florence aims to address the health of immigrants and its broader determinants – in particular, poverty and social exclusion. In this regard, the Community Health Partnership gives priority to:

- reinforcing and developing communications and information measures on primary and emergency health care for immigrants;
- intervening to check the work and workplace conditions of immigrants;
- educating adult immigrants about their rights and opportunities within the Italian system;
- supporting education for immigrant children outside of school hours;
- providing courses for immigrants working as caretakers of the elderly; and
- providing a multi-area agreement for supporting women (including those of immigrant status) in need.

In light of the above, the Community Health Partnership provides the following services for immigrant populations: access to general practitioners and paediatricians, Chinese cultural mediators, the Plum Flower Centre, education on maternity and paternity for the foreign population, prevention of TB among the immigrant population, prevention of work accidents, incorporation of immigrant children into sporting activities, and a referral desk for access to housing and work opportunities.

Access to general practitioners and paediatricians

Multiple factors can prevent immigrants from accessing a local health care focal point (or general practitioner). Factors that prevent this include lack of information on procedures that must be followed to obtain a health care registration card and difficulties in communicating, due to language barriers. As stated earlier, immigrants resort more frequently to using hospitals to address sicknesses, and do so when these are in advanced stages. The Partnership aims to increase the number of immigrants with a residence permit enrolled in the health care service. In this way, they can fully benefit from the services of general practitioners and paediatricians, which (in Italy) serve as the entrance point for a range of treatment options and referral services.

This activity is implemented through the involvement of groups of doctors and civil-society/voluntary groups. In particular, general practitioners offer free visits to foreign patients – even to those living on a temporary basis in Italy – regardless of the number of patients they have in their charge. Also, in the north-west zone of Florence, there are specialized primary care and gynaecology clinics for non-EU immigrants.

Chinese cultural mediators

In the municipality of Campi Bisenzio, bilingual Chinese cultural mediators work to ensure proper use of primary health services, to reduce the risks of self-treatment or treatment by nonmedical personnel. The project entails cooperation between the local health care trust, the general practitioner and paediatrician, and cultural mediators. Cultural mediators are usually native speakers who are well integrated into the local society and who work on a regular contract with the local health unit.

Plum Flower Centre

On 6 October 1995, the centre for traditional Chinese medicine, Plum Flower, was established in the primary care centre in San Donnino (Campi Bisenzio), within Local Unit No. 10. It is open to adults and children, both Italian citizens and immigrant residents, although it is specifically designed to serve the needs of the resident immigrant Chinese population. The Centre operates intersectorally and integrates treatments with traditional Chinese medicine into Western therapeutic procedures, thus serving as a bridge between different cultural approaches to sustaining health. It employs interdisciplinary doctors, therapists and nursing staff, who serve as bridges between different cultural models of health care. The Community Health Partnership works to link community members to the Centre services.

Education on maternity and paternity for the foreign population

The Partnership aims to develop an information and education plan on pregnancy, taking into account immigrants' geographic origins and respecting their cultural heritage and religious beliefs.

TB prevention among the immigrant population

Given the increase in TB infections in the Tuscany Region, there is a need to inform immigrant community members – particularly the families of people already ill – of the means by which TB is transmitted. The Partnership produces and disseminates information for immigrant groups on the prevention and treatment of TB.

Prevention of work accidents

The Italian National Insurance Institute for Work-related Accidents (INAIL) pursues a number of objectives: to reduce accidents, to provide workers operating in risk environments with insurance coverage, and to ensure a reintegration of injured workers. Data provided by the Institute show that, in the field of merchandise transport, there is a high incidence of work-related accidents and muscular skeletal diseases, particularly among immigrant workers (INAIL, 2007). A new intervention will target companies with particularly high incidences. This activity is promoted by the Prevention Department of the Health Unit of Florence.

Incorporation of immigrant children into sporting activities

The north-west zone of Florence includes municipalities that are among those with the highest percentage of immigrant children in Italy – for example, 15% in Campi Bisenzio. The participation of immigrant children in sporting activities is low, however, when compared with that of other children. This is due to cultural differences and social inhibitions and to difficulties in accessing extracurricular opportunities for socialization. The project promotes the participation of immigrant youth in sporting activities through special events/initiatives. The Italian Union of Sports for All supports this project.

Referral desk for access to housing and work opportunities

As housing and employment are key determinants of health, this project entails the opening of a single office to provide orientation, counselling and information to resident immigrants on housing and job opportunities in the north-west zone of Florence. It supports them in securing first-house mortgages, special loans and job search services in Florence Province.

Lessons learned

One of the greatest challenges faced by the Community Health Partnership of the north-west zone of Florence has been reorienting stakeholders and the public to see health services as not only being available in hospitals and specialized centres, but also being available through different community structures and in people's homes. Convincing partners of the cost–effectiveness of bringing health services into the community has been one of the most difficult tasks of the Partnership.

Community health partnerships have managed to achieve significant outcomes in different sectors – mainly social and health services, but also other sectors that act on the broader determinants of health. For instance, efforts to provide affordable

housing and adequate transportation have been implemented in a way that does not separate the community into advantaged and disadvantaged areas.

Also, the partnerships have served as mechanisms for the participation of local communities in decision-making processes. In the past two years, the involvement of labour unions, civil society and the voluntary sector in community health partnerships has been essential to the effective implementation of initiatives.

Local ownership of priorities is at the core of the community health partnerships. Because the partnerships' activities are based on an assessment of community needs, the services provided are not a pre-assembled set imposed by a higher level of government. Rather, they are delineated, monitored and regularly adjusted to meet the specific health and social needs of a particular population. The membership of the Committee and the convening of the round-table consultations also further strengthen local ownership.

The Tuscany Region is currently evaluating the best legislative instruments and modalities with which to continue the experience of the community health partnerships. More specifically, work is being done towards a law that will effectively extend the community health partnerships to the entire Tuscany Region, where municipalities have an important role in the programmes for health and the best ways to govern them.

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10. Italy (Veneto Region): integration of social and health services for immigrants – the case of Padua

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Summary

The aim of this case study is to describe Padua's experience in the field of social and health services for immigrants. A unique aspect of this experience is the high level of integration of these services. This is based on the commitment of all the social actors (public and private) to provide services for everyone – including foreign-born people – for their health and well-being, thus safeguarding their right to health.

Padua is a city in the Veneto Region, whose capital is Venice. The Veneto Region is located in north-eastern Italy and has 4.7 million inhabitants. The economic model for the Region is characterized by: a prevalence of small and medium-sized companies; production based on traditional manufacturing sectors (such as food, textiles, shoes and wood); and decentralization of the companies within the territory. Padua, the home of one of Europe's oldest universities, has 210 000 inhabitants and a thriving economy. Due to its economic success, Veneto is among the regions in Italy that attract the most immigrants. According to the latest Italian National Institute of Statistics report on the foreign population living in Italy, 350 215 foreigners reside in the Veneto Region, accounting for 7.3% of its population. Padua has 58 498 resident immigrants, showing a 10.9% increase for 2006. To respond to the social and health needs of an increasing number of immigrants, Padua has created an integrated system of services.

The main organization that provides social and health care services for legal and illegal immigrants in Padua is the High Professional Immigration Body, a part of Local Health and Social Authority No. 16. It is the result of a collaboration of institutional bodies that – with different contributions – have implemented a coordinated system of plans and activities. Services created specifically for foreigners are: the Listening Centre, which provides information and health and social orientation services; a multi-ethnic unit for obstetrics and gynaecology; a unit for dermatology; and units for community paediatrics. The Municipality of Padua and Local Health and Social Authority No. 16 signed a memorandum of understanding about the management of health services for unaccompanied foreign minors. The voluntary sector in Padua also responds to the health needs of immigrants through a network of outpatient services. The implementation of such services is possible precisely because of the integration of related health and social services.

Padua's experience with immigrants shows how the implementation of efficient interventions for the target group comes from the creation of a system that coordinates the roles of the local actors involved. In Padua, these actors include Local Health and Social Authority No. 16, the municipality, the Veneto Regional government, the provincial government, the hospital,

the police headquarters, the Diocese of Padua, the university, and the elementary and secondary schools. The successes of the social policies of the Municipality of Padua and of the activities of the stakeholders, including the High Professional Immigration Body, are a result of a coordinated network in which network partners have the common objective of integrated community development and social inclusion.

Socioeconomic and policy context

The Veneto Region of Italy is situated in the north-east of the country and is divided into seven provinces. It covers 18 380 km^2 and has a population of 4 773 554 people (Veneto Statistics Office, 2008a). Over the last 35 years, the population has increased by more than 600 000 residents. In the Veneto Region, 350 215 foreigners are listed as legal residents, which represents a twofold increase since 2001. The Region's resident legal immigrant population is about 12% of Italy's total legal immigrant population, which is 2 938 922 immigrants in a total population of 59 131 287 people. Today, legally resident foreigners comprise 7.3% of the Region's population, a percentage that is higher than the national average (4.9%) and is one of the highest in Italy, after the Lombardy and Emilia Romagna regions (ISTAT, 2008).

According to the last Italian National Institute of Statistics (ISTAT) report, Padua Municipality has 19 661 immigrants, which represent 9.35%f the overall population (ISTAT, 2008). In 2006, the foreign population increased 10.9% (ISTAT, 2008); it is the second highest increase recorded in the Veneto Region (only Venice had a larger increase: 13.8% (ISTAT, 2008)).

The Veneto Region statistical report for 2008 notes that the Region has developed economically over recent years (Veneto Statistics Office, 2008b:9). According to the report, in 2005 the Veneto Region economy produced a consistent 9.3% share of the national GDP and was third in regional rankings for production of national wealth, after the Lombardy Region (20.9%) and the Lazio Region (10.9%). Between 1997 and 2007 employment in the Veneto Region increased 16%. Once again, a relevant contribution came from the foreign population.

In the past few years, the predominant countries of origin of immigrants have changed and, consequently, this has altered the composition of the foreign population in the Region. In the period 2004–2006, the number of immigrants from eastern Europe doubled, with a significant rise in regularization: 48 000 new residence permits a year (including immigrants from the newer EU countries). In 2005, the largest number of immigrants obtaining their residence permits originated from the countries of central and eastern Europe (CCEE) (133 000 people, 45% of the total for the year), thus Europeanizing the process of immigration (Veneto Region Immigration Observatory, 2006).

The influx of immigrants is unevenly distributed over time, as characterized by duration of stay. A significant proportion of immigrants, estimated at about 55 000 people, has resided in the Veneto Region for more than 10 years, whereas between 130 000 to 135 000 foreign-born people have been in Veneto for over 5 years. Also, between 20 000 and 25 000 foreigners have been in the Region for less than two years. These influxes involve a considerable proportion of citizens from eastern Europe (Moldovans, Romanians and Ukrainians), a proportion from Africa (especially Ghana and Morocco) and a proportion from the Balkan states (especially Albania, Montenegro and Serbia).

With the increase in the overall foreign population, the number of new foreign minors and women in the Veneto Region is worth noting. Since the early 1990s, this subpopulation has grown, which can be interpreted as a consequence of the increase in permits granted for family reasons. The overall increase in minors and women in the immigrant population demonstrates the tendency of family heads to settle and seek stabilization in Italy; at the same time, it points to an increasingly consistent establishment of a greater number of foreigners as a structural component of the population.

The Veneto Region health system

The Veneto Region health system is organized to satisfy the health needs of the resident population, to maintain its health and well-being and to ensure that essential levels of health care are provided within a progressively decentralized regional health care system. An important feature of this health care system is the integration of health and social services to provide better-quality patient care, both across the hospital network and in the Region. The hospital network is made up of 61 public hospitals (grouped into 21 local health and social authorities), two hospital trusts in the cities of Padua and Verona, and two universities, which include the school of medicine. The regional level provides health and social services to the resident population through

organizations instituted at the local level, a network of population-based health care organizations (local health and social authorities), and accredited public and private hospitals.

Through a multisectoral approach, the Veneto Region – in compliance with National Law 328 (the Social Services Framework Law of 2000) and the Codified Law on Immigration (which covers assistance to foreigners enrolled in the National Health System) – promotes initiatives for the elderly and for the inclusion of immigrants in, for example, housing, work, education and support for professional training. National Law 328 (Parliament, 2000) allows an integrated system of social interventions and services and provides for activities that aim to eliminate user difficulties. The Law also designates the municipalities as the main suppliers of these social services.

In this multisectoral approach, health and social services play a very important role. For these services, immigrants with regular residence permits in the Veneto Region have the same access as Italian citizens. Illegal immigrants, however, have access to basic health care and emergency treatment; if they choose to use these services their presence is not communicated to the police. The Veneto Region, as elsewhere in Italy, creates no legal obstacles for immigrants with regular permits who want to use health and social services. It is worth noting, however, that in Italy immigrants with regular permits tend to use the emergency services, and a small number use specialists and offices for consultations in the area of prevention.

The response must therefore be to increase immigrant uptake of preventative health services, and it must also tend to the integration of the social, mental and physical well-being of immigrants. The health system in the Veneto Region, characterized by the ability to combine health care and social needs, is moving in this direction. The Veneto Region was the first Italian region to adopt a model based on the integration of health and social services managed by local health and social authorities and on the integration of social and education services managed by local authorities.

In the Veneto Region, integration is promoted through the activities of health and social districts. Throughout the Region, these districts provide and coordinate the response to demands for primary care and hospital services and operate health and social programmes to which immigrants with regular permits have access. Health care includes primary care, medicine, home care and visits, inpatient care, and outpatient rehabilitation.

Health and social activities are divided into two groups:

1. One group concentrates on health care of social relevance, health promotion, prevention of illness and control and limitation of disabling, congenital or acquired diseases. Such services are provided, through the districts, by the local health and social authority.

2. The other group concentrates on social services that are relevant from a health care perspective. It supports individuals that require support due to disability or exclusion that affects their state of health. Such services are handled by the municipalities.

Although the integration of health and social care is an important starting point for acting on the determinants of health of legal immigrants in the Veneto Region, evidence points to the need to tackle the disparity that exists in access to services between Italian-born users and immigrants. Such disparities often arise from scarce knowledge about immigrant health care needs and from the difficulty in both involving them in health education and illness prevention and in overcoming their distrust of public institutions. Responses to these needs include the creation of cultural mediation services. The Veneto Region, in line with national and regional trends for areas with large numbers of immigrants, provides cultural mediation services that arise from a single health authority and from the social services of municipalities. These services improve and promote communication with immigrants and facilitate their access to public services.

Cultural-mediation services are part of an integrated network of services established by public and private social entities that work together in the area to reach immigrants who are reticent and have difficulty in approaching institutions.

The Veneto model therefore embodies a consolidated integrated system of health and social services in which the public and private social sectors in the Region (with a place reserved for associations of immigrants) work together to attain the goals set for the well-being of the immigrant population.

Programme benefiting the target population

This section analyses the main social and health interventions for immigrants carried out in Padua. These interventions come from partnerships within the public sector (intra-institutional partnerships) and between the public and private social sector (inter-institutional partnerships). The primary intervention profiled is the High Professional Immigration Body of Local Health and Social Authority No. 16, which is the main body that provides social and health services for immigrants in Padua. This section will also describe an innovative service created by the Body – in collaboration with the Municipality of Padua – for unaccompanied foreign minors. Finally, this section will present the CUAMM-Caritas Polyclinic as an example of a service that stems from an inter-institutional partnership.

Social services for immigrants in the Municipality of Padua have three priorities. The first priority is to favour and promote partnership work via a network that involves all the people working in the field of immigration. This objective includes all the initiatives designed to improve the integration of services necessary to carry out individual projects, as well as the development of integration between institutions. To realize these goals, the Municipality of Padua has been promoting numerous educational and training initiatives that aim to help connect social workers, volunteers and representatives of public institutions and private non-profit-making organizations. In addition this network provides a specific training course on some issues that relate to immigrant living conditions and also deals with guidance on education, careers and health services.

The second priority is to promote interventions that provide an immediate response to the primary needs of individuals, helping them to regain their individual skills. Many resources have been made available, including the Day Centre La Bussola and a facility called Casetta Borgomagno, where first interventions are also carried out together with activities designed to improve social integration. These two facilities provide important guidance on health issues, by providing information about health issues and about the services already available in the city.

The third priority is to create a flexible network of front line services for new immigrants. This has been put into practice by means of some initiatives aimed at gathering and connecting specific information about the world of immigration. For example, the Open Windows desk, a joint project between the Municipality of Padua and cultural mediators, is an information and advice centre based in an area with a high density of illegal immigrants with correspondingly high rates of prostitution and drug abuse.

The High Professional Immigration Body

The High Professional Immigration Body of Local Health and Social Authority No. 16 of Padua is a "unique body of its kind in Veneto and it has been considered a structure in the forefront even at a national level" (Veneto Region Immigration Observatory, 2006). Although it was formalized by a decision in April 2004, it had already started its activities in 2003. The idea for the project came from the work of paediatrician Maria Grazia D'Aquino, Head of the Paediatric Department of District No. 1 of Local Health and Social Authority No. 16. In preceding years, she had noticed changes in patients seeking health and social services, changes characterized by:

- a growing number of foreign minors (as a result of a progressive permanent settlement of immigrants and family reunification) using the services and adult family members requesting specific services on behalf of their children, such as vaccinations against infectious diseases;
- a growing number of women (mothers and sisters of such minors) who approached the health authority for specific issues, such as pregnancy; and
- a significantly high number of illegal immigrants and cases of social isolation among such immigrant patients.

The involvement of other institutions was a priority, because their material resources and knowledge were needed to develop an efficient response. These other institutions were also interested in the immigrant situation in Padua.

The High Professional Immigration Body is the result of a successful partnership of (initially) the Veneto Region, the Municipality of Padua, the Province of Padua, the Local Health and Social Authority of Padua, schools and universities, and the non-profit-making or third sector. The number of actors involved in the planning of the Body later increased (including, for example, police headquarters and the Diocese of Padua), but continued to meet for monthly sessions to coordinate activities. At these monthly round tables, the different actors met to analyse in detail the ongoing interventions for immigrants, to set

priorities, and to decide about the studies needed and the main factors to consider in planning services. The third sector played a prominent role in coordinating these round tables, frequently supplying important feedback – the result of its involvement in the operational management of services – and contributing in this way to the development of new projects.

In partnership with different actors in the Region, the High Professional Immigration Body has implemented the following specific services aimed at helping foreigners.

- The Listening Centre helps immigrants with or without a residence permit. Specialized staff provide information and health and social-orientation services. The Centre, with the aid of cultural mediators, provides information about the different aspects of health protection, such as: how to ask for an STP (Stranieri Temporaneamente Presenti or Foreigner Short Stay Permit); how to ask for a medical, paediatric or gynaecological examination; and what to do to get legal and/or social advice.
- A multi-ethnic unit for obstetrics and gynaecology, designed specifically for all female immigrants, is also available. In this unit, specialist nurses and gynaecologists provide such services as obstetric care, gynaecological care and prevention of sexually transmitted diseases.
- A unit for dermatology is also available.

Units for community paediatrics, present in the five local health and social authority districts, provide such services as paediatric examinations, vaccinations, antenatal classes and a support service for parents. The support service includes courses in preparation for birth and parenthood, with courses specifically for parents of children 0–12 months. Ad hoc professional advice and counselling are also provided.

Care of unaccompanied foreign minors

Care of unaccompanied foreign minors is a particular concern. A memorandum of understanding between the Social Service Department of the Municipality of Padua and the High Professional Immigration Body was signed in November 2003, concerning the health care of unaccompanied foreign minors who arrive in Padua. The Social Service Department provides protection and accommodations for these minors by placing them in reception centres or in a foster family. To protect the minors' health and the health of the people they live with, the Social Service Department developed an intervention model that guarantees prophylaxis, diagnosis and treatment.

To put this model into practice, the Social Service Department of the Municipality of Padua chose Health and Social District No. 1 of Local Health and Social Authority No. 16. The reason for this choice is that many immigrants, often illegal, had turned to the mother–child service of this district, and therefore its staff were experienced in dealing with such complex situations. Two other health care and social districts of the town, District No. 2 and District No. 3, agreed later to such a memorandum of understanding, because of the rise in the number of foreign minors.

According to guidelines set out in the memorandum, the Social Service Department of the Municipality of Padua sends a note containing the minor's personal data and health problem to the paediatric clinic of the health and social district. The minor, regardless of age, must consent to undergo diagnosis or it cannot be carried out. The Social Service Department of the Municipality of Padua then provides social workers to accompany the minor to the first examination, to follow-up blood tests and examinations, to collect prescriptions and to keep the minor's medical reports, National Health System card and personal health booklet.

All staff and facilities of the health and social district are available to the minor, and the local health and social authority is charged with all the expenses for preventive and follow-up health care services. Later, the health and social district informs both the minor and social services of test results and, whenever they reveal problematic health conditions, the district sends a report to the office (of the Social Service Department of the Municipality of Padua) that submitted the request for examination.

The services implemented by the High Professional Immigration Body are provided in the head office of Health and Social District No. 1, which started the implementation of the interventions for unaccompanied foreign minors. These services are part of the rationale for social networks (referred to by National Law 328 in its articles, including articles 1, 3, 6 and 19) and are characterized by the use and exploitation of resources for immigrants that are already present at a local level. The integration process – which has existed for many years in the Veneto Region and has involved the regional health and social services, local bodies, and third-sector actors – has influenced the implementation of the above-mentioned services. With their considerable experience and sharing of goals, instruments and languages, these partners have enabled the creation and consolidation of the High Professional Immigration Body.

The CUAMM–Caritas Polyclinic

The polyclinic is a service jointly developed by the Social Service Department of the Municipality of Padua, Caritas Diocesana (the Catholic charity of the diocese), and the University College for Aspiring Missionaries and Missionary Doctors (CUAMM).

In managing the polyclinic, tasks are divided between the planning role of the Municipality of Padua and the operational role of the two organizations, as follows.

- Caritas's staff, working at help centres, are the first to meet the immigrants. During interviews, they try to understand the immigrants' living conditions, paying particular attention to determinants of health – that is, they analyse the aspects of immigrants' lives that influence their physical, mental and social condition. These determinants are: their housing and working conditions (stable job, unstable job or unemployment) and whether or not they can pay privately for their health care. Based on this evaluation, staff decide whether or not to give immigrants an access card to the polyclinic. This card is valid for six months, and it can only be used for treatment at the CUAMM–Caritas Polyclinic. The card is no longer valid when a person obtains a regular residence permit, since this gives them access to the National Health System. Once the six months have expired, the card can be extended, provided that, after a second interview, a person proves to be still in need of care.
- CUAMM organizes doctors' duty shifts. Doctors volunteer their services to the polyclinic, and they specialize in the following medical disciplines: paediatrics, gynaecology, neurology and child neurology, cardiology, dentistry, and primary care (general practitioners).

The CUAMM–Caritas Polyclinic was planned according to Deming's cycle or the PDCA (plan – do – check – act) cycle, and its functioning depends mainly on the check phase. Every year the Municipality of Padua extends the financing of the service according to the financial statements and the reports submitted. The reports, which have to be sent by CUAMM and Caritas every six months, must show clearly the user-flow trend, which refers to the number of beneficiaries, their age, gender, country of origin and the treatments requested and given.

These two examples – the High Professional Immigration Body and the CUAMM–Caritas Polyclinic – highlight the extent of social and health policy integration in both Padua and the Veneto Region. Attention to integration is deeply rooted in the culture and law of the Region: Regional Law 55 of 15 December 1982 (Parliament, 1982). This law formally integrated the health and social systems of the Veneto Region. Thus local health units (Aziende Sanitarie Locali) became local health and social units (Aziende Socio Sanitarie Locali). For this study, the authors have referred to the latter as local health and social authorities, which most closely resemble the United Kingdom's local health authorities in terms of concept and activities, but with added responsibility for social care/interventions.

Lessons learned

What follows is a brief description of lessons learned about planning, managing and evaluating the activities to promote the health of migrants in Padua.

Financing

The High Professional Immigration Body functions on a small budget. This organization received initial funding of €40 000 from the Veneto Region, which allowed it to establish a multi-ethnic unit for obstetrics and gynaecology. Once the funds were spent, all services supplied by the High Professional Immigration Body were financed by Local Health and Social Authority No. 16 (see the section on "Programme benefiting the target population"). Local Health and Social Authority No. 16 functioned on money from its own budget, which formally expresses the objectives, strategies and programmes established by the general management of the health service for operational units. Budgeting is a complicated planning, reporting and checking process that involves not only the general management and the single operational units, but also involves the service called Management Control. This service verifies, through analysis of programme criticalities, the relevant fluctuations in budget (divergence analysis), to control the programme direction and take corrective action. In this specific context, the High Professional Immigration Body is an operational unit of Local Health and Social Authority No. 16, the general management

of which provides a yearly budget for implementing concrete responses to the social and health care needs of the immigrant population in Padua.

A careful evaluation of the programme's objectives resulted in optimization of the resources allocated from the budget. The evaluation allowed the High Professional Immigration Body to manage resources in a way that created and strengthened a service network able to:

- adequately inform the immigrant population about the opportunities given by the right to health – for example, through the Listening Centre;
- ensure adequate assistance to minors, teenagers and immigrant families through the different services implemented.

Human resources

The High Professional Immigration Body functions by using human resources already present in Local Health and Social Authority No. 16. The specialists (such as gynaecologists, dermatologists, infectious disease specialists and paediatricians) and the nursing staff involved in the different services for immigrants are employed by Local Health and Social Authority No. 16 and provide their services as extra work. Because they believe in and strongly identify themselves with the mission of the organization, these personnel ensure regular service. It is an example of a social network that works well due to the contribution of the personnel (particularly voluntary personnel) involved. The only personnel assigned to the High Professional Immigration Body by the general management of Local Health and Social Authority No. 16 are two administrative employees.

Cultural/language mediators also work with the staff of the High Professional Immigration Body. They work for Cooperativa La Frontiera or belong to the register of mediators of the Municipality of Padua. They cover Arabic-, Chinese-, French- and English-speaking linguistic and cultural areas. The mediators help facilitate communication and education, thus improving comprehension between staff and immigrants. During the activities of these mediators, shortcomings in the mediators' knowledge of specific social and health issues for this target group became evident. In response to this, the head of the Body arranges specific training for mediators, to provide informed mediation. The training provides insight into how immigrants are conditioned socioeconomically and psychologically – for example, by lack of employment, underemployment in unprotected sectors, illegality, social exclusion and housing problems.

In 2006, in collaboration with the mediators, the head of the High Professional Immigration Body organized training courses on the management of immigrant patients. These courses were for administrative employees that worked at the desks of Local Health and Social Authority No. 16 and police headquarters. As an example of these courses, the one scheduled for 26 October 2007 was entitled "Non-European foreigners: which law and which assistance?" Finally, two new training courses for general practitioners and social and health care personnel of Local Health and Social Authority No. 16 will start in 2008. It is worth noting that the demand for specific training on immigration came from the personnel involved.

Communication

After identifying a lack of awareness, among immigrants, about available local services, the High Professional Immigration Body, in conjunction with mediators, organized a communication programme aimed at informing immigrants about their right to health care. This right was established by National Law 40 (Parliament, 1998) and by Presidential Decree 394 (Ministry of the Interior, 1999), which specify that all immigrants, including illegal immigrants, are entitled to have emergency health care, basic health care and essential medications. For illegal immigrants, this is facilitated through use of the STP card. Encouraging access to the National Health System and reducing inequalities linked to differing health system usage patterns are among the key tasks of such organizations as the High Professional Immigration Body. The Listening Centre deals specifically with this (see the section on "Programme benefiting the target population").

The following information booklets are produced by the High Professional Immigration Body:

- *A listening centre for foreigners*
- *Are you sick? Remember that health is a right*
- *I'm pregnant: a short guide to introduce immigrant mothers to birth*

- *The growth of a child*

The last two booklets were financed by the Province of Padua. The booklet about sickness provides immigrants with information about the following.

- **How to ask for an STP card.** The booklet explains that this has to be requested from the local health and social authority and explains that no service provider will report them to the police.
- **Where health services for foreign people are located in the territory and which services are offered.** In particular, the booklet describes the services of the multi-ethnic unit for obstetrics and gynaecology, the unit for dermatology, the unit for unaccompanied minors and the units for community paediatrics.

Potentially transferable lessons

A major strength of the social and health interventions for immigrants in Padua was the ability to create a network and to work in partnership. In this case, all the actors that worked with the immigrant population in Padua worked as part of a network. The network was reinforced by the local context, where health and social integration was already present. Some lessons learned through the activities in Padua described above may be applicable in other European contexts.

The first lesson learned is about the importance of communication and information management. Communication is an essential instrument for building social capital. Local Health and Social Authority No. 16 and the Municipality of Padua promoted the use of a network for internal communication, external communication and the sharing of information of public utility. This helped create the conditions required for service implementation.

The second lesson is about the need for cross-disciplinary governance that integrates public, private and third-sector actors and allows them to establish learning processes to strengthen skills. The High Professional Immigration Body provides direction and control, but makes room for other actors to contribute whenever they have the skills and experience to intervene. In the Italian context, this put into practice the subsidiary concept, based on the Italian Social Services Framework Law of 2000 (Parliament, 2000) that facilitates the harmonization of different stakeholder activities.

Finally, the third lesson learned is that the analysis of the target group's needs should shape the definition and implementation of services. In Padua, interdisciplinary social workers assess the needs of the immigrant community. These social workers engage the immigrant population directly and are the main channel for assessing needs. They have the opportunity, through direct contact with the immigrants, to monitor their requirements and subsequently share them during the coordination round tables convened by the High Professional Immigration Body. This has enabled the interventions to be designed in a way that is sensitive to emerging needs, with particular attention given to the demands of the most vulnerable target groups of immigrants.

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11. Latvia: reducing the impact of poverty on health

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Summary

Reducing poverty and social exclusion are among the key long-term goals of Latvia's social policy. The Public Health Strategy of Latvia highlights social and economic problems including inequality, poverty and social exclusion as major determinants of ill-health.

This case study provides information on poverty and socioeconomically disadvantaged groups in Latvia, primarily drawing from data sources available in late 2007 and early 2008. It also describes how the Latvian health system works to meet the needs of vulnerable population groups, in particular through the Regulations of the Cabinet of Ministers on Health Care Organization and Financing Procedure and the exemption of patients of socioeconomically and otherwise disadvantaged population groups from having to make contributions for health care.

In 2007, 21% of Latvia's population lived below the poverty threshold. Poverty affects children and youth most severely. It affects them through their living conditions, possibilities to obtain quality health care and education, professional opportunities, and integration into the labour market. In 2006, 21% of Latvia's children (aged 0–17 years) were at risk of impoverishment. In relation to this, in 2007 the risk of impoverishment for large families was 46%, and for single-parent families it was 34%. In Latvia, unemployment (one of the risk factors for social exclusion) affects mainly the long-term unemployed, unemployed youth and the unemployed of pre-retirement age. Unemployment increases the risk of social exclusion, because it increases the risk of impoverishment and prohibits people from gaining adequate income. Poverty among job seekers in Latvia is 54%.

On 1 January 2007, the Regulations of the Cabinet of Ministers on Health Care Organization and Financing Procedure came into force. This legislation states that a person who is not in the register of a family doctor (about 5% of the total population) will receive primary health care services and prophylactic tests from state emergency medical services. Also, to ensure health care accessibility, the following groups are exempt from patient contributions: children up to 18 years of age; pregnant women and women during the postnatal period (until day 42); the poor; participants in the National Resistance Movement; people who suffered because of the accident at the Chernobyl nuclear power plant; TB patients; people with mental disorders (receiving psychiatric treatment); and people receiving care at state social centres and local government rest homes. Likewise, patient contributions are not required for: emergency medical assistance, if the patient is in critical condition; vaccination within the framework of the state immunization programme; receiving a preventive examination; and receiving treatment for various infectious diseases. Taking into consideration that extended treatment can impoverish a patient, the state has also established a ceiling for patient contributions. In addition, it has taken measures to ensure financial accessibility to necessary pharmaceuticals.

In Latvia, action on the upstream determinants of health includes activities to promote the inclusion of target groups into the labour market, to improve their financial situation and to facilitate their access to necessary services (including education), thus promoting their social inclusion.

Socioeconomic and policy context

Poverty and socioeconomically disadvantaged groups

Social exclusion in Latvia is affected by such factors as poverty and inequality of household income, high unemployment (especially long-term unemployment), inadequate skills for the labour market, and large regional and urban/rural differences (SKDS Marketing and Public Opinion Research Centre, 2006).

Despite economic growth until 2008, a significant part of the country's population lives below the poverty threshold, and there is a high probability that this proportion will increase (taking into account the current economic situation in Latvia and globally, particularly since late 2008). In Latvia, there are no reliable data on the proportion of the population considered to be poor, and there is no nationally defined poverty line.

For the purposes of measurement and comparison, the poverty threshold used by Eurostat – which is set at 60% of the median equivalent income – is used in this case study. Households of different sizes and structures are compared by a method that incorporates equivalence scales, where each member of the household is described by a weighting factor. The weighting factor used depends on the age of the person and whether the person lives alone or together with others. According to Central Statistical Bureau of Latvia data, in 2007 the relative poverty line or poverty risk threshold in Latvia was LVL 237 (€338) per month per equivalent consumer. The proportion of the population living under this relative poverty line in 2007 was 21%. Without social transfers, 28% of the population in 2006 would have been subjected to the risk of impoverishment – that is, 5 percentage points more. Distribution of household income is uneven; the Gini coefficient (which varies from 0 to 1, with 1 being the greatest inequality of income distribution) was 0.35 (2007) and it continues to increase, mainly due to the large difference between wealthy and poor inhabitants (Central Statistical Bureau of Latvia, 2009).

Based on research done by the SKDS Marketing and Public Opinion Research Centre in March 2006, 55% of respondents acknowledged that it was difficult or impossible to provide a satisfactory standard of living for them and their families. When asked what factors would stimulate the unity of Latvian society, the most common answers were related to solving economic problems and the welfare of society (SKDS Marketing and Public Opinion Research Centre, 2006). Thus, in Latvia, poverty is one of the main factors that hinder social integration.

Although the number of women employed in Latvia is comparatively high, there is a tendency for poverty among women. Because women generally receive a lower average salary, this tendency affects both their present and future. This is because their material provision for the future depends on the amount of money in their pension, which in turn depends on the amount of money paid to social insurance (Central Statistical Bureau of Latvia, 2009).

According to the *National strategy report on social protection and social inclusion 2008–2010*, the main population groups subjected to the risk of impoverishment in Latvia are: people of retirement age (especially women and single retired people); people of pre-retirement age; large families with several children and single-parent families; and children (Government of the Republic of Latvia, 2008). Specific population groups subjected to the risk of impoverishment and social exclusion in Latvia include: the disabled and people with functional impairments; the unemployed (particularly, long-term unemployed); the homeless; prisoners and ex-prisoners; Roma; and victims of human trafficking (Government of the Republic of Latvia, 2006).

This section further explores aspects of exclusion faced by people with disabilities, children living in poverty, the unemployed, socially disadvantaged Roma, and migrants.

People with disabilities

According to data provided by the State Social Insurance Agency, about 5% of Latvia's population have disabilities. In 2006, the largest proportion of people with disabilities was younger than retirement age. Also, a tenth of the households with a disabled person are poor (Ministry of Welfare, 2007).

A low rate of employment is one of the risk factors of social exclusion of disabled people, and social services are not focused on support for these people. As the severity of disabilities increases, so does the proportion of unemployment in this group. For these people, the greatest part of their income consists of social benefits or pensions, which means they do not have enough money to cover all health care expenses without further assistance. Since 1 January 2008, people with severe disabilities, who need special care, receive a monthly allowance – LVL 100 (€143) – to improve their social situation; they also receive a social

benefit or pension from the state (Public Health Agency, 2008).

Children living in poverty

In Latvia, many families live in poverty (Latvian National Human Rights Office, 2003). Poverty affects children and youth most severely. It affects them through their living conditions, possibilities to obtain quality health care and education, professional opportunities, and integration into the labour market. In 2006, the risk of impoverishment for children (aged 0–17) was around 21%. In relation to this, in 2006 the risk of impoverishment for large families was 46%, and for single-parent families it was 34% (Central Statistical Bureau of Latvia, 2008).

To explore adolescent perceptions of family affluence, the cross-national WHO Health Behaviour in School-aged Children study, put four questions to representative samples of children aged 11, 13 and 15 years in each of 35 countries. The questions were: (a) Does your family own a car, van or truck? (b) Do you have your own bedroom for yourself? (c) During the past 12 months, how many times did you travel away on holiday with your family? (d) How many computers does your family own? The results of the study were scored and scaled to give a maximum affluence score of 8, with low family affluence being defined as a score of 0–3. In Latvia, according to data for 2005/2006, 33% of adolescent respondents indicated low family affluence (score of 0–3); 46% indicated middle family affluence (score of 4 or 5); and 22% indicated high family affluence (score of 6 or 7) (WHO Regional Office for Europe, 2008).

The unemployed

In Latvia, unemployment, one of the risk factors for social exclusion, affects mainly the long-term unemployed, unemployed youth and unemployed people of pre-retirement age. Because it increases the risk of impoverishment and prohibits people from gaining adequate income, unemployment increases the risk of social exclusion. In turn, social exclusion itself is a factor that increases the level of unemployment and reduces the chance of finding a job.

In the *National strategy report on social protection and social inclusion 2008–2010*, the unemployed were identified as a social group that requires extra support from the state (Government of the Republic of Latvia, 2008). In 2007, 4% of Latvia's people were unemployed. At the end of 2008, 7% of the economically active population was registered as unemployed at the State Employment Agency. In 2007, 56.2% of the unemployed had been so for up to 6 months, 16.1% for 6–12 months and 27.7% for longer than a year (State Employment Agency, 2008).

The lowest registered rates of unemployment at the end of 2008 were 4% and 3.7%, respectively, in the Kurzeme Region (the western part of the country) and in Riga's surroundings (central Latvia). The rate of unemployment, however, is still high in rural areas, especially in the Latgale Region (the eastern part of the country), where the rate of unemployment at the end of 2007 was 4.9%. At the end of 2007, the real approved unemployment rate in three of Latgale's districts (Balvi, Ludza and Rezekne) was greater than 10% (State Employment Agency, 2008).

Major reasons for the high unemployment rate in three of Latgale's districts are underdeveloped infrastructure and entrepreneurship, and a low level of self-employment. The remarkable differences in economic activities and GDP per person between Riga and the rest of Latvia make it difficult to develop a coordinated social benefit system for the country (Ministry of Regional Development and Local Government, 2006).

Data collected by the State Employment Agency show that, at the end of 2007, 45.4% of unemployed people were women. Comparing this number with data from the previous years shows that the rate of unemployment among women is decreasing. An increase in unemployment, however, is seen in all age groups. At the end of 2007, the highest unemployment rate was among people aged 35–54 years (43.2%).

Acquiring appropriate education and professional skills is a precondition for participating and becoming competitive in the labour market. The level of unemployment among the poorly educated and unskilled segment of the population is comparably high. This is due to the lack of professional qualifications and inadequate education and skills to meet the demands of today's labour market. The market now demands skill sets in the areas of information technologies, communications, business administration, and knowledge of foreign languages.

Socially disadvantaged Roma

Roma are mentioned as one of the groups in Latvia at risk of impoverishment and social exclusion (Baltic Institute of Social Sciences, 2005). There were 8582 Roma living in Latvia at the beginning of 2008, which was 0.38% of the total population (Office of Citizenship and Migration Affairs, 2009). Leaders of Roma NGOs and researchers, however, estimate that there could be between 15 000 and 18 000 Roma (0.6% of the total population) living in Latvia (Baltic Institute of Social Sciences, 2005). In general, Roma have lower incomes, poorer living conditions (such as overcrowded dwellings and less nutritional diets), and they often have no formal employment (Latvian Centre for Human Rights and Ethnic Studies, 2003).

The number of Roma children attending educational institutions in Latvia is comparatively low. Also, Roma children rarely get involved in preschool education (Government of the Republic of Latvia, 2006). According to the results of the population census in Latvia in 2000, only 7.9% of Roma who are 15 years of age and older have a secondary school education and only 0.4% of them have a higher education. According to data provided by the State Employment Agency of Latvia (2008), there were 46 illiterate people among the total number of unemployed and 39 (85%) of these were Roma. The complete number of illiterate people among Roma in Latvia, however, cannot be determined (Ministry of Welfare, 2005; Cabinet of Ministers, 2006b).

Migrants

The current Latvian state policy on immigration has been developing since the country gained independence. The Immigration Law defines regulations for entry, residence, transit, emigration, detention, protection, and expulsion of foreigners (Latvian Foreign Policy Institute & Konrad Adenauer Foundation, 2006). Although the population of Latvia is composed of many nationalities, studies have reported that fear of immigrants, including employment seekers from abroad, is quite widespread (Baltic Institute of Social Sciences, 2005).

Even though the level of migration to the EU from the NIS is high, Latvia has not become a destination country for immigration when compared with other eastern European countries. Reasons for this include the low level of social welfare in Latvia and a strict immigration policy (Latvian Foreign Policy Institute & Konrad Adenauer Foundation, 2006). Emigration from the country, however, is noteworthy. In 2005, the stock of emigrants was 232 865 (10.1% of the country's population), with top destinations including: the Russian Federation, the United States, Germany, Israel, Canada, Lithuania, Australia, the United Kingdom, Estonia and Ireland (World Bank, 2008). Recognizing this noteworthy emigration, the government signed, in September 2006, the Statement of Intent on the development of state and private partnership models, which aimed to promote the return to Latvia of those Latvian nationals who left the country to seek work abroad (Government of the Republic of Latvia, 2008).

Each semester, the Office of Citizenship and Migration Affairs compiles statistical information on foreigners currently residing in Latvia with valid temporary or permanent permits of residence. As of 1 January 2008, 330,555 foreigners from 90 countries resided in Latvia with permanent residence permits and 12 815 resided with temporary residence permits (Office of Citizenship and Migration Affairs, 2009). The number of undocumented immigrants or immigrants residing irregularly in the country is unknown.

Health inequities

There is evidence of socially determined inequities in health system access, health behaviour and health outcomes in Latvia. The amount spent by patients on co-payments in Latvia is one of the highest in Europe. Moreover, the amount contributed to a co-payment is not proportional to the payer's income (Müller et al., 2005). Also, low income limits the possibility of receiving health care services or purchasing medicine. In 2005, 30% of the population did not access the health services they needed, with those from more socioeconomically disadvantaged groups being less likely to access necessary services (Xu et al., 2009). Also in 2005, 56% of non-user financial constraints were listed as the reason for not seeking care, with this percentage increasing to 70% among non-users from the poorest quintile (Xu et al., 2009).

According to the EU Survey on Income and Living Conditions (2005), 16% of respondents in Latvia worry about their ability to cover health care expenses (European Community, 2007). In 2007, health care expenditures per month for one household member were about LVL 8.00 (€11.50) in rural areas and LVL 11.00 (€15.70) in urban areas. In 2007, expenditures for health care increased by 70%, including the expenditures for medicine (64%). Expenditures for dental care increased 2.6 times that same year (Central Statistical Bureau of Latvia, 2008). Areas with low levels of income are associated with higher

hospitalization rates and, therefore, higher costs for treatment, instead of timely outpatient diagnosis and treatment (European Community, 2007). Residents of rural areas may face particular challenges; lower spending on health care in rural areas tends to be associated both with lower income and with reduced availability of services (Tragakes E et al., 2008).

Health inequities among children living in poverty

The profile of children at greatest risk of suffering from social exclusion is grouped as follows: families with three or more children; single-parent households; disadvantaged families; being from a rural area; being disabled; or having disabled parents (EC, 2008). Children from these risk groups can have higher incidences of chronic conditions. This is especially true for children from rural areas because, unlike access to health services and health specialists in cities, their access is affected by such factors as the cost of transport (Ministry of Welfare, 2002).

Compared to their more affluent counterparts, socioeconomically deprived children are more likely to face unhealthy living conditions, including inadequate nutrition, poor housing, alcoholism in the family, exposure to violence and unintentional injuries. They are also more likely to be born prematurely and have a lower-than-average birth weight (University of Latvia Institute of Philosophy and Sociology & Baltic International Centre for Economic Policy Studies, 2007).

Minorities and migrant populations

Systematically collected disaggregated data by ethnicity or nationality is not available for disease incidence, infant mortality, life expectancy and disability. Therefore, it is very difficult to arrive at any conclusion that identifies or characterizes differences in health among minorities or migrant populations. Because of lower education levels, unemployment and poor household conditions, Roma are at higher risk of inequitable health outcomes than other population groups (Latvian Centre for Human Rights and Ethnic Studies, 2003).

Although data about the nationality and ethnicity of patients in Latvian hospitals are not collected systematically, there is, however, information from in-depth interviews with health care personnel (Latvian Centre for Human Rights and Ethnic Studies, 2003). Information about child delivery comes mostly from midwives and shows that the Roma rate of child birth (per 1000 Roma inhabitants) is two to three times higher than that among Latvian and Russian inhabitants. The death rate of newborn babies among Roma is almost 5% higher than the average rate for Latvia. Given the very limited amount of data available, great caution needs to be taken in the use of these data (Latvian Centre for Human Rights and Ethnic Studies, 2003).

Health system response to poverty and measures that address determinants of health

Reducing poverty and social exclusion are among the key long-term goals of Latvia's social policy. Inequality is not only a social problem, but is also a public health problem (Government of the Republic of Latvia & EC, 2003). The Public Health Strategy of Latvia highlights social and economic problems including inequality, poverty and social exclusion as major determinants of ill health. Goal 2, target 2.3 of the Public Health Strategy states that the proportion of low-income residents should be significantly reduced (Cabinet of Ministers, 2001).

The aim of this section is twofold: (a) to describe measures in place to secure health services for the most socioeconomically disadvantaged populations and (b) to briefly highlight some measures for social protection that act on the determinants of health of vulnerable population groups.

Health system in Latvia

The medical services guaranteed by the state are offered to citizens and non-citizens of the Republic of Latvia and to citizens of the EU, of the European Economic Area and of Switzerland who reside in Latvia due to employment or who are self-employed people, as well as to their family members. These health care services are also provided – from the state budget and resources of service recipients – to foreign nationals who have a residence permit in Latvia, to refugees and people who have been assigned an alternative status, as well as to people under arrest and convicts.

In Latvia, health care is provided at four levels.

1. **Emergency care.** This is first-aid service for acute conditions and injuries.
2. **Primary health care.** This is offered at outpatient clinics, at outpatient departments of hospitals and at the place of residence of a person.
3. **Secondary health care.** This is offered at outpatient medical institutions, at outpatient departments of hospitals and at emergency medical assistance institutions.
4. **Tertiary health care.** This highly specialized health care is offered at specialized medical centres and at institutions with medical personnel from one or several medical sectors with certification in a specialization.

Resources for health care are assigned through a state budget subsidy, administered by the Latvian Health Compulsory Insurance State Agency. The state budget for the health sector reimburses the purchase of drugs included in the so-called positive list. The state budget also finances activities that promote health, prevent disease (such as vaccination), and monitor state sanitary and epidemiological conditions. The Latvian Health Compulsory Insurance State Agency establishes agreements with medical treatment institutions and medical personnel for the provision of services. Regulations of the Cabinet of Ministers on Health Care Organization and Financing Procedure delineate the health care services not financed from the health budget (negative list) – for example, cosmetic services, homeopathic treatment and cosmetic surgery (Health Compulsory Insurance State Agency, 2006). To receive health care services, a person needs to pay a patient contribution. From1 March 2009, for a visit to a family doctor, the fee is LVL 1.00 (€1.43); for a visit to a specialist, the fee is LVL 5.00 (€7.14); and for hospital treatment, the fee ranges from LVL 5.00 to LVL 12.00 (€7.14 to €17.14) per day, depending on the type of hospital (Cabinet of Ministers, 2006a).

People can receive state-paid secondary and tertiary health care services only by referral from a family doctor or specialist (except patients with particular diseases). If a person wants to receive health care services not included among state-paid services, then expenses need to be covered by the patient or a third party – for example, an insurance company.

Regulations of the Cabinet of Ministers on Health Care Organization and Financing Procedure

On 1 January 2007, the Regulations of the Cabinet of Ministers on Health Care Organization and Financing Procedure came into force. These Regulations determine the type and amount of health care services paid by the state and the amount contributed as co-payments; they also determine procedures for these payments, as well as the organization of waiting lists for planned health care services; and finally, they decree that the state will provide a person who is not in the register of a family doctor (about 5% of the total population) with emergency medical services, primary health care services and prophylactic tests (Cabinet of Ministers, 2006a). Also, to ensure access to health care, the following groups are exempt from patient contributions:

- children younger than 18 years of age;
- pregnant women and women during the postnatal period (until day 42);
- poor people, recognized as such if average income for every member of the household does not reach 50% of the national minimum salary (currently LVL 180 (€257)) (Cabinet of Ministers, 2003);
- participants in the National Resistance Movement;
- people who suffered because of the accident at the Chernobyl nuclear power plant;
- TB patients;
- people with mental disorders (receiving psychiatric treatment); and
- people receiving care at state social centres and local government rest homes.

Likewise, a patient contribution shall not be paid under the following circumstances:

- upon receiving emergency medical assistance (if the patient is in critical condition);
- for vaccination (for example, against diphtheria) within the framework of the state immunization programme;
- when receiving a preventive examination; and
- when receiving treatment for different infectious diseases (such as HIV/AIDS, diphtheria, scabies, TB, syphilis and viral hepatitis).

Children younger than 18 years do not have to pay for family physician home visits. Also, lower patient contributions are applied to the disabled who belong to disability group I (where integration into society is not possible without social assistance and where employment and self-care possibilities are very limited – that is, physical and mental capabilities are reduced by 60–100%) and to people older than 80 years of age. Taking into consideration that extended treatment can impoverish a patient, the state established the so-called ceiling for patient contributions.

A very important aspect of accessibility is the ability to receive necessary pharmaceuticals. Within the framework of the reimbursement system for the purchase of drugs and medical devices, patients with particular diagnoses are compensated for 100%, 90%, 75% or 50% of their expenditures. In 2005, the compensation of expenditures for the purchase of medicine was launched according to the principle of reference price – that is, the state disburses the most inexpensive medicine from among those with equivalent action and adapts a compensation percentage that ensures compensation to the greatest number of patients (Cabinet of Ministers, 2006a).

To improve children's health, to provide assistance to families with small children and to deal with cases of social risk, the state has planned to carry out the following activities: financing (from the state budget) school lunches for primary school children and developing palliative care teams (available also outside Riga) to provide assistance to families of children with incurable diseases (Government of the Republic of Latvia, 2006).

Government measures to address the determinants of health

The social inclusion policy of Latvia is developed in accordance with the common social inclusion policy of the EU, which aims to substantially decrease poverty in Europe by 2010 (Ministry of Regional Development and Local Government, 2006). To implement the priority tasks, various state, municipal, EU Structural Fund and EU EQUAL Initiative[1] activities, in cooperation with social partners, have been implemented during the period 2006–2008. These activities promote the inclusion of target groups into the labour market, improve their financial situation and facilitate their access to necessary services, thus promoting their social inclusion.

Examples of activities to promote social inclusion, and thus action on the upstream determinants of health, include the following.

Measures have been taken to improve the financial situation of families and children, by reducing taxes, increasing social allowances for child-care leave, improving the housing situation for families with children and promoting alternative care and access to social care services for families with children. For example, since 1 January 2006, social payments from the state budget have been made in the case of unemployed mothers who receive a maternity allowance and in the case of parents who do not work but who look after disabled children.

To improve the social conditions of disabled children and their families, some legislative changes have been made: since 2008, the person (such as parent or any other person) who takes care of such a child receives an allowance (LVL 50 (€70) per month), regardless of whether or not this person is employed. Also, in 2008, the allowance for care of disabled children with severe disorders increased (from LVL 50 (€70) to LVL 150 (€215) per month) (State Social Insurance Agency, 2007).

To increase employment opportunities for socially excluded groups, pilot projects have been launched, including: youth traineeships offered by employers; and subsidized work places for the handicapped, the long-term unemployed and the unemployed of pre-retirement age (Government of the Republic of Latvia, EC, 2003).

The state programme The Roma People in Latvia 2007–2009 was created to facilitate the effective and sustainable integration of Roma in Latvia and to ensure equal opportunities, a better quality of life and tolerance in Latvian society towards Roma. In addition, two Ministry of Education and Science programmes – The Education Development Concept and Provision of Education for National Minorities – promote the inclusion of Roma children in the education system (SKDS Marketing and Public Opinion Research Centre, 2006).

More activities are listed in the *National report on strategy forsocial protection and social inclusion 2006–2008* (Government of the Republic of Latvia, 2006.

[1] Part of the EU strategy that seeks to ensure that no person has been deprived access to the labour market.

Lessons learned

The SKDS Marketing and Public Opinion Research Centre (2006) study revealed that, in 2006, the resources available to individuals or their family members for health care services were restricted for about a third of the population of Latvia. It also revealed that access to health care services is affected by a person's wealth and by their daily priorities.

In terms of action on the socioeconomic determinants of health, a definition of the official poverty line would make it possible to calculate the number of low-income residents, assess the depth of poverty and evaluate the quantity and scope of the necessary measures. Currently, the variety of methods for calculating the subsistence level results in a broad range of possibilities for data interpretation and speculation when assessing the prevalence of poverty in the state (SKDS Marketing and Public Opinion Research Centre, 2000).

To improve living standards and act on poverty as a determinant of health, it is very important to integrate more people into the labour market. Actions in this direction should continue to build an adequate human resource base for a dynamic labour market, while facilitating the creation of an inclusive labour market that balances the interests of social security, employment and businesses (Government of the Republic of Latvia, 2006).

There is a continuing need for intersectoral and multi-agency coordination mechanisms. Social exclusion and related problems affect a broad range of social groups, and the solution to the problem is dependent on cooperation between many institutions (Ministry of Welfare, 2006).

Research entitled *Current issues in societal integration*, carried out by SKDS Marketing and Public Opinion Research Centre in 2006 (SKDS Marketing and Public Opinion Research Centre, 2006), revealed that a significant number of Latvians have reservations about helping people who have come to live or work in Latvia, people who have gone to work in other countries, Roma and other ethnic minorities, sexual minorities, and other marginalized groups (Ministry of Welfare, 2005). Action is needed to promote integration and tolerance.

Acknowledgements

The authors would like to thank the following staff from the State Public Health Agency for their contributions to this study: Gunta Rozentāle, Head of the Department of Public Health Data Analysis; Jolanta Skrule, Deputy Head of the Department of Public Health Data Analysis; Margita Štāle, Senior Public Health Analyst; and Iveta Gigele, Public Health Analyst.

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12. Montenegro: women's health project for internally displaced Roma [1]

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Summary

An estimated 20 000 Roma live in Montenegro, comprising about 3.3% of the overall population. About 4600 of these are internally displaced persons from Kosovo [2]. Many of the internally displaced persons live in camps that generally have poorer living conditions than those in Montenegrin Roma communities.

Although data on the health status of Roma in Montenegro are sparse, they show that this group has a disproportionate risk of poor health; that its members do not access preventative or curative health care sufficiently; and that they are unable, for administrative or financial reasons, to act on health guidance given when they do access health care.

This case study profiles the project Significance of Behaviour Modification for Protection and Improvement of Roma Women's Health (referred to hereafter as the Women's Health Project), which was carried out in the Roma internally displaced person's Camp Konik I in Podgorica for a period of a year, from September 2006 to September 2007. The total camp population was about 1300 people at the time of the Project. Camp residents came to Montenegro from Kosovo just prior to, during and following the North Atlantic Treaty Organization (NATO) intervention in the former Yugoslavia in 1999.

The Project was implemented by the Institute of Public Health, part of the Ministry of Health, Labour and Social Welfare, in cooperation with the Montenegrin Red Cross. The United States Consulate in Montenegro contributed about US$ 13 000 to the support of the Project.

The main short-term goal of the Project was to encourage pro-health behavioural changes among Roma women inhabitants of the camp. The long-term goal was to improve their overall health status, in part through improved relations with area health workers.

Project goals were to be achieved primarily through regular workshops led by physicians. Over the duration of the Project, there were about 50 workshops, with the topics selected by Roma Project participants through discussions with Project leaders. Among other issues, the topics discussed included: sexual health, including contraception; pregnancy; the prevention

[1] In this case study, the encompassing term Roma refers to various communities that self-identify as Roma and others that resemble Roma in certain aspects but insist on their ethnic difference. Please refer to the CE Roma and Traveller's glossary (available at http://www.coe.int/T/DG3/RomaTravellers/source/GlossaryRoma.doc) for a description of these groups, as well as the World Bank *Roma and Egyptians in Albania* (World Bank, 2005a) for additional background.

[2] Reference to Kosovo in this publication, including in the bibliography, should be interpreted as: Kosovo (in accordance with Security Council resolution 1244 (1999)).

of a number of diseases, such as breast cancer, heart disease, lung disease and HIV/AIDS; immunization; tobacco control; and child health.

In the second phase of the Project, the booklet *Save our health* was published. It was distributed to women and discussed during workshops, and its content was focused on women's rights, reproductive rights and technology, pregnancy, sexually transmitted infections, breast cancer, smoking, TB, and gastrointestinal illnesses.

Several projects were implemented in the camp at the same time, so attributing changes to one project is difficult. It is clear, however, that there were noted improvements in health knowledge among Project participants, improvements in health behaviour among all female camp residents, and strengthened relations between camp residents and area health providers.

Those participating regularly in the workshop demonstrated marked improvements in knowledge about women's health. Participants also described the workshops as a kind of support group; for many, it was the first opportunity they had to discuss family planning and domestic violence with other women. Workshop participants and local physicians commented that they felt their communication was improved as a result of the workshops.

Health behaviour improved as well, although (again) it is not possible to establish a causal relationship between the changes and the Project. For example, before 2003, there were tens of births in the camp each year. Since the end of the Project, there have been no deliveries in Camp Konik I; all women have given birth in health care facilities. During and following the Project, tens of women went to the camp outpatient facility to request intrauterine devices, to avoid pregnancy, as well as condoms, to avoid pregnancy and/or sexually transmitted infections.

Several important lessons can be distilled from this project. Among them are the importance of complementary efforts to comprehensively address the social determinants of health and the efficacy of facilitating contact between health care workers and marginalized communities of Roma. The Project also faced particular challenges that limited the sustainability of improvements in health knowledge and behaviour. First, despite efforts of several governmental and nongovernmental agencies, camp residents continue to believe that return to Kosovo is impossible. As a result, no durable solution for these internally displaced persons has been identified, and this lack of clarity limits short-term integration into Montenegrin social, economic and political life. Second, the Project represents only a small step towards changing traditional attitudes and knowledge or women's roles and rights. Additional projects and, more importantly, debate and changes driven by the Roma community itself are needed to sustainably change some of the social structures that limit this group of women's access to health care and their overall health status.

Socioeconomic and policy context

Montenegro is in the southern Balkans, and its total territory encompasses 13 812 km^2. The country has 294 km of coastline, including four ports (Government of Montenegro, 2008).

Montenegro was part of the Socialist Federal Republic of Yugoslavia, which started to break up with Slovenia's declaration of independence in 1991. During the breakup period and until 2006, Montenegro was part of the successor states to the Socialist Federal Republic of Yugoslavia. First, Montenegro was a component of the Federal Republic of Yugoslavia until 2003, when it evolved into the looser State Union of Serbia and Montenegro (Government of Serbia and Montenegro, 2003). Montenegro declared independence in June 2006 (UNDP & UNFPA, 2006: para. 1).

According to the 2003 register of Montenegro, the country's total population that year was 617 740 people, of which 62% lived in urban areas (MONSTAT, 2003:46). Data from the 1991 register indicate a total population of 591 269 people, showing a population growth of 4.5% between 1991 and 2003. The overall population of Montenegro has been ageing since the 1950s, and the birth rate has slowly decreased, while life expectancy has increased.

Montenegro has a fairly large population of refugees and internally displaced persons (IDPs) who fled war and upheaval in Croatia, Bosnia or Kosovo in the 1990s. The most recent data (2004) show about 27 000 refugees and IDPs, representing over 4.2% of the total population. IDPs from Kosovo are 68% of the total refugee/IDP population, and refugees from Bosnia and Herzegovina and Croatia comprise 23% and 8% of the total refugee/IDP population, respectively (Government of Montenegro, 2004:9).

Since the mid-1990s, Montenegro has undertaken major macroeconomic reforms. These include privatization of previously state-owned industries and market liberalization. To facilitate stability, Montenegro adopted the euro as its currency in 2002 (World Bank, 2005c:3). Since 2000, the country's GDP has increased steadily; from 2000 to 2005, the GDP per person went from about US$ 1500 to about US$ 3300 (World Bank, 2005b).

Poverty remains a general problem. The most recent data (2003) show that the consumption based poverty rate in Montenegro is 12.2% (UNDP, 2006:14). Many more Montenegrins find themselves grouped around this level of consumption, meaning that though they do not fall below the official poverty line, they struggle to obtain a minimum basket of goods and are vulnerable to falling below the poverty line. Consumption for about 25% of the population is at a level of less than 50% above the poverty line (World Bank, 2005c:15).[3] This precariousness is likely due in part to low employment rates. In 2004, employment rates were about 7% *lower* than they had been in 1998 (World Bank, 2005c:ii). In an Institute for Strategic Studies and Prognoses/United Nations Development Programme (UNDP) household survey, 15.8% of non-Roma, non-refugee (and non-IDP) Montenegrins between the ages of 15 and 65 years reported that they were not working, but ready to work if given an opportunity (UNDP & Institute for Strategic Studies and Prognoses, 2003:13).

While poverty is a general concern, inequalities persist and may be deepening along geographic, gender and ethnic lines. The poverty rate in the north of Montenegro is almost twice as high as the national average, and the unemployment rate among women is nearly twice as high as that among men (UNDP & UNFPA, 2006: para. 4, 5). As a result, the Gini coefficient (a widely used measure of wealth inequality) for Montenegro is among the highest for the western Balkan countries (UNDP & UNFPA, 2006: para. 4).

In October 2007, Montenegro signed a Stabilization and Association Agreement with the EU (Government of Montenegro, 2007), marking an important step in Montenegro's road to EU accession. As part of the accession process, Montenegro has started to harmonize its legislation with the body of common procedures and laws– *acquis communautaire* – all EU Member States must respect. As a so-called potential candidate for EU accession, Montenegro can now access the Instrument for Pre-accession Assistance. Funds from this can be used to support institution building, as well as cross-border cooperation (EC, 2006). Once Montenegro becomes a candidate (versus a potential candidate), it can access additional Instrument for Pre-accession Assistance funding streams, including funds for human resources and regional and rural development (EC, 2006).

Montenegro's health care system

Public medical institutions in Montenegro are organized as a network of primary, secondary and tertiary health care, consisting of 18 primary health centres (with 114 satellite units), 7 general hospitals, 3 specialized hospitals, the Clinical Centre of Montenegro, the Institute of Public Health, and the Pharmacy Department of Montenegro. The private sector, which is not integrated into the public health care system, includes 165 facilities, as well as a large number of pharmacies (Government of Montenegro, 2003:4).

Primary health care institutions (which include primary health care facilities as well as the Institute of Public Health) employ 3334 health workers (about 45% of Montenegro's total medical staff). Of these, 568 are doctors, 1769 are medical personnel with higher and secondary school education, and 686 are nonmedical personnel (Institute of Public Health, 2006:12). The Pharmacy Department has 40 public pharmacies, with a total of 331 employees. Primary health care includes prevention and treatment and also rehabilitation for most diseases in the areas of paediatrics, general medicine, occupational medicine and gynaecology.

Table 12.1 outlines basic indicators for health care personnel coverage. Compared with the workload of doctors working in the EU, the workload of doctors working in Montenegro is substantially larger.

[3] The poverty rate is a minimum living standard calculated on the basis of actual consumption patterns and minimum caloric needs.

Table 12.1. Comparison of basic indicators for health care personnel coverage

Indicators	Montenegro	EU
Doctors per 100 000 residents	193.01	317.75
General practitioners per 100 000 residents	28.72	97.66
Dentists per 100 000 residents	43.80	61.00
Pharmacists per 100 000 residents	16.69	71.94
Nurses per 100 000 residents	487.42	699.77

Note: Given indicators for Montenegro, according to data of Institute of Public Health for 2005, relate to public health care sector (private health care sector is not included in these data). Indicated number for general practitioners relates to chosen doctors for adults and it does not include chosen pediatricians at the level of primary health care, and it was given according to the definition of WHO.

Source: Institute of Public Health (2006:162). Reproduced with the permission of the copyright holder. Data were calculated based on data published in the Statistical Yearbook 2005, issued in 2006.

The Health Policy for the Republic of Montenegro until 2020 defines the following general goals (Ministry of Health, 2005).

- **Prolonging life.** This is the current primary goal of the health care system, and it includes both disease prevention and treatment.
- **Priorities in Montenegro's health care development.** The goal of prolonging life will be achieved primarily through primary health care system reform. Every Montenegrin should have a family doctor. Administrative changes may benefit Roma in particular. Until recently, Roma, who disproportionately lack identity documents, were often unable to access primary health care. The elementary package of health services envisioned in primary health care reform includes free access to health care, regardless of documentation of health insurance status.
- **Improving quality of life.** Widespread public health problems can decrease quality of life (as well as productivity) on a population and an individual basis.
- **Insurance against financial risks.** Health problems may cause significant negative financial consequences for Montenegrin citizens and their families. The cost of medical technology and of treatment and prevention are rising faster than the average salary. So, it is necessary to ensure that health care financing will allow access to necessary care and will distribute financial risk among the population.

To ensure affordable coverage, the health care financing system has been changed to ensure near universal coverage. Health care financing is provided by the Fund for Health Insurance, which is compulsory for all Montenegrins. The state is responsible for paying the contributions of certain categories of citizens who are temporarily or permanently exempt. Contributions for the employed are paid according to gross earnings, with 15% of total employee earnings allocated to the Fund (50% paid by the employee and 50% by the employer). The self-employed must pay as well. The Pension and Disabled Persons' Fund covers the contributions of retired people, while the Employment Agency pays on behalf of those who are officially unemployed.

Reducing inequities in health conditions

The health policy aims, first, to avoid exacerbating health inequalities and, second, to actively engage in reducing health inequalities through the allocation of health resources to activities that specifically target vulnerable groups who may be missed – for diverse reasons – by universal measures. This health policy goal will be achieved through synergies with other national strategies largely within the domain of social welfare, including the Development and Poverty Reduction Strategy, the National Action Plan for Children, the National Action Plan for Youth, the National Action Plan for Gender Equality, the Strategy for Social Welfare Development for the Elderly 2008–2012, the Strategy for Violence Prevention, and the Decade of Roma Inclusion Action Plan. Also, the Ministry of Health, Labour and Social Welfare, specifically, has adopted related strategies, including the National Strategy for Health System Development in Montenegro, the National Strategy for Reproductive Health, the National HIV/AIDS Strategy, the National Tobacco Control Strategy, the National Strategy for Mental Health Protection, and the National TB Strategy.

Socioeconomic conditions and demographic summary of the Roma in Montenegro

An estimated 20 000 Roma live in Montenegro, comprising about 3.3% of the overall population (Hammond, 2005:10). About 4600 of these Roma are IDPs from Kosovo (Jovica Zaric, UNHCR Field Assistant, personal communication, May 2008). Many of the IDPs live in camps that generally have poorer living conditions than those in Montenegrin Roma communities. Most of the IDPs from Kosovo speak Albanian, rather than Montenegrin, making communication with the major ethnic population in Montenegro more difficult (UNDP, 2005:68). The Roma population increases in the summer, when as many as several thousand migrate to Montenegro to seek income on the Montenegrin coast, a tourism destination (Sabahudin Delic, Deputy Minister for Human and Minority Rights Protection, personal communication, May 2008).

Roma are concentrated in particular areas of Montenegro, 68.7% living in central Montenegro, 24.8% living along the coast, and 6.5% living in the north. More than 71% of Roma are less than 30 years of age (UNDP, 2005:68).

Data on the health status of Roma in Montenegro are sparse. These data, however, show that Roma: disproportionately experience risks of poor health; do not access preventative or curative health care sufficiently; and are unable, for administrative or financial reasons, to act on health guidance given when they do access health care.

According to data collected by the Institute for Strategic Studies and Prognoses and UNDP for the Development and Poverty Reduction Strategy, the overall poverty rate in Montenegro is 12.2%, while it is 52.3% for Roma, and 38.8% among refugees (UNDP & Institute for Strategic Studies and Prognoses, 2003:14). Refugees are a vulnerable group, so the existence of higher poverty rates among Roma is indicative of their extreme exclusion. Indicators in other domains, such as educational attainment, living conditions and employment, suggest the role these areas play in higher poverty rates among Roma. For example, unemployment in Montenegro among non-Roma aged 25–54 years is reportedly 15%, while it is 36% among Roma (UNDP, 2006:16).

The majority of Roma in Montenegro live in ethnically homogeneous settlements, with about 47.6% of the total population living in impoverished housing (UNICEF, 2007:28). These settlements are generally on the periphery of towns, though not exclusively. However, even Roma who are not on the periphery are generally segregated in a single neighbourhood. This residential segregation leads to educational segregation as well. Moreover, Roma enrolment in education is somewhat limited by administrative procedures and Roma poverty. For example, to enrol in preschool education, parents must present the child's birth certificate, proof of immunization and proof of parents' employment (or registration for unemployment). Those lacking these documents are not given priority. Parents of children who enrol must pay €30 a month in user fees, which is beyond the reach of many Roma families (OSI EUMAP, 2007:316–317). Because of these and other factors, educational enrolment rates are lower among Roma. Of non-Roma Montenegrins, 4% have no or incomplete elementary school, while 55% of the Roma are in this position. Of the non-Roma Montenegrin population, 47% has completed elementary school, compared with 2% of the Roma (UNDP, 2006:26).

Living conditions in many Roma settlements are extremely poor. Of the overall population in Montenegro, 18.6% lives in *housing poverty* – that is, a lack of piped water and/or a toilet in the house. In contrast, 74.7% of the Roma live in such a situation (UNDP, 2006:13). Given the above indicators, particularly living conditions, one would expect that Roma might have greater health needs than other sectors of the Montenegrin population. Despite this need, they are often unable to procure the services they need to ensure good health. According to data collected by UNDP, 62% of Roma indicated that they could not afford to buy prescribed medicines, as opposed to 8% of the overall population (UNDP, 2006:31).

Nutritional intake is also inadequate among Roma. A study undertaken by UNICEF in Serbia and Montenegro found that the diet of Roma children is low in meat, fruit, vegetables and dairy products and is high in potatoes, beans, and bread (UNICEF, 2007:43).

The data given above describe some of the social determinants of Roma health in Montenegro. However, there are fewer data on their health system usage patterns and actual health status. Existing data are scattered, but they again show a pattern of disparity between Roma and the overall population. For example, when asked about whether any children under 14 years of age were vaccinated, 3% of the non-Roma living in Montenegro stated that their children were unvaccinated, as opposed to 11% of the Roma (UNDP, 2006:32). Also, a survey of 209 Roma women in Nikšić found that only 30% reported using modern contraception (Center for Roma Initiatives, 2005:32).

Policy framework for Roma health and inclusion

In 2005, the Government of Montenegro adopted the Action Plan for the Decade of Roma Inclusion. The Action Plan contains sections on education, employment, housing and health. The Montenegrin Development Poverty Reduction Strategy Paper, the National Action Plan for Children, and the Economic Reforms Agenda provided a policy framework for the Action Plan. The equity goals focus on rural poverty, and activities to promote child health and education that are enshrined in these earlier strategies are reflected in the Action Plan. Moreover, data collected in a 2003 household survey (UNDP & Institute for Strategic Studies and Prognoses, 2003), some of which is outlined above, guided both the development of the Development Poverty Reduction Strategy Paper and the Decade Action Plan. A committee of 15 people, representing governmental and international agencies, drafted the Action Plan (Zekovic, 2008).

Key health activities envisioned in the Decade Action Plan for the health sector include: collecting data; health education; mainstreaming Roma health into other governmental strategies and activities; and facilitating contacts between health care professionals and the Roma community, particularly through encouraging Roma to seek medical care more frequently (Government of Montenegro, 2004:35–37). The Ministry of Health, Labour, and Social Welfare coordinates the Action Plan. Few of the health activities included in the Plan have been undertaken, due in part to lack of funding.

In 2007, the Government of Montenegro adopted an overall Roma integration strategy, in part to facilitate broad stakeholder commitment to Roma inclusion and in part to create a comprehensive strategy to underpin planned activities. The health portion of the strategy is very similar to the Decade Health Action Plan, but the health portion of the overall Roma integration strategy differs from the Decade Health Action Plan. The difference is that it contains two additional areas of activity: (a) an increase in the number of physicians in primary health care centres near Roma communities and (b) support for the education of Roma to become health professionals (Ministry of Human and Minority Rights Protection, 2007:20–21).

The integration strategy commits the Ministry of Human and Minority Rights Protection to spend 0.2% of its national budget on Roma inclusion between 2008 and 2012. According to this formula, about €1 million will be available in 2009. In addition to these funds, line ministries (such as the Ministry of Health, Labour and Social Welfare have their own budgets for Roma inclusion activities (Veselj Beganaj, Coordinator, Roma Circle, personal communication, May 2008).

Implementation of the strategy is overseen by the Ministry of Human and Minority Rights Protection. A commission chaired by the Ministry, which includes vice ministers from other line ministries and a representative of Roma civil society, provides formal programme direction and accountability of strategy activities. In May 2008, the commission awarded about €290 000 of government funds to Roma inclusion projects consistent with strategy priorities, including projects to improve Roma housing conditions, health, employment, information/media, education, involvement in political life, and children's inclusion. Grantees include NGOs, municipalities, centres for social work, and media outlets. Before the end of 2008, the commission intends to announce another competitive project application process and award an additional €110 000 (Remzija Ademovic, Senior Advisor, Ministry of Health, Labour and Social Welfare, personal communication, May 2008).

To improve coordination among relevant actors, as well as to create a coherent government Roma programme implementation plan, Decade Action Plan oversight is expected to move, in the near future, to the Ministry of Human and Minority Rights Protection. Thus, both the Decade Action Plan and the Roma integration strategy will be overseen by the Ministry of Human and Minority Rights Protection.

Nikšić, a municipality with a substantial Roma population, has developed a local action plan, based on the Montenegrin national integration strategy, for Roma integration. Many of the health-related activities are local adaptations of broader objectives outlined in the national integration strategy, such as increasing health insurance coverage and making infrastructure upgrades in Roma settlements. Some of these activities will be covered by the national budget, while others are slated to be covered by municipal funds (Municipality of Nikšić, 2008:24–26).

Even before the adoption of these programmes, the Montenegrin government had undertaken some Roma inclusion programmes, particularly in the field of education. One education programme that seeks to increase literacy among adults included specific health literacy elements. Another programme included the training and employment of Roma education assistants, who assist both teachers and Roma students inside the classroom (Sabahudin Delic, Deputy Minister for Human and Minority Rights Protection, personal communication, May 2008).

In addition to these governmental activities, international agencies and national NGOs foster Roma inclusion through various programmes. UNDP has undertaken important data collection activities and has trained Roma data collectors to participate.

UNDP is also the principal recipient of two grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria, both of which target Roma explicitly. TB activities include X-ray screening among Roma, and HIV activities are focused on prevention among young people (Vladimir Jovicic & Rajko Strahinja, project managers, UNDP, personal communication, May 2008).

UNDP, UNICEF, UNHCR and a NGO legal centre support civil registration and other activities among both IDPs and Montenegrin Roma. In cooperation with civil society, UNDP also has a programme in three municipalities to increase the number of Roma who have birth certificates and/or identification documents. Thus far, over 400 personal documents have been obtained (Olivera Dimic, Roma/DP Project Coordinator, UNDP, personal communication, May 2008). As part of a regional project, UNICEF plans to target Roma adolescents for a youth-friendly health services programme. In addition to the civil registration project, UNHCR provides ongoing social and legal assistance to Roma IDPs. Finally, IOM provides material, social and medical assistance through a Health Club project for 595 Roma born before 1945. The profile of IOM beneficiaries highlights the problem of civil registration; prior to the start of the project, 67% of the Roma participating had no identity documents (Oleg Jestrovic, Coordinator, Roma Health Assistance Programme, IOM, personal communication, May 2008).

Project to improve Roma women's health

Project background and financing

This case study provides a profile of the project Significance of Behaviour Modification for Protection and Improvement of Roma Women's Health (referred to hereafter as the Women's Health Project), which was carried out in the Roma IDP Camp Konik I in Podgorica for a period of a year, from September 2006 to September 2007. The total camp population was about 1300 people at the time of the Project. Camp residents came to Montenegro from Kosovo just prior to, during and following the NATO intervention in the Federal Republic of Yugoslavia in 1999. Most speak Albanian and/or Romanes, the Roma language, and do not speak Montenegrin, the national language of Montenegro.

The Women's Health Project was implemented by the Institute of Public Health, a part of the Ministry of Health (which became the Ministry of Health, Labour, and Social Welfare in 2007), in cooperation with the Montenegrin Red Cross. Technical project staff included a public health specialist, a microbiologist, a specialist in social medicine and an epidemiologist. The Institute of Public Health provided additional technical support.

The United States Consulate in Montenegro contributed about US$ 13 000 to this Project. Project funds covered salaries for some staff, as well as project material costs. The Government of Montenegro, through the Institute of Public Health, provided cost sharing, in the form of provision of technical expertise. As the project was entirely funded by a one-time donation, the financing is not sustainable. Since the Project was undertaken at an IDP camp, which the Government of Montenegro expects will be a temporary facility, sustainable financing is not readily available. It is important, however, to note that there have been few returns to Kosovo in recent years, and no durable solution has been identified for Roma IDPs in Montenegro (UNHCR, 2008). The Government of Montenegro, specifically the Bureau of Refugees and IDPs, and UNHCR are seeking durable solutions for all refugees and IDPs in Montenegro.

Project site

Camp residents are provided with free electricity and water. The Montenegrin Red Cross has an office in the camp, and they facilitate educational enrolment and health care access for camp residents. In cooperation with other Red Cross delegations and partners, the Montenegrin Red Cross also directly provides food and other humanitarian assistance, preschool and kindergarten classes, and literacy training for adult camp residents (Mensude Krpuljevic, Montenegrin Red Cross, personal communication, May 2008).

Key health problems identified by physicians serving residents of the camps included hepatitis A, skin diseases, TB, asthma, and gastrointestinal illnesses. The camp has a primary health care facility that is open two hours a day.

Project activities

The main short-term goal of the Project was to encourage pro-health behaviour changes among Roma women inhabitants. The long-term goal was to improve the overall health status of female Roma residents of the camp, in part through improved relations with area health workers.

Women were chosen as the target population based on the experience of the Montenegrin Red Cross with projects that provided health education via a family approach. Previously, when men were present in workshops and counselling sessions, women often failed to play a leadership role, and sensitive women's health issues, such as domestic violence, could not be discussed. The Women's Health Project thus focused on women, with the explicit aim of empowering them to discuss and address reproductive and sexual health issues, in addition to general health concerns. Moreover, despite men making many resource decisions and serving as family spokespeople in Roma communities in Kosovo and Montenegro, women make family health-related decisions. Therefore, it is most important that women are educated about basic adult and children's health issues. Most participants had attended previous Red Cross workshops and most were between 25 and 35 years of age.

Over the duration of the Project, physicians led about 50 regular workshops, which were the primary means of obtaining Project goals. Project participants selected the topics for these workshops, which included, among other issues: sexual health, including contraception; pregnancy; the prevention of a number of diseases, including breast cancer, heart disease, lung disease and HIV/AIDS; immunization; tobacco control; and child health. The workshops were held in Montenegrin. About 50 women attended some of the workshops, with about 25–35 attending most of the workshops. Most of the local physicians who led the workshop received modest compensation for their participation.

In the second phase of the Project, 2000 copies of the booklet *Save our health* were published. The booklet, which was in Montenegrin, was distributed to women and discussed during workshops. The booklet's content focused on women's rights, reproductive rights and technology, pregnancy, sexually transmitted infections, breast cancer, smoking, TB, and gastrointestinal illnesses. Although most of the women had a limited ability to read Montenegrin, they were learning how to read and write in this language in concurrent Red Cross workshops. The Montenegrin Red Cross helped distribute copies of the booklet. Additional copies of the booklets were distributed within so-called festivals for education of adults, which were organized by the Montenegrin Chamber of Commerce, and also distributed to NGOs that worked with the Roma population.

Project results

Project results were discerned through pre- and post-workshop tests and through conversations with the Montenegrin Red Cross and physicians in the vicinity that cared for camp residents. Several projects were implemented in the camp at the same time, so attributing changes to one project is difficult. It is clear, however, that there were noted improvements in health knowledge among Project participants, improvements in health behaviour among all female camp residents, and strengthened relations between camp residents and area health providers.

Improvements in knowledge about health were noted by comparing pre- and post-workshop test results. Those regularly participating in the workshops demonstrated marked improvements in knowledge about women's health. Participants also described the workshops as a kind of support group; for many, it was the first opportunity they had to discuss family planning and domestic violence with other women. Learning that many other women struggled with common problems made women feel confident about seeking change – whether through requesting the insertion of an intrauterine device, calling the police following an incident of domestic abuse, or insisting that their children make regular preventive visits to the doctor.

Workshop participants and local physicians commented that they felt their communication improved as a result of the workshops. Roma camp residents explained that they felt more comfortable seeking health care in the camp primary health care facility and in the surrounding area. Physicians, nurses and other health care workers explained that they better understood the health status and needs of Roma, the ways in which camp living conditions influenced women's health, and the ways in which traditional gender roles shaped Roma women's health.

Health behaviour improved as well, although again, it is not possible to establish a causal relationship between the changes and the Project. For example, before 2003, there were tens of births in the camp each year. Since the end of the Project, there have been no deliveries in Camp Konik I; all women have given birth in health care facilities. This change is beneficial to women's and infant's health, and it also means that all children are registered at birth, facilitating their access to educational, health and social services in the future. Additionally, there appears to be greater use of family planning technology, as the

number of births has decreased while the adult population has remained stable. There were 81 children born in the camp in 2005, 53 in 2006, and 42 in 2007 (Mensude Krpuljevic, Montenegrin Red Cross, personal communication, May 2008). However, since this project began in September 2006, it is clear that the trend of decreasing births started prior to the Women's Health Project, with the Project reinforcing the ongoing changes.

During and following the Project, tens of women went to the camp primary health care facility to request intrauterine devices, to avoid pregnancy, as well as condoms to avoid pregnancy and/or sexually transmitted infections. Also, as they became more aware of women's rights and were encouraged to play an active role in taking care of their and their children's health, female camp residents began accessing additional services, such as domestic violence counselling, paediatric check-ups and gynaecological check-ups. Before the Project, women very rarely sought these services, particularly domestic violence counselling and gynaecological services.

Lessons learned

Importance of synergistic efforts

Significant improvements in health behaviour occurred during and following this project. This was likely due in part to other projects in the camp; several different concurrent projects reinforced changes and contributed to increased trust in local service providers among camp residents. During the same time period as the Women's Health Project, the Ministry of Education opened a preschool and kindergarten in the camp, and NGOs and local schools facilitated the enrolment of camp children into local elementary schools. For the first few years, the camp existed, almost no children went to school. By May 2008, 78% of camp children of preschool age were enrolled, and 56% of camp children of elementary school age were enrolled (Mensude Krpuljevic, Montenegrin Red Cross, personal communication, May 2008). Also during the same period of time as this project, the Danish Red Cross conducted a camp hygiene programme and the Montenegrin Red Cross held adult literacy classes. Together with the Women's Health Project, these efforts encouraged Roma living in the camp to take proactive steps to improve their health and socioeconomic situation.

Efforts to encourage change in behaviour were facilitated by the increased availability of services. Encouraging camp residents to enrol in school and access health care would have been less effective without concrete assistance for taking action. For example, the opening of the primary health care facility and the provision of free family planning commodities were all essential to enabling changes in behaviour. It is unlikely that health education would have been as effective if the services did not also change to become more readily available, accessible, and appropriate to female Roma Camp Konik I residents.

Importance of involving health care workers

In part, health services became more appropriate for Roma due to health care worker involvement in the Project. Although they were not designated as a target group in the Women's Health Project, area health care workers were indirect beneficiaries of the Project. As a result of their involvement in assessing health conditions in the camp, in developing the *Save our health* booklet and, most importantly, holding regular workshops with Roma women, local physicians, nurses and other health care workers learned about the health status of Roma IDPs. They now have a better understanding of the administrative, language, socioeconomic and cultural barriers (namely traditional gender roles) to Roma women increasing their access to health care. As a result, they are much more capable of dealing with these barriers, through such activities as helping Roma to obtain required documentation and explaining the need for gynaecological care.

Lack of durable solutions for IDPs contributes to ongoing health problems

The Montenegrin government, several international and national NGOs, and international organizations have cooperated to decrease the social exclusion of Roma living in Camp Konik I. There are changes in identifying durable solutions for camp residents. Few IDPs have returned to Kosovo in recent years, and the Montenegrin Red Cross expects few to return in the near future (Mensude Krpuljevic, Montenegrin Red Cross, personal communication, May 2008). This lack of clarity and the linguistic and cultural distinctness of IDPs living in the camp from their neighbours limit short-term integration into Montenegrin social, economic and political life.

The unresolved status of Roma IDPs influences both their mental and physical health. It is widely agreed that the trauma associated with displacement, as well as the stress and uncertainty of camp living, contributes to psychosocial difficulties (WHO, 2000). These difficulties may contribute to unhealthy behaviour, such as tobacco use and alcohol abuse, as well as the perceived elevated rates of domestic violence in Camp Konik I.

Lack of integration also contributes to inadequate access to health care. For example, IDPs are registered with general practitioners in the primary health care facility in the camp, meaning that they have the right to see only these practitioners for routine care. This facility, however, is open two hours a day. In case of need outside of this time, Roma can access emergency or specialized care, but are unable to see general practitioners in the local health facility. While many appreciate having the health facility and other services at the camp, such as kindergartens, the fact remains that Roma IDPs are neither integrated citizens of their home country nor of their host country. This poses obstacles to full access to health and social services.

Difficulty in addressing upstream determinants of women's health

In some cases, the workshops included in the Women's Health Project were the first time Roma women discussed the upstream determinants of their health status, including the position of women in traditional Roma families in Kosovo. While women identified and discussed this issue and, in many cases, took unprecedented steps to improve their health status, such as getting regular gynaecological check-ups or seeking assistance for domestic violence, the Project represents only a small step in changing the traditional roles and rights of these women. Additional projects and, more importantly, debate and changes driven by the Roma community itself are needed to sustainably change some of the social structures that limit Roma women's access to health care and their overall health status. Montenegrin Roma NGOs, such as the Centre for Roma Initiatives in Nikšić, have encouraged community discussions on Roma women's status within and outside the Roma community.

Acknowledgements

The authors would like to thank Marta Schaaf, consultant to the WHO European Office for Investment for Health and Development, who provided essential input to the drafting process, as well as the following people interviewed for this study: Sabahudin Delic, Deputy Minister for Human and Minority Rights Protection; Dubravka Velasevic, Senior Advisor to the Ministry of Health, Labour and Social Welfare; Remzija Ademovic, Senior Advisor Ministry of Labour and Social Affairs; Marijana Vukcevic, Advisor to the Secretary, Secretariat for European Integration; Lela Bjelobrkovic, Advisor to the Secretary, Secretariat for European Integration; Slobodan Zivkovic, Social Policy Officer, UNICEF; Branka Kovacevic, Programme Specialist, UNICEF; Olivera Dimic, Roma/DP Project Coordinator, UNDP; Vladimir Jovicic, Project Manager TB, UNDP; Rajko Strahinja, Project Manager HIV/AIDS, UNDP; Oleg Jestrovic, Coordinator of the Roma Health Access Programme, IOM; Zana Blagojevic, IOM; Stephanie Woldenberg, Associate Protection Officer, UNHCR; Darka Minic, Community Service Assistant, UNHCR; Jovica Zaric, Field Assistant, UNHCR; Veselj Beganaj, Coordinator, NGO Roma Circle; and, Ivana Durutovic, Programme Assistant, NGO Roma Circle.

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13. Poland: poverty and health

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Summary

Because of their very limited ability to pay for services offered by health care providers and private health insurers, the poor are generally more dependent on health care services financed by public payers than people with a better economic status. Although general improvements in health care delivery of publicly financed services can be viewed as improvements in health care delivery for the poor, problems with transparency, serious shortcomings experienced by a health care system and unintended inequalities in access in some areas of a country can reduce equity in access to health and health care, with the poor suffering to a much greater extent than people with a higher socioeconomic status. General improvements in the health care system are important for people living in poverty, but such improvements are not sufficient to protect the poor's rights to equity in health and health care. Therefore, solutions that address the poor directly are needed.

This case study presents selected solutions for protecting poor people's free access to health care services in Poland. The study focuses on five solutions introduced in the Polish health system to assure the poor better access to health care:

1. mandatory, universal insurance of all eligible people, regardless of their socioeconomic status
2. voluntary insurance in the mandatory, universal health insurance system
3. free access to publicly financed health services for poor uninsured people
4. prohibiting treatment of private patients by public health care providers
5. protecting the access of insured poor people to dental health care services.

In 1999, a new universal health insurance system was introduced in Poland. After its introduction, it became evident that the new system, despite all efforts, did not include some groups and that the voluntary insurance did not protect everybody against exclusion from the system. All information on unintentional exclusions was analysed to identify new social groups and include them as insured mandatorily. The number of listed groups, therefore, was increased – from 17 in the first legal act on universal health insurance to 35 in the next versions of the act.

Decision-makers also became aware that not all social groups of excluded people could be named. Therefore, in 2004, a so-called safety valve was introduced to protect very poor people against exclusion. In September 2007, the solution was modified to better meet their needs. Thanks to it, all of the poorest people (insured and uninsured) got free access to health care. However, unlike insured people, the poorest uninsured people receive mostly inpatient care.

Socioeconomic and policy context

Poverty

Before its transformation to a market economy, the Polish economy was in a much more serious crisis than economies of the other CCEE. The crisis was generated by an unsuccessful national policy, based on foreign credits. Among other things, the policy resulted in serious restrictions on consumption levels of *all* households, regardless of their economic status. This crisis caused strong social dissatisfaction, which in 1989 led to economic transformation – a process of establishing a democratic state with a market economy.

At the very beginning of Poland's transformation, poverty was a serious problem. The whole period can be divided into four sub-periods (Golinowska et al., 2005:281, 282):

1. **1989–1993.** During this period, an economic crisis, generated by Poland's transformation, caused increased unemployment and a decrease in personal income. Also during this period, Polish policy-makers focused on offering better social protection to the groups with the greatest suffering, such as employees of bankrupt state-owned farms and workers of bankrupt enterprises belonging to heavy industry.

2. **1994–1997.** This was a period of fast economic development and the development of a new social security system, adjusted to a market economy.

3. **1998–2002.** During this period, economic development was slower than during the preceding one, and public financial resources were significantly limited. Also during this period, new economic reforms and decentralized social policies were introduced.

4. **2003 to the present.** During this period, economic development was more rapid, and the country's social policy was strongly influenced by social strategies applied by the EU and by the transfer of EU financial resources to Poland.

In describing the income gradient that affects the poor, absolute poverty and relative poverty are measures of the poverty threshold, or poverty line. The World Bank defined absolute poverty as US$ 2.00 a day per person (adjusted to represent PPP in relation to the 1993 consumer prices of each country), which corresponds to a low standard of living in a low-income country. Relative poverty is an indicator of income level below a given proportion (typically 50%) of the average national income. In high-income countries, there are far more pockets of relative poverty than of absolute poverty (WHO Regional Office for Europe, 2005).

Absolute poverty in Poland affects less than 2% of the population (World Bank, 2000; Golinowska et al., 2005: 144, 147). It means that this kind of poverty is smaller in Poland than it is in many other countries. However, relative poverty has been estimated to be significant – only 68% of the Polish population has never belonged to the relative poverty group during the period 1997–2000 (Golinowska et al., 2005:73, 144, 147).

Recently, the Polish economy has experienced rather accelerated growth, along with a substantial growth in earnings and a continuous decrease in unemployment. Despite these improvements, Poland still has very high unemployment (including long-term unemployment) and many other groups with low economic status.

Inequalities in access to health care directly financed by households

Between the mid-1960s and early 1990s, the health status of the Polish population deteriorated, due to an increasing number of cases of cardiovascular and oncological diseases, as well as to an increasing number of car accidents; this adverse trend was also visible in other parts of the CCEE. At the beginning of the social and economic transformation period in 1992, however, mortality in Poland began to decrease.

Despite this positive trend, an inequality in health can be observed: there are regional differences in average longevity, with people in three southern regions of Poland and one northern region living longer than people in the other parts of the country. The regional differences in average longevity are more visible among men than among women (2.92 and 1.86 years, respectively). According to empirical studies, the levels of unemployment, education and household expenditures have had a major influence on regional differences. In general, poverty is a key factor for health inequalities in Poland (Sowa, 2007).

Access to health care is also unequal. In 2003, household expenditures for health care amounted to 30% of all public and private expenditures for health care, compared with 10% at the beginning of the 1990s (Golinowska, 2004:35–36). Because private health insurance covered only a small part of the Polish population in 2003, households made mostly out-of-pocket payments for health care.

According to the Green Book, the level of health care and drug expenditure depends on the socioeconomic status of a household (Golinowska, 2004:35). Households of the richest farmers spent almost twice as much as those of the poorest ones. Differences between expenditures of the richest and poorest employees are sixfold (see Table 13.1).

Table 13.1. Average monthly household expenditures for health care per person in 2003 (in Zl) [a]

Type of household and category of expenditures	Quintile groups					
	Total	First	Second	Third	Fourth	Fifth
Altogether						
Total household expenditures	643.84	298.04	416.09	554.18	736.29	1 263.98
Health care & drug expenditures	30.24	9.63	15.87	25.57	40.48	62.47
Drug expenditures	19.88	6.53	10.84	17.85	27.45	38.42
Employees						
Total household expenditures	673.16	306.05	438.06	575.19	751.31	1 352.31
Health care & drug expenditures	22.97	7.90	13.44	20.13	27.41	48.21
Drug expenditures	12.84	5.23	8.01	12.31	14.94	24.81
Farmers						
Total household expenditures	461.20	399.75	326.48	380.27	505.93	697.04
Health care & drug expenditures	18.64	15.34	11.31	17.82	20.93	27.92
Drug expenditures	12.37	10.42	6.80	11.91	14.88	17.93
Self-employed						
Total household expenditures	817.24	363.16	527.50	706.51	901.74	1 645.30
Health care & drug expenditures	26.44	9.28	16.55	24.48	30.02	53.89
Drug expenditures	13.22	4.76	9.44	12.56	14.04	26.22
Pensioners and people on disability benefits						
Total household expenditures	697.67	334.90	483.69	641.43	821.68	1 258.29
Health care & drug expenditures	53.54	17.94	33.08	48.52	71.11	101.89
Drug expenditures	40.18	14.03	25.91	38.24	54.16	71.94
People maintained on non-earned sources of income						
Total household expenditures	436.66	278.80	264.92	334.15	464.08	882.47
Health care & drug expenditures	14.52	5.87	6.32	11.40	18.55	32.31
Drug expenditures	9.72	3.85	4.99	8.24	12.65	19.96

[a] Currently, €1.00= Zl 3.40 and US$ 1.00= Zl 2.11.

Note. The numbers are from studies based on a national sample of all households in Poland conducted by the Central Statistical Office.

Source: Golinowska (2004:36–37). Reproduced with the permission of the copyright holder.

During the transformation period, the share of household expenditures for health care, when compared with total household expenditures, increased at least three times. The growth was caused mostly by increased expenditures for drugs – an average growth of 10% a year during the period 1999–2003. During this period, the growth of total costs for health care was 6.2% a year. In 2003, the highest average share of household spending for health care was for pensioners and people obtaining disability benefits, and the lowest share was for people maintained on non-earned sources. Most money was spent for drugs – about 50% in households of the self-employed and about 75% in households of pensioners and people obtaining disability benefits. The authors of the Green Book (Golinowska, 2004:38) came to the following conclusion: a further "fast increase of private health care expenditures is not possible in forthcoming years".

Further growth of direct household expenditures for health, however, is unavoidable in Poland. Among other things, growth will be generated by demographic trends. Poland (as well as many other countries of the region, such as the Czech Republic, Hungary and Ukraine) belongs to a group of so-called old countries. These old countries experienced long declines in fertility and improvements in mortality. According to Chawla, Betcherman & Banerji (2007:68–69):

> Those countries already have population structures dominated by older age groups. The proportion of the population in the younger age group has been so significantly reduced that the traditional population pyramid with a wide bottom already shows strong signs [of] being flipped on its head within the next two decades.

In Poland, demographic projections prepared separately by the Central Statistical Office and the Gdansk Institute for Market Economics are very similar, with the projections of the latter being based on an International Labour Organization (ILO) model. According to these projections, the number of people in the country over 65 years old will increase from 12% to 18% in a period of 20 years (Golinowska, 2004:186).

In the future, most elderly people will be retired or pensioned and, due to it, their economic status will likely be lower. Simultaneously, their health status will deteriorate. These trends are illustrated by the data presented in Table 13.2.

Table 13.2. Self-evaluation of health status by men and women in Poland in 2004

Health status	Gender	Percentages of age groups (years)					
		Total	0–14	15–29	30–49	50–69	≥70
Health status less than good	Male	34.7	9.5	11.9	34.1	67.6	82.8
	Female	41.5	8.3	14.4	36.5	72.6	89.3
Long-lasting health problems	Male	32.8	17.6	15.0	26.9	60.3	81.1
	Female	39.8	14.9	15.9	32.6	67.6	85.7
Long-lasting chronic diseases	Male	40.8	24.0	20.3	37.1	70.5	87.8
	Female	50.9	20.9	26.0	47.3	81.1	92.8

Source: Central Statistical Office (2007a:21, 23, 25). Reproduced with the permission of the copyright holder.

Besides the increase in health care expenditures attributable to the elderly, a further increase in health care expenditures will also result from other well-known factors, such as:

- rapid development of medical technologies
- pressure of medical professions to increase their personal income
- growing social demand for high-quality health care services.

The above-mentioned trends will cause a further increase in inequalities in health and access to health care. The only chance to reduce these inequalities is to develop adequate equal access to services financed by public payers. Attainment of such a goal demands implementation of comprehensive strategies at national and subnational levels, as well as reliable instruments that can be used by health policy-makers to monitor and evaluate existing inequalities.

Poverty and access to health care financed by public payers

The inequalities in access to publicly financed health care in Poland are generated by poor management, insufficient transparency, a deficit of specialists, an insufficient level of financing and historic causes, among other things. In Poland, for example, access to selected specialist outpatient services for cardiology, eye treatment, haematology and endocrinology, as well as part of inpatient services, is limited. Also, an example of an inequality that resulted from historical causes is the location of many hospitals being dictated by the military policy of the Warsaw Pact and not by the contemporary needs of the Polish population.

Equal access to health services

As Whitehead & Dahlgren (2006:8) stated, "Inadequate access to essential health services is one of several determinants of social inequities in health. It may not be the major determinant, but it is an important one for the health sector to tackle directly – to put its own house in order."

Poland introduced its system of universal health insurance in 1999 (National Assembly, 1997a). In the beginning, it consisted of 17 sickness funds. Later, these funds were transformed into the 16 regional branches of the National Health Fund, which many decision-makers claim is a monopolistic solution and a temporary one. The Fund's basic task is to make contracts with service providers and control the fulfilment of such contracts. Besides the Fund, the role of payer in health care is also played by some ministries (such as the Ministry of Health and the Ministry of National Defence) and by territorial self-governments, but their total share in health care expenditures is considerably smaller than that of the Fund.

Mandatory health insurance provides coverage for all social groups, making it impossible to choose not to participate in the system because of income level, social group or source of income. The revenues from universal health insurance contributions are the major public source of health care financing (Kuszewski & Gericke, 2005:23-49). A condition for using services financed by the universal health insurance is the regular payment of contributions. Generally, the person insured is largely compensated by the income tax system and, in most cases, a contribution is calculated by an employer and paid by him or her on behalf of the insured person. Also, for some groups of insured people – for example, unemployed people without unemployment benefits – the state budget pays the contribution.

Health care benefits are offered to payers of contributions and to members of their households. People covered by mandatory insurance are authorized to use the health care services free of charge, if they can prove to the health care provider that their contribution was paid. In some cases, however, they make co-payments for some services, such as prescribed drugs, orthopaedic devices and spa treatments. Formal access to health care services financed by the National Health Fund is almost unrestricted; however, there is a serious discrepancy between the Fund's formal obligation and its real ability to cover costs of health care services, which is not transparent. At present, one of the priorities of the Polish health care policy is to establish an official package of health benefits – that is, a set of health care services financed by the universal health insurance system.

The following sections present five Polish solutions for ensuring better access to health care for the poor:

1. mandatory, universal insurance of all eligible people, regardless of their socioeconomic status
2. voluntary insurance in the mandatory, universal health insurance system
3. free access to publicly financed health services for poor uninsured people
4. prohibiting treatment of private patients by public health care providers
5. protecting the access of insured poor people to dental health care services.

Poland also makes other efforts to reduce inequalities in access to health care services; for example, a contracting policy is being developed by the National Health Fund to gradually reduce unintended differences in access to health services in particular regions of the country. A comparison of financial resources contracted and spent annually per person for particular kinds of services (such as dental services) by the 16 regional branches of the National Health Fund helped reveal some serious unintended differences among regions. This comparison led to the establishment of a proper policy to introduce gradual necessary changes (National Health Fund, 2007b:7). This, however, is not discussed further in this case study.

Mandatory, universal insurance of all eligible people

In Poland, almost everyone is insured mandatorily through universal health insurance (see Table 13.3).

In 2006, there were 37 821 925 mandatorily insured people registered with the National Health Fund. At the end of 2005, the Polish population was equal to 38.1 million people (Central Statistical Office, 2007b). This number, however, should be lower, because hundreds of thousands of people have left Poland for better job opportunities abroad. Therefore, the mandatory insurance could be recognized as a basic (core) solution that protects equal access to health care services for Polish citizens. In practice, this right is seldom violated – the small number of complaints or court cases is an indicator of this. Despite general guarantees of access, there are additional solutions to ensure that access to health care services financed by public payers is also protected for marginalized groups.

Table 13.3. Mandatorily insured in the National Health Fund at the end of 2006

Administrative region	Insured mandatorily		
	Total	Payers of contributions	Family members eligible for Fund benefits
All	37 821 925	27 683 897	10 138 028
A region not specified	21 229	21 183	46
Dolnoslaskie	2 852 220	2 183 411	668 809
Kujawsko-Pomorskie	2 078 970	1 512 502	566 468
Lubelskie	2 202 770	1 586 426	616 344
Lubuskie	1 010 932	740 372	270 560
Lódzkie	2 554 636	1 936 496	618 140
Malopolskie	3 190 555	2 377 447	813 108
Mazowieckie	5 084 277	3 821 895	1 262 382
Opolskie	968 811	726 172	242 639
Podkarpackie	2 090 470	1 461 013	629 457
Podlaskie	1 184 833	849 531	335 302
Pomorskie	2 195 566	1 559 512	636 054
Slaskie	4 579 982	3 235 067	1 344 915
Swietokrzyskie	1 292 238	925 055	367 183
Warminsko-Mazurskie	1 441 577	1 022 910	418 667
Wielkopolskie	3 376 103	2 460 235	915 868
Zachodniopomorskie	1 696 756	1 264 670	432 086

Source: National Health Fund (2007b:56). Reproduced with the permission of the copyright holder.

Voluntary insurance in the mandatory, universal health insurance system

All people not covered by mandatory insurance – native- and non-native-born Polish citizens, and all citizens of EU and non-EU countries legally coming to Poland – may declare their desire to be insured voluntarily by the National Health Fund. Once insured, their rights and duties are equal to those of all people insured mandatorily. At the end of 2006, 33 336 people (including 28 060 payers of contributions and 5 276 members of their families) were voluntarily insured. This is not many when compared with 37.8 million people insured mandatorily (see Table 13.4).

Table 13.4. Voluntarily insured in the National Health Fund at the end of 2006

Administrative region	Voluntarily insured		
	Total	Payers of contributions	Family members eligible for health care services financed by the Fund
All	33 336	28 060	5 276
A region not specified	0	0	0
Dolnoslaskie	2 607	2 314	293
Kujawsko-Pomorskie	1 189	1 076	113
Lubelskie	829	758	71
Lubuskie	487	409	78
Lódzkie	1 334	1 243	91
Malopolskie	3 599	3 087	512
Mazowieckie	7 043	5 925	1 118
Opolskie	1 034	944	90
Podkarpackie	783	777	6
Podlaskie	712	574	138
Pomorskie	5 830	3 989	1 841
Slaskie	2 131	1 892	239
Swietokrzyskie	288	231	57
Warminsko-Mazurskie	596	541	55
Wielkopolskie	2 295	2 232	63
Zachodniopomorskie	2 579	2 068	511

Source: National Health Fund (2007b:56). Reproduced with the permission of the copyright holder.

Contribution rates are the same for those insured mandatorily and voluntarily. However, for those insured voluntarily, the base for calculation of their contribution cannot be lower than that of an average salary (wage) in Poland. Only a few groups, such as foreign students studying in Poland (from outside the EU), are allowed to pay much lower contributions. As a result, people with a very low economic status cannot afford the cost of voluntary insurance. Therefore, an additional solution was introduced to protect their free access to health care.

Free access to publicly financed health services for poor uninsured people

All uninsured Polish citizens whose economic status is very low and who live in Poland are eligible for health care services financed by the National Health Fund, which in this case obtains financial resources from a part of the state budget managed by the Ministry of Health (National Assembly, 2003b, 2004). All services are offered to the uninsured on the basis of a decision made by local communal authorities with jurisdiction for the area in which the person lives, and all pre-hospital emergency services are financed by a state budget for all citizens, regardless of their socioeconomic status. Also, uninsured Polish citizens (including those with low economic status) are eligible for health care services financed by public payers in the following cases:

- pregnant women, during pregnancy and child delivery
- children (less than 18 year old).

Also, free access to health care services is offered to all people (regardless of their citizenship) in case of:

- alcohol or drug addiction (National Assembly, 1982, 2005)
- selected psychiatric treatment (National Assembly, 1994)
- selected infectious diseases, such as TB (National Assembly, 2001)
- prisoners (during their stay in a prison) (National Assembly, 1997b)
- refugees (National Assembly, 2003a).

However, since the Schengen Agreement was applied in Poland, each person entering the country with a Schengen Visa has been obliged to have health insurance. Due to EU regulations that stem from this Agreement, the legal solutions presented above, as well as some bilateral international treaties (such as that between Poland and the Russian Federation on free access to medical treatment) became relatively less important.

Thanks to the legal solutions presented above, more than 47 000 Polish citizens (and 78 foreigners from such countries as Algeria, Armenia, China, the Congo, India and Vietnam) got free access to health care services financed by a Polish public payer in 2007 (see Table 13.5).

Table 13.5. Health care services offered to uninsured Polish citizens, financed in 2007 [a]

Health care services	Total costs (in Zl)	Number of patients	Average cost of health care service (in Zl)
Selected infectious diseases			
TB	3 097 300	1 250	2 478
Other	58 985	42	1 404
Drug abuse	10 083 631	9 689	1 041
Alcohol abuse	17 388 178	20 311	856
Selected psychiatric diseases	17 353 866	12 895	1 346
Pregnancy and child delivery	1 128 660	1 006	1 122
Children less than 18 years old	1 523 843	1 347	1 131
Drugs (pharmaceuticals)	23 648	706	33
Total	50 658 111	47 246	1 072

[a] The financing provided for health care services in 2007 covered services delivered in parts of both 2006 and 2007.

Source: Bureau of International Settlements (2008:5,13). Reproduced with the permission of the copyright holder.

The application of an uninsured Polish citizen with a very low economic status for a decision about free access to health care services could be submitted to a local administration by several different actors, such as the uninsured, health care providers, a branch of the National Health Fund or the local public administration. When the application is submitted, professional social workers conduct interviews to verify the applicant's economic and legal status. Then a local decision-maker allows (or disallows) free access to health care services. Local authorities do not pay for treatment and, therefore, do not feel restricted in deciding favourably for the uninsured.

In 2004, communal authorities were allowed to permit free access to health services that lasted 30 days. If a longer treatment was needed, a new decision was necessary. Nowadays, due to new legal solutions introduced in September 2007, such permits can be given for 90 days. Moreover, in January 2008, all uninsured Polish citizens (with very low economic status, as well as pregnant women and children less than 18 years old) received the same access as insured Polish citizens to health care services in the other EU countries during their stay abroad.

The solution that allows free access to health services for uninsured poor people is not only important to direct beneficiaries, but is also important to health care providers, because they can obtain remuneration for treatment offered to this group of patients. In this case, medical doctors are very strong allies of the uninsured poor; they exert pressure on local decision-makers to make timely decisions, as well as complain to the Ministry of Health or insist on clarification of all ambiguities in legal procedures.

The solution described in this section was introduced in October 2004. In 2005, 1550 poor uninsured people were treated, and the cost of their treatment was Zl 6.35 million (€1.87 million). In 2006, the number of people increased to 3634, and the cost of their treatment was Zl 12.1 million (€3.56 million). In the first part of 2007, treatment of 2573 people cost Zl 6.3 million (€1.9 million). Although these numbers are marginal, the solution is created just for marginal groups not covered by mandatory or voluntary health insurance. However, before the solution was introduced, the group of beneficiaries was expected to be much larger. In an official document presented to the National Assembly (parliament) together with a bill for the law, the total cost of all services for treatment of uninsured poor people was estimated to be Zl 500 million (€147 million). This great discrepancy between estimated and real cost was investigated by the Supreme Chamber of Control, which reports directly to the National Assembly.

The number of the uninsured poor differs among administrative divisions (see Table 13.6). In 2006, the number of uninsured poor people treated in two regions (the Mazowieckie and Lódzkie regions) grew noticeably in comparison with the number for 2005. Also, in 2006, almost 45% of all uninsured poor patients were treated in these two regions (compared with 17% in 2005). Moreover, in two other regions (the Dolnoslaskie and Slaskie regions), the number of uninsured poor patients also increased noticeably.

Table 13.6. Number of uninsured poor and cost of their treatment

Administrative region	Cost (in Zl 1000 by year)		Number (by year)	
	2005	2006	2005	2006
Dolnoslaskie	65	404	38	242
Kujawsko-Pomorskie	167	225	55	88
Lubelskie	197	242	33	57
Lubuskie	30	133	6	52
Lódzkie	515	2 178	192	796
Malopolskie	988	1 479	380	431
Mazowieckie	217	2 461	73	816
Opolskie	126	250	40	86
Podkarpackie	96	79	28	25
Podlaskie	578	498	195	181
Pomorskie	178	169	48	74
Slaskie	598	1 571	169	423
Swietokrzyskie	26	144	14	56
Warminsko-Mazurskie	108	171	16	61
Wielkopolskie	389	502	117	110
Zachodniopomorskie	890	532	146	136
Total	4 990	11 038	1 550	3 634

Source: Ministry of Health (2007:72–73). Reproduced with the permission of the copyright holder.

There are at least two reasons for the increase. The first is that many homeless people from other parts of Poland came to big Polish cities, like Warsaw. For Warsaw, in particular, sources within the local administration believe that about 90% of all homeless people living in Warsaw came recently from the other parts of the country. The second reason is that new rights of uninsured poor people were well communicated; many posters and leaflets appeared in places where the uninsured poor were found, such as centres offering free meals or other forms of social support. Also, germane information was spread among all health care providers.

In most cases, poor uninsured people were treated in hospitals – more than 95% of all costs were spent for this kind of treatment. In this case, the Lódzkie and Mazowieckie regions are not exceptional. However, real access for poor uninsured people to other services, such as primary health care, dental services and orthopaedic devices, is very limited (see Table 13.7).

Table 13.7. Number of uninsured poor people and costs of their treatment, 2005–2007

Category	2005		2006		2007		Remarks
	Cost	%	Cost	%	Cost	%	
Total number of uninsured people	1 550	--	3 634	--	2 573	--	Costs shown for 2007 are for the first half of the year
Total cost (in Zl 1000)	6 351.96	--	12 105.01	--	6 307.92	--	Costs shown for 2007 are for the first half of the year
Cost (in Zl 1000) by kind of treatment:							
Primary health care	0.22	0.00	0.09	--	0.02	--	--
Ambulatory specialist care	6.96	0.11	9.19	0.08	3.28	0.05	--
Hospital treatment	6 064.66	95.48	11 660.90	96.33	6 010.96	95.29	--
Psychiatric treatment	95.70	1.51	246.52	2.04	147.98	2.35	Inpatient and outpatient treatment
Medical rehabilitation	38.71	0.61	67.57	0.56	36.30	0.58	--
Long-term care	73.41	1.16	78.65	0.65	39.06	0.62	--
Dental services	0.02	0.00	0.15	0.00	0.00	0.00	--
Spa treatment	0.00	0.00	0.00	0.00	0.00	0.00	--
Emergency care and medical transport	0.00	0.00	0.00	0.00	0.00	0.00	--
Health care services contracted separately	72.06	1.13	39.69	0.33	65.59	1.04	This category also includes costs of expensive hospital health care services.
Orthopaedic devices and other appliances	0.22	0.00	2.25	0.02	4.73	0.07	--
Drug reimbursement	0.00	0.00	0.00	0.00	0.00	0.00	--

Source: National Health Fund (2007a). Reproduced with the permission of the copyright holder.

Among possible explanations for this limited access to other services are the following.

- Most uninsured poor people ask for medical care when they are seriously ill.
- Hospital emergency room services are available 24 hours of the day and are the easiest to access.
- Most uninsured poor people (such as the homeless) are unable to buy drugs and often live in extreme conditions. Therefore, the most effective way for them to receive treatment is by using providers of hospital care, even in so-called standard cases where outpatient treatment is sufficient.

Prohibiting treatment of private patients by public health care providers

Public health care providers are not allowed to deliver their health care services to private patients (National Assembly, 1991). Among other things, this solution was established to better protect the access of poor patients to health care services. The solution is based on the assumption that health care providers prefer private patients over those who obtain services financed by public payers.

According to a Polish law, the National Health Fund is obliged to treat *equally* all health care providers that compete for a contract, regardless of their status: public or private. Publicly owned providers under contract with the Fund, however, cannot treat private patients, unlike private providers, who are allowed to do it – even when they are under contract with the Fund.

Dental services and some sectors of primary health care are mostly private, but the number of patients treated privately by primary health care doctors is relatively small, due to good access to similar services financed by a public payer. In specialist outpatient care, however, private health care providers are apparent, though not dominant. On the other hand, public providers strongly dominate the hospital sector. In this sector, only selected relatively uncomplicated services, mostly performed by district hospitals are delivered by private hospitals. This short description reveals that, so far, the solution to prohibit treatment of private patients by public health care providers plays its role in at least two important areas of the Polish health care sector: specialist outpatient care and hospital care.

Protecting the access of insured poor people to dental health care services

The percentage of people (2 years of age and older) who discontinued dental consultations at least once was 14.5% (see Table 13.8).

Table 13.8. People who discontinued dental services at least once in 2004

Category	Total number of people (in 1000s)	People who discontinued service (in 1000s)	Per cent
Altogether	37 479.5 [a]	5 447.1	14.5
Urban areas [b]	23 035.7	3 709.3	16.1
Rural areas	14 443.8	1 737.8	12.0
Age groups:			
2–14	5 682.8	332.4	5.8
15–29	9 349.3	1 400.2	15.0
30–49	10 710.7	2 165.4	20.2
50–69	8 280.0	1 313.8	15.9
≥70	3 456.6	235.2	6.8

[a] The Polish population 2 years of age and older.

[b] Towns and cities.

Source: Central Statistical Office (2007a:261–264). Reproduced with the permission of the copyright holder.

Sometimes people discontinue going to a dentist because they are simply frightened or are too busy to go. However, 46.7% of Polish people who had gone to a dentist and then stopped declared that they had to discontinue going because of the cost. Also, 26.9% of these people did not want to wait too long, 11.4% stopped going because of too long a distance to travel to a dentist and 5.7% did not know a good dentist (see Table 13.9).

Table 13.9. Reasons for discontinuing dental services

Category	Total number of people	People (in 1000s) who discontinued dental services			
		Reason			
		Lack of money	Long waiting time	Distance too long	Did not know a good dentist
Total	5 447.1	2 545.6	685.4	78.3	5.7
Urban areas [a]	3 709.3	1 799.7	451.7	29.9	4.0
Rural areas	1 737.8	745.9	233.7	48.3	1.8
Age groups					
2–14	332.4	146.5	53.4	8.9	1.4
15–29	1 400.2	616.2	147.7	11.8	1.4
30–49	2 165.4	1 057.0	265.6	16.0	2.9
50–69	1 313.8	626.7	188.5	20.4	--
≥70	235.2	99.3	30.2	21.1	--

[a] Towns and cities.

Note. The Central Statistical Office included three additional categories – lack of time (too busy), fear and other reasons – but they were excluded from Table 13.9.

Source: Central Statistical Office (2007a:265–268). Reproduced with the permission of the copyright holder.

Because access to dental services is limited in Poland, additional solutions were introduced to provide poor people with better access to these services. In the case of treating teeth, only standard services are financed by a public payer; for children younger than 18 years old, pregnant women and people with psychiatric disorders, the scope of services provided is broader. Many people with an economic status that is average or higher ask for services beyond the standard provided. In such cases, however, they were obliged to cover all costs of the services – the National Health Fund did not cover the part of their treatment equal to the costs of basic services. This solution was expected to help secure public resources for services offered to poor people who could not afford the out-of-pocket costs of extra services.

Unfortunately, this formal solution was ineffective, leading dentists and patients to often agree on the following informal solution: dentists charged their patients only for the costs of extra, out-of-pocket services – less the cost of standard treatment. In such cases, the dentist obtained the balance of money from the National Health Fund. Because of the informal solution, the solution presented was recently replaced by a new one. Nowadays, in case of dental services that are more expensive than the standard cost, the National Health Fund covers expenditures equal to the cost of standard services.

Lessons learned

In 1999, a new universal health insurance system was introduced in Poland by a law on universal health insurance (National Assembly, 1997a) that included comprehensive solutions on access to health care services financed by a public payer. Because earlier solutions for access were incremental, inconsistent and vague, the new solutions introduced together with universal health insurance were a very distinctive break with the past.

Because free access to health care services was recognized as one of the most important social rights, comprehensive solutions for the new health system were worked out carefully. It was also decided that mandatory participation would be complemented by the option of voluntary access to health care services, which was recognized as a *safety valve*. In this way, all those interested, whose free access to health care services was unintentionally denied, got an opportunity to join the system. After the new system was introduced, however, it occurred that some groups were not included and that the voluntary insurance did not protect everybody against exclusion from the system. For example, the children of uninsured parents, the homeless and youngsters kept in holding facilities (different from prisons) were not included in the system on a mandatory basis, and these people had no ability to pay contributions to join the system voluntarily.

Members of some excluded groups informed policy-makers that their rights were violated. Some so-called silent groups, however, did not effectively protect their free access to health care, which required that decision-makers be informed indirectly, by health care providers, researchers or NGOs. All information on unintentional exclusions was analysed to identify new social groups, so that they could be insured mandatorily. Therefore, the number of groups listed had to be increased – from 17 in the first legal act on universal health insurance to 35 in the next acts on universal health insurance (Mokrzycka, 2007).

Decision-makers also realized that not all social groups of excluded people could be named. A legal act, introduced in 2004, therefore provided an additional safety valve to protect the very poor from exclusion (National Assembly, 2004). In September 2007, the solution was modified to better meet their needs. Because of it, all the poorest people (insured and uninsured) got free access to health care.

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14. Republic of Moldova: children living in poverty – implications for the health system

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Summary

Challenges in the transition to a market economy, slowed economic growth and the rise of unemployment have led to the deterioration in the quality of life for the majority of the Republic of Moldova's people. Children, who represent the most vulnerable group and are exposed to a variety of social risks, have been most affected. This case study analyses child poverty in the Republic of Moldova, provides an overview of key indicators for child health, describes how efforts to provide health insurance coverage and strengthen primary health care can improve the health of disadvantaged children, and briefly introduces issues related to public expenditure and the new National Health Policy in relation to this topic. It also discusses lessons learned for scaling up the health system's ability to meet the needs of vulnerable children.

In the Republic of Moldova in 2002–2003, 53% of the country's children lived in poverty, compared with 43% of the entire population. The country's children face a higher risk of poverty than the overall population and are also more deeply situated beneath the poverty line than are adults. Currently, social transfers given to families with children do not significantly reduce poverty. Poverty and increased family instability have led to a rise in the number of children left without care.

Since the implementation of mandatory health care insurance in 2004, children are insured by the state. Every child is under the supervision and monitoring of a family physician, according to the approved standards for their age. When required, the family physician refers a child to specialized ambulatory medical services and conventional hospital care (outpatient and inpatient) services, as well as to tertiary care. Strengthening primary health care is a priority for the national health system. Both mandatory health care insurance and the strengthening of primary health care can increase children's access to medical care, including access for children from socioeconomically disadvantaged households.

The Government of the Republic of Moldova recognizes the civil, political, social and cultural rights of children and has undertaken many activities in the past decade to safeguard and improve the health and social needs of this sociodemographic group. The current situation, however, calls for further attention, and it is hoped that implementation of the new National Health Policy will contribute to this over the course of its 15-year term.

The following lessons have been learned about how the health system can better meet the needs of children living in poverty in the Republic of Moldova. Through the health system's stewardship role, the existing legislative framework needs to be analysed and, if necessary, laws and policies need to be modified, to ensure that children living in poverty and their families have access to health and social services. Strengthening health service delivery will require increases in the availability of disaggregated data on the health status of children living in poverty and will also require improvements in the quality of primary health care services and interventions that target children and adolescents. Investments in both human resources and

strengthened capacity at the primary health care level are needed. Also, geographical inequities in the service network, as well as financial barriers, further limit the access of disadvantaged children and their families to the health system. Moreover, decreasing the number of uninsured people and financing interventions that will have the largest effect on the bottom of the pyramid – that is, poor children – need to be prioritized.

Socioeconomic and policy context

In the Republic of Moldova, on 1 January 2008, the total registered population was 3 572 703 people, which includes 882 682 children (24.7% of the population). For the purposes of this study and in accordance with the definition given in the United Nations Convention on the Rights of the Child, the use of the word "children" refers to human beings less than 18 years of age. Of these children, 316 276 (35.8%) live in urban areas and another 566 406 (64.2%) live in rural areas (Moldova Statistics, 2008).

After 10 years of continuous and sharp decline, the Moldovan economy started to recover in 2000. Between 2000 and 2006, growth in GDP averaged 5.7% a year. Although inflation receded, it remained in the two-digit range. Also, the national currency remained relatively stable against key foreign currencies. According to the medium-term expenditure framework for 2007–2009, annual growth in GDP is projected to be 6% yearly, based on expectations of growth in the service, industrial and agricultural sectors (Ministry of Finance, 2006).

A salient feature of the Moldovan economic and social situation is the large migration of Moldovan citizens seeking employment opportunities abroad. In 2005, the number of emigrants was 705 500 (Ratha & Xu, 2008). As of mid-2006, about a quarter of the economically active population was employed abroad (IOM, 2007). In 2006, the National Bank of Moldova estimated remittances to be over 35% of the GDP, compared with 31% in 2005. These remittances have contributed significantly to the resumption of economic growth and have mitigated poverty (Government of the Republic of Moldova, 2007a:2).

Poverty in the Republic of Moldova is measured on an annual basis, and measurements are based on Household Budget Survey data from the National Bureau of Statistics. The extreme poverty line is based on the monetary value of a food basket, defined in terms of minimal daily use of calories, amounting to 2282 kcal per person per day (the food basket value is calculated according to the minimum existence level). In 2005, the extreme poverty line amounted to MDL 279 (US$ 22) per month, with about one in six citizens (16%) living in extreme poverty. The absolute poverty line is estimated on the basis of expenditures for total consumption, which raises the value of the food poverty line by supplementing it with nonfood items and services. The absolute poverty line for 2005 was estimated at MDL 354 (US$ 28) per month, with about one in three citizens (29%) living in absolute poverty (Government of the Republic of Moldova, 2007a:99–100). According to the 2005 Household Budget Survey data, 23% of the population lived below the relative poverty line in 2005 (Government of the Republic of Moldova, 2007a:100).

The situation of children living in poverty

UNICEF defines child poverty as "deprivation of the material, spiritual and emotional resources needed to survive, develop and thrive, leaving them [children] unable to enjoy their rights, achieve their full potential or participate as full and equal members of society" (UNICEF, 2005:18). This "suggests that the poverty children experience with their hands, minds and hearts is interrelated" (UNICEF, 2005:18). For example, material poverty leads to malnutrition, which in turn affects a child's health and education, which in turn may impact their long-term development. Children from disadvantaged backgrounds are more likely to do poorly in school and – subsequently, as adults – are more likely to have lower incomes and higher fertility rates and to be less empowered to provide good health care, nutrition, and stimulation to their own children, thus contributing to the intergenerational transmission of disadvantage (Grantham-McGregor et al., 2007). Also, to address the lack of financial resources, children from poor households may be engaged in child labour, which may negatively affect their cognitive and physical development by depriving them of schooling. Children in rich households also may suffer deprivation – for example by living in an environment that gives them little stimulation or emotional support.

The analysis of child poverty makes a very important contribution to poverty-reduction policies. Data reveal that child poverty is more sensitive than adult poverty to unfavourable economic trends. In the period between 2002 and 2003, 53% of the children in the Republic of Moldova lived below the extreme poverty line compared with 43% of the entire impoverished population (IMF, 2006:2–4; Menchini & Redmond, 2006:23–24). The low incomes of many parents – an important contributor

to child poverty – are explained by low salaries and salaries that are paid late. Child poverty in the Republic of Moldova has a prominently *rural face* (Government of the Republic of Moldova, 2007a:102).

The Republic of Moldova's children face a higher risk of impoverishment than do people in the entire population, and that risk is directly proportional to the number of children in the family. Thus, the birth of the second child makes the risk of impoverishment 10% higher than the medium risk level for the country; the birth of the third child makes it 50%; higher; the birth of the fourth child makes it two or three times higher; and so on. Children are also situated more deeply below the poverty line than adults. In 2005, the depth of general poverty was 8.0% and that of children was 10.1% (Government of the Republic of Moldova, 2006; Prohnitchi & Oprunenco, 2006:11).

Parliament approved a new law on social protection, Law No.133-XVI, on 13 June 2008 (Parliament of the Republic of Moldova, 2008). The Law targets the poorest households with cash transfers and provides a method for calculating a family's incomes from all sources and comparing it with the national threshold (Government of the Republic of Moldova, 2008). A family income assessed as being lower than the national threshold thus triggers the monthly cash transfer to the family, to bridge the gap between the real income and the national threshold.

Poverty and increased family instability have led to a rise in the number of children left without care. Research for the report *Institutionalization of children in Moldova and its alternatives* was carried out by IMAS (Institutul de Marketing si Sondaje [Marketing and Studies Institute]) in December 2004 within the Capacity Building in Social Policy Reform project, which was funded by the EU and implemented by the Ministry of Labour and Social Protection in collaboration with the Every Child Consortium (IMAS, 2004). According to the research, children are institutionalized for different reasons: 36% of them because of diseases and disabilities; 27% because of parental poverty; 16% after death of their parents; 8% because of family problems; and 4% because of parental unemployment. It is worth mentioning that some children are institutionalized because of the lack of primary educational institutions in their vicinity (0.2%). Often children are institutionalized when they are left without permanent supervision by parents who leave to work abroad (IMAS, 2004). The research also found that:

- The study participants recognized the family as the optimal environment for a child to develop and perceived that specialists (in institutions) do not have at their disposal the tools and funds needed to simulate this environment.
- The child protection system is not properly oriented towards preventing child abandonment, and little support is given to disadvantaged families to keep their children at home, so the main measure utilized to protect abandoned children is institutionalization.
- System fragmentation and the lack of a legislative framework can create major difficulties in elaborating policies and orienting them towards specialized services that can offer an alternative to institutionalization for children.

Health status and health behaviour of children

Investment in early childhood development can potentially reduce health inequities within a generation (WHO, 2008). Experiences in early childhood (defined as development during the prenatal stage of life to 8 years of age), and in early and later education, lay critical foundations for the entire life-course (Irwin, Siddiqi & Hertzman, 2007). The study of early childhood development shows that brain development is highly sensitive to external influences during this period, with lifelong effects. Good nutrition is crucial and begins in utero with adequately nourished mothers. Mothers and children need a continuum of care from pre-pregnancy, through pregnancy and childbirth, to the early days and years of life (WHO, 2009). A more comprehensive approach to early life is needed, and it should build on existing child survival programmes and extend interventions in early life to include social or emotional development and language or cognitive development (WHO, 2008).

Mother-and-child health in the Republic of Moldova, as well as the prevention of HIV/AIDS, sexually transmitted diseases and TB, are priority areas in developing national programmes, their implementation being set as an objective in the Economic Growth and Poverty Reduction Strategy (Government of the Republic of Moldova, 2007a). Also, national health policies are increasingly acknowledging the need for a life-course approach to addressing noncommunicable diseases, given their disproportionate share of the burden of disease in the Republic of Moldova.

Indicators of child health have improved recently in the Republic of Moldova. Following a considerable decrease in infant mortality for the period 2000–2004, the rate of decrease slowed down. While the infant mortality rate was 12.2 deaths per 1000 live births in 2004, it grew insignificantly in 2005, to 12.4 deaths per 1000 live births, and then decreased to 11.8 deaths per 1000 live births in 2006. Thus, the objective set in the MDGs to reduce this indicator to 12.1 deaths per 1000 live births

in 2006 was reached (UNDP, 2003; Ministry of Health, 2005:18). The perinatal mortality rate also decreased in 2006, to 10.4 deaths per 1000 live births, compared with 11.5 deaths per 1000 live births in 2005. Although efforts made over the last few years have improved the situation and made it slightly better than in other NIS countries (14.1 deaths per 1000 live births), the infant mortality indicator is still high in comparison with that of EU countries (8.8 deaths per 1000 live births) (Ministry of Health, 2006:18–20).

Of the total number of deaths registered in children younger than 1 year of age, 78% took place in hospitals, while 22% took place outside hospitals (Ministry of Health, 2006:18–20). According to UNICEF data, the high rate of infant mortality at home is caused by parents' insufficient knowledge of how to supervise children in the family, including failure to recognize signs of disease and to seek timely health care. The structure of infant mortality for 2006 shows a continuing prevalence of perinatal diseases (33.3%), congenital malformations (30.3%), respiratory diseases (18.3%), infectious diseases (3.2%), diseases of the nervous system (1.6%) and others (5.6%). Also, the rate of infant death due to traumatic injuries and poisonings has stabilized at 7.7% (Ministry of Health, 2006:18–20).

Since 2003, mortality in children younger than 5 years of age has decreased, the indicator declining to 14 deaths per 1000 live births in 2006 (Ministry of Health, 2006:18–20). Although the situation is slightly better than in other NIS countries (18.1 deaths per 1000 live births in 2004), due to efforts undertaken, the indicator is still high in comparison with EU countries (10.4 deaths per 1000 live births in 2005). In 2006 the mortality rate of children under 5 years of age was higher in rural communities (14.6 deaths per 1000 live births) than in urban communities (13 deaths per 1000 live births).

Noncommunicable diseases are of increasing concern in the Republic of Moldova. Diseases of the circulatory system, digestive system and cancer are the main causes reported for adult mortality. Also, risk factors associated with lifestyle are prevalent. According to the Ministry of Health, about 46% of males and 28% of females smoked in 2006. The standardized rate of mortality caused by diseases conditioned by smoking in 2004 in the Republic of Moldova was twice the average for the European Region (Ministry Press Service, 2007). As a good deal of adult health is rooted in childhood and adolescence, efforts are underway to increase health literacy and healthy behaviour among this young age group. For example, the Centre of Primary Health Care of the State University of Medicine and Pharmacy "Nicolae Testemitanu", in Chisinau, studied the attitudes of high school youth towards smoking, with the aim of defining tactics and messages to promote a healthier lifestyle and discourage smoking. The study found that the majority of those questioned tried smoking between the ages of 14 and 15 years. During the month before the study began, 61% of those questioned had not smoked a single cigarette, while 16% were smoking up to 5 cigarettes a day and another 12% up to 10 cigarettes a day. A third of respondents had bought the cigarettes in stores without any obstacles, evidence of a weakly enforced law. The study also highlighted the particular vulnerability of youth from low-income households to smoking and other unhealthy behaviour. As a result of this study, an antismoking campaign was initiated.

Health system

During the period 2004–2006, the health system underwent substantial reform. This included extension of the network for primary health care, the introduction of mandatory health care insurance (children and pregnant women are insured by the state and receive fully subsidized health insurance) and an increase in state budget contributions. Currently, about 75% of the Republic of Moldova's population is covered by health care insurance, and more than 80% of the population has access to family doctors. The Ministry of Health has developed the National Health Policy and the Health Care System Development Strategy for 2008–2017 (Ministry of Health, 2007a:72, 2007b), which were approved and adopted by the government in 2007. The primary objectives of these are to improve access to (and the quality of) health services, to use financial resources more efficiently, and to guarantee and develop primary health care.

Interventions that benefit children living in poverty

In recent years, child and maternal mortality have decreased. This is due to improved access to maternal and child health care and to improved health care quality. Medicine is provided free of charge – and is paid from the state budget – to children under 5 years of age for treatment of most general disorders and to pregnant women for prevention and treatment of anaemia (iron and folic acid preparations) as outpatients. The Standards for Supervision of Pregnant Women and Children as Outpatients, the Health Child Development Card and the Quality Standards of Youth Friendly Health Care Services were established to improve services provided to children and adolescents at the primary care level.

In 2006, the National Communication Campaign "Pentru un Fat Frumos si Sanatos" (For a Sound and Fair Infant) was initiated and subsequently appeared to significantly contribute to improving access to maternal health services. The data collected in the *rayons* (districts) of the country show that, during 2006, the number of pregnant women registered for pregnancy health care prior to their 12th week of pregnancy increased up to 81%, compared with 69% in 2005. In 2006, about 88% of pregnant women took iron supplements, compared with 62% in 2005; in 2006, 76% of pregnant women took a folic acid preparation, compared with 32% in 2005; and in 2006, 91% of pregnant women were aware of danger signs during pregnancy, as compared with 59% in 2005.

While the above-mentioned interventions have contributed to improving child and adolescent health in the Republic of Moldova during the past decade, this section focuses (for the purpose of this case study) on mandatory health insurance and strengthening primary health care to address inequities in health system access, including access by children. It also presents how the new National Health Policy aims to address the health needs of children living in poverty.

Since the implementation of mandatory health insurance in 2004, children are insured by the state. Every child is under the supervision and monitoring of a family physician, according to the approved standards for their age. When required, the family physician refers a child to specialized ambulatory medical services and conventional hospital care (outpatient and inpatient) services, as well as to tertiary care.

The National Health Insurance Company (NHIC) was founded as an independent body in September 2001, to act as a single purchaser of health services in the Republic of Moldova. It is answerable to the government, and a parliamentary representative is its chairperson. By law, the NHIC is a state agency with an administrative council, executive board and control commission.

Coverage by the social health insurance scheme managed by NHIC is compulsory for employees in all sectors. For people employed in 2008, 3% of their payroll tax was deducted and another 3% was deducted from their employers. But this makes up only 35% of NHIC's funds. Contributions from the central government budget to the mandatory health insurance fund constitute a relatively large proportion of overall contributions (65.5%); these contributions are aimed at insuring specific groups of non-contributors – such as children, students in full-time vocational or higher education, postgraduate students in mandatory study programmes, officially registered unemployed people, pregnant women and those in postpartum care, and pensioners (Government of the Republic of Moldova, 2007a:14).

Serious challenges, however, remain for providing health coverage and financial protection. While ensuring coverage of the whole population has been a key aim of the implementation of mandatory social health insurance, some vulnerable population groups, especially people with low incomes, are not covered through payroll or government transfers. Self-employed people can join the system on a voluntary basis, but ensuring payments from them presents difficulties. The number of self-employed (individual farmers and individual entrepreneurs in the service sector and in small commerce) was estimated to be 33% of the working age population permanently living in the country in 2005, which is a very high proportion of the general population. Only 7.5% of self-employed people bought mandatory social health insurance policies in 2005. Hence, the challenge facing Moldovan policy-makers is to develop a mechanism for extending NHIC coverage to the currently uninsured – as a means of securing equitable protection against financial risk – to make social health insurance coverage universal.

Currently, about 75% of the Republic of Moldova's population is covered by health care insurance. The estimated 25% that is not covered resides mainly in rural areas and has no adequate access to health care services due to financial difficulties and lack of transportation (Ministry of Health, 2006). This group is at higher risk of incurring catastrophic out-of-pocket expenditures for health care, which can increase child poverty at the household level. The Government of Moldova, with support from the WHO Regional Office for Europe, is currently analysing levels of catastrophic health expenditures among this group and is working to develop a strategy to incorporate the uninsured into the mandatory health insurance programme (Matt Jowett, Senior Health Financing Specialist, WHO Regional Office for Europe, personal communication, November 2008).

As highlighted above, there are significant gaps in health insurance coverage and access between rural and urban areas. In rural areas, a poor household spends 28 times less for health care services than does a prosperous one (National Budget Survey, unpublished data, 2005). In addition, a prosperous family from an urban area spends about MDL 27 (US$ 2.10) every month for health care, while in rural areas a prosperous family spends only MDL 3 (US$ 0.23) every month. Uninsured people, however, may benefit from minimal health care provided free of charge by the state, which includes services provided by national programmes, consultations with family doctors and life-saving treatment.

In the pre-project stage of the World Bank Health Services and Social Assistance Project, the feasibility study master plan for infrastructure and human resources for primary health care (Ciurea, 2007) ascertained that 49% of primary health care facilities were built before 1980. 39% do not fulfil seismic-safety requirements, 80% have no connection to the sewage and water systems, 30% have no family doctors, and the confirmed availability of family doctors in some *rayons* is only 50–60% (Ababii et al., 2008). Also, many primary health care institutions operate in deteriorated premises and need funds for repair or relocation. Moreover, only 91 of the 979 primary health care institutions have new health care vehicles. When combined with low salaries for medical staff, all these factors contribute to problems in delivering adequate primary health care (Ciurea, 2007; Ababii et al., 2008).

Another problem is coverage in rural areas by family physicians. Because of social and material circumstances, it is difficult to attract doctors to rural areas and retain them there. According to the Ministry of Health annual report for 2007, the number of family physicians per 10 000 population was considerably lower in rural areas than in urban areas (Ababii et al., 2008). Based on the norm of 1500 people to a family doctor, the average for urban areas in 2007 was 6.9 family doctors per 10 000 population. In Chisinau and Balti for that year, it was 7.0 and 6.6 family doctors per 10 000 population, respectively. In the *rayons*, the number of family doctors per 10 000 population was 3.9 in Leova, 3.4 in Rezina, 2.9 in Hincesti, 2.8 in Cantemir and 2.5 in Cimislia. Thus, in some cases, one family doctor serves between 5000 and 7000 people, and these are dispersed between 5 and 6 villages. To improve this situation and create incentives for medical personnel to work in rural areas, the Law of Health Protection was enacted with stipulations about benefits, such as free living accommodation, compensation for a portion of housing expenditures, and an employment allowance of 30 000 MDL (US$ 2300) for doctors and 24 000 MDL (US$ 1840) for nurses going to work in rural areas after graduation (Government of the Republic of Moldova, 2007b).

An analysis of available data suggests that clear links exist between levels of poverty and health outcomes for children in the Republic of Moldova. The analysis also confirms the role of the state-run health care system in reducing health disparities among children. Because of the particularly high reliance of children on functioning state-run health services, the Republic of Moldova needs policies that focus on improving access to affordable, quality service. Health budgets and health reform efforts therefore need to be monitored to ensure funds are used to reduce health disparities and to ensure efforts are being made to improve the level and quality of health care (UNICEF, 2006:41–48).

Two areas of public expenditure are particularly important to children's development and can help advance the realization of children's rights and address inequities: namely, health and education. For 2004, WHO estimates put Moldovan public health expenditure at 4.2% and total health expenditure at 7.4% of GDP, which is close to the average for the WHO European Region and demonstrates an increase from previous years. For countries of the NIS, the total health expenditure as a percentage of the GDP is high and is increasing at a faster pace than elsewhere in the WHO European Region. However, in terms of PPP, the health expenditure in the Republic of Moldova is one of the lowest in the WHO European Region, and it is significantly lower than the average for countries of the NIS (Atun et al., 2008).

The combination of unfinished health and education reforms and continuing low levels of public expenditure and investment in these areas mean that, despite the correlations in patterns of income and non-income measurements of poverty among children, it is important not to rely solely on results for income poverty as the measure of child well-being. Child well-being depends not just on the presence of more income resources, but depends also on parental and governmental decisions on how to allocate resources. Even where parents do want to invest in children, a lack of well-functioning health or education services or utility infrastructure can hinder such investment.

Noting the aforementioned challenges and opportunities, work to improve the health of children living in poverty still remains to:

- continue efforts to reach uninsured households, to reduce catastrophic health expenditures that exacerbate child poverty;
- continue efforts to strengthen primary health care, including such care in communities with higher rates of poverty and rural areas with geographical barriers to accessing services, to include a life-course approach to high-quality health promotion, disease prevention and integrated disease management services, while also serving as a platform for intersectoral and interdisciplinary cooperation on the determinants of health; and
- increase public expenditure on initiatives to improve the access of children and their parents to a comprehensive range of quality social services that will facilitate breaking the transgenerational transfer of poverty (and, within this context, consider early childhood development interventions).

The Government of the Republic of Moldova recognizes the civil, political, social and cultural rights of children and has undertaken many activities in the past decade to safeguard and improve the health and social needs of children living in poverty. In 2007, it approved the National Health Policy (Ministry of Health, 2007b). This Policy represents a set of priorities

and lines of development in the health sector, many of which promise to address the needs identified above.

The Policy was established by political will, for a term of 15 years, to strengthen the population's health and reduce the inequalities between different social groups and regions in the country (Ministry of Health, 2007b:9–12). The goals of the National Health Policy are to create optimal prerequisites for the maximum realization of the health potential of every individual throughout their entire life and to attain adequate life standards for the population. The goals of the National Health Policy most relevant to improving the health of children living in poverty are as follows:

- to ensure the economic and social security of the population
- to ensure a healthy start in life
- to maintain the health of the country's young people
- to create a healthy and safe environment
- to provide rational nutrition and increase physical activity
- to achieve better performance of the health protection system.

The principles and ways of achieving these and the other Policy goals are through:

- a commitment by the state
- intersectoral action
- equality and solidarity
- sustainable financing and the generation of resources
- decentralization of responsibilities
- community involvement and interaction.

Lessons learned

This section sets forth the author's analysis of how the health system in the Republic of Moldova can improve the health of socioeconomically disadvantaged children.

Stewardship

Within the stewardship function, the author proposes that the health system can take action in the following nine areas.

1. **Clarify roles and financing streams.** To address the problems related to children's poverty and to ensure sustainability, the role of government engagement, the implications of this role for central and local authorities, and the means of providing financing streams need to be clarified.

2. **Modify the legislative framework and improve policy coordination.** To ensure that children living in poverty have access to social assistance and universal and equitable access to education and health services, laws and policies need to be reviewed and, if necessary, modified. In addition, performance standards and monitoring mechanisms are required for the provision of services and for collaboration and complementary action among the private, nongovernmental and public sectors.

3. **Oversee a comprehensive health system.** Safeguarding the health of children requires the existence of a functioning system of essential health care at the primary, secondary and tertiary levels. Planning at the national level for child health will have to cover sustainable financing mechanisms, human resources, quality in service provision and the use of services.

4. **Focus on the bottom of the pyramid.** Experience has shown that even in low-income settings, innovative country-specific approaches can reduce mother-and-child mortality. The challenge now is to prioritize and formulate a way to provide health services accessible to poor children in greatest need, in keeping with national and international goals, such as the MDGs. Prioritization of meeting the needs of disadvantaged children should be reflected in health-sector reforms and sector-wide approaches.

5. **Include all stakeholders in setting priorities.** The process of setting priorities must involve multiple stakeholders from

government, including social agencies, professional associations, NGOs and other sectors of civil society. Bringing together stakeholders will help to build a broad consensus, encourage collaboration and increase the probability that interventions will be successful. Stakeholders must carefully balance cost–effectiveness with equity and consider the need to invest more to reach poor and underserved groups.

6. **Ensure that health policies focus on youth.** Health policies should take into account the specific needs of children and adolescents, both through youth-friendly services and through the creation of social environments that are conducive to health-promoting behaviour among youth. Policies should aim to reduce health gaps (also reaching low-income children), facilitate a participatory approach that will result in interventions that resonate with youth culture, include mechanisms and resources to engage other sectors and civil society, and be backed by legislation that acts on determinants of health. For example, increasing cigarette prices (through taxes) is a proven means of decreasing cigarette smoking, especially among children, as smoking among children will fall by about twice as much as smoking among adults (Chaloupka et al., 2000). In addition, restrictions should be imposed on cigarette advertising and promotional messages that target youth.

7. **Address violence and trafficking.** Children from socioeconomically disadvantaged households face a greater risk of being victims of interpersonal violence. Violence against children, in its many forms, has an effect on their immediate and long-term health, and must be addressed through comprehensive action. Trafficking of children is also a serious problem that has to be addressed through coordinated efforts.

8. **Improve the quality of medical services.** Decentralized planning and those responsible for health-sector reforms need to facilitate system-wide adoption of good practices, including those benefiting children. Potential actions include conducting strategic planning for, and involving health professionals and managers in, assessing the current quality of care and determining the best way to improve quality within existing resource constraints. In addition, formulating, adopting and monitoring standards for clinical practice in the private and public sectors, and promoting the sharing of lessons learned within and between countries, could be useful.

9. **Collect data and make it available.** The national health system and service providers lack sufficient information about children living in poverty. They also have very little data disaggregated by socioeconomic status. Such information is required to ensure that universal interventions meet the needs of the children who most need them and to provide the rationale for introducing targeted measures within universal care, as required.

Resource generation

Within the realm of resource generation, the author proposes that the health system can take actions, including the following two.

1. **Invest in primary health care capacity.** Several urgent actions need to be taken to strengthen primary health care. These include improving the provision of equipment, drugs and supplies, and adequate skilled human resources. Central to reducing child morbidity and mortality, including perinatal mortality, are skilled health personnel, especially at the primary health care level and in rural areas.

2. **Strengthen human resources.** In the Republic of Moldova, inadequate human resources are a major barrier to improving the accessibility and quality of care, resulting in children being adversely affected. Weaknesses include the severe shortage of medical personnel (also due to emigration), inadequate skills of available personnel, rapid turnover and loss of skilled workers, and the inefficient use and distribution of those who are already in the system. Low salaries and poor working conditions are root causes of poor performance and high turnover of health care professionals (Ciurea, 2007; Atun et al., 2008). Strategic planning for building and retaining an appropriately skilled health workforce is crucial to progress in health care for the target group, as is creating conditions for health workers to realize their full potential and motivating them to work with the poorest population groups. International cooperation on the migration of health professionals could also be beneficial, so that it is characterized by fair and equitable recruitment practices and guided by a code of practice (Buchan, 2008).

Service delivery

According to the author, three actions relevant to health system service delivery could significantly improve access by disadvantaged children.

1. **Access to health care services.** Problems faced by poor and other disadvantaged children in accessing health services

include (but are not limited to) geographical distance from services, lack of transport and cost of services (such as informal payments and lack of insurance). There is a need to increase analysis of access barriers and ensure that the provider network addresses the geographical and financial accessibility and availability of health services.

2. **Use a holistic approach to services.** Intersectoral collaboration and referral are needed increasingly to address the complex health and developmental problems disadvantaged children may have, as well as addressing some socioeconomic determinants. The health system in the Republic of Moldova needs to ensure a holistic approach to services, thus involving health-promotion, disease-prevention and integrated disease-management programmes, as well as ensuring coordination among a variety of providers, sectors, institutions and settings (WHO Regional Office for Europe, 2008).

3. **Other service usage obstacles.** For other reasons, including social and cultural reasons, some people do not use the health services provided, particularly prophylactic or preventive services. Identifying and overcoming obstacles of this type require working with children and their parents or relatives to better understand their needs, analyse problems and find acceptable solutions.

Financing

The author suggests that the following four aspects of health system financing could be beneficial in addressing the needs of children living in poverty.

1. **Protection against the financial risk of using care.** Health systems have to ensure that ill health and the use of health services do not impoverish disadvantaged children and their families. Thus, financial arrangements should sustain the redistribution of resources to meet health needs, reduce financial barriers to the use of needed services and protect the poorest against the financial risk of using care (WHO Regional Office for Europe, 2008).

2. **Coordination and monitoring of aid and financing mechanisms.** Monitoring is needed for health-sector financial reforms, sector-wide financial approaches and the implementation of other financial mechanisms – such as poverty-reduction strategy papers, cost sharing and direct budget support – to ensure that they benefit the poor and other socioeconomically marginalized groups. Some major new sources of health-sector funding – including the World Bank, the EU and the Global Fund – provide an opportunity to streamline the pro-equity agenda and social protection through health system actions, rather than funding specific fragmented interventions. It is important to ensure that these developments contribute to building sustainable health-system capacity and provide children living in poverty with access to health services.

3. **Prioritization in relation to need.** Financing mechanisms should foster good quality, comprehensive health services and progress towards universal access. In the Republic of Moldova, the financing of primary health care is based on capitation, without adjustments for risks, such as age and likelihood of illness. Therefore, funds should be prioritized to the family doctors that have more children on their lists. For institutionalized children, children without parents and other socioeconomically disadvantaged groups, the highest possible financing is needed to motivate medical personnel to work with these groups.

4. **Financial design for disadvantaged groups.** Financial arrangements should also provide incentives for the efficient organization and delivery of health services, link the allocation of resources to providers on the basis of their performance and the needs of those most in need, and promote accountability and transparency in the use of funds (WHO Regional Office for Europe, 2008). Where new mechanisms of financing are introduced, they should be designed to facilitate poor children's and other disadvantaged groups' access to services, to provide monitoring of the effects of such financial policies and to allow such mechanisms to be adapted to local conditions.

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15. Romania: controlling TB among the Roma – a community approach

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Summary

According to UNDP estimates, about 2.5 million Roma live in Romania, although the 2002 census only reported 535 140. The difference might be explained by existing stigmatization that leads some Roma to declare themselves as non-Roma or by their desire to be integrated as Romanians. Currently, Roma are among the poorest and most disenfranchised people in Romania; most poverty-related social programmes do not reach Roma communities, and their problems are rarely documented. Although limited in scope, existing data for key health indicators suggest significant disparities between Roma and the majority Romanian population.

TB is a resurging and growing public health threat in Romania, a problem that also affects Roma disproportionately, as do many other diseases. TB rates have been rising since the late 1980s, culminating in 2002 in 30 985 notifiable cases of the disease (142.2 cases per 100 000 population). Although the incidence of the disease has been declining since 2004, mortality from TB has risen. Also, although Romania has shown some consistent effort in reducing the burden of TB, by adopting the directly observed treatment short-course strategy in 1998 and expanding the strategy coverage to 100%, a number of challenges still exist. The marginalization of poor and ethnic minorities, such as Roma, has led to self-administration of treatment, resulting in higher mortality, treatment default and failure rates. This case study highlights one approach that was successful in increasing TB-related knowledge and encouraging timely detection of cases and completion of treatment in Roma communities.

Using a knowledge attitude practice survey and other data, the Ministry of Public Health and the international health and human rights organization HealthRight International [1] crafted a community-based information, education, and communication campaign to:

- expand knowledge about TB in vulnerable groups and Roma in Bucharest, Ilfov and Neamt counties;
- reduce the stigma of (and negative attitudes towards) TB within these groups; and
- increase the detection of cases and adherence to treatment for TB.

The target of the campaign was to reach 16 000 people, Roma and other community members, living in conditions that may increase their chances of acquiring TB. The community-based information, education, and communication campaign involved

[1] HealthRight International was known as Doctors of the World-USA from 1990 to February 2009

the recruitment and training of 40 peer health educators (representatives from the Roma community itself), the development of educational messages and materials, and the delivery of educational sessions within the community by the most qualified peer health educators. All the health services promoted during the project were offered within the Romanian public health system.

The programme was officially launched in May 2005 in the cities of Bucharest and Piatra Neamt, with community-based sessions implemented in three communities from August to November 2005. Overall, 24 peer health educators carried out 480 education sessions, reaching 11 530 people. The programme was thoroughly evaluated, using a pre-experimental, static group design. The comparison between populations exposed (experimental group) and non-exposed (control group) to an information, education, and communication intervention revealed that exposed respondents are better informed than non-exposed respondents about treatment for (and the transmission of) TB and that they are more likely than the non-exposed population to behave in an appropriate way if they had TB. When the project ended, the Ministry of Public Health took over the financing of the targeted health promotion, as well as some of the skilled peer health educators as Roma health mediators, thereby moving towards sustainability.

Socioeconomic and policy context

Since 1991, Romania has been facing the challenge of changing from a communist regime to a democracy and market economy and is currently adjusting to its new status as an EU Member State. Despite a rapidly growing economy, poverty remains a problem for many Romanians, with 14% of the population surviving on less than US$ 2.50 per day. The GDP per person in 2007 was US$ 10 152, which represents an improvement from 2003, when it was US$ 7140 (WHO Regional Office for Europe, 2007). Poverty and social disparities induce health inequalities, such as a high incidence of TB, a high number of children with low birth weight, and a high rate of child-and-mother anaemia among low socioeconomic groups.

Demographic trends since 1989 show a continual decline in population. Between the 1992 and 2002 censuses, a 4.9% decline in the population was recorded, from 22.81 million inhabitants to 21.69 million. The decline was due to emigration, a decrease in the birth rate and an increase in mortality. Also, about 55% of the Romanian population is urban.

According to the UNDP *2003–2005 national human development report for Romania*, the poverty rate was 25.1% in 2003 and the severe poverty rate was 8.6%, as compared with 35.9% and 13.8%, respectively, in 2000 (UNDP, 2005). The urban poverty rate was 13.8%, while the rural poverty rate was 38.0% (UNDP, 2005). The poverty rate increased during the period of recession (1996–1999), reaching its peak in 2000. The robust GDP growth that started in 2000 was accompanied by a decline in poverty. Also, the MDG Report for 2003 shows the total enrolment rate in primary education to be 97%, being a bit lower (95.2%) in rural areas (United Nations System in Romania & Government of Romania, 2003). In 2006, the unemployment rate was 5.6% (National Institute of Statistics, 2007b).

During the period between the Second World War and the early 1990s, the Romanian health system provided universal health coverage through government financing, central planning and management, and a state monopoly of health services. During this period, primary health care was provided mainly by dispensaries, which were part of the hospital system. Due to the nationalized economy, health care was characterized by the absence of a private sector as well as by all professionals in health care being salaried civil servants. Constant underfunding and bad management led to demands for health reform, which came about after the collapse of the government in 1991, when the system began the transition from a centrally planned state system to a more decentralized health insurance system. Some elements of the privatized system in Romania are a free choice of physicians, the general practitioner's role as gatekeeper and manager of his practice, privatization of medical institutions, and the introduction of a national health insurance system (Bara, van den Heuvel & Maarse, 2002).

Some historical considerations about Roma in Romania might help to explain the difficulties in defining or delimiting the Roma groups. In the nineteenth century, the Roma population was classified in two groups: nomads and sedentary (settled). Later, more of the nomadic group settled in rural areas and became farmers, which led to a gradual loss of language and cultural practices. At the end of the nineteenth century, part of the rural Roma population migrated to urban areas, settling at the periphery of cities.

In the last half of the 1900s, the country's communist regime did not encourage its citizens to identify with a minority ethnic group. The regime forced nomadic Roma to settle down, resulting in shifts in their lifestyle and culture, and nomads almost disappeared. In the post-communist period, however, their status as an ethnic minority was officially recognized. The transition

period offered the opportunity to develop new ethnic policies and positive measures against discrimination, in contrast to the socioeconomic policies of the previous communist regime.

The total population for Romania at mid-year 2005 was estimated to be 21 623 848 people (WHO Regional Office for Europe, 2007). The Roma population, one of several minority ethnic groups in Romania, is estimated anecdotally to number between 1.8 million and 2.5 million people. The 2002 census, however, revealed only 535 140 people, but these official data have to be considered in the context that belonging to the Roma community is still linked to stigmatization. Also, with increasing integration, many Roma do not identify themselves as a minority group.

The Roma demographic profile is dominated by young adults, due to the high mortality and fertility rates of Roma, compared with the rest of the population. An important characteristic of Roma families is the extended family, where several family nuclei live within the same household.

The health status of the Roma population is still difficult to assess, due to the lack of disaggregation of health data by ethnic affiliation. The Roma self-perception of their health was investigated through a number of studies, which concluded that 72.5% of the Roma population do not claim any health problems, 11.2% claim minor problems, 14.0% perceive serious health problems and 2.3% declare themselves to be handicapped people. A study of Roma health status (Cace & Vladescu, 2004), based also on questionnaires applied to a national sample, showed similar percentages: 55% of the adults considered themselves to be in good or very good health, while 20.4% considered their health to be neither good nor bad. When compared with the perceptions at the national level, the Roma are more optimistic about their health status.

The *Reproductive health survey: Romania 2004* (Ministry of Health et al., 2005) revealed that only 50.1% of Roma men and 53.1% of Roma women had health insurance, compared with 79.3% of men and 84% of women in the general population. The same survey investigated the use of selected health facilities within one year; some results are presented in Table 15.1. In comparison with the general population, the Roma tended to use health services less frequently, indicating lower access to health facilities.

Table 15.1. Percentage of people with access to selected health facilities

Ethnic affiliation by gender	Access to selected health facilities (in per cent)				
	Family physician	Specialized ambulatory care	Hospital	Ambulance	Dental services
Male					
Romanian	57.6	31.3	14.2	2.4	19.6
Roma	45.8	19.5	11.4	4.1	9.5
Female					
Romanian	66.9	35.7	15.3	3.2	32.4
Roma	55.2	17.0	26.0	11.0	11.9

Source: Ministry of Health et al. (2005).

The Ministry of Public Health and the international health community consider TB to be a resurging and growing public health threat in Romania, a problem that also affects Roma disproportionately. Since the late 1980s, the country has faced a steady increase in the incidence of TB, culminating in 2002 in 30 985 notifiable cases of the disease (142.2 cases per 100 000 population). Also, researchers in Romania report that in 2000, the countrywide incidence of TB was 112.4 cases per 100 000 population, as opposed to 163.9 cases per 100 000 populations in Bucharest's Sector V, a neighborhood that is primarily Roma (Didilescu et al., 2001). Since 2004, the incidence of the disease has been declining, though mortality from TB has risen from 6.9 deaths per 100 000 population in 1990 to 9.6 deaths per 100 000 population in 2004.

Homelessness and vulnerability to forced evictions, overcrowded living conditions and a lack of access to safe water and adequate sanitation are problems that affect the Roma disproportionately. Other factors that lead to inequalities in health are: low levels of education; poor nutrition; poor communication between health professionals and Roma health system users; lack of access to information on health issues; and lack of identity cards and documentation, which precludes access to health insurance.

Figures for the percentage of Roma population covered by the country's health insurance scheme vary from 70% (UNDP & Center for Health Policies and Services, 2004) to 84% (Cace & Vladescu, 2004). With regard to coverage, registering with a

family doctor is important for two reasons: it indicates that either people are contributing to the social health insurance fund or they do not contribute, but are still entitled to health benefits under to the Minimum Guaranteed Income Law (Parliament, 2001). According to the Law, there is a minimum salary that any employer must guarantee. That level also represents the level of the minimum guaranteed income that a person can receive if they can prove that they have no other income or have an income below that level. The Minimum Guaranteed Income Law was introduced to improve the social protection of all vulnerable groups and was intended to tackle poverty. In both cases, people have access to the entire range of health care services.

Barriers that affect Roma access to health services include the following.

- **Lack of insured status.** Access is limited to emergency health services and chronic diseases, and there is no access to free or reimbursed drugs.
- **Lack of identity documents.** This is an impediment to access to health services and social assistance.
- **Poverty.** This impedes some of the Roma from visiting doctors, because they are unable to afford the secondary costs related to clinic visits, such as bus fares and/or days lost from work. The inability to make informal payments to providers is also a factor – 35% of the general population has offered gifts or unofficial payments for the medical services they received (Center for Politics and Health Care Services, 2002).
- **Discrimination and attitudes of certain medical representatives towards Roma.** Laws and regulations explicitly condemn such attitudes, but there is no system in place to identify (and impose sanctions for) discrimination.

Until 2002, health interventions that targeted Roma populations were isolated and unintegrated. To address these shortcomings, a local Roma NGO, Romani CRISS, introduced the health mediator model, which was made into an official profession within the Romanian public health system in 2002 by the Ministry of Public Health. As a result, mediator-led projects increased Roma access to health care services. Project activities varied from direct delivery of services to health promotion and health education.

The health mediators are recruited from local Roma populations and receive training in health care promotion; they then work with local communities to encourage healthy behaviour and to raise awareness about (and encourage use of) available health care services. As of 2007, the Ministry of Public Health had hired roughly 250 health mediators in Romania. The health mediator initiative is entirely supported by the Ministry of Public Health in partnership with local health authorities, and it has resulted in improved coverage of medical services in Roma communities.

Programme benefiting the target population group

Taking into account that Roma belong to a hard-to-reach group at greater risk for TB, the overall objective of the specific intervention in TB was to increase Roma community members' knowledge of TB and the services available to deal with it. This would contribute to recognizing the symptoms and detecting the disease earlier, to adherence to treatment and, ultimately, to improving treatment outcomes. By this measure, a two-pronged approach to improved access to specialized health care services focused on (a) training providers in better communication skills for greater sensitivity towards Roma culture and (b) a community based education campaign to increase community knowledge of TB. To address barriers Roma face in accessing health services and to address underlying factors that result from their minority status, an advocacy component for better understanding various laws and statutes associated with health and social services was integrated into the project.

HealthRight International partnered with the Ministry of Public Health and the National TB Control Program to implement the project Tuberculosis Control among the Roma in Romania: a Community Approach. Funding for this project was provided by the United States Agency for International Development (USAID) and OSI. This project aimed to strengthen the implementation of the TB directly observed treatment short-course strategy in Roma communities. HealthRight International collaborated closely with the national government and county partners to ensure sustainability of the results, by integrating a number of initiatives into national policies and TB control practices and by the planned transfer of all master copies of its prolific products.

The main objectives of the project were to:

- assess and improve Roma knowledge of community health issues, TB in particular;
- facilitate increased Roma access to public health services;
- build advocacy capacity, by developing skills and mobilizing networks of stakeholders, both from Roma communities and government and other authorities; and
- develop advocacy strategies that will create a more enabling environment for Roma health.

The project, implemented within the framework of a broader three-year TB control programme (with USAID as the primary donor), focused on the development and implementation of a national health education strategy for TB control. It sought to broaden the impact of HealthRight International's TB health education activities within Roma communities, by supporting several levels of Roma participation in health promotion activities.

The main project sites were Bucharest, Constanta, Ilfov and Neamt counties, which comprise about 16% (National Institute of Statistics, 2007a) of the Romanian population and 17.7% of its TB burden (National TB Control Program, 2006).

The project reached 11 530 beneficiaries with community-based TB education. In addition to education, the project identified people suspected of having TB and provided treatment support to patients, and/or their families, to encourage adherence or testing of family members. As a direct result of this project, a total of 607 community members with symptoms of TB were evaluated for the disease and 49 (8.1%) new cases were identified. An additional 450 contacts were referred for evaluation, and 69 individuals were accompanied to see a medical provider.

The financial resources required were secured from two main sources: (a) the Ministry of Public Health, through the National TB Control Program, supported diagnosis and treatment, as well as the cost of health professionals involved; and (b) USAID and OSI, through HealthRight International, supported training of peer health educators (PHEs) and health professionals, elaboration and dissemination of information, education and communication materials, and project management staff. All necessary health services were provided by the health system through a specialized network of TB specialists and laboratories, as well as through local family doctors.

The PHEs were selected from local Roma communities and were trained to provide information and new skills to the beneficiaries. At the end of the project, some PHEs were also hired as Roma health mediators. The Roma health mediators are employees of the Ministry of Public Health, and their main role is to foster mutual trust between the public health authorities and Roma communities, by facilitating communication between members of the community and medical staff. At the level of policy-making and stewardship, the project provided important feedback and input for adapting and reshaping the National Tuberculosis Control Programme.

At its start, the planning process for the project defined TB baseline knowledge, attitudes and practices among 153 Roma in Bucharest, Ilfov and Neamt counties. The research found the following.

- Just over half the people surveyed had heard of TB.
- Only 15–30% could recall symptoms of TB.
- Half did not know that TB was contagious.
- Of the respondents, 43% did not know that TB could be treated.
- A third of the respondents believed that TB could be transmitted through food or objects.
- Fear of losing work was an overwhelming reason not to disclose TB status (> 70%), with social isolation a close second (> 50% avoided visiting acquaintances with TB).
- Less than half would tell their families of their disease status, as they were subjected to pity, avoidance and rejection.

The project continued with a rigorous mapping of the communities, to identify potential sites appropriate for project intervention, such as those with a large population of Roma with little access to health services. To gain access, HealthRight International did substantial legwork and made substantial efforts to develop trust. The educational campaign was supported by a variety of

informative, educational materials in various media (such as print and video), which were pretested on the target audiences. During the filming of a video, the team found the face of the Roma for the larger media campaign, Mr. Busuioc, whose picture was also featured on other project materials (see Fig. 15.1), as well as in a *Lancet* medical journal article (Sepkowitz, 2006). Mr Busuioc is a cured Roma TB patient who was recruited to serve as a spokesperson for the importance of completing TB treatment. He was chosen to represent the campaign after he was interviewed for the TB education film and proved to be open and charismatic when speaking about TB.

Fig. 15.1. Information, education, and communication materials: manual, posters, brochures

Source: HealthRight International (2005). Reproduced with the permission of the copyright holder.

A significant result of the project is the development of a Roma TB information, education, and communication kit, based on the materials developed. The kit's master materials and design, as well as 200 copies, were provided to the Ministry of Public Health for its work with Roma health mediators.

From targeted Roma communities, 40 PHEs were selected and trained. Of those 40, 28 who demonstrated appropriate skills and commitment were retained to lead peer education activities in their communities.

The peer health educators (PHE) training curriculum was developed through a process of consultation and feedback, as was the script for the PHE-led community education sessions. In general, the sessions consisted of about 20 community members being shown a film, followed by discussion (facilitated by the PHEs) of different prevention, diagnostic and treatment aspects of TB. Complementary print materials were also prepared to reinforce the information on TB symptoms, transmission, diagnosis and treatment. PHEs encouraged people with symptoms of TB to seek diagnosis and proper treatment if they tested positive. Also, the PHEs provided treatment support to patients, either by accompanying them to the doctor's office or encouraging family members to support them to do so.

The project was thoroughly evaluated. The objectives of the evaluation were to:

- ascertain the information level for TB within the communities involved in the project (Bucharest and Ilfov and Neamt counties);
- identify the attitude towards TB of the members of these communities, to decrease its stigma and increase concern for treatment; and
- compare changes with the baseline study and with a control population.

For the evaluation objectives, a pre-experimental, static group design was employed. This is a two group experimental design:

one group (called exposed or experimental group) is subject to the treatment (in this case, the information, education, and communication intervention) and the other (called non-exposed or control group) is not. Measurements on both groups (exposed and non-exposed) were made after the information, education, and communication intervention. For the sampling method, the test units were not assigned at random.

To measure and analyse knowledge, attitude and behaviour towards TB more consistently, indicators were developed. The resulting information is synthesized in Table 15.2. For further information about these indicators please contact the authors.

Table 15.2. Indicators of TB

Indicators	Mean non-exposed (n = 151)	Mean exposed (n = 149)	Maximum score	Mean at random answer
Knowledge of general aspects of TB	12.20	12.20	24	11.20
Knowledge of TB treatment	7.93	8.47 [a]	13	5.23
Knowledge of TB symptoms	6.70	6.60	11	5.50
Knowledge of TB transmission	10.09	10.79 [a]	16	7.00
Overall knowledge (general + treatment + symptoms + transmission)	36.93	38.12 [a]	64	28.93
Attitudes (general attitudes and attitudes towards potential stigma)	8.58	8.32	13	4.33
Practices (when TB revealed and when hospitalization needed)	9.08	9.42 [a]	10	3.33

[a] This is significantly higher than the non-exposed population, based on the tests of between-subject effects, from a multivariate analysis.

Source: HealthRight International (2005). Reproduced with the permission of the copyright holder.

The comparison between the exposed and non-exposed population on the key indicators revealed that, in terms of knowledge of TB treatment and TB transmission, the exposed respondents are better informed than the non-exposed ones and that they are more likely than the non-exposed respondents to behave in the appropriate way if they had TB.

Before the intervention, the Ministry of Public Health had financed the diagnosis, treatment and health promotion activities through two main national programmes (the National Tuberculosis Control Programme and the HIV/AIDS Programme). The health promotion activities, however, were not targeted at groups at risk and/or vulnerable communities but rather were targeted at the general population. During the project the external partners of the Ministry of Public Health (HealthRight International, supported by USAID and OSI) funded all the targeted information, education, and communication activities. After the project ended, the Ministry of Public Health took over the financing of the targeted health promotion, as well as some of the skilled PHEs as Roma health mediators, thereby moving the intervention towards sustainability.

The project successfully created linkages between PHEs and municipal authorities. Advocacy training assisted PHEs in better understanding various laws and statutes associated with health and social services. Also, in all the activities that focused on developing capacity within the health system, the project incorporated discussions on outreach to Roma communities. This was included in training on working with vulnerable communities, which was integrated into the overall TB training for private sector providers. HealthRight International also used its own partnership with local authorities to promote PHEs, who were often invited to speak at programme-related meetings and a conference and were introduced as key contacts for accessing Roma communities. During the course of these activities, PHEs also learned about the scope of other social problems in their communities, including the lack of identity cards and health insurance, low school enrolment of children, and unhealthy housing.

The project never intended to create or introduce separate health services for the target population, knowing well that such services would have been regarded as additional stigmatization. All the health services promoted during the project were offered within the Romanian public health system.

Lessons learned

Collaboration is the key to success

No one sector can effectively address the complex challenges faced by the Roma community. Collaboration among government agencies and private-sector and civil-society actors at the local, national and international levels is essential to building and sustaining new interventions that aim to reduce risk factors or directly address the determinants of health. Flexibility and adaptability are key issues, as no single experience can be replicated without adaptation and innovation.

Effective mechanisms for facilitating collaboration include working groups with active participation from government and civil-society actors who can come to meetings prepared to give approval on key decisions. Meeting agendas and expected outcomes, as well as roles, need to be clearly defined, and schedules need to be adhered to. It is also imperative to have local experts and community members as speakers at conferences, to highlight interdisciplinary perspectives.

Engage the Roma community

The Roma community itself must directly engage in assisting in developing equity. The Roma must be empowered as agents of change for their own lives and for the lives of their community members. One common denominator in all interventions that target vulnerable people is the positive role that those communities can and will play in their own development process, if provided with the requisite skills and opportunities.

Confront discrimination directly

The third lesson to emerge from the review of these USAID-funded programmes relates to the issue of discrimination. Just as poverty requires direct action, so too does discrimination. Future efforts in assisting in developing equity should pay close attention both to the ways in which poverty and discrimination are linked in the case of the Roma community in Romania and how best, during programme design and implementation, to address discrimination.

Two-pronged approach to programme implementation

At the national level, the primary partner – the National TB Control Program – was engaged in conceptualizing and implementing TB awareness strategies. At the local level, the feasibility and effectiveness of interventions, such as peer education and community-based outreach models, were emphasized. Targeting both providers and vulnerable populations, the project increased the levels of knowledge, skills, and intended behaviour and practices.

Comprehensive approach to programme implementation

HealthRight International was able to successfully incorporate local donors, health providers and civil organizations in building the capacity of the PHE network, particularly in Neamt County. Activities ranged from training to continuous support during daily activities and, most important, included assistance in creating partnerships with local authorities.

Several factors aided collaboration between actors, including the relatively small scale of the project area (Neamt County only has three TB dispensaries and one TB hospital), the wide geographic distribution of the PHEs (which led to TB patients being referred from often hard-to-reach communities), the implementation of a food incentive programme for patients (which was seen as a positive step both by providers and patients), and a long-felt need among all actors for this type of engagement (which was deterred by the lack of skills and motivation to create it).

The use of the existing health services structures

No new health services or health care facilities were created during the project. The whole intervention was based on the existing public health system, resulting in a more client-oriented approach and increased access. On one hand, the health professionals dealing with the Roma community, such as family physicians and nurses, had strengthened their capacity to

manage TB by improving their knowledge and skills; on the other hand, new health professionals, such as community nurses and Roma health mediators, were brought into the system.

Health system approach

The success of the project relied also on interventions being designed to strengthen existing health system activities. The programme design was incorporated into general health policies for TB, but it also took into consideration the overall health structure. Moreover, the provision of health services was influenced by adaptation and enhanced accessibility. Furthermore, human resources and financial resources were redirected to sustain the new intervention, as well as to ensure long-term sustainability.

Following the successful work of HealthRight International in a difficult to reach community, there was increased recognition and acceptance of the role of NGOs – for example, in TB control programmes, in particular, and in extending the reach of the health system to communities, in general. Moreover, NGOs received greater recognition in official reports and were incorporated in the planning process, including the 2006–2015 national TB strategy (Ministry of Public Health, 2006). The role of NGOs as partners was also recognized in such international funding applications as The Global Fund to fight AIDS, Tuberculosis and Malaria.

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16. Serbia: Together for Health project

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Summary

On 27 January 2005 – after the Government of Serbia adopted the Action Plan for Roma Health within the Decade of Roma Inclusion 2005–2015 and allotted a budget line for its implementation – the Ministry of Health of Serbia publicly requested the submission of proposals for Action Plan Implementation. Of the 92 proposals received, 64 were accepted. Among these was the project Together for Health. The project was undertaken as a partnership between the Ministry of Health and Primary Health Care Centre Obrenovac. The project covered the area of a suburban municipality of Belgrade and involved two NGOs: Roma Society of Grabovac and the Centre for Integration and Culture of Roma from Kosovo [1] and Metohia in Serbia.

The project's goal was to improve the reproductive health of Roma women. The project covered Roma women aged 15–49 years, displaced from Kosovo and Metohia, currently residing in the municipality of Obrenovac or in two small villages in the vicinity of Obrenovac. The project lasted from September 2006 to August 2007.

The project's activities consisted of:

- assessing the socioeconomic status of Roma families, which was immediately followed by
- delivering targeted health education and offering a full gynaecological examination to all women in the project and
- providing information on basic social rights and how to access services.

The first part of the project, the evaluation of the socioeconomic status, involved 134 families. Data were obtained from women surveyed when they appeared for an examination. Indicators of access to basic social benefits revealed that 49% of these families had received some kind of social benefit – such as a child allowance – and 51% of them could not exercise all of their entitlements in the sphere of social welfare or financial support to families with children. The reasons for the inability to exercise entitlements included insufficient information on how to claim benefits, lack of personal documents and working- age members of a household not being registered in the labour market records. In this context, the social status of these families is far from acceptable.

[1] Reference to Kosovo in this publication, including in the bibliography, should be interpreted as: Kosovo (in accordance with Security Council resolution 1244 (1999)).

The second part of the project focused on the delivery of targeted health education and a full gynaecological examination of all women in the project. This involved monthly sessions at Primary Health Care Centre facilities. For women involved in the project, transportation was organized as a round trip between their residence and the Centre. Although the original project plan was to include 60 women in systematic examinations, 114 women were examined as part of the project. In the course of the project, it was discovered that the Roma women had very little knowledge of reproductive health issues, including the means available to prevent unwanted pregnancies. Through the health education component of the project, Roma women showed increased interest in planning the number of children they had and using a contraceptive method to avoid unwanted pregnancies.

The third part of the project entailed the use of social workers as mediators to connect the Roma community with services that correspond to the basic social rights. First and foremost, this included services to register citizens of Serbia, as Roma were often without basic documents, followed by social and health services.

When the project ended, its achievements were greater than expected. The data obtained from the project emphasize the need for continuing activities of this type and for intersectoral cooperation on education, housing, active employment, social services and health insurance.

Socioeconomic and policy context

Serbia is a landlocked country in central south-eastern Europe. The last census, conducted in 2002, puts its population at 7 498 001 people, excluding data from Kosovo and Metohija (Statistical Office of the Republic of Serbia, 2002). The ethnic composition of Serbia is heterogeneous; the majority of the population is Serb, but another 37 nationalities also live in the country. With the outbreak of war in the former Federal Republic of Yugoslavia in 1991, Serbia faced a serious refugee problem for the first time since the Second World War. The greatest numbers of refugees are from Bosnia and Herzegovina and from Croatia. Depending on the source of data, estimates of the number of refugees and IDPs have varied from 350 000 to 800 000 (Statistical Office of the Republic of Serbia, 2006a).

The country's population, both permanent residents and refugees, is characterized by a greater proportion of elderly people, decreasing average family size, and declining numbers in rural and remote areas. These are especially marked in south-eastern and western Serbia. Conversely, minorities, including Roma, show different demographic characteristics. Minority groups are relatively young with a family size larger than that of the average Serbian family. According to the current age structure, Serbia has one of the oldest populations in Europe and the world, with 17.2% older than 65 years (Statistical Office of Serbia, 2006a).

By 2000, recorded per person GDP had fallen to about half of its 1989 level, and large domestic and external debts were accumulated. Also, poor economic performance adversely affected the living standard of the vast majority of the Serbian population (Statistical Office of the Republic of Serbia, 2006a). The year 2000 marked a renewed transition to a market economy and democratic society. Between 1999 and 2006, the total GDP (without data from Kosovo and Metohija) went from US$ 19.1 billion to US$ 30.4 billion, with GDP per person rising from US$ 2535 in 1999 to US$ 4103 in 2006 (Statistical Office of the Republic of Serbia, 2006b). The World Bank considers Serbia to be an upper-middle-income country (World Bank, 2007). The unemployment rate in 2006 was 21.6% (Statistical Office of the Republic of Serbia, 2006c). In 2005, the percentage of children enrolled in the secondary schools was 77.09% (Statistical Office of the Republic of Serbia, 2006a).

In 2007, people in Serbia were considered poor if their income was below the poverty line – that is, RSD 8883 (as of 1 April 2007, US$ 1 = RSD 60 and €1 = RSD 80) a month per consumer unit (the minimum amount of money required to satisfy minimum living needs) (Table 16.1). The dramatic increase in the levels of poverty in Serbia during the 1990s had a serious effect on the ability of citizens to enjoy their rights to health, to adequate food and housing, to education, and to decent work, among other things. Refugees, IDPs and socially excluded groups (including the Roma population) constitute the poorest of the poor.

Table 16.1. Key poverty indicators in Serbia, 2002 and 2007

Key poverty indicators	2002	2007
Absolute poverty line per adult equivalent (in RSD)	5234	8883
Percentage of the total population classified as poor	14.0	6.6
Depth of poverty (in %)	3.0	1.3
Severity of poverty (in %)	1.0	0.4

Source: Statistical Office of the Republic of Serbia (2008:10). Reproduced with the permission of the copyright holder.

Also, the population of rural regions is significantly poorer than that of urban regions. In 2006, the poverty index of other regions was almost two and half times higher than the poverty index of the urban population (13.3% and 5.3%, respectively) (Statistical Office of the Republic of Serbia, 2006b). The level of inequality in Serbia is close to the average for the group of east European economies in transition (Bogicevic et al., 2003).

Serbia's Poverty Reduction Strategy, adopted in October 2003, aims to halve the country's poverty by the year 2010. The main three recommendations or strategic directions for this aim are as follows:

1. dynamic economic growth and development, with an emphasis on job creation within the private sector;
2. preventing the emergence of new poverty that can result from economic restructuring and rationalization of public administration; and
3. efficient implementation of existing programmes and development of new programmes, measures and activities that directly target the poorest and most vulnerable social groups of the population (including children, the elderly, disabled people, refugees and IDPs, Roma, the rural population, and the uneducated, especially in the least developed regions).

Particularly relevant to the topic of this case study is the third strategic direction, which aims to initiate the process of raising qualifying vulnerable groups above the poverty line and enabling them to have equal access to health services, employment, education and communal services (Government of Serbia, 2008).

Health and health inequities

The health status of the population improved from 1980 to 1990, as seen in trends of steadily decreasing infant mortality and mortality from communicable diseases and increasing life expectancy. These positive trends slowed during the 1990s, due to the cumulative effects of political and economic crises, but showed improvements again after 2000. From 1996 to 2006, life expectancy at birth for men in Serbia increased by a year, while life expectancy for women increased by one and half years. In 2006, the infant mortality rate for Serbia (without Kosovo and Metohia) was 7.4 infant deaths per 1000 live births, compared with 14.6 infant deaths per 1000 live births in 1996. Reducing deaths due to easily preventable diseases (such as acute respiratory infections, diarrhoeal diseases and vaccine preventable diseases) has improved child survival rates. The low infant mortality rate also reflects prior investments in health and maternal education, together with a generally good level of antenatal, delivery and postnatal health services (Statistical Office of the Republic of Serbia, 2006a). Also, the maternal mortality ratio is low and declined between 1990 and 2006, from 11.0 maternal deaths per 100 000 live births to 5.6 maternal deaths per 100 000 live births (Government of Serbia, 2006).

As highlighted in the *Second progress report on the implementation of the Poverty Reduction Strategy in Serbia*, there are gaps in health between particularly vulnerable groups and the general population (Government of Serbia, 2007). For example, due to the considerable payments required from the beneficiary, accessibility of health care services, especially among the poorest, is limited. Serbia is one of the countries where out-of-pocket payments comprise the largest part of private health costs (85%) and where the share of health costs in total household final consumption expenditures registered an upward trend. National Health Accounts – produced to facilitate the monitoring of the health care costs of vulnerable groups – provide evidence that the use of health services of the general population is much higher than that of the poorest segment, because these services require an out-of-pocket payment (Government of Serbia, 2007).

The Health Insurance Law from 2005 (National Assembly, 2005b) sets the groundwork for particularly vulnerable categories of people to have their mandatory health insurance paid for from the government budget, thus giving them the same rights as other health insurance beneficiaries. The *Second progress report on the implementation of the Poverty Reduction Strategy in Serbia* states that "funds allocated for this category of beneficiaries are not sufficient", although there have been visible increases in earmarked funds (Government of Serbia, 2007). Also, despite legislation providing for the needs of vulnerable groups, part of the population still does not exercise these rights, and people without residence face particular problems.

Roma in Serbia

According to the 2002 census, Serbia has 108 193 registered Roma, which is 1.44% of the country's total population (Statistical Office of the Republic of Serbia, 2002). However, Roma organizations estimate that numbers are four to five times higher.

Among the reasons for these higher estimates is the belief that better-situated Roma prefer not to declare themselves as such for fear of stigmatization.

Based on the survey of multiple indicators of the situation of children and women (Statistical Office of the Republic of Serbia and Strategic Marketing Research Agency, 2006), health indicators among all Roma are two to three times higher or lower than national averages. These inequities require targeted interventions – that is, activities that would focus on disadvantaged Roma and take place simultaneously with general reforms. Table 16.2 shows a comparison of indicators for child mortality, child health and nutrition.

Table 16.2. Indicators of child mortality, child health and nutrition

Indicator	General population				Roma population living in Roma settlements, 2005		
	2001	2003	2005	2007	Boys	Girls	Total
Under-5 mortality rate (per 1000 live births)	11.8	10.4	9.2	8.3	36	23	28
Infant mortality rate (per 1000 live births)	10.2	9.1	8.0	7.1	32	20	25
Percentage of live births below 2500 grams	ND	ND	4.9	5.6	ND	ND	9.3

Note. The indicators of child mortality, child health and nutrition do not include data for Kosovo and Metohia.

ND = not determined.

Source: authors' compilation from Government of Serbia (2007); Institute of Public Health of Serbia (2009); Statistical Office of the Republic of Serbia and Strategic Marketing Research Agency (2006).

Immunization coverage in Serbia is estimated to be 97.7% of all children (Statistical Office of the Republic of Serbia and Strategic Marketing Research Agency, 2006). According to the survey of multiple indicators of the situation of children and women (Statistical Office of the Republic of Serbia and Strategic Marketing Research Agency, 2006) only 27% of children living in Roma settlements received all vaccinations. The same survey shows that the percentage of children who had all the recommended vaccinations at the specified age was 44%, whereas it was 37% for the most vulnerable children and only 9.2% for children living in Roma settlements. No significant gender-related differences were observed for all children, but solid indicators of the turnout for inoculation proved to be the level of the mother's education and living in an urban area (62% living in an urban area compared with 52% from rural areas).

The general maternal mortality rate has dropped considerably since the early 1990s, from 11.1 maternal deaths per 100 000 live births in 1990 to 5.6 maternal deaths per 100 000 live births in 2005. The survey of multiple indicators of the situation of children and women show no territorial differences – that is, urban versus rural population – in *mortality in fertile women*, but there were considerable differences between the average for the general population of women and Roma women (Table 16.3). Further research is needed to establish the principal causes of deaths among Roma women in their fertile period.

Table 16.3. Indicators of women's health (without data for Kosovo and Metohia)

Indicator	General population	Roma population living in Roma settlements, 2005
Maternal mortality ratio (per 100 000 live births)	6.5	ND
Antenatal care – at least one visit to doctor during pregnancy (in %)	99.3	88.9
Skilled attendant at delivery (in %)	99.2	92.9

Source: authors' compilation from Government of Serbia (2006), Statistical Office of the Republic of Serbia and Strategic Marketing Research Agency (2006).

Keeping in mind social deprivation, social exclusion and conditions that are peculiar to particular ethnic groups, it is evident that Roma are one of the most socially vulnerable groups in the country. Difficulties that Roma face in general are poor housing conditions, unemployment, poverty, social exclusion and lower levels of education. These adverse conditions jeopardize the health of all Roma and, in particular, that of Roma women and children. The book *The art of survival: where and how the Roma live in Serbia* (Jakšić & Bašić, 2005) highlights both the difficult living conditions of the Roma population in Serbia and the discrimination they face in everyday life. Qualitative research on poverty in children has described some of the obstacles Roma children face while using health services – for example, "I have to wait at the doctor until everyone is finished, and then it's our turn, for us the Gypsies" (UNICEF, 2004).

The 2006 recommendation of the CE Committee of Ministers on better access to health care for Roma and Travellers in Europe (CE Committee of Ministers, Recommendation Rec(2006)10) defines basic principles that guarantee the rights, participation and equal access to health services of the Roma population in Europe. The document recommends that all member states provide the Roma population with physical, geographical, cultural and suitable access to health care.

A number of documents reflect Serbia's national strategic orientation of following international law and placing an emphasis on improving the health of particulary vulnerable groups. These documents include: *Better health for all in the third millennium* (Ministry of Health of Serbia, 2003); *Public Health Strategy of the Republic of Serbia* (Ministry of Health of Serbia, 2005); *Poverty Reduction Strategy Paper* (Government of Serbia, 2003); and *Strategy for empowerment of the Roma* (Ministry of Human and Minority Rights, 2009). These documents recommend goals and measures for improving the health of the Roma population and for dealing with matters of education, housing, access to public services, employment, personal documentation issues and, particularly, displaced Roma men, women and children. The Strategy for Integration and Empowerment of Roma, which was in keeping with government commitments through the Decade of Roma Inclusion 2005–2015, was never adopted by the Government; however, action plans evolved from it in the areas of education, employment, health and housing, and these were adopted by the Government of Serbia. Action plans define priorities, measures and monitoring methods for reaching their goals by 2015 (Decade of Roma Inclusion 2005–2015, 2008). Among the primary goals are beginning health research and evaluating the morbidity and mortality rates of the Roma population. In recent years, much of the research on socially determined health inequities in Serbia has dealt with the health issues of Roma families.

Roma in Obrenovac Municipality

The Municipality of Obrenovac is situated in north-western Serbia and encompasses the middle of the Lower Kolubara River Basin. It lies within the administrative boundaries of Belgrade and is 27 km from the city's central area. According to the Statistical Office of the Republic of Serbia, between 1948 and 2002, the population of Obrenovac Municipality increased from 41 024 to 70 974 people, which puts it among the medium-sized municipalities of Belgrade. From 1948 to 2002, the number of households grew from 8800 to 23 856, with the average household having 3.1 members. The average age in the municipality is about 39.4 years. An analysis of the population's age distribution shows that the youngest contingent (up to 19 years of age) accounts for 26.6%. A slightly higher share of this age group resides in suburban (28.8%) and urban settlements (28.6%), as opposed to rural areas (23.6%). The ratio of women to men is closely balanced, at 50.2% to 49.8%, respectively (Statistical Office of the Republic of Serbia, 2002).

According to two NGOs of Obrenovac – the Roma Society of Grabovac and the Centre for Integration and Culture of Roma from Kosovo and Metohia in Serbia – an estimated 5000–8000 Roma live in Obrenovac Municipality. This accounts for 6.6–10.6% of the municipality's total population.

The experiences of Roma NGOs and of epidemiological, outpatient-care and psychosocial services within the Primary Health Care Centre Obrenovac have shown that Roma settlements lack basic sanitation services and other basic infrastructure. The people living in these settlements, for the most part, lack valid health insurance – for example, their health insurance cards are not renewed or have expired – and their level of general health literacy is low. Despite health problems, there is evidence that routine regular health check-ups are infrequent. During childbearing years, the health of Roma women is particularly poor. The overall situation leads to frequent illnesses from common infections, as well as serious illness at a much higher rate than the general population.

MDG 5 refers to the improvement of maternal health in women of childbearing age. Serbian national target number 2 of MDG 5 aims to: improve the maternal health of women, by maintaining the fertility rate at the present rate of 26 children born per 1000 women aged 15–49 years; halve the abortion rate of 2069.5 abortions per 100 000 women in 1990; and double the percentage of women using modern contraceptive methods. The survey of multiple indicators of the situation of children and women shows a low percentage of women (33%) using modern contraceptive methods). Among Roma women, this number is much lower (1%) (Statistical Office of the Republic of Serbia and Strategic Marketing Research Agency, 2006).

Together for Health project

The Ministry of Health of Serbia project Together for Health was carried out in partnership with the Primary Health Care Centre of Obrenovac and two NGOs: the Roma Society of Grabovac and the Centre for Integration and Culture of Roma from Kosovo and Metohia in Serbia. The project aimed to improve Roma women's reproductive health and to raise their level of awareness and health literacy. It emphasized the importance of changing their behaviour from passive to active, to safeguard their health. It also emphasized action on the key determinants of health, such as access to social services and possession of identity cards. The project lasted from September 2006 to August 2007. Its objectives were to:

- assess the socioeconomic status of Roma families
- deliver targeted health education and a full gynaecological examination to all women in the project
- provide information on basic social rights and how to access services.

The main part of the project was carried out at the facilities of Primary Health Care Centre Obrenovac, and part of the project was carried out in the field, through home visits. The Primary Health Care Centre Obrenovac has ensured the use of its premises for examinations and has provided dwellings for women and children, necessary diagnostic instruments, refreshments, and transportation. During the implementation phase of project Together for Health, staff included a social worker (who was also a project coordinator), two Roma mediators, a gynaecologist, a nurse and a hygienist. All project services were free of charge, and all project beneficiaries were accepted, regardless of their health insurance status or possession of civil/identification documents. Outreach services provided health education activities and information, using health mediators active in the community. The project took into consideration cultural attitudes, offered (rather than imposed) services to women, and explained the project's benefits for the women and their families. The services offered were of the same quality as those offered to the general population, and all diagnostic methods and equipment used were of high quality.

During the project, work with individuals was done through individual examinations and social surveys, and the health education of Roma women was carried out in small target groups. Through community work, the public was informed about the project and home visits took place. As part of their regular tasks, outpatient care units of the Primary Health Care Centre Obrenovac met with Roma families, which are usually large and socioeconomically disadvantaged.

Reports from women of numerous abortions attest to a low level of knowledge about reproductive health in Roma families. The lack of health literacy influences risk and health behaviours and use of emergency health interventions and curative interventions only, without asking for preventive services. The project worked to address this through health education sessions specifically tailored for women and their families. This was coupled with preventive health services that gave beneficiaries the opportunity to test their new knowledge.

Family socioeconomic status assessment

This part of the project, the evaluation of the socioeconomic status, involved 134 families. Data were obtained from women surveyed when they appeared for an examination. Examined indicators included: household members type of union (marital, consensual, incomplete); family type; type of housing; education level; rights exercised (such as social security, retirement and disability); and inclusion of the children in the educational system. During the evaluation period, 134 Roma families were covered. These included 52 families dislocated from Kosovo and Metohia and 82 families from Obrenovac Municipality (the settlements of Grabovac, Šljivice and others).

Data show that households among those from Obrenovac Municipality) had, on average, 4.69 members and households among those dislocated from Kosovo and Metohia had 6.17 members. Frequently, these are households with 3 or 4 children, besides their parents. In 40% of the families of Roma displaced from Kosovo and Metohia, there are also members of an additional generation or two, such as a grandmother, a grandfather, a father-in-law and/or mother-in-law. This situation results from their having left their homes together and is compounded by the difficulty they face in settling in a new environment. Also, cultural factors, environment, and demographic trends of Kosovo and Metohia further influence the size and composition of the households.

The most common type of union in Roma families from Kosovo and Metohia is marital (52%), followed by consensual unions (27%) and incomplete unions that result from separation, divorce or death (21%). Consensual unions among families originating from Obrenovac account for 40% of all unions, marital unions account for 32%, and incomplete unions account for 28%. The large number of consensual unions is a result of Roma perceiving it as a more comfortable way of life, without

formalities and paperwork, with the possibility of changing partners. Some consensual unions, however, lead to bureaucratic confusion, because of the different last names of mothers and children, as well as problems in proving economic common-law unions [2] and ensuring social rights and obligations.

A large number of displaced families from Kosovo and Metohia live in collective shelters or other emergency temporary housing (31% compared with 20% of Roma families living in permanent residences). Yet, the majority of these displaced families have managed to find a place to live with their relatives or friends. This shows a certain level of solidarity (cohesion within the ethnic community), which is also demonstrated by their households being located mostly in so-called Roma settlements at certain locations in Obrenovac Municipality. The number of Roma families from Kosovo and Metohia that rent a flat is very small (8%), which corresponds to the particularly disadvantaged financial situation of this group.

With regard to level of education in families covered by the project, the data show that the majority of parents (85%) are elementary school graduates or have not finished the eighth grade of elementary school. As for the Roma families originating from regions of Kosovo and Metohia, 33% of the parents never attended school. This is explained by their being from rural areas and regions of Kosovo and Metohia where the opportunities for work were mainly to practice agriculture and raise livestock. Also, the distance to (and accessibility of) school facilities discouraged parents from having their children start school. Moreover, as the families were large, there was an issue of deciding which children should go to school. Furthermore, the parents in only 5 of 134 families evaluated (about 4%) had completed some high school education.

In 103 families, according to participants surveyed, both parents were unemployed, which accounts for 77% of the total number of families. This figure needs to be interpreted with care, in that some may have been involved in the informal economy and declared themselves as unemployed. This percentage of unemployed is understandable when the point of origin of families is taken into consideration. In only 4 of the 134 Roma families evaluated (3%) were both parents lawfully employed, as identified through social security and employer contributions.

The questionnaire, based on a household sample, also included a question intended to give more accurate insight into the employment/unemployment of Roma in the households covered. It featured the question: Do adults in the households (in this case the parents) perform any work (irrespective of the amount of salary, type of work, or type of work contract)? The survey found that in every family, at least one parent performed a job, although working conditions, salary and protection against professional injuries were certainly below any standard or average. It should be noted that most project participants were registered with the unemployment office, which does not necessarily mean that they did not work. Using contemporary recommendations and the methods of the ILO, a survey of the Roma workforce was applied on a household sample. The survey results agree with those highlighted above: they show that in the majority of the families, regardless of their origin, at least one parent worked.

Survey findings indicate that, in these Roma families, women were housewives, taking care of the children, and men were in charge of such occasional seasonal work as collecting recycled raw materials, physical labour (low-wage jobs, requiring physical strength). Also, most Roma of working age and covered by the project – that is, the women surveyed who showed up for examinations and their partners – assumed that declaring themselves as unemployed entitled them to some assistance. In their view, to be officially registered at the unemployment office means getting health insurance for themselves and for members of their families.

Besides income from the above-mentioned jobs Roma perform to provide for their families, 49% of the total number of families surveyed obtain some of the corresponding social benefits, such as child allowance benefits, or material entitlement to families (commonly known as *social assistance* or *welfare*). The percentage of families receiving this assistance would be higher if problems related to necessary documentation were solved. Families from Kosovo and Metohia face particularly complicated situations due to their status (internally displaced and lacking documentation) and lack of certifiable assets.

Of school-age Roma children, 68% are enrolled in regular schools, 9% (from Kosovo and Metohia) attend special schools and 23% are not enrolled (or those who started and quitted school). Special schools are institutions for children with disabilities who cannot attend regular school. Contrary to regular primary schools, classes in special schools have fewer children and follow a special curriculum, according to children's abilities. These special schools are mostly for children with a mild mental disability (intelligence quotient (IQ) 50–70). Most Roma children in these special schools are not disabled, but lag behind children of the same age because of social deprivation, adverse conditions for learning, and their parents' low educational

[2] "Economic common-law union" is a term used to denote a specific category of union for the purpose of exercising certain pecuniary social welfare entitlements. In these cases the onus is on de facto partners to prove they live together, so that the exact number of members of their household can be determined when processing their requests, such as benefit claims.

abilities. Their parents enroll them in special education schools because their school records are poor and they cannot keep up with the curriculum designed for their age. For a child to be enrolled in a special education school, she/he has to undergo examination by a commission, which decides on the appropriate continuation of the educational process. Also, there is evidence that Roma children are sometimes unwelcome in regular schools, where other children may discriminate against them and may misunderstand their living conditions and culture.

Provision of targeted health education and gynaecological examinations

A total of 114 Roma women were involved in this aspect of the project. Of these women, 86 were examined while 28 were not, but were educated instead about reproductive health. Reasons for not being examined included: some of the women were menstruating; some had recently been examined at the Primary Health Care Centre Obrenovac; some women or girls were not sexually active; and several women rejected the examinations because of fear or prejudice.

All women present, whether examined or not, received information on the importance of contraception and sexually transmitted diseases and of personal and intimate hygiene. After this, the examinations were carried out. They consisted of analysing vaginal discharge or conducting a Pap smear, performing a colposcopic examination, a bimanual examination and a palpatory breast examination.

The examinations led to the following diagnoses and treatments: a Pap smear led to a secondary level of health care; a polyp of the orifice of the uterus was found and taken care of; 6 women had multiple myomas of the uterus and were included in monitoring and follow-up examinations; 62 women were treated for vaginal secretion; and 3 women had breast dysplasia and were monitored periodically.

Of all women examined, 14 were pregnant and 9 were or are undergoing sterility treatments. Five of the women had never been pregnant and were either not married or married only recently. The project showed that the majority of women had had at least three childbirths and that 37 of these women had had four and more. Also, 21 women had more than three abortions. Project findings show that the notion of women needing to have as many children as possible is still present and that this notion is embedded in the upbringing, education, tradition, and significantly low level of knowledge of birth control and prevention of unwanted pregnancies among these women. Through the Together for Health project, pregnant Roma women entered into the regular programme of counseling of pregnant women at the Primary Health Care Centre Obrenovac Parenting School, and five women who had never been pregnant joined workshops dedicated to preventive services related to reproductive health.

With regards to contraception use, there were differences between married women or women living in consensual union and other women. The former rarely opted for any contemporary method of contraception. They indicated that it was difficult for them to take a position on future pregnancies as they felt that they were not the one making the decision. During the course of the Together for Health project, a list of women interested in using an intrauterine device was created, and the number of women on the list increased from 1 to 15 – mostly single mothers. The authors of the present case study believe it might be worthwhile to secure funding for the use of intrauterine devices among Roma women (such as a levonorgestrel-releasing intrauterine system) within some future project.

Provision of information on basic social rights and how to access services

All families included in the project accessed information on their elementary rights and entitlements to social security, which covers health care, education, social insurance, pensions and disability insurance. To provide the Roma with better access to information and fulfillment of rights to which they are entitled, the project contacted institutions and organizations in the local community.

With regard to access to health services, Roma can face: (a) a lack of documentation, a lack of knowledge and insufficient health literacy; and (b) perceived and real discrimination in health services. The implementers of the project were aware of the difficulties of overcoming the barriers presented by poverty and social exclusion and of changing deeply rooted habits and ways of life practiced for decades. In light of this knowledge, the Together for Health project did not aspire to unrealistic goals.

For many of the Roma, involvement in the project was an opportunity to get in touch with a government service without coercion and pressure, but on a strictly voluntary basis. The small effort to participate has resulted in their getting acquainted with rights to which they are entitled in health care, family planning and reproductive health. Project managers also hope

that families involved in the project will transfer their knowledge and experience to families that are not aware of available services. In this way, the project aimed to increase the number of Roma with confidence in the health care system – to provide support rather than present obstacles – and to promote cooperation, participation and integration.

Several key factors beyond the power of the health sector influence health service usage. At the moment, one key factor is possession of personal documents (such as an identification card) that would enable all Roma to access basic health services. Provision of personal identification cards is within the mandate of Ministry of Interior and is based on legality of residence – that is, the legal status of housing in which Roma reside. As many Roma covered by this project live in so-called illegal houses or with relatives, they often lack the personal document (card) that opens the door to social welfare services.

In addition, the situation of Roma might improve if unemployment and informal employment were addressed by the labour and social welfare sector. This would ensure that Roma are not exploited, but rather benefit from their work through health and social welfare contributions to their well-being.

In light of the needs mentioned above and in conjunction with other services/institutions, the project resulted in:

- identification of socially vulnerable people, connecting them with responsible services
- cooperation with the Ministry of Interior, to obtain and renew personal identification cards
- cooperation with the health insurance branch, to obtain health care cards
- cooperation with the unemployment office.

Lessons learned

Needs and opportunities identified

Research conducted through the project suggests the need for measures that address the following barriers: (a) lack of documentation, lack of knowledge and insufficient health literacy; and (b) perceived and real discrimination in health services.

Lack of documentation, lack of knowledge and insufficient health literacy

As Roma use health services *when in need*, a community-based health promotion service needs to be established through primary health centres and Roma mediators. This would ensure that health information is tailored and culturally sensitive to Roma women and men and is provided regularly in their own settings, thus encouraging a proactive approach to (and interest in) maintaining health.

To improve the reproductive health of Roma women, programmes that target gender inequity need further work, and future programmes need to target Roma men, as well as family planning.

There is also a need to reinforce intersectoral cooperation, especially for the Roma population that is internally displaced, which is often destitute and disappointed, frequently invisible to the system, and lacks documents and personal identification.

Closer collaboration with the education sector is needed to increase the Roma population's basic literacy of social rights and health education. Particular attention should be given to Roma girls during the time they attend school, and this attention should aim to decrease the drop-out rate among them. Also, the project's detection of a low level of elementary education and a significant number of families that want to educate their children in special schools indicates the need for cooperation between educational and pedagogical institutions. The health system has opportunities to facilitate this, as the local board for evaluation and categorization of developmentally challenged children is in the Primary Health Care Centre Obrenovac, and the board's secretary is a social worker.

Perceived and real discrimination in health services

The project detected a need for Roma-friendly health services at the primary health care level. Roma can perceive administrative obstacles as a deterrent or an act of discrimination. The Health Care Law (National Assembly, 2005a) and the Health Insurance Law (National Assembly, 2005b) entitle everyone to health care. Any person with a health card can be sure that their rights are

guaranteed. The problem of real or perceived discrimination in health services is related to difficulties in dealing with issues related to permanent residence and health insurance.

Project findings suggest that perceived and real stigma and discrimination linked to poverty and to being Roma can be addressed in two ways:

1. through work with Roma NGOs as equal partners in project implementation; and
2. through work with existing outreach services in the social and health care services, encouraging them to approach the Roma communities and thus bridge the social gap between Roma and non-Roma populations.

Resource requirements

During and before the design phase of the project, project planners had misgivings about it reaching the goals set, due mainly to perceptions that Roma women could potentially lack interest in participation. Project planners speculated that Roma women would not respond to first and subsequent examinations. The number of project beneficiaries, however, exceeded the number anticipated, which in itself speaks for the success of the project. The successful project uptake was made possible by good organization and by the readiness of the staff at Primary Health Care Centre Obrenovac to engage in project implementation. The staff enabled the use of Centre vehicles to transport women to and from examinations, provided full support of other services to the project, and recognized and responded to the need for the inclusion of a health professional of Roma origin in the project. Another, even more important, reason for the successful project uptake was cooperation with Roma NGOs, which worked to gain the confidence of the project's target group.

A basic prerequisite for implementing the Together for Health project in another place – other than financial (which is not critical, considering the cost–benefit) – is the existence of adequate human resources. The project team, including mediators, gained unique experience that resulted in positive programme outcomes. During the selection of human resources, the quality of experts was examined, as were their organizational and communication skills. As for the mediators, the status they had in the ethnic community was important, as were their level of cooperation and the interest they demonstrated in the project from the beginning. No special training sessions were held with the project team, but the level of organization, mutual planning, reporting and communication was exceptionally high.

Sustainability

The Government of Serbia provided funds for the project to the Ministry of Health, to promote Roma health within the Decade of Roma Inclusion 2005–2015. Funds deposited in the account created especially for this project were used according to the approved project budget, where every payment and expenditure was recorded. They were controlled by an analytical card for the account balance, which is available for inspection and was a compulsory and integral part of the financial documentation of the project. This model is sustainable in the future, if financing sources are available (where financiers could be other institutions and donors, for example). Although the Ministry of Health launched a new public request for proposals following the end of the project in August 2007 – of which 39 were approved in 2008 – no proposal for the continuation of the Together for Health project was received. Thus, the desired sustainability of the project was not achieved, despite its evident success.

For this project or similar ones to continue, the support of local self-governing authorities is needed. It is recommended that such projects be linked to a strategy or policy, so that their existence will not be ad hoc, sporadic and unconnected. In addition, project funds should be allocated from the budget of the local self-governing authority, following an assessment of project needs.

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17. Slovakia: Healthy Communities

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Summary

In Slovakia, about half of the Roma population is integrated into the overall population, while the other half live in so-called Roma settlements. As in many countries in the Region, Roma settlements in Slovakia are often geographically isolated and characterized by a lack of infrastructure, hygienic amenities, and social and health services. Due to these and other factors, employment rates, educational attainment, and health literacy are especially low in Roma settlements.

Poor living conditions and socioeconomic exclusion influence the health status of the settlements' inhabitants, and Roma living in these settlements are among the population groups most exposed to health-related risk factors. While isolated Roma communities are believed to generally experience poorer health status than the general population of the country, there are currently no ethnically disaggregated data in Slovakia to illustrate health disparities on a national level.

The Public Health Authority of the Slovak Republic has developed the Programme to Support the Health of Disadvantaged Communities from 2007 to 2015, to address the needs of Roma and other disadvantaged groups. It was endorsed by the government in April 2007.

Prior to this, in 2003, the Association for Culture, Education and Communication (ACEC), a NGO, had initiated the Healthy Communities programme, as a pilot programme, in 11 Roma settlements. As of January 2008, the programme has been active in 67 Roma settlements with a total population of more than 45 000 inhabitants. The aim of the programme is to improve the health status of the Roma population through increased human resource capacity, health literacy, health care access and assessments of Roma health. This turned out to correspond fully to the objectives of the new governmental programme.

Most programme staff are Roma women recruited from within Roma settlements. They complete a Ministry of Education accredited programme designed by the ACEC, which aims to build participant's capacity to undertake community health work in Roma settlements. ACEC staff (including the programme manager, education manager, programme assistant and educational programme trainers), representatives from the Slovak Red Cross and the Operation Centre of Medical Emergency, and physicians contribute to the training.

The programme team includes 4 coordinators (workers from the target community), 88 health assistants (also from the target community) and 18 regular volunteers. The volunteers are inhabitants of the settlements and help health assistants carry out their work, mainly while organizing the inoculation of children. In addition to the 18 regular volunteers, there are several ad hoc volunteers. Also, local governments, elementary schools and about 100 physicians are involved, as needed.

The ACEC has noted the particularly low level of health literacy among settlement inhabitants. For this reason the presence and activities of health assistants are very important, because they share information with settlement inhabitants about various

forms of ill health, as well as the means required to treat them, information on health promotion and prevention, and approaches to improving access to health care.

A significant and notably effective strategy is the employment of health assistants from the settlements in which the programme is being implemented. Health assistants selected in this manner have the advantage of being able to communicate with settlement inhabitants on sensitive issues. They are also the most effective connection between the community and local doctors, as well as the regional authorities. Moreover, training and empowering Roma from isolated settlements creates a cadre of advocates who can speak on behalf of their communities.

The Healthy Communities programme has also helped significantly to include disadvantaged Roma in the new decentralized and privatized health system. The programme does this through the creation of sustainable links with other service providers and local governments. Moreover, the involvement of physicians ensures that they are more aware of Roma community health needs. In parallel with the creation of sustainable links to other service providers and local governments, Roma health assistants report that Roma communities are building trust in the health care system and that they have a better understanding of their health care rights and entitlements.

Socioeconomic and policy context

After an initial downturn, the Slovak economy grew substantially between 1993 and 1998 and has grown more or less steadily since then (Hlavacka, Wagner & Riesberg, 2004). However, in parallel with economic growth, there is evidence that the Slovak population living on US$ 4.30 per day or less – the World Bank's recommended benchmark for measuring absolute poverty in Europe – grew during that same period. The 1988 household survey identified 0.2% of the population as living on US$ 4.30 per day or less. The last survey, in 1996, found the rate had jumped to 11.4% (World Bank, 2005). The percent of the population living in relative poverty – that is, below the risk-of-poverty threshold set at 60% of the national median equivalent disposable income (after social redistribution) – was 12% in 2006 (Eurostat, 2006).

As stated in the National Report on the Strategies for Social Protection and Social Inclusion 2006–2008, the 20% of the Slovak population with the highest income had 3.9 times more income than the 20% of the population with the lowest income, with a corresponding income inequality under the EU average (4.8). Children under 17 years of age (18.7% of the Slovak population) and young people aged 18–24 years (16.3% of the Slovak population) are much more endangered by impoverishment than people older than 65 years (7.1% of the Slovak population) (Ministry of Labour, Social Affairs and Family, 2006:7).

In 2007, the unemployment rate (11.1%) fell by 2.3 percentage points relative to the 2006 rate. The reported unemployment rate for 2007 was the lowest in seven years. Despite this, it is still above the EU average (7.1%). The regions of the country with the highest unemployment rates are the two eastern regions, Košice and Prešov, and the south-central region of Banská Bystrica, with unemployment rates of more than 20% (Ministry of Labour, Social Affairs and Family, 2008). The main causes of the high unemployment rate in the Slovakia are a lack of jobs for people with lower qualifications and the need for reform of the content of education to meet labour market demands (Ministry of Labour, Social Affairs and Family, 2006:6).

Social exclusion and adverse living conditions can result in children from vulnerable Roma communities leaving school early. According to a UNDP report on the living conditions of Roma in Slovakia (Filadelfiová, Gerbery & Škobla, 2007), as many as 35% of Roma older than 25 years did not finish their basic education. About the same share (36.6%) finished basic education. Also, only 15.4% of the Roma population reached high school or higher education. (Ministry of Labour, Social Affairs and Family, 2006:6).

The current national life expectancy in Slovakia is 74.2 years (UNDP, 2008). Life expectancy among males, however, varies by as much as 5–6 years in different districts (Infostat, 2006), with socioeconomic and environmental determinants believed to be the main causes for these differences.

In 2002, the main noncommunicable diseases accounted for about 89% of all deaths in Slovakia; external causes accounted for about 6%; and communicable diseases accounted for less than 1%. In total, 54% of all deaths were caused by diseases of the circulatory system and 22% by cancer (WHO Regional Office for Europe, 2006).

Slovakia, along with Bulgaria, Hungary and Romania, has one of the largest populations of Roma in Europe, relative to the total population of the country. In Slovakia, this represents an estimated 400 000 inhabitants – meaning 7% of the overall population (Vaňo & Mészáros, 2004). About two thirds of Slovakia's Roma population live in eastern and south-central Slovakia.

The Office of the Plenipotentiary for Roma Communities is a state advisory organ that focuses on solving problems in Roma communities and that implements systematic measures for the improvement of their position and integration into majority society. According to materials obtained from the Plenipotentiary, at the end of 2004, 1575 Roma communities had been identified in Slovakia. In 772 villages or towns, Roma communities were integrated with the majority society. Of the remaining communities, 168 were identified as Roma communities within a larger town or village, 338 were Roma settlements located on the outskirts of a town or village, and 281 were Roma settlements remote from any other town or village. Of all the Roma communities, 149 were classified as segregated (Office of the Plenipotentiary for Roma Communities, 2004).

Roma communities are divided into three categories, according to their spatial distribution. Settlements where Roma inhabitants live diffusedly among the majority of the population are considered integrated/diffused. Integrated/concentrated settlements refer to concentrations of Roma in villages and towns where, according to majority opinion/perception (on the part of the majority of the population), the Roma populous exceeds 80% and the locality is made up of at least three dwellings; if there are less than three, the locality is not considered a settlement (Radičová et al., 2004:200). Residential Roma communities that are physically separated from a village or town, but are physically located within their territories, are considered segregated settlements. A totally segregated settlement creates an individual urban unit, which is physically separated from the village or town (Mušinka, 2002:648). The Office of the Plenipotentiary for Roma Communities defines a segregated settlement as a "residential system that is located on the edge, or away from the village/town, inside which there is no accessible running water and the share of illegal dwellings is higher than 20%" (Office of the Plenipotentiary for Roma Communities, 2004).

The following data were collected from sociographic research on Roma settlements in Slovakia, conducted by the Social Policy Analysis Centre (SPACE) between 2003 and 2004. The data are available on the Office of the Plenipotentiary for Roma Communities web site (Office of the Plenipotentiary for Roma Communities, 2008).

About a third of the dwellings in Roma settlements are informal (legal property rights are unclear). These dwellings generally consist of shacks made of scavenged materials, prefabricated dwellings, non-residential buildings, and some houses. Of informal dwellings, 49% were in segregated Roma settlements. Of these, 16% were shacks. In Roma settlements, the infrastructure was insufficient. The following data describe the status of village and town concentrations, settlements located on the edge of a village/town, and settlements located further away or separated by natural or artificial barriers. While 91% of these settlements had electricity, 81% lacked sewerage, compromising hygiene and contributing to the spread of disease. Also, 59% lacked gas, and 37% lacked piped water. According to the Office of the Plenipotentiary for Roma Communities, in total, 46 settlements had nearly no infrastructure (piped water, sewerage, gas and paved access road). The population of these especially deprived villages was 6355 people (Office of the Plenipotentiary for Roma Communities, 2004).

In the most isolated settlements, secondary illiteracy – that is, even those that have completed primary school, and even secondary school, experience significant difficulty in reading and writing – is a problem.

Health and health care

The health status of Roma living in segregated settlements is related to their lower rates of employment, inadequate living conditions, lack of equitable access to public services, and lower educational attainment and health literacy. These inequities result in inadequate personal and communal hygiene, leading to infectious and parasitic diseases, such as respiratory tract infections, TB, scabies, pediculosis capitis, pyodermia, mycosis and hepatitis, and the occurrence of lice is also very frequent. Lack of sexual education, in particular, leads to higher rates of venereal disease. Vulnerability to these and other diseases is heightened by the low rates of vaccination (Ministry of Health, 2007).

Lack of education and secondary illiteracy hinder access to health care. Offshoots of these shortcomings are poor health literacy and a poor ability to understand and navigate the health system, particularly the health insurance system. Also, high unemployment – often 100% in isolated settlements – decreases the ability of Roma to pay costs related to health care and contributes to their overall feelings of frustration and to their lack of motivation. These and other factors may contribute to drug abuse and family violence. Drug addiction among Roma creates a higher risk of infection by the HIV and hepatitis B and C viruses and by other sexually transmitted diseases. All these factors have a negative influence on the community (Šaško, 2002).

Currently, no study summarizes the health status of the Roma community as a whole in Slovakia. Given this, many of the indicators provided in this case study come from an analysis of data collected by the Association for Culture, Education and

Communication (ACEC) Healthy Communities health assistants. These data have been summarized in monthly reports filed by programme coordinators and reflect contact with more than 45 000 Roma in the 67 settlements where the programme operates.

The Constitution of Slovakia guarantees universal free access to health care, based on participation in a mandatory health insurance scheme. Since the country's independence, the Slovak health system has made the transition from a tax-based system with health care provided by the state to a decentralized health insurance system that includes both public and private providers. Responsibility for financing, oversight and management of health care facilities has gradually shifted from the Ministry of Health to territorial units and municipalities. Also, many facilities – including local health centres, pharmacies and polyclinics – were privatized (Hlavacka, Wagner & Riesberg, 2004). Under the new system, most of the equity in health care provision has been maintained, as the density of providers is comparably high. In rural areas, however, the density of providers is lower and distances longer which affect particularly Roma living in settlements in remote areas. Equity in financing health care may have been reduced to some extent, as insurance contributions from employees and employers are proportional instead of progressive. In addition, private out-of-pocket payments have increased, although (until recently) Slovakia relied on a relatively small share of private expenditures (Hlavacka, Wagner & Riesberg, 2004).

Before 1989, all residents of Slovakia, including Roma, were required to participate in preventive health check-ups. The social, economic, and health system changes that have occurred since 1989 have shifted responsibility for health to the individual, posing particular challenges for the poor and excluded. Also, pursuant to legislation in force, everyone is entitled to a preventive examination (adults once in two years, children more often), but people have to contact their general practitioner themselves. This is not always done, and demand for preventive health care is low among the Roma (Radičová, 2002).

Slovakia now has six health insurance companies (Ministry of Health, 2008), each of which is in competition with the others to gain the greatest number of clients. As noted, this represents a substantial break from the pre-1989 system, where health care was guaranteed by the state. Socially excluded groups, including the Roma, are often not aware of how the system has changed and how to navigate it. So, even though some inhabitants of Roma settlements did not purposely change insurance providers, they received a new insurance card from one of the new insurance companies. According to current legislation, this card is valid unless the client provides a sworn statement to the Office for the Supervision of Public Care that they did not intend to change insurance providers. Due to a lack of awareness of this legislation, many Roma failed to provide the sworn statement. A consequence of this is that these Roma may provide incorrect insurance information when they receive health care and/or are hospitalized and may be required to pay the entire costs incurred. Indeed, as part of the current ACEC Healthy Communities programme, health assistants are helping inhabitants of settlements to resolve this predicament.

In 2003, the Government of Slovakia produced a comprehensive Roma strategy, entitled *The basic thesis of the approach of the Government of Slovakia for the integration of Roma communities* (Office of the Plenipotentiary for Roma Communities, 2003). The Slovak strategy for Roma is built on the principles of integration. Under these principles, the balanced and stable opportunity of an ethnic group to participate in the public and economic life of the country is based on equal opportunities that do not endanger a group's identity (language and cultural). This concept, while fulfilling its own goals, arises from the human–legal principles stated in the Constitution of Slovakia and in international agreements on human rights (Office of the Plenipotentiary for Roma Communities, 2003).

The Programme to Support the Health of Disadvantaged Communities from 2007 to 2015 is consistent with the government strategy for Roma, having the reduction of health inequities as its primary goal. Programme documents suggest that, to measurably reduce health inequities, a broad shift in the way health is perceived is required in Roma settlements. The Programme aims to eliminate inequities in the approaches to prevention and health care and current health status, morbidity and mortality. It also aims to address determinants of health, including wages; consumerism and lifestyle; status – that is, the symbolic expression of inequality; ability to work; education and the approach to education; and influence and power. The Programme is split into two phases. The first phase focuses on Roma inhabitants living in settlements. The second phase – as of 2009 – involves parallel activities for other disadvantaged communities, such as homeless people and refugees (Ministry of Health, 2007).

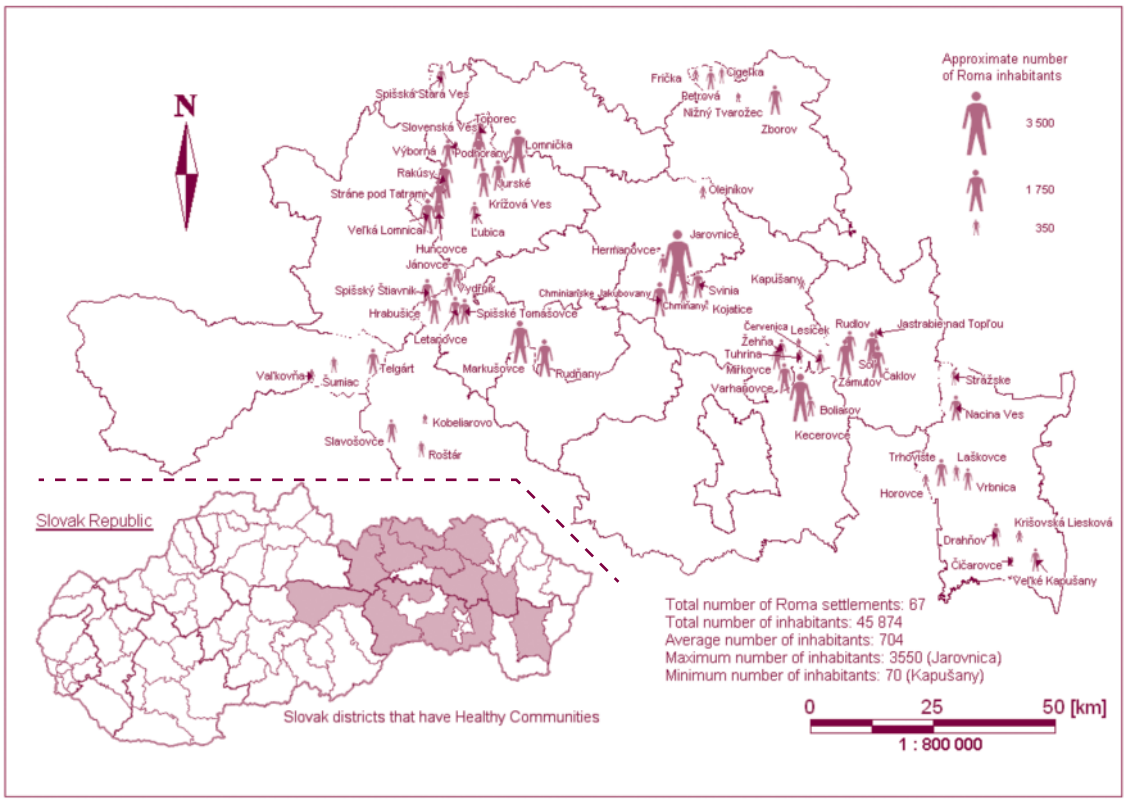
Slovakia also participates in the Decade of Roma Inclusion 2005–2015, an international initiative to improve Roma status. As part of this, the Slovak government has created a Roma Health Action Plan. Although the activities carried out by health assistants through the ACEC Healthy Communities programme are outside the framework of the Decade of Roma Inclusion 2005–2015 Health Action Plan, they are in synergy with the Action Plan objectives – namely, data collection, improved Roma access to health care, improved sexual health, and increased vaccination rates.

The ACEC Healthy Communities programme is currently the largest initiative to improve Roma health in Slovakia. To facilitate the development of additional programmes, ACEC attempts to provide, in collaboration with the Ministry of Health and the Office of the Plenipotentiary for Roma Communities, a database and trained cadre of personnel that can be used to implement other Roma health programmes.

Programme benefiting the target population

The Healthy Communities programme is implemented in 67 Roma settlements, with a total population of more than 45 000 inhabitants. Fig. 17.1 shows the number of inhabitants in Roma settlements in which the programme is currently implemented. The data on the number of inhabitants in the settlements (from a survey conducted in December 2007) were provided by health assistants in cooperation with the mayors of the villages.

Fig. 17.1. Roma settlements where Healthy Communities operate in Slovakia



Source: ACEC, unpublished data (2008). Reproduced with the permission of the copyright holder.

The aim of the programme is to improve the health status of the Roma population through increased human resource capacity, health literacy, access to health care, and assessments of Roma health. The inhabitants of 67 Roma settlements are the primary target group of the programme. Secondary target groups are: community workers, including health assistants, coordinators and volunteers; general practitioners and paediatricians in the regions; and representatives of local authorities. The specific individual goals and activities are as follows.

Increase Roma human resource capacity

Increased human resource capacity is accomplished through the training of health assistants and coordinators from the Roma settlements. These staff become important human resources for linking their communities to available health services and

improving individual responsibility for health. They also build local partnerships for health, and its determinants, through establishing or improving communication among paediatricians, general practitioners, local councils and the Roma community. Many staff are women, and their employment strengthens their role in the Roma community. Additional details on the activities of each are provided below (see the section on "Healthy Communities programme staff activities").

Increase Roma health literacy

Increased health literacy includes improving the awareness of healthy behaviours and lifestyles among Roma. The issues addressed include infectious and parasitic diseases, sexual health, and adequate hygiene and sanitation. Increased health literacy also covers education on the need for vaccination and other illness prevention and health promotion activities. Activities for increasing health literacy include community education sessions (also in partnership with local institutions) and integration – by health assistants – of health education into home visits and other outreach activities (see next objective).

Increase Roma access to health care

Increased Roma access to health care entails increasing settlement inhabitants' knowledge of how the Slovakian health system works, how to access health care, what their rights are as patients and to what health insurance they are entitled. It also includes increasing health outreach activities in the settlements. Activities under this objective include vaccination campaigns; home visits to provide first aid and to support the care of new mothers; advising and (when needed) accompanying settlement inhabitants to receive health care or resolve health insurance issues; and meeting regularly with local practitioners and authorities. Through these meetings, general practitioners and paediatricians are sensitized to the particular health needs of isolated Roma settlements, as well as to how to better work with Roma patients. Also, representatives of local authorities are sensitized to the needs and desires of Roma communities. It is hoped that, in the course of the programme, their lasting relationships with Roma settlements will result in important action on the determinants of health, such as infrastructure for potable water and sanitation, and other improvements.

Increase assessments of Roma health

A very important function of the Healthy Communities programme is to contribute to the assessment and monitoring of Roma health. Health assistants – through collecting data on health status, preparing reports and ensuring that these are shared with local practitioners – provide an important service. Trnava University's Department of Public Health Care cooperates in collecting data and creating questionnaires. In addition, a team of specialists from the University of Wisconsin in the United States is currently preparing a questionnaire that focuses on the health status of Roma women.

Healthy Communities programme staff activities

Health assistants

Health assistants monitor the health status of settlement inhabitants and serve as bridges between the community and local health services. They meet or telephone local practitioners or paediatricians, or both, a minimum of once a week. Health-assistant activities include, but are not limited to:

- visiting homes regularly, to assist individual patients and their families to access health care;
- accompanying the patient on doctor or hospital visits, or both, when needed, to facilitate communication and ensure that the patient understands information given by the doctor;
- assisting local health services to organize vaccination campaigns against hepatitis and flu, targeting both children and adults;
- assisting new mothers with care of newborn babies;
- assisting settlement inhabitants with chronic illnesses, including facilitating follow-up visits;

- providing counselling on how to make homes and the community more hygienic, taking into account resource constraints;
- organizing community health education sessions to provide sex education, address basic hygiene, and discuss access to the health care system;
- helping inhabitants resolve issues related to health insurance; and
- providing basic first aid.

In a weekly report, which is handed in together with the monthly work statement, the health assistant records every action carried out in their particular settlement. When health assistants are newly hired, they first visit community leaders and residents in the settlement in which they will work to inform residents about their role. The effectiveness of each health assistant depends to a large extent on their level of motivation. For instance, they must be proactive in providing home visits and follow-up visits and in organizing health education sessions. In the case of vaccination campaigns or disease outbreaks, health assistants may all work together. In 2007, health assistants and volunteers supported local health services in efforts to vaccinate children and adults against hepatitis A and B.

Coordinators

The coordinator secures fluent communication between all stakeholders involved in programme implementation and is responsible for oversight of programme activities. This is done through in-person visits to settlement inhabitants and regular (once or twice weekly) contact with every health assistant within their group. The purpose of this communication is to ensure quality service delivery by health assistants – for example, through motivation and ensuring task fulfilment. The coordinator keeps the health assistants informed about training opportunities and ensures appropriate completion of weekly reports and monthly work statements. In addition, coordinators play an active role in ensuring cooperation with general practitioners and paediatricians – for example, with vaccination campaigns – and local authorities.

Due to very high unemployment rates in the settlements, health assistants and coordinators are contracted to perform work and are paid regular monthly incomes. Aside from their monthly salary, the health assistants receive a financial allowance for the purchase of items for their first aid kit. Aside from their monthly salary, coordinators receive a financial allowance to cover telecommunication and travelling costs.

Training and education

As of March 2008, the majority of health assistants (76.1%) were recruited directly from the settlements in which they operate. Of the health assistants who do not live directly in the settlement (23.9%), the majority of them live in the same area – that is, in the village of which the settlement is part. Coordinators are also recruited from and live in the communities they serve.

Due in part to the staff's poor living conditions, low levels of education and pessimism about the future, ACEC focused particularly on training, motivating and increasing the self-efficacy of the staff recruited. This required human and financial investment from ACEC, which provided ongoing and direct support to settlement-based work.

Before starting the training, coordinators and health assistants must complete a selection process, to ensure that those who attend the training will subsequently work within the programme. In collaboration with local mayors and coordinators, ACEC selects health assistants, and every new health assistant undergoes an interview with the coordinator and education manager. Among their qualifications, health assistants must be literate, should know how to communicate their requirements and position and have the communication skills needed for further growth, and should have good relations with the community. When selecting health assistants, motivation to work as an assistant in the field is also an important qualification.

ACEC established the training programme Community Worker – Implementation of Knowledge and Skills in Working with the Roma Community, which became accredited by the Ministry of Education in 2004. All health assistants must complete this programme. The health assistants and coordinators attend three training sessions annually, which are focused on three areas: information, motivation and specialization. The educational plan is divided into three individual theme blocks:

- **theme block 1:** basic information, motivation and specialist training;

- **theme block 2:** communication skills, communication and use of the communication skills learned within the programme, conflict resolution and model situations; and
- **theme block 3:** responsibility and motivation, planning of tasks, and working habits.

An ACEC team of trainers leads the training sessions. Doctors and representatives from the Operation Centre of Medical Emergency services and the Slovak Red Cross also take part in these education sessions. Every training cycle is evaluated by a test, which is completed by all training attendees. As part of the training and orientation, lectures by ACEC trainers cover specific health assistant tasks and the overall living conditions and health situation in the settlements in which they work.

To provide further support during the implementation of programme activities, field manuals have been created and additional specialist training is available. The manual for health assistants describes concrete tasks and contains the form for weekly and monthly reports. The manual for coordinators describes their tasks and responsibilities. Coordinators and health assistants also participate in specialist training sessions, which are led by representatives of the Slovak Red Cross and the Operation Centre of the Emergency Services. These training sessions cover basic first aid. Coordinators and health assistants thus have first aid kits and blood pressure meters for their work in the Roman settlements.

So far, 88 health assistants and 4 coordinators have completed the training programme. It is important to note that the training described above and increased feelings of self-efficacy that stem from their work have inspired some health assistants to pursue further education on their own. Some have returned to complete elementary school, while others have pursued other types of training.

Monitoring and evaluating the programme

The programme includes four types of monitoring and evaluation. First, ACEC programme managers make regular visits to settlements to assess the work of coordinators and health assistants. Also, coordinators oversee health-assistant activities, as explained above. Second, weekly and monthly reporting cycles support the monitoring function. Third, regular meetings are held between programme managers, coordinators, health assistants and representatives from the local health services. These meetings are particularly useful for sharing experiences and suggesting possible programme improvements or changes. Fourth, to better understand certain aspects of the programme, questionnaires were distributed to 67 health assistants in March 2008.

The aim of the questionnaire was to obtain feedback from health assistants and, by this means, to monitor and assess the educational activities, the working environment, the skills and experience acquired, and the positive changes and risks within the project. The questionnaire was created in cooperation with the Faculty of Health and Social Work of the University of Trnava. It consisted of 22 questions (open and closed) focused on the various areas mentioned at the beginning of this paragraph. The data from the questionnaire was processed by simply totalling the individual possibilities and converting them to percentages. An analysis of the responses to the questionnaire showed that health assistants perceive the significance of their work for the community as either necessary (43%), highly significant (33%), or significant (24%).

With regard to working relationships with paediatricians and general practitioners, 31% of health assistants reported that communication with doctors was excellent, 30% reported that it was very good, 38% reported that it was good, and 1% reported that it was not so good. When asked whether or not health assistants perceived that doctors approached them as an equal partners in solving problems in the Roma communities, 57% reported “yes, always”, 33% reported “sometimes” and 10% reported “I don’t know”.

The following indicators/indices for changes and improvements noted since the start of the health assistant work were obtained from the questionnaire for health assistants (percentages refer to the number of respondents who gave positive replies to each):

- higher number of immunizations and associated prevention (29%);
- higher number of preventive inspections (18%);
- better and higher quality hygiene, especially for children (14%);
- better communication on many levels – with the inhabitants of the communities, with the doctors and health personnel, with the teachers, or with the mayor – and, as a consequence, better cooperation (13%);
- higher measure of responsibility for their own health and for the health of their children (8%);

- higher awareness of the health of the inhabitants of the settlements/villages (5%);
- overall improvement in the health situation in the settlements (as a result of prevention) and higher measure of responsibility and independence (5%);
- more opportunities for settlement inhabitants to gain knowledge and to turn to someone (health assistant) with health problems, which fosters the acceptance of the health assistant's role (3%);
- other (5%).

In the category of *other*, there are answers such as:

- greater attention by the mayor for the events occurring in the settlements
- greater interest in the elderly
- greater interest to educate themselves
- improvement in housing
- improvement in children's upbringing
- better school attendance.

Monitoring a sample of inhabitants of Roma settlements where the Healthy Communities programme was underway has provided evidence of a sequential increase in the use of preventive health care. According to Union Health Insurance Company, participation in preventive health check-ups increased significantly from January to December 2007. The average of total preventive health check-up usage in 2007 among adult insurants in Slovakia was 16%, and in the Roma inhabitants/identified sample it was 36% (Zelníková, 2008).

Lessons learned

Programme staffing, local ownership and empowerment

In overseeing this programme, ACEC has come to appreciate the advantages of employing Roma health assistants and coordinators from the very same settlements in which the programme operates. First, these individuals are able to communicate in a culturally appropriate manner with settlement residents about sensitive issues. Second, health assistants create lasting relationships with local physicians and councils. These relationships will facilitate access to essential services and improvements in Roma settlements well beyond the end of the Healthy Communities programme. Third, training and empowering Roma from excluded settlements creates a cadre of advocates that can speak on behalf of their communities, inspires other settlement residents to do similar work, and builds the capacity of individuals that may contribute to their communities in other ways following the programme. Fourth, having health assistants come from the communities they serve helps to ensure their motivation and commitment to helping their own communities. Also, health assistants have collaborated in collecting data for projects in disciplines other than health. They further build trust between themselves and their communities by providing regular home visits, by assisting in navigating the health system when requested and by providing first aid.

The training of Roma from settlements is an important element of the programme, and ACEC has learned that ongoing monitoring, supervision, training and support are required to maintain motivation and facilitate continued growth in the abilities of health assistants. This also facilitates continuing programme improvements, as coordinators and health assistants are encouraged to discuss how the programme is progressing and to suggest changes.

The empowerment of health assistants, coordinators, and volunteers from the target communities is essential to the long-term sustainability of the programme. The underlying principle applied in operations is to never undervalue the contribution of anyone in the community. For example, if someone volunteers and has no health training, but nevertheless has a lot of motivation, the programme incorporates their contribution. Motivation and commitment, particularly in health assistants, must be nurtured through the approach to training and programme management. In some settlements, these assets have resulted in activities continuing even when funding has been limited or temporarily suspended. In other cases, they have resulted in additional resources being raised by the community itself for implementing programme objectives.

Increasing health literacy

ACEC has noted the particularly low level of health literacy among settlement inhabitants. This is especially so for somewhat taboo health issues, such as sexual health. For example, in giving health education sessions, health assistants ascertained that many teenage girls did not know about birth control or sexually transmitted infections. It is therefore important that health assistants receive adequate training to deliver health education. It has also become evident that, as the need arises, health assistants require further specialized training. For instance, there was a jaundice epidemic in some of the targeted settlements, and it would have been helpful to provide health assistants with specific training in jaundice. It might also make sense in the future to choose the number of health assistants according to the difficulties posed by settlement living conditions, rather than the number of inhabitants.

Orienting users to a changing system and sharing tools and know-how

The Healthy Communities programme generally facilitates the inclusion of vulnerable groups in the new, decentralized and more privatized health system. One way the programme does this is through the creation of sustainable links with other service providers and local governments. For example, the involvement of physicians ensures that they are more aware of Roma community health needs, which helps Roma communities build trust in the health care system and perceive themselves as Slovak citizens with health care rights and entitlements. The monitoring and evaluation structure of the programme reinforces these connections, and regular consultations with participating doctors ensure that the programme context remains within that of ongoing health system reform. Generally, local government representatives in villages where the programme is implemented cooperate very well with health assistants and coordinators. Many of these representatives have also expressed interest in writing about the positive contribution of the project.

The programme has led to the creation of specific tools that can be used nationally, such as the training curriculum accredited by the Ministry of Education. This education plan was used in the programme Roma for Society (Phase III), which aimed to build human resources for Roma settlements (30 people from 11 locations). The target group for the programme was settlement inhabitants who had completed primary education or secondary education but without passing their exams. After having completed the education programme, ACEC employed them as supervising workers in projects focused on education and health education. Of this group of 30 settlement inhabitants, 70% of them went on to apply themselves in such education programmes as Healthy Communities and the Young Roma Artist Education Fund. The Roma for Society (Phase III) programme was implemented by ACEC and financed by the European Social Fund through the Ministry of Education.

In addition to increasing the number of inhabitants of settlements reached by its activities, ACEC also aims to increase the number of settlements that benefit from this programme. The Healthy Communities programme was presented at a nationwide conference of paediatricians in Slovakia in May 2007, where discussions took place with specialists on the programmes results and possibilities for its expansion in the future. The programme was also presented in the Slovak media and in the United States, at Columbia University in New York City and at the University of Wisconsin-Green Bay.

Overall programme financing comes from international and national private businesses. The financial support provided by the private sector is flexible and independent of legislative amendments. Financing is secured contractually for maintaining current operations until the end of 2009. Obtaining independent (private) funds for Roma-related activities is difficult. In the case of ACEC, funding is made possible through mutual trust built up from long-term cooperation with partners.

Acknowledgements

The author of this study would like to thank Michal Kubo, ACEC Project Assistant, for his input.

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18. Spain: Health Promotion among Navarre Ethnic Minorities programme

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Summary

In the 1980s, before the commencement of the Health Promotion among Navarre Ethnic Minorities programme, the Roma population in Spain and in the autonomous community of Navarre experienced poverty and social exclusion, unhealthy housing and environmental conditions, insufficient access to public services, prejudice, and discrimination. As a result, they incurred higher mortality, morbidity and the prevalence of unhealthy behaviour. These health consequences had more to do with lack of equity in life opportunities, access and use of resources than with genetic factors intrinsic to the Roma minority.

In response to the health and social inequities described above, the Health Promotion among Navarre Ethnic Minorities programme began in 1987. It was initiated by a NGO, the Saint Lucia Foundation Patronage, which initially coordinated it while requesting that it be incorporated into public services. The Health Department of Navarre honoured the request and placed the programme's management first in the Directorate for Primary Health Care and later in the Health Promotion Service of the Public Health Institute of Navarre. In 1987, the programme was implemented in four basic health zones. By 2005, it had expanded to 15 zones and had direct contact with more than half of the 6000–7000 Roma living in Navarre. It is implemented in the health zones with the largest Roma populations.

The programme's objective is to reduce health inequities by improving the health of the Roma community. The activities and work strategies include: (a) health mediation, using Roma mediators; (b) coordination and collaboration with local and central authorities; (c) peer education; (d) empowerment and participation of the Roma community; and (e) exhaustive training of Roma mediators. The programme has three main partners at the central level of coordination: the Public Health Institute, Gaz Kaló (a Roma association that brings together Roma associations of Navarre), and central health, social and education services. In each implementation zone, the programme is represented by an Intersectoral Commission. This local Commission analyses the community situation, records Roma requests and needs, monitors local activities and objectives, and evaluates the programme.

Evaluations have provided evidence that the programme has had an impact on the health of the Roma community in Navarre. The programme has contributed to higher levels of primary health care coverage, strengthened the reproductive health of women and improved child health. It has increased the participation of the Roma community in health education and in chronic disease and other prevention programmes. It has also increased school attendance of Roma children younger than 12 years to 90%.

The Health Promotion among Navarre Ethnic Minorities programme began at a time in Spain when there was no other specific programme for the Roma population and when the concept of inequitable access to health services by the Roma population was not acknowledged. The programme has thus played a pioneering role in sharing lessons learned and in orienting the National Strategy for Health Equity for the Roma Population.

Socioeconomic and policy context

In Navarre

In the 1980s, before the commencement of the Health Promotion among Navarre Ethnic Minorities programme, the Roma population in Spain and in the autonomous community of Navarre experienced poverty and social exclusion, unhealthy housing and environmental conditions, insufficient access to public services, prejudice, and discrimination. As a result, they incurred higher mortality, morbidity and the prevalence of unhealthy behaviour. These health consequences had more to do with lack of equity in life opportunities, access and use of resources than with genetic factors intrinsic to the Roma minority.

Table 18.1 shows the characteristics of the Navarre and Roma communities when the programme was in its early stages.

Since the beginning of the programme and continuing through to today, data on Roma health has been scarce in Spain and in Navarre. However, the literature available has shown that the Roma population generally has worse health outcomes and behaviour than the general population. To start, infant mortality is 1.4 times higher than the national average, and life expectancy for the Roma population is between 8 and 9 years below the average (Montoya, 1994). Next, there is a higher incidence of infectious disease (Fos et al., 1987; Cabedo García et al., 2000), mainly hepatitis B and C, with frequently observed mother-to-child transmission (Delgado Sánchez, 1990). A higher incidence of HIV is also observed, mainly among intravenous drug users. In addition, vaccinations for children are deficient (Regional Government of Andalusia, 1996), and

Table 18.1. Navarre and Roma characteristics

Navarre characteristics	Roma ethnic minority characteristics
Overall population characteristics	Settled during the 15th century
519 277 inhabitants (53.5 inhabitants/km^2)	6000–7000 people (1% of total population) in 1300 families (700 in Pamplona)
2 municipalities with > 20 000 inhabitants	Young population: 24% less than 12 years old
Pamplona and Comarca: 55% of total population	Birth rate: five times higher than that of the general population
Health expectancy: 74.6 years for men; 81.0 years for women (77.7 and 85.0 years, respectively, in 2004)	Fertility rate: 6.7 times higher than that of the general population
Main morbidity/mortality from chronic and degenerative diseases	Deficient vaccinations for children
High levels of well-being indicators	Health-damaging nutritional habits (too rich in lipids)
Low birth rate	Tobacco and coffee used excessively, starting in early childhood
Health services	Abuse of medicine
Primary care: 51 health zones (55 zones in 2008).	High indices of domestic and work accidents
Specialist care	Preventive measures scarcely taken
Social services	Primary care services scarcely used
Municipal social services: health zones	Emergency health services and private providers of health services used often
Educational services	
Schools (for 3–12- and 12–18-year-olds)	

Source: compiled from Montoya (1994); Regional Government of Andalusia (1996); Dueñas Herrera et al. (1997); Viñes (1997); Mora Léon & Martinez Olmos (2000); Sastre Gussoni et al. (2000); Navarre Institute for Statistics (2007); FSG (2008).

follow-ups of prevention programmes are generally inadequate, especially in areas with a low socioeconomic level (Sastre Gussoni et al., 2000; Sánchez Serrnao et al., 2002). Moreover, there are health-damaging eating habits and nutrition (excessive consumption of sugar, coffee and fats), which also affect dental health in the case of children (Mora Léon & Martínez Olmos, 2000). Added to these examples are the improper use of medications and a higher incidence of accidents and unintentional injury (Sánchez Serrano et al., 2002), such as burns, falls, pedestrian traffic accidents, bone fractures and cuts. Furthermore, the Roma are a high-risk group for congenital malformations. The studies consulted make reference to genetic and cultural factors (endogamy) (Martínez-Frías, 1998; Martínez-Frías et al., 1998).

Although the socioeconomic conditions in which the Roma population live have improved in recent years, social inequalities persist. A large percentage of Roma do not perceive health as a priority: housing, finances or employment come before health. They perceive health to be the absence of disease and perceive disease to be an incapacitating phenomenon linked to death. This perspective leads to immediateness in seeking help, with transport by the family and infrequent use of ambulance services. It also leads to excessive use of emergency room services, lack of strict compliance with treatment (suspending it when symptoms disappear) and the partial use of health services, where appointments are seldom made for consultations with doctors. Also, health services have difficulty in clearly differentiating between the cultural and socioeconomic aspects of the Roma health situation. Moreover, health services are occasionally inflexible when confronting differences; for example, within the Roma community, the concepts of health and disease transcend the individual and extend to the group and community, leading to lack of comprehension by the medical establishment of the importance of relatives and their possible involvement. Furthermore, health services may face communication barriers when it comes to Roma. These barriers include the vocabulary used by professionals, written communication of professionals versus oral communication of Roma, different criteria for quality assessment of treatment (for Roma: length of time, empathy, concern), and mutual prejudice.

Roma women also experience an increased incidence of certain diseases or risk factors. These are related to the traditional role assigned to mothers and wives. For example, they have a high fertility rate, with pregnancies starting at a very young age and continuing into middle age (Dueñas Herrera et al., 1997). Also, information on family planning is scarce, so that some birth control methods are not used, because they are unknown or because of the persistence of myths and faulty ideas (Reig Majoral et al., 1999). Moreover, there is very little prevention of gynaecological diseases (Dueñas Herrera et al., 1997). Roma women also experience premature ageing, with an incidence of diseases atypical for the age groups affected, such as diabetes, bone ailments and cardiovascular problems. Among Roma women, the burdensome role of caretaker and the excessive degree of responsibility – both in and out of the home – causes symptoms of depression, anguish and anxiety in some cases.

Women's health tends to come last, and the following situations may arise. Women usually find it very difficult to have outpatient home-based care, because their gender role is incompatible (to a certain extent) with the one of patient at home. Also, in the case of mental health, women tend to abandon treatment prematurely.

It is important, however, to also underscore the strengths of the Roma community. This allows the programme to also use an asset approach to improve Roma health. Such assets include the following.

- Community support and cohesion, particularly through the extended family, can provide a sense of security and can aid in protecting individuals. Strong Roma cultural identity is also an entry point for social cohesion and associative movements.
- Some norms of behaviour, customs and habits of the Roma population can benefit health. For example, despite difficult environmental conditions, Roma adhere to a number of hygienic practices, such as the widespread use of bleach as a disinfectant and clear differentiation of unclean objects or areas from clean ones.
- The role women play, as caretakers and transmitters of knowledge, gives them leadership when it comes to health.
- Respect for the elderly has an influence on youth.

In Spain

The Health Promotion among Navarre Ethnic Minorities programme began at a time in Spain when there was no other specific programme for the Roma population and when the concept of inequitable access to health services by the Roma population was not acknowledged. The programme has thus played a pioneering role in sharing lessons learned and in orienting the National Strategy for Health Equity for the Roma Population (Ministry of Health and Consumer Affairs & FSG, 2005).

The Roma population in Spain is between 650 000 and 700 000 people (Ministry of Health and Consumer Affairs & FSG, 2006), accounting for an estimated 1.6% of the country's total population (44 million). The Roma population arrived in Spain during pilgrimages to Santiago de Compostela. There is evidence of their residing in Spain since 1425. There is also evidence of legal procedures for social confinement of the Roma population dated as early as 1499, and these procedures can be documented until 1943 (Gomez Alfaro, 1993).

The Spanish Constitution of 1978 prohibits discrimination on the basis of race, sex, beliefs/opinions or religion. In 1985, the First Plan for Roma Development (Primer Plan de Desarrollo Gitano) was approved. The Plan has received €3 million annually since 1989 and is managed by the autonomous communities and the town councils. Also in 1989, an initiative began to provide financial support to nongovernmental groups through projects that focus on life opportunities and social inclusion of the Roma population. This initiative receives an annual budget of an additional €3 million, and social service administrations manage both streams of funding of the Plan for Roma Development. Even though health is often among the issues addressed by financed projects, it is usually not the main objective. One exception, however, is the Health Promotion among Navarre Ethnic Minorities programme.

In 2003, the evidence available showed that there were disparities between the health system usage of the Roma population and that of the population as a whole. In response, the National Strategy for Health Equity for the Roma Population was launched. The Ministry of Health and Consumer Affairs (Directorate-General for Public Health, Health Promotion Area) and the Roma Secretariat Foundation (FSG), a NGO that has been operating since the 1960s, have put together a project of joint collaboration aimed at promoting health care equity for the Roma population in Spain. Within the framework of the collaboration agreement, the Ministry of Health and FSG have worked together on such measures as the following.

- The Experts Working Group on Health and the Roma Community was created to assess, mediate and build capacity for Roma health issues. It targets health professionals and administrators, as well as representatives of civil society.
- Training and awareness-raising of hundreds of health professionals throughout the country has occurred. To facilitate this process, the *Handbook for action in the area of health services with the Roma Community* (Ministry of Health and Consumer Affairs & FSG, 2006) was created.
- Several national seminars on health services and the Roma community have taken place.
- The National Survey on the Health of the Roma Population was carried out and will be compared with the National Health Survey for the general population; the data are forthcoming.

The Strategy has been endorsed and adapted by some of the autonomous communities, which have expanded its scope and increased its effectiveness. In the same vein, FSG is now coordinating a European-wide project inspired by the National Strategy for Health Equity for the Roma Population. It involves eight countries (SASTIPEN, 2007).

In 2005, the State Council of the Roma Community (Consejo Estatal del Pueblo Gitano) was created as a mechanism for consultation and assessment. The Council is composed of 40 members (50% from Roma associations and 50% from state-sector administrations, with representatives from employment, housing, health, education, culture and other sectors). Linked to the Council are working groups composed of representatives from Roma associations and state administrations, as well as other topic-specific experts. There is a working group on health (the Health Working Group of the State Council for the Roma Community: Grupo de Salud del Consejo Estatal del Pueblo Gitano), and it contributes to the National Strategy for Health Equity for the Roma Population, as well as undertakes complementary measures.

In this general context, in 2003 and in keeping with EU Directive 2000/43/CE (EC, 2000a) and Directive 2000/78/CE (EC, 2000b) related to the equal treatment of all people independent of their ethnic affiliation or race, the Council for Equal Treatment and against Discrimination (Consejo para la promoción de la Igualdad de trato y no discriminación de las personas por el origen racial o étnico) was created. In 2005, the Foundation Institute of Roma Culture (Fundación Instituto de Cultura Gitana) was inaugurated, to further an increased awareness of Roma issues and an appreciation of the Roma culture by the general population.

In 2008, a new document was published, *Roma community and health: conclusions, recommendations and proposals* (Ministry of Health and Consumer Affairs & FSG, 2008). This publication shows the first results of the Roma National Survey on Health; it also includes proposals and recommendations to improve areas where health inequities have been described. The analysis of the Roma National Survey on Health is nearly complete, and results and conclusions will be available in the near future.

Health Promotion among Navarre Ethnic Minorities programme

Background

Responding to the health and social inequities described above, the Health Promotion among Navarre Ethnic Minorities programme began in 1987. It was initiated by a NGO, the Saint Lucia Foundation Patronage, which initially coordinated it while requesting that it be incorporated into public services. The Health Department of Navarre agreed to the request and placed its management first in the Directorate for Primary Health Care and later in the Health Promotion Service of the Public Health Institute of Navarre, under the direction of a social worker. Considered to be of great importance among health promotion professionals at this time, the principles of the Alma-Ata International Conference on Primary Health Care (WHO, 1978) largely inspired the development of the programme. As a consequence, the reform of primary health care taking place in Navarre was an opportunity to improve the Roma community's health service access.

In 1987, the programme was implemented in four basic health zones [1]. By 2005, it had expanded to 15 zones (including Barañain, Burlada, Huarte, Villava, Tafalla, Estella, Tudela, San Adrian, Lodosa, Peralta, Carcastillo, and four in Pamplona) and had direct contact with more than half of the 6000–7000 Roma living in Navarre. It is implemented in the health zones with the largest Roma populations.

Objective

The programme's objective is to reduce health inequities by improving the health of the Roma community. It considers the strengths of the Roma community and uses an assets approach to improve health outcomes, address the socioeconomic and environmental determinants of health, and increase access to health services. It does this by coordinating health, social and education services and by using trained Roma mediators.

Partners and funding

Currently, the programme has twelve Roma health mediators and a coordinator, in addition to a professional from the Health Promotion Section responsible for the management of the programme. All staff members work part time. Funding comes entirely from the Public Health Institute (Servicio Navarro de Salud/Osasunbidea), Government of Navarre. The budget is ensured through grants for health promotion that the Institute convenes annually. The programme budget in 2007 was €143 499. Most of it is destined to cover the salaries of the mediators.

The programme has three main partners, listed below, which represent the central level of coordination.

1. **Public Health Institute.** At the Department of Health Promotion, a social worker, along with other technicians in the Department: helps coordinate activities and provide technical support for social and health workers and Roma from implementation health zones; ensures selection and training of mediators – for example, ensures weekly contacts for training; assesses needs; and does general monitoring and evaluation. The Institute is also responsible for financing activities, and hiring and training mediators.

2. **Gaz Kaló.** As a Roma association that brings together Roma associations of Navarre, this partner shares responsibility for training and providing technical support for mediators.

3. **Central Health, Social, and Education Services.** This partner handles central health services, including the Foral Plan for Drug Dependency and the Directorate for Primary Health Care.

In each implementation health zone, an Intersectoral Commission represents the programme. This local Commission analyses the community situation, records Roma requests and needs, monitors local activities and objectives, and evaluates the programme. A local Commission normally includes representatives from at least the following entities:

[1] Basic health zones are the smallest units of the organizational structure of the Spanish health care system. They are usually organized around a single primary care team (*Equipo de Atención Primaria*), which is also the main management unit of the zone, coordinating illness prevention, health promotion, treatment and community care activities (Durán, Lara & van Waveren, 2006).

- the Health Care Primary Centre (one social worker, responsible to the Commission and maintaining contacts with the central-level coordinator);
- social services of the municipality (one technician);
- educational centres (one representative);
- a Roma association (one person); and
- the Roma mediator of the implementation zone.

Since 1987, an annual budget has been guaranteed, with the budget for 2007 being €143 499.90. Throughout these 20 years, the number of mediators recruited annually has varied, between 5 and 13.

Activities

The activities and work strategies of the programme include: (a) health mediation, using Roma mediators; (b) coordination and collaboration with local and central authorities; (c) peer education; (d) empowerment and participation of the Roma community; and (e) exhaustive training of Roma mediators.

The central actors are the mediators from the Roma community (one in each implementation zone). Their selection by the Public Health Institute is based on a test of their educational level, the respect and value their own community grant them, their adaptability, their commitment to promote health, their initiative, and their respect for confidentiality. Once they are selected, the Intersectoral Commission is created, and mediators are then trained by the Public Health Institute in collaboration with Gaz Kaló, which will also ensure their continuous training afterwards (once a week).

When starting, mediators follow an initial training course that focuses on the following areas:

- know-how and tools for their professional activity, such as guidance on how to write a report, manage group dynamics and conduct interviews;
- health needs of Roma people: chronic diseases, lifestyle, mental health, children's and women's health;
- aspects of personal empowerment, such as dealing with stress, managing workloads, and increasing awareness of socioeconomic conditions facing the Roma community and of Roma culture and health;
- functioning of other services used by the Roma community, such as social, education, housing and employment services, and work; and
- aspects of health education, such as vaccination, programmes and resources for health, family planning, healthy habits, and substance abuse.

The subsequent weekly training for mediators focuses on aspects of health education that correspond to the needs of their communities.

A model programme starts with a census, carried out by the mediator, of all families within the community, to assess their needs and requests. A so-called history of every family is created, and the mediator keeps this information confidential. The history focuses on family health: vaccination status, food habits and nutrition, family planning, and control of pregnancies. On the basis of this census, the mediator, together with the social and health services responsible for the implementation health zone where the Roma community lives, develops a work plan, which eventually involves the schools attended by the children from the community. During the first year, priority is given to vaccinating children and to training mediators: in the beginning, 50% of a mediator's time is dedicated to individual or group training. As the years go by, this part of the mediator's time is reduced to 20–30%. The workplan incorporates other activities, such as prevention programmes, breast cancer, chronic diseases, dental health and mental illness.

In these later years, the work of the mediator consists mainly of following the workplan, in conjunction with all necessary services. This is done through regular meetings with health services, to coordinate actions with the social worker and paediatrician, and through meetings with social services or school teachers, when mediation is necessary. In so doing, a mediator develops the important skills of mediation, coordination and health education.

The programme increases mediators' opportunities for education, emphasizes and gives importance to their skills and assets, and strengthens their leadership abilities. Choosing such an approach has led to establishing more intermediate objectives than originally proposed. It has also meant working at a slower pace than that set in other types of programmes that promote health. This approach, however, is part of the technical and ethical criteria of this programme, and abandoning it would mean failure.

Monitoring and evaluation

Evaluations provide evidence that the programme has had an effect on the health of the Roma community in Navarre. During the past 20 years, the programme has been implemented in 23 of the 55 health zones in Navarre. It has contributed to higher levels of primary health care coverage, strengthened the reproductive health of women and improved child health. It has also increased participation of the Roma community in health education and chronic disease and other prevention programmes. Moreover, it has increased school attendance of Roma children younger than 12 years to 90%. In 2004, the programme was recognized by Eurohealthnet as a European good practice model on equity in health.

Programme results were achieved in the following diverse areas.

- **Primary health care.** Among Roma families: 90% are now covered; 80% of Roma have their clinical histories recorded; 80% of children are vaccinated and 70% of adolescents are vaccinated against hepatitis B; and 39.7% of children attend the dental prevention programme.
- **Women's health.** Among women of reproductive age: 62% attend family planning centres; 75% control their pregnancy in primary health care centres; 25% attend prebirth courses; and 72% go to the breast cancer prevention programme.
- **Health education.** In 85% of the 15 implementation health zones, group education projects were convened. These projects covered health topics identified through the assessment of community needs.
- **School attendance.** Among Roma children, 90% attend school until they are 12 years old (primary school), although only 33% continue to attend compulsory secondary education until 16 years. Also, high levels of absenteeism are recorded.

The qualitative results of the programme also deserve mention. The Health Promotion among Navarre Ethnic Minorities programme has succeeded in empowering Roma communities through their active participation and the control they gain over their health and its determinants. Health education in Roma communities has been increased. Intersectoral collaboration has benefited Roma communities and professionals in public services, having reduced mutual prejudices and increased mutual comprehension and acceptance.

The programme also aims to value and strengthen the role of Roma women, who are educators, caretakers of children and the elderly, and primarily responsible for passing on Roma cultural norms. Work that targets them has a multiplying effect, with repercussions on family members. With the participation of mediators from the programme, and in conjunction with the Centre for Attention to Women and Roma organizations, a study about whether the health of Roma women in Navarre is improving is underway. Information from this study will be used in the design and modification of interventions that aim to benefit the Roma community. Preliminary quantitative results, based on an analysis of data from 320 women, show that 80% of these women think it is important that their children study, 45% think that their daughters should marry after 20 years of age (67% of the surveyed women were married before 19 years of age), and 67% consider the ideal number of children to be between 1 and 4 (37% of those surveyed had had between 5 and 10 children). Of the women surveyed, 91.0% had the last birth in a hospital, 75.0% had access to gynecological check-ups, and 94.3% considered birth-control methods to be necessary and knew of services to access these (72% had used a birth-control method). In terms of qualitative results, women reported an evolution in how they see themselves within their own Roma culture, and they indicated that there is a need to maintain and improve their culture, paying equal attention to both.

A parallel process that analyses and considers the role of men is also fundamental. The programme therefore tries to work on men's responsibility for their health, on risk-taking attitudes (mainly for the prevention of traffic accidents and substance abuse) and on encouraging them to share domestic and family responsibilities.

Lessons learned

A complete evaluation of the programme (covering 1987–2006) was undertaken. Some conclusions about the programme follow.

Changes in health needs

The Health Promotion among Navarre Ethnic Minorities programme has been successful in creating a real concern about health in Roma communities. For example, in the beginning, actions were based more on children's and women's health. Now, however, a real request from the community does exist; for example, more and more educators work on absenteeism problems.

Since its beginning, the Health Promotion among Navarre Ethnic Minorities programme has focused mainly on women and children, for their benefit and an as entry point to the greater community. Recently, however, some other issues that need to be addressed have been discussed.

- **Lifestyle and prevention of disease.** Unhealthy nutrition, lack of proper physical activity, obesity and stress should receive emphasis, because these have proven to be among the more difficult health damaging patterns that need to be addressed within Roma communities.
- **Education.** Increasing school enrolment until the age of 16 years, especially among women, should be emphasized, to improve communication between families and school, to reduce absenteeism and drop-out rates, and to produce better coordination between health and scholarship programmes within the implementation health zones. Effectively, a parallel improvement of educational levels of the community has to accompany the efforts to improve Roma health.
- **Mental health.** Access to and adequate use of resources (such as understanding diagnosis and compliance to treatment) present great difficulties, but Roma also suffer from under-diagnosis, particularly of depression in women and self-medication.
- **Occupational health.** Despite the progressive inclusion of the Roma community in the primary-sector labour market, some high-risk economic activities persist, such as the use of inadequate tools or vehicles and the lack of security measures. Interventions to reduce such activities should be further developed and could easily find a place within the programme as an entry point for adult men.
- **Other health determinants.** Professionals within the programme are aware that they should take advantage of any opportunity to improve housing and employment conditions, as these are difficult (but fundamental) aspects that influence the health of the Roma.

Mediator's role

The role of mediator carries some rewards, but mediators report that changes are also needed. It is rewarding when they are recognized as professionals and as a referent person from the community and as a social and health professional in their area of work. It is also a great responsibility: after eight hours of work, they cannot close an office and leave their work problems and worries behind, because they live in the community with the people they help and are always available.

Mediators report difficulties, however, in being recognized as a professional by health professionals. Therefore, work should be done on this issue, as it is important to the success of adapting services to better serve the diversity of communities and cultures that characterize the places in which people live. At the beginning of the programme, health professionals were more involved in educational events about Roma culture. This should be promoted again, together with a wider approach to developing social and interpersonal skills for health professionals during their pre-service training and to improving cultural competencies.

Culturally appropriate approaches to prevention

Other programme challenges are related to preventing sickness among the Roma. It is important to focus on prevention in a way that incorporates how the Roma culture views health. The Roma concept of health, which emphasizes curative aspects, makes it particularly difficult for them to attend, for example, regular check-ups or cancer screenings.

Organization of the programme

With regard to improving organization, the Health Promotion among Navarre Ethnic Minorities programme could benefit from:

- making the monitoring system of all different implementation zones homogeneous and including information from health services, to better evaluate, compare and analyse health outcomes in light of their wider determinants;
- frequently reviewing and redefining evaluation indicators, to adapt the evaluation process to the changes of the Roma community; and
- strengthening and reviewing the relationship between the development of the programme and the services available from primary health care centres.

Evaluations conducted thus far show that four aspects of the programme are particularly relevant to improving the health of the Roma community. First, the programme respects the rhythm of Roma people, because it accompanies them in their community life.

Second, the programme began in a period when the principles of the Alma-Ata International Conference on Primary Health Care (WHO, 1978) were considered to be of great importance among health promotion professionals and, concurrently, when a reform of primary health care was taking place in Navarre. The structure of the programme is what makes it so adaptive to (and respectful of) Roma community needs. Therefore, a lesson worth retaining could be: it is very important not to loose an opportunity to embed the principles of health promotion within services when restructuring is planned, because this might have very important long-term effects.

Third, advances in equity in health for the Roma community are facilitated by policies that promote the community's involvement in civil society, social inclusion, and antidiscrimination measures. Thus, it is important to develop policies that result in improvement of the socioeconomic conditions that determine the health of the Roma population. Policies should include actions aimed at decreasing inequities in access (to opportunities) that face this population.

Fourth, health, as a resource for life, is fundamental to the social integration of the Roma population. Some key strategies to reach this goal are:

- to guarantee consistent and complete access to culturally sensitive services;
- to undertake capacity building among the Roma population, particularly in programmes that promote health and prevent sickness; and
- to ensure the participation of the Roma community in all phases of activities that reduce health inequities, from analysis to execution to evaluation.

Acknowledgements

The authors would like to thank Maria Teresa Abaurrea Azkona of the Roma Association Gaz Kaló and also thank Maria Pilar Marín Palacios and Pilar García Castellano of the Department of Health Promotion, Public Health Institute (Servicio Navarro de Salud/Osasunbidea), Government of Navarra, Spain, for their contributions to this case study.

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19. Sweden: FRISK – addressing underemployment and sick leave

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Summary

The influence of the work environment on physical health and mental well-being is substantial. Negative stress, often the result of a heavy burden of work combined with a lack of influence over one's work, dramatically increases the risk of cardiovascular disease and mental illness. Also, long-term sick leave is correlated with limited decision-making powers in the workplace.

Norrbotten County has the highest sick-leave rate in Sweden, accompanied by one of the lowest rates of disposable income per inhabitant. When compared with the national average, the County also suffers from higher rates of unemployment, lower levels of educational attainment and a lower life expectancy.

To improve public health and reduce health inequities, the Swedish Parliament endorsed the intersectoral Swedish Public Health Policy in 2003. This policy specifies 11 domains of action, each aspiring to the national goal of creating social conditions conducive to good health for the entire population. One domain is categorized as "better health in work life".

Thus, in 2003, Norrbotten County announced its Declaration of Intent for Health and Development in Norrbotten, as a commitment to national public health goals. The Declaration underscored the importance of health as an asset for (and an outcome of) development and resulted in the formation of United Regional Initiators Start the Fight (Förenade Regionala Initiativtagare Startar Kampen, FRISK), an umbrella initiative that provides evidence, know-how and opportunities for intersectoral collaboration to reduce sick-leave rates.

The reduction of absence due to sickness serves as a vehicle for simultaneously improving health and economic productivity. To this end, FRISK brings together government authorities, municipalities, the business community, trade unions and other key organizations in a joint effort to halve Norrbotten's sick-leave rate by 2008. The programme targets three realms of the workplace.

1. **Management.** This realm aims to improve managements' attitudes, communication methods and level of health promotion. It also aims to enhance individual authority over work decisions and encourage the appropriate use of valuable skills to reduce stress-related illness.

2. **Work environment.** This realm aims to require the workplace to have an organizational structure and physical environment conducive to good health, including the guarantee of safety and security for its workers. Opportunities should also be provided for improved eating habits, physical activity and mental well-being.

[1] At the time of the case study drafting process the author was working as Process Leader FRISK-satsningen at the County Administrative Board Norrbotten; now she is working as Director of Psychiatric Services at the County Council of Örebro.

3. **Lifestyle.** This realm aims to use the workplace as a setting for increasing health literacy and empowering individuals to make healthy lifestyle choices.

Absence levels for sickness in Norrbotten have decreased, from 3.38 million net days in 2002 to 2.11 million net days in 2006, and continue to decline. The programme has contributed to this reduction by:

- creating a platform that catalyses stakeholder action around a common goal
- encouraging leadership and intersectoral collaboration
- enabling opportunities for know-how exchange
- providing resources, such as cost–benefit analyses for new health promotion initiatives.

Socioeconomic and policy context

In early 2003, the Government of Sweden adopted its first comprehensive national public health policy (Källestål, 2003). Its main goal was to create societal conditions that ensure good health, on equal terms, for the entire population. The basis for this policy was the work performed by the Swedish National Committee for Public Health (2001), using a series of national public health reports.

When summarizing the trends in health, three issues were considered important:

1. the steadily increasing life expectancy
2. the pattern of declining self-estimated good health among young people
3. the remaining health gap between social strata.

An important strategic decision was made to have the Swedish public health goals address determinants of health. This is contrary to the commonly used health problem base for health targets. The goals are directed towards society, including cultural issues, and attempt to put health issues on the political agenda, as well as on the social agenda.

Eleven objective domains

Public authorities at all levels should be guided by 11 public health domains of action – that is, objectives that cover a number of established policy areas, including economic policy, social welfare, the labour market, agriculture, transport and the environment. Municipalities, county councils, NGOs and other actors can incorporate the objectives into their activities, and the domains can also be used as a basis for formulating interim targets at various levels in society. These 11 domains are:

1. participation and influence in society;
2. economic and social security;
3. secure and favourable conditions during childhood and adolescence;
4. healthier work life;
5. healthy and safe environments and products;
6. health and medical care that more actively promotes good health;
7. effective protection against communicable diseases;
8. safe sexuality and good reproductive health;
9. increased physical activity;
10. good eating habits and safe food; and
11. reduced use of tobacco and alcohol, a society free from illicit drugs, and reduced harmful effects of excessive gambling.

These domains cover the most important determinants of Swedish public health. The benefit of using determinants as a basis

for policy is that they enable us to evaluate progress. In turn, this supports political decision-making, as determinants can be influenced by certain types of societal measures. The first group of objectives (1–5) includes initiatives to: develop social capital, counteract wider disparities in income and reduce relative poverty; give children the opportunity to grow up on fair and safe terms; support high employment; create accessible areas for recreation; and promote safe environments and products. The latter group of objectives (7–11) focus on lifestyle factors and should not *blame the individual*, but should support and facilitate healthier living. Objective 6 recognizes the importance of partnerships with health care providers, and these providers are challenged to focus more on preventing disease, promoting health and fostering intersectoral work.

The focus on health determinants makes it possible to achieve change through political decisions and places the main public health effort outside of health care. The target groups are national, regional and local authorities, as well as the private and voluntary sectors. The changes needed have to take place in the labour market, in welfare policy and in consumption patterns, as well as in health care policy.

The monitoring and evaluation of public health goals is one important means of making policy changes. According to national public health policy, the evaluation of the national public health goals are to be reported every fourth year to the Government in two reports: one on public health policy from the Swedish National Institute of Public Health and the other as part of the national public health report from the National Board of Health and Welfare of Sweden.

As highlighted in the Swedish Public Health Policy (Källestål, 2003), the work environment influences health outcomes. According to the 2003 report on the public health policy by the Swedish National Institute of Public Health (Ågren, 2003:58), negative stress – that is, tough work requirements combined with a low level of influence over one's work – dramatically increases the risk of both cardiovascular diseases and complaints about mental problems, including depression and sleeping disorders. A link has been established between limited decision-making powers and the incidence of sick leave. Long-term sick leave, in particular, is aggravated by the lack of influence. Also, the strain of monotonous work is closely associated with muscular pain, which is a leading cause of sick leave.

The work environment can be a determining factor of inequities in health. According to the 2003 report on the public health policy by the Swedish National Institute of Public Health (Ågren, 2003:58), the statistics show considerable differences in average life expectancy and ill health between high-income and less well-off municipalities in Sweden, with much higher mortality and greater ill health among blue-collar workers than among white-collar workers in managerial positions. Improvements in occupational health, as well as using the workplace as a vehicle to promote health and education, can reduce the amount of sick leave, improve health outcomes for all socioeconomic groups and help reduce health inequities.

Distribution of sick leave

Sick leave is very unevenly distributed in the population (Swedish Ministry of Health and Social Affairs, 2006). The distribution and extent of sick leave varies with gender, age and level of education. Women have a substantially higher level of sick leave than men, and account for 64% of those on sick leave. Older people have a higher rate of absence for sick leave than younger people. Also, sick leave is more common among the unemployed and those who have been repeatedly unemployed.

There are also wide socioeconomic differences (Swedish Ministry of Health and Social Affairs, 2006). Receipt of benefits for sickness or compensation for sickness and activity compensation for disabled people during rehabilitation and training is more common among people of low educational attainment. There are striking geographical differences in sick leave. Moreover, while sick leave categorized by those born inside and outside Sweden is proportional to the distribution of these groups in the population, those born abroad are overrepresented among recipients of benefits for sickness and invalidity.

Norrbotten, regional and local level

Norrbotten contains a fourth of Sweden's total geographic area, but has only 2.8% of the country's population. During the period 2000–2006, EU Structural Funds (intended to increase economic and social cohesion among Member States) covered Norrbotten through Objective 1, to meet the specific challenges of the regions concerned (very low population density, climatic handicaps, long distances and outlying location with regard to national and European markets) (Gløersen et al., 2005). Historically, Norrbotten's economy has been based on forestry, mining and hydroelectric power. In recent years, the presence of service industries has increased. At the regional and local level, county councils and municipalities have major responsibility for conducting public health work. FRISK, which is short for Förenade Regionala Initiativtagare Startar Kampen (United Regional Initiators Start the Fight), was created as part of the commitment by Norrbotten County to work towards the

national public health goals and as a response to a national call in 2003 to halve the sickness benefit rate by 2008.

The sick-leave rate is a measure of the number of days the social insurance agency has paid sickness allowance, occupational injury benefits, rehabilitation benefits, sickness benefits or activity compensation from social insurance for disabled people during rehabilitation and training, reckoned as net days per population. It does not thus include days with sick pay from employers. In 2002, Norrbotten's sick-leave rate was the highest in Sweden. This was especially true for people aged 50–65 years. Factors that influenced the rate included: a historical prevalence of manual labour or blue-collar jobs with higher physical demands, an unbalanced age structure (more elderly people than youth), lower educational attainment and lower levels of entrepreneurship.

In Norrbotten, life expectancy among men and women is about two years less than the national average. Traditional livelihoods, such as logging and mining, which are physically demanding, are potential factors that influence life expectancy. Higher rates of death from cardiovascular diseases (due to unhealthy eating habits and lack of physical activity), suicide and alcohol-related diseases, particularly among men, also reduce life expectancy. Moreover, mental well-being – strongly linked to social cohesion, people's sense of opportunities and their hopes for the future – should not be underestimated.

Norrbotten has one of the lowest rates of disposable income per inhabitant in Sweden. In comparison with national averages, Norrbotten's unemployment rate is higher (in 2006, 9.9% were unemployed or in special arranged activities called labour market schemes, compared with 6.3% nationally) and its educational level is lower (48.5% compared with 43.8% nationally with only elementary school plus upper secondary school education level of two or fewer years). In terms of socioeconomic inequities, studies show that some of Norrbotten's municipalities are among the nation's least affluent. Among Norrbotten's municipalities, there are also significant differences in socioeconomic status. Moreover, studies show a socioeconomic gradient in sick-leave rates in Norrbotten, as is the case throughout Sweden.

The Norrbotten government is working to address these issues through its regional development plan, which emphasizes young people, entrepreneurship, education and gender equity. The plan includes measures to promote a more flexible labour market. It also aims to improve the employability of people who do not have jobs or have a reduced capacity to work. On the local level, some of the 14 municipalities have created committees or steering groups for safety issues and health and some of them have created committees or steering groups for public health issues. Most of these committees or steering groups work in collaboration with primary health actors, the police, local entrepreneurs, the employment service agency and the social insurance agency.

Interventions that benefit the target population group

FRISK, besides being the acronym for Förenade Regionala Initiativtagare Startar Kampen, also means *healthy* in Swedish. It is an umbrella initiative that provides evidence, know-how and opportunities for intersectoral stakeholder collaboration to reduce sick-leave rates. FRISK was created in 2003, in response to a national governmental goal that called for halving, by 2008, sickness absence – that is, the number of days the social insurance agency paid sickness allowance.[2] Norrbotten County, with the highest sick-leave rates in Sweden, took on the challenge.

FRISK targets the following three realms of the workplace.

1. **Management.** This realm aims to improve managements' attitudes, communication methods and level of health promotion. It also aims to enhance individual authority over work decisions and encourage the appropriate use of valuable skills to reduce stress-related illness. There is a clear connection between sickness absence and management's health promotion, attitudes, demands, goals and clarity of intentions.

2. **Work environment.** This realm aims to require the workplace to have an organizational structure and physical environment conducive to good health, including the guarantee of safety and security for its workers. The highest possible level of employee safety and security should be guaranteed, and opportunities should also be provided for improved eating habits, physical activity and mental well-being.

3. **Lifestyle.** This realm aims to use the workplace as a setting for increasing health literacy and empowering individuals to make healthy lifestyle choices, thus affecting all aspects of a person's life and allowing them to more fully engage in society, while reducing the economic costs associated with ill-health.

[2] It should be noted that each organization may count the different values of short- and long-term absence more exactly, including days of sick pay.

FRISK process leadership and assistance is housed within the County Administrative Board and the committee is chaired by Norrbotten's governor, Per-Ola Eriksson. The initiative's purpose and partners are embodied in the Declaration of Intent for Health and Development in Norrbotten. The Declaration underscores the importance of health as an asset for (and an outcome of) development. Each Declaration signer is responsible for ensuring that actions towards the goal of halving sickness absence by 2008 are carried out within their organization. Each signer also commits to working across organizational boundaries to improve public health in Norrbotten.

As of 2004, FRISK Declaration-signer organizations included:

- the County Administrative Board – 275 employees;
- the County Council – 7275 employees;
- the County Labour Board – 450 employees;
- the municipalities (14) in Norrbotten – 27 150 employees;
- the Swedish Work Environment Authority – 25 employees;
- the Social Insurance Agency – 500 employees;
- Luleå University of Technology – 1500 employees, 13 500 students;
- the Confederation of Swedish Enterprise – which organizes 50 employer associations and 2171 member companies;
- Företagarna Norrbotten (the Federation of private enterprises in Norrbotten) – 2000 member companies and 18 local associations;
- Tjänstemännens Centralorganisation (the Swedish Confederation of Professional Employees) – 18 associations, with 36 000 white-collar members;
- Landsorganisationen (the Swedish Trade Union Confederation) – 16 associations, with 61 000 blue-collar members;
- Sveriges Akademikers Centralorgaisation (the Swedish Confederation of Professional Associations) – 26 associations that represent academic members;
- the Norrbotten Chamber of Commerce – 5 employees who work for a favourable business climate in the County;
- the Norrbotten District Sports Federation – 6 employees and an umbrella organization for sports, with 110 000 members;
- the Church of Sweden – 34 parishes; and
- the police – 625 employees in four police districts.

FRISK's strategic operations are led by a committee comprised of the heads of the Declaration-signer organizations. All Declaration signers are accountable for halving their sickness absences by 2008. The office housed in the County Administrative Board manages the FRISK process, which includes the functions of promoting continued commitment and action, spotlighting effective practices, providing evidence on the economic costs of sick leave, providing resources for initiative design, and creating opportunities for exchange between stakeholders. FRISK also has thematic work groups. These build know-how for addressing factors that affect health and sick-leave rates, such as gender. The gender work group identifies means to educate people on sexual violence, promote entrepreneurship among women and address salary differences.

Methodologies

Data elaboration

Part of the FRISK method is data elaboration. The FRISK process, mentioned in the preceding paragraphs, has focused on the Norrbotten perspective on sickness absence and, in particular, on the major development trends shown in Norrbotten statistics. These statistics form a platform for the necessary intersectoral cooperation for health promotion efforts and activities all over

the county. To help raise awareness and strengthen its commitment to take action to reduce sick leave at the municipal level, FRISK has elaborated detailed data that compare local rates with county/regional and national rates.

Management approaches

Another part of the FRISK method is its approach to management. FRISK spotlights examples of leadership and management that positively influence workplace health in Norrbotten. For example, several actors have developed management training with a focus on positive health effects and health promotion. Different employers also collaborate for the exchange of experiences. For example, Gällivare, the FRISK Municipality of 2005, brings different organizations together through The Initiative Cooperation employers' group, to foster information exchange on management approaches to promoting health and addressing environmental issues.

Workplace improvements

Still another part of the FRISK method is workplace improvements. FRISK actively works to highlight efforts to improve the work environment and increase worker safety. One of the experiences highlighted is that of Aitik, one of the biggest copper mines in Europe, which has involved all workers in risk analysis training and reviews. As a result of this involvement, the number of industrial injuries has been reduced by 85%, and sickness absence has been reduced by more than 40%.

Network development

Network development is another part of the FRISK method. FRISK promotes and provides information resources for the expansion of professional networks, particularly cross-organizational and cross-border networks. For example, the employers' group Initiative, in Gällivare, supports people who require rehabilitation and changes in work conditions, so they can be reintegrated into the labour market. The network has gone beyond sectoral boundaries to become an inspirational model that provides guidance to other actors in Norrbotten.

Individual empowerment

Individual empowerment is still another part of the FRISK method. By giving its 2006 Municipality of the Year Prize to Svefi Academy in Haparanda, FRISK highlighted the importance of supporting the rehabilitation of people with long-term unemployment or disabilities (reduced capacity to work). As there are many people with long-term exclusion from work life, there is a need for sharing know-how that reaches and rehabilitates them.

Examples of local action

To help share know-how on ways to reduce sick leave and contribute to economic development, FRISK creates a profile of local action. The experiences in Gällivare (Aitik mine) and Haparanda (FAROS project) illustrate this. Historically, compared with national averages, both municipalities have had higher rates of sick leave and reduced life expectancy. Gällivare, in the northern part of the country, is a mining community. Haparanda, a community near the border with Finland, has a large immigrant population, high rates of sick leave and lower than average life expectancy, especially among men.

Gällivare: Aitik mine

Aitik, just outside Gällivare and owned by Boliden Mineral AB, is one of the biggest copper mines in Europe, with 410 employees and an extraction rate of about 18 million tonnes of ore annually. Since 2002, the number of industrial injuries has been reduced by 85%, and sickness absence has been reduced by more than 40%. The following mechanisms have facilitated this progress.

Work-environment questions at Aitik always top the agenda. In 2002, Aitik had 35 industrial injuries per million hours of work and a sickness absence rate of almost 9%. Boliden took drastic steps and formulated an ambitious vision: operations without accident-related sick leave. New work-environment goals for the whole group were adopted and are followed up in the group annual report. This put work-environment issues at the top of the agenda, and the company introduced a series of concrete measures.

Healthy management. First and foremost, management's ability to act directly to improve the work environment was improved. All managers were trained in *the manager's responsibility for the work environment*, and a number of advanced courses were run in different specialized fields.

Work-environment licence. The entire staff has taken part in risk-analysis training and, in connection with the training, they have carried out analyses of their own workplaces. All the subcontractors have also been trained and have received their own work-environment licence, the so-called Aitik Card, which shows that they have been approved.

Focus on employee engagement. Employees are encouraged to report all incidents and events during operations. Near accidents are reported through simple report booklets, and they are all put on a notice board to inform the staff. In 2005, there were 160 reported near accidents, and the number of reports increases every year. When a near accident is reported, Aitik uses a simple method to make a quick risk analysis and to remedy the situation. In that way, the reporting employee gets quick feedback and sees that the system works.

Aitik's efforts to improve the work environment have paid off: sickness absence in 2005 was no more than 5%, and the number of industrial injuries per million hours of work has fallen to six. The company is nevertheless continuing to work towards its *zero vision* and introduced a new work-environment management system at the end of 2006.

Haparanda: FAROS project

To face the high rate of incapacity in Sweden, the government initiated a pilot programme in which the Social Insurance Agency and the County Labour Board found new ways and work methods to get unemployed people and workers on sick leave back in the labour market. The pilot programme was named FAROS, the acronym for Förnyad Arbetslivsinriktad Rehabilitering, Organisation och Samverkan (Renewed Work-oriented Rehabilitation, Organization and Collaboration).

The areas selected for pilot projects were Blekinge, Västra Frölunda, Västerås, Norrköping and Haparanda/Övertorneå. The programme ran for three years, 2002–2004, and followed the existing regulations of the Social Insurance Agency and the County Labour Board, but new ideas and methods were used to achieve more effective collaboration that could be applied throughout the country.

The pilot programme was oriented towards creating a joint occupational rehabilitation programme between the National Labour Market Board and the Social Insurance Agency. The programme was goal-oriented and clearly structured with methods and services that supported people throughout the entire rehabilitation process, towards the ultimate goal of employment. The point of departure from normal procedures was that the programme was able to make all necessary decisions without stopping or delaying the work as it passed between agencies. A number of scheduled checkpoints were built into the working model and a limit of 12 months was set for the entire rehabilitation programme.

Haparanda Municipality has high levels of unemployment and the county's highest rate of incapacity, with a large percentage of people with temporary or permanent disability pensions. The project in Haparanda included Haparanda and Övertorneå municipalities sharing the same premises. A specific team with representatives from the local offices of the Employment Service Agency and the Social Insurance Agency made up the task force.

As a result of the FAROS project, contact routes were shortened, thus facilitating quick decisions and overcoming obstacles where regulations and routines were sometimes disharmonious. Cross-border collaboration, sensitivity to the wishes of the individuals needing help in re-entering the labour market and Operation Door-to-Door were three important factors that contributed to the project's success. The FAROS project in Haparanda and Övertorneå produced the best result in Sweden in getting the unemployed and workers on sick leave back to work life. In the last year of the project, almost 50% of the target population got new jobs. Today, the FAROS-process model is used throughout Sweden.

Lessons learned

In Norrbotten, sickness absence decreased from 3.38 million net days in 2002 to 2.11 million net days in September 2006. The rate of sickness absence continues to decline, and FRISK achieved the goal of halving the 2002 sickness absence at the end of 2007.

FRISK has contributed to the reduction of sickness absence not by implementing hands-on projects, but by creating a platform that catalyses stakeholder action around a common goal, encourages leadership and intersectoral collaboration, provides opportunities for the exchange of know-how and offers resources (such as evidence of cost-effectiveness). Lessons learned from the implementation of FRISK can be grouped in the following areas: political leadership, evidence and exchange of know-how.

Political leadership

FRISK's efforts to reduce sick leave are based on the belief that public health status is a reflection of the quality of the society and of its government. This means that if we want a healthy (and productive) society, leadership must take responsibility. Norrbotten Governor Per-Ola Eriksson has shown leadership on this issue, and the County Administrative Board has been central in bringing all actors together and holding them accountable to the commitments embodied in the FRISK Declaration. Through the FRISK committee, all Declaration signers are further supported in keeping health issues high on their agendas. These regional efforts are reinforced by political support from the national level, particularly from the Swedish National Institute of Public Health.

Evidence

FRISK has been working to analyse Norrbotten data on both economic costs and the socioeconomic status of people on sick leave. Luleå University of Technology has collaborated in these efforts, particularly in the evaluation of local experiences. Information on economic costs is essential for underscoring the importance of the issue on the decision-making agenda, whether within a company/entity or at political levels. Several of the local municipalities and companies have done cost analyses of sick leave. They use it to guide internal decision-making processes for activities that promote health. More analysis is needed on the profile of people on sick leave, including their age and socioeconomic status. Further qualitative research is also needed to provide insight into the full range of reasons behind long-term sick leave. Such research should be conducted with both employees and employers – for example, covering such questions as: why another kind of job for these employees cannot be found or when this alternative job was presented to you, why were you not interested in taking it?

Exchange of know-how

A cornerstone activity of FRISK has been to facilitate the exchange of information on effective evidence-based practices for reducing sick leave. This has a bearing on the quality of life of those who go on sick leave. For example, studies show that people who get their sick leave pensions earlier can suffer from higher levels of depression. They may feel that they cannot contribute to the community and that they lack a sense of purpose. This perpetuates negative mental health, which in turn can influence overall well-being. Many kinds of work, however, can be done by people who do not operate at 100% physical capacity, reducing the need for early sick leave pensions. FRISK helps facilitate the exchange of knowledge on how to incorporate people with partial capacity into the workforce.

Employers and employees need to be made aware of these opportunities. They also need to be aware of practices to improve occupational health and reduce negative stress, to offer health education opportunities, to create a workplace environment that promotes health – for example, through opportunities to exercise and through healthier cafeteria selections – and to draw people who are on long-term sick leave back into the workforce. The annual Public Health Fair and the Municipality of the Year Prize are two means that FRISK uses for sharing know-how.

Acknowledgement

The author would like to thank Anna-Mari Ruisniemi, of FRISK-satsningen, County Administrative Board Norrbotten, for the input she provided.

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20. Switzerland: immigrants facing poverty and social exclusion – the Migration and Public Health Strategy

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Summary

Foreigners comprise about a fifth Switzerland's population, and immigrants comprise about a third. Overall, there are inequalities in health status between immigrants and Swiss nationals. The immigrant population faces difficult socioeconomic and working conditions, uncertainties about residence status and greater exposure to risks to health, including unhealthy behaviour. It also faces a lack of information, lower participation in sickness-prevention activities and various deficiencies in Switzerland's health care system, such as lack of interpreting services and underdeveloped transcultural skills. Switzerland has recently increased its efforts to integrate foreigners and is elaborating appropriate cross-sectoral policies.

The programme described in this case study is the Federal Office of Public Health's Migration and Public Health Strategy, which was implemented between 2002 and 2007 and has recently been refined and extended until 2013. The programme comprises activities and projects in five areas: (1) education; (2) public information, prevention and health promotion; (3) health care provision; (4) therapy for traumatized asylum seekers; and (5) research. The case study describes the programme, providing information about its implementation, its effects and the lessons learned.

The Migration and Public Health Strategy addresses health determinants, including access to the health system, discrimination and cultural attitudes. It also addresses health literacy, substance abuse, smoking, unsafe sex, eating habits and physical activity. To various degrees, it aims to ensure accessibility, acceptability and quality of health services.

The programme's main achievements were to put immigrant health on the health system agenda and to raise the visibility of problems and needs in this area. Various projects also contributed to direct improvements for the target group, the immigrant population. The greatest challenge was to increase awareness of the issue among the diverse actors and stakeholders of the Swiss health system and within the Federal Administration. Various educational activities have helped to build specific human resource capacities (such as interpreters and nursing staff). Possible improvements have been identified at the strategic and institutional level (such as agenda setting, mainstreaming the health of migrants as an issue to be addressed in policies and programmes, and the creation of cross-sectoral networks), for greater involvement of key integration-policy actors and further promotion of so-called cultural change in the health system.

Socioeconomic and policy context

The immigrant population: socioeconomic characteristics

In the Swiss population, 21% are foreigners and another 7% are naturalized immigrants. Overall, immigrants or people having an immigrant background comprise almost a third of Switzerland's inhabitants. Immigrants in Switzerland are not a homogeneous group: their demographic, social, economic and individual characteristics vary considerably. In comparison with the Swiss population, the immigrant population is younger and has more men than women, although in recent years the immigration of women has increased. Of foreigners in Switzerland, 85% are of European origin, 7% are of Asian origin, 4% of African origin and another 4% of North and South American origin. While most immigration is associated with employment and the reuniting of families, about 3% of immigrants in Switzerland are asylum seekers. In addition, an estimated 70 000 to 180 000 foreigners live in Switzerland illegally (undocumented migrants or *sans papiers*).

In Switzerland, immigrants are overrepresented at both ends of the socioeconomic spectrum. While the proportion of the immigrant population in the highest income and qualification classes is higher than the average for the population as a whole, the average level of education and vocational qualification among the immigrant population is generally lower than that of the Swiss population. Also, immigrants are overrepresented in low status employment sectors and positions. On average, wages for immigrants are lower, and unemployment and poverty are more common, than among native Swiss. This is particularly the case for immigrants from outside the EU (Swiss Federal Statistical Office, 2005; Federal Office for Migration, 2006).

Health-related characteristics of the immigrant population

Various health-related inequalities can be found between immigrants and the Swiss population as a whole. Health monitoring of parts of the immigrant population (Gabadinho & Wanner, 2006; Rommel, Weilandt & Eckert, 2006) and other studies give an indication of the health status of immigrants and their situation with respect to important health determinants. Nevertheless, Switzerland lacks systematic statistical data on the health status of immigrants. The various existing standard databases do not allow different groups to be systematically distinguished – for example, by residence status or country of origin.

Morbidity and mortality

The data available show that, in comparison with the Swiss population, immigrants generally face more health problems, such as parasitic and infectious diseases (for example, malaria, TB and hepatitis) and sexually transmitted diseases (HIV/AIDS, in particular). Also, children who have recently immigrated to Switzerland often have problems with oral health. Immigrants – in particular, older people – frequently report problems related to poor working conditions, such as rheumatism or chronic back pain, which are often combined with depression and emotional crises. Another group with specific health problems are immigrants who have suffered violence. Also, studies indicate a higher prevalence of mental disorders in immigrants than in the Swiss population. This is particularly true if immigration was forced or caused by the experience of violence. Mortality rates differ between immigrant populations and the native Swiss population in both directions. Mortality from cardiovascular and cerebrovascular diseases – the two most common causes of death in Switzerland – is lower among immigrants. This is also true of breast cancer. Conversely, perinatal, neonatal and postnatal mortality are higher among immigrants than among the Swiss population.

Health-related behaviour

Various studies show that, in comparison with the Swiss population, the smoking rate among immigrants is higher and alcohol consumption is lower, while there is no clear difference in the prevalence of drug abuse. On average, immigrants seem to be less active in sports and exercise than the Swiss population, and they show a higher risk of obesity. In sex-related behaviour, unwanted pregnancies and abortions are significantly more common among immigrant women than among women in the Swiss population, due to the lower use of contraceptives. Also, the uptake of preventive health measures varies. Studies report lower participation of immigrants in programmes of cancer prevention, HIV/AIDS testing and vaccination campaigns.

Owing to language and cultural barriers, health literacy is assumed to be lower in the immigrant population, with deficits related mainly to information about (and knowledge of) the health care system and preventive services. Apart from differences in health-related behaviour, lack of trust in the health system and lack of compliance may lead to inequalities in the use of health services and, consequently, in health status.

Causes of health-related inequalities

Whether or not a person has an immigrant background is not considered to have a direct influence on their health status, but this factor is relevant when combined with other factors. In Swiss immigration policy, for example, country of origin is a determining factor for residence status and thus has a direct effect on the general conditions for integration and, consequently, on socioeconomic status and an individual's life circumstances. Not all immigrants in Switzerland, therefore, are affected equally by health-related inequalities. However, aspects of the health system expose certain groups of immigrants to higher health risks and increase their vulnerability, causing health-related inequities.

Apart from the aforementioned socioeconomic factors and problems related to the poor work and living conditions to which immigrants are often exposed, questions of accessibility and adequacy arise in relation to health care and health promotion services in Switzerland. Essentially, every person living in Switzerland has mandatory health care insurance, with basic services open to everybody. This applies also to asylum seekers (although their access to health care services is often limited by gatekeeping practices) and to people living in Switzerland without legal status (*sans papiers*). In reality, however, *sans papiers* are often without insurance for economic reasons. Also, people whose applications for asylum are rejected and who remain in Switzerland illegally are not covered by insurance; they are covered only in emergency situations.

For immigrants, access to (and adequacy of) health care services are also affected by language and cultural barriers. Personnel in health care institutions and in organizations active in health promotion and sickness prevention often lack transcultural skills, and the use of translation services is hindered by institutional, financial and administrative barriers. Moreover, health-promotion and sickness-prevention programmes and campaigns are rarely designed in ways that adequately address the needs of the immigrant population.

Integration and health-related policies targeted at immigrants

In Switzerland, policies to promote the integration of the immigrant population have been limited for a long time to local or regional activities and left largely to private initiatives. Although various cantons and cities have been active in this area, it was only in 2000 that a federal programme was launched to promote integration. Since then, integration policies have evolved at the local and regional level, as well as at the federal level, which has led to a growing number of projects and institutions dedicated to integration. Currently, federal integration activities are dispersed across various sectoral policies, which differ in scope and approach and show a limited degree of cross-sectoral coordination. In 2006, however, the federal government began to develop a cross-sectoral programme to promote the integration of the immigrant population into mainstream social, economic and, eventually, political structures. In 2007, the Interdepartmental Working Group on Migration, representing a broad range of federal offices, proposed a package of measures to be taken in various areas of the federal government's activities (Federal Office for Migration, 2007).

The Federal Office of Public Health has considerable experience with integration-related activities. As long ago as 1991, it promoted HIV/AIDS-prevention measures targeted specifically at selected groups with different national origins. In 1995, this project was expanded to include the prevention of substance abuse and the promotion of general health and to cover additional groups. By 2002, the Federal Office of Public Health had created a special service dedicated to the special health needs of immigrants. In collaboration with the former Federal Office for Refugees, the former Federal Aliens Office and the Federal Commission for Foreigners, this service elaborated the Migration and Public Health Strategy, which was approved by the federal government in 2001 and implemented in 2002–2007 (Federal Office of Public Health, 2002). In June 2007, the Federal Council approved a refined version of the programme (Federal Office of Public Health, 2007a) and extended it to 2013. Information on these programmes can be found online (Federal Office of Public Health, 2007b).

The Migration and Public Health Strategy

Objectives and activities

The Migration and Public Health Strategy (Federal Office of Public Health, 2002) is a national programme with the long-term objective of establishing a health system of institutions capable of serving a society and clientele whose nature and needs have changed as a result of immigration. It aims to benefit the immigrant population in Switzerland, in general,

and no specific groups are defined as distinct beneficiaries. The programme contains various projects in five areas of intervention.

1. **Education (advanced and continuing training).** Activities in this area include developing courses that promote transcultural skills in health care personnel and establishing a certified training programme for intercultural interpreters.

2. **Public information, prevention and health promotion.** The federal government supports the promotion of information about the health system and, specifically, targeted activities in sickness prevention and health promotion. Activities also include raising the awareness of health care service providers.

3. **Health care provision.** Projects to facilitate access to health care services are supported in this area – for example, Migrant-friendly Hospitals with projects of their own (Saladin, 2006), such as the Competence Centre for Health and Integration in Eastern Switzerland.

4. **Therapy for traumatized asylum seekers.** The Federal Office for Migration supports institutions that specialize in therapy for traumatized asylum seekers and also supports the decentralization of such institutions.

5. **Research.** Various research projects address important issues of immigration and health (Federal Office of Public Health, 2006). One important project – the first of its kind and an important basis for further interventions – is monitoring the health status of the immigrant population in Switzerland (Gabadinho & Wanner, 2006; Rommel, Weilandt & Eckert, 2006).

Table 20.1 lists the most important activities within the Migration and Public Health Strategy 2002–2007.

Table 20.1. Selected projects and activities within the Migration and Public Health Strategy

Project area	Name of project/activity	Partner(s)
Education	Development of qualitatively standardized training programmes for, and officially recognized certification of, about 500 professional intercultural interpreters	INTERPRET: Swiss association for interpreting and intercultural mediation
Education	Promotion of education to develop immigrant-specific expertise for health care professionals	Charlotte Olivier Foundation Swiss Red Cross Caritas Switzerland
Public information, prevention and health promotion	AFRIMEDIA: Programme of HIV/AIDS prevention for immigrants from sub-Saharan Africa	Swiss Red Cross Swiss AIDS Federation
Public information, prevention and health promotion	SUPPORT: Low-threshold health promotion and prevention projects conceived and implemented by immigrant networks	Health Promotion Switzerland Radix Health Promotion
Public information, prevention and health promotion	Migesplus: Internet platform that provides information in various foreign languages on various health issues (such as oral health, infectious diseases and substance abuse) Information brochure *Health guide Switzerland*, and information courses for immigrants based on this brochure	Swiss Red Cross
Health care provision	Migrant-friendly hospitals: network of hospitals to promote activities and exchange experiences in this area (such as interpreting services and information in foreign languages) and publication of a handbook	H+ Swiss Hospital Association Network of Health Promoting Hospitals
Health care provision	Competence Centre for Health and Integration in Eastern Switzerland: addresses professionals in health care and social services – for example, in public relations, information, counselling and triage, education, networking and project development	Caritas Switzerland
Research	Monitoring the health status of the immigrant population in Switzerland	Scientific Institute of the German Medical Association, Bonn, Germany Swiss Forum for Migration and Population Studies
Research	Various basic research projects in the immigration and health sector	Various research institutes, such as Swiss Forum for Migration and Population Studies and university hospitals

Organization, management and implementation

Implementation of the programme is the responsibility of the Federal Office of Public Health's Equal Opportunities and Health Section, in collaboration with the Federal Office for Migration and the Federal Commission for Foreigners. In terms of resources, from 2002 to 2007 the Federal Office of Public Health earmarked an annual budget of about CHF 3 million, which included funds for four full-time positions. The Section's main tasks are to conceive, initiate, finance, oversee and monitor the various projects, which are contracted out to various (mainly private sector) actors. Hence, the federal government's role is primarily one of promotion and coordination.

As various actors from different fields are involved in implementation, a range of mechanisms and institutions were established to coordinate this interdisciplinary and intersectoral network. A *planning group* coordinates the different federal offices involved and delivers cross-sectoral information. At the operational level, informational and networking functions are served by two *forums*, whose participants include the relevant Federal Office of Public Health section and representatives of the Federal Office for Migration and the Federal Commission for Foreigners (the Small Forum of Migration and Health), together with all the other actors involved in implementation and other interested parties (the Large Forum of Migration and Health). An Inter-institutional Accompanying Group, which brings together representatives of numerous institutions active in the areas of immigration, health or both, is designed to provide information on (and coordinate) the various activities; it also supports implementation and establishes contacts with partners at the regional and cantonal levels. Currently, the programme leader participates in the Interdepartmental Working Group on Migration, a cross-sectoral federal working group set up in 2006 to develop measures that promote further integration of foreigners in Switzerland (see, for example, the section on "Integration and health-related policies targeted at immigrants").

To ensure participation of the immigrant population at a strategic level, the Migration Sounding Board, composed of twelve immigrants with expertise on health issues, was created. Its purpose was to advise on implementation, from the perspective of immigrants and of specialists in the field; to reflect on the Strategy and its results; and to communicate the programme through networks. Friction, arising from differing expectations and role perceptions, however, led to the dissolution of the Migration Sounding Board in 2004. Participation of the immigrant population is now ensured through an enlarged delegation of the Forum for the Integration of Migrants in the Inter-institutional Accompanying Group.

Planning, monitoring and evaluation

The Migration and Public Health Strategy was planned by a competent service within the Federal Office of Public Health, in collaboration with the former Federal Office for Refugees and the Federal Commission for Foreigners. The main planning tasks were assigned to the Swiss Forum for Migration and Population Studies, which developed the foundation of the Strategy using the Delphi method, a systematic interactive method for obtaining forecasts from a panel of independent experts. A structured questionnaire that deals with problems and possible solutions in immigration and public health was answered by 145 experts. These experts then commented on and evaluated the summarized results. Also, focus groups with about 70 selected stakeholders were convened to discuss the strategy, which was then formulated by the Swiss Forum for Migration and Population Studies in collaboration with the Federal Office of Public Health. The objective of this process was mainly to reach political and professional consensus on the strategy to be pursued. As a result of the design of the process and of the inadequate inclusion of representatives of the immigrant population, the initial objective of conducting a needs assessment could not be achieved systematically.

The planning process was overseen by an advisory board (strategic committee), which represented responsible federal authorities, other federal offices and cantonal administrations. In addition, the Swiss Forum for Migration and Population Studies was supported by a scientific advisory board.

Monitoring is a major task for programme management, which oversees the activities and projects in the five main areas. It must operate at the project level and is performed through contracts with project partners. Monitoring activities include meetings with project leaders about milestones, interim and final reports, self-evaluation, and financial audits. Other instruments are participation in strategic and advisory project boards and informal contacts. At the programme level, monitoring is less formalized and includes regular meetings between the programme leader and the responsible line manager.

All the projects supported within the programme had to include measures for self-evaluation. As is the case with most Federal Office of Public Health programmes, the Migration and Public Health Strategy underwent a comprehensive professional evaluation by external experts (Ledermann et al., 2006). The evaluation examined the strategic conception of the programme, its

implementation (management, organizational structures and processes) and effects. The programme was thoroughly examined as a whole, as were the projects financed. The criteria applied in the programme evaluation were the existence of empirical evidence, the internal and external coherence of the programme, the sustainability, adequacy and efficiency of implementation (organization and outputs), and its effectiveness and efficiency. This evaluation was included in the programme's budget and amounted to about 5% of the programme's total cost. The main results are reported in the section on "Lessons learned".

Support and funding for the programme

The Migration and Public Health Strategy is grounded in a decision by the Federal Council – the Swiss government. Since the Strategy was conceived for the periods 2002–2006 (later extended to 2007) and 2008–2013, continuity is guaranteed, because decisions of this kind are not affected by changes in government which, in any case, are uncommon in the Swiss political system. The Federal Council's decision allowed the programme to be financed through the Federal Office of Public Health's credit for preventive measures. The Migration and Public Health Strategy is completely funded by the Federal Office of Public Health, except for therapy for traumatized asylum seekers (financed by the Federal Office for Migration), the agencies for intercultural interpreters (financed by the Federal Commission for Foreigners through its integration promotion programme) and some additional individual contributions from project partners. As the programme is derived from a Federal Council decision, financial sustainability is essentially assured in the medium term. Once the decision is made by the government, implementation can only be endangered by budgetary cuts imposed by Parliament or by strategic decisions within the competent federal office. In part, this was the case with the Migration and Public Health Strategy, which did not receive all the initially budgeted financial resources due to cuts in the Federal Office of Public Health's prevention funds. As the evaluation of the programme showed, strategic support within the Federal Office of Public Health was given but could be improved.

Health issues addressed by the programme

Rather than operating in one specific setting, the Migration and Public Health Strategy tackles various issues that relate to health inequities in four areas of intervention (with basic research as a fifth area). Essentially, the programme follows an integrative approach, which means that immigrants' needs should be integrated into established health structures and that measures designed specifically for the immigrant population should be the exception. Interventions were therefore aimed at the health system, in general, and at mainstreaming migration-related issues within the established structures, to raise awareness.

One major area of intervention is the promotion of the transcultural skills of health care professionals at all levels. Educational measures are designed to improve the understanding of immigrant issues within the health care system and to enable health care personnel to give sufficient attention to immigration-specific situations and to handle the specific needs of their heterogeneous clientele professionally and adequately. In this way, the programme is intended to tackle upstream health determinants, such as discrimination and different cultural norms of behaviour and attitudes. Establishing a certified professional training course for intercultural interpreters and promoting their services in the health care system are further steps in this direction. These measures are also meant to facilitate access to the health care system; this is the main objective of the projects in the area of health care provision. A Swiss adaptation of the EU project Migrant-friendly Hospitals and support for a regional competence centre for health and integration involve activities in (and collaboration with) health care institutions – that is, hospitals.

These activities illustrate the Federal Office of Public Health's efforts to establish equal access to the health system for all, independent of language, cultural or other barriers. The programme also implicitly addresses questions about the right to health, such as organizational improvement of health care institutions (for example, provision of information material and procedures adapted to immigrants' needs), non-discriminating accessibility, and acceptability (for example, increased sensitivity to gender and immigrant-related issues, and culturally appropriate interactions with patients). All these aspects are seen as different facets of the quality of health care services. Insofar as they concern patient-friendliness and services adapted as much as possible to specific needs, they influence the quality of the process. Also, support for specific services that offer therapy for traumatized asylum seekers is an example of a specifically targeted measure, which complements established health structures that do not offer this kind of treatment or are unable to interact adequately with this clientele.

The activities in information, prevention and health promotion tackle various health determinants, such as health literacy, addiction, sexual health and infectious disease. The projects supported are carried out mostly by specialized NGOs with experience in working with the immigrant population and with direct access to immigrant groups. The main objectives of these projects are to provide information about specific health-related issues and the health system in general and to empower

the immigrant population – that is, to mobilize self-help resources. Information is provided on specific health-related issues, including substance dependence and sexual and reproductive health. Information on the health system in general is provided through the *Health guide Switzerland* brochure (Swiss Red Cross, 2005) and the Migesplus web site (Migesplus, 2007). The activities in this area of intervention should improve the effect of measures that prevent sickness and promote health.

Issues that relate to the coverage of certain services by health insurance – such as financing translation services or assuring coverage in case of inability to pay insurance premiums – can only be influenced partially by the Migration and Public Health Strategy. These issues concern the health insurance system and are subject to changes in the legal framework, involving the federal government or even Parliament. The activities of the Migration and Public Health Strategy, however, are situated at lower levels of public action – that is, they involve only the administration or partners in civil society, or both.

Lessons learned

The preceding evaluation of the Migration and Public Health Strategy, as well as the experience of the Federal Office of Public Health, allows us to summarize some of the most important lessons learned during the implementation of the programme: greatest successes and effects of the programme, challenges for implementation, important conditions for successful implementation, and possible improvements.

Greatest successes and effects of the programme

The main achievement of the programme was that it put the issue of immigrants on the health system's agenda and increased the visibility of problems and needs in this area. Other effects include knowledge transfer and networking among different actors in the health system and in the area of integration. Various projects contributed to direct improvements for the immigrant population. For example, a number of hospitals have taken steps to improve patient information, treatment procedures and the availability of interpreting services or have created specific treatment or counselling structures for particularly vulnerable groups. Various educational activities have helped to build specific human resource capacities (such as intercultural interpreters and nursing staff) and to train health care staff in transcultural skills.

Challenges for implementation

The most significant challenges were to raise awareness of the issue of migrant health among the various actors in the Swiss health system and within the Federal Administration and to gain their support for implementation. This is not only true for the Federal Office of Public Health, the other federal offices involved (such as the Federal Office for Migration) and the cantons, but is also true for numerous institutions and organizations in the health system, such as associations of health care providers.

To a certain extent, these challenges need to be considered within the context of ongoing discussions about different strategies and projects to reform the health system and its financing mechanisms, restrictions and budgetary cuts in public services. These discussions take place in a political and social climate that is still somewhat wary of measures that appear to favour the immigrant population. In this context, the programme's issues are not the primary concern of the various actors and institutions in Switzerland's health system.

Another important challenge was to ensure the participation of the immigrant population. In the 1990s, the efforts of the Federal Office of Public Health in preventing HIV/AIDS were carried out by a team of five professionals with experience with immigrants. Their task was to work together with specific community mediators, recruited from different national groups, who were supposed to spread the messages about prevention within their specific community. An evaluation of those activities (Efionayi-Mäder et al., 2001) concluded that, while this was an innovative and effective approach, in practice the voluntary mediators were not adequately qualified to perform their task – they proceeded somewhat haphazardly rather than systematically, and some of them were not accepted as key players within their community. In addition, over the years, the approach led to a certain thematic fragmentation and a lack of strategic orientation, and it impeded openness towards other themes and national groups. These considerations resulted in the formulation of an overarching strategy and in organizational adaptations, such as the Migration and Public Health Strategy discussed in this case study. This programme was intended to include participation of the immigrant population at a strategic level, but as described above, the Migration Sounding Board created for this purpose did not work well and was reorganized after 18 months.

The Federal Office of Public Health remains convinced that immigrant networks are an important resource for measures that prevent sickness and promote health. It is currently conducting a study to determine the potential of formal and informal networks within Switzerland's immigrant population and to develop proposals on how to include immigrants in health-related activities.

Important conditions for successful implementation

Apart from obvious prerequisites – such as initiative, political will and support, and financial resources – important conditions for the successful implementation of a project-based programme of this kind are:

- the existence of appropriate, reliable and experienced partners to carry out projects;
- thorough planning and management of the programme and projects;
- the establishment of interdisciplinary networks and binding cooperation structures; and
- a commitment to ensure participation of the immigrant population on the basis of clearly defined mutual expectations.

Possible improvements

The Federal Office of Public Health's own experience, along with the evaluation of the Migration and Public Health Strategy, shows that there is potential for improvement along three routes. First, strategically, planning could be improved by setting goals that are achievable and that can be used to support management planning, at both programme and project levels. These goals should be based on a systematic analysis of migrant health and barriers to health system access. The newly formulated Phase II of the Migration and Public Health Strategy (Federal Office of Public Health, 2007a) largely takes this into account. Also, to raise the visibility of the Strategy and the issues being considered and to create support for its implementation, agenda-setting activities (inside and outside the Federal Administration) are considered necessary. To this end, mainstreaming activities (such as communication and networking) will receive more attention and resources in the next phase of the programme, and it will be important to use existing cross-sectoral networks and, if necessary, to create new ones.

Second, the Strategy's effect is expected to be increased through greater involvement of integration-policy actors, who should include public health issues in their regular activities of promoting integration and counselling immigrants. Future agenda-setting activities should thus focus not on public health, but should focus on integration. It is considered necessary to use existing cross-sectoral platforms at the federal level (such as the Interdepartmental Working Group on Migration), sector-specific coordination platforms at the cantonal level (such as the Conference of Cantonal, Regional and Communal Integration Delegates and the Conference of Cantonal Health Promotion Delegates), and platforms for vertical cooperation between the Confederation and the cantons. This approach should enable intermediate health determinants to be influenced in a way that promotes health.

Third and last, efforts in mainstreaming immigrant-related health issues are needed to focus attention on them and to further promote *cultural change* in the health system, thus increasing awareness of the specific requirements of a culturally (and otherwise) diverse clientele. Making campaigns, projects and treatment services more effective will eventually improve the overall quality of the Swiss health system. Also, promoting transcultural skills at all levels of the health system – including health care personnel and management, and also campaign and project managers – is seen as an important route to further improving immigrants' access to health services.

All these improvements entail mid- to long-term changes. The sustainability of the programme (and its financial resources) is therefore an important prerequisite. Sustainability should be achieved by embedding the issues and objectives within institutions, such as the Federal Office of Public Health and other relevant federal (and cantonal) authorities, as well as NGOs and private actors in the areas of immigrants and integration, public health, and health care. This is one objective of agenda-setting activities; another is the (political) sensitization of possible funding partners, namely the cantons, that are not only responsible for health care provision, but – from 2008 – will also be responsible for implementing the federal integration-promotion programme. The vision presented here involves the creation of a strong cross-sectoral advocacy for health.

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21. Tajikistan: the guaranteed benefit package – an attempt to improve the poor's access to health services

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Summary

Universal and equitable access to affordable, sustainable and quality health care is the ultimate goal of every health care system. As in many other countries, Tajikistan (a former republic of the Union of Soviet Socialist Republics (USSR)) has initiated reform of its health sector. Although Tajikistan's economy shows steady growth, the Government of Tajikistan is still considering securing additional financing for health care services through non-budgetary sources, such as payroll taxes, voluntary insurance and increased private financing from patient cost sharing. Alongside this, it is now recognized and understood that informal payments constitute a significant part of overall spending on health care and that such payments constitute a major impediment to health care reform. Implementation of the guaranteed benefit package is the first attempt to legitimize these informal payments and to incorporate them into formal health care financing in Tajikistan. This seems to be the most realistic scenario under current socioeconomic conditions in Tajikistan, although there is concern about keeping a balance between expenses covered by the state and patient payments, to ensure access, affordability and sustainability of services for low-income people.

This study aims to:

- assess the links between the poverty level of households and their ability to pay for health services, using data from the Tajikistan Living Standards Survey (and other sources) to investigate the level and distribution of out-of-pocket payments for health care in Tajikistan;
- examine the extent to which such payments give rise to inequities in access to health care; and
- study to what extent initial steps in health financing reform – namely, implementing the guaranteed benefit package – affect access to health services.

With the start of health-financing reform in Tajikistan in 2005, an assessment of the linkages between poverty and health care access and utilization serves as a tool for policy-makers and stakeholders. It can be drawn upon and referred to when expanding current efforts targeted at the most vulnerable strata of Tajikistan's society and when designing policies and interventions.

Socioeconomic and policy context

Tajikistan is located in the south-eastern corner of central Asia. In 1991, it was the poorest of all the former Soviet republics, with a GDP per person of slightly more than US$ 2000. Despite this, the country had relatively high human development indicators, reflecting the legacy of social development achieved during the Soviet era: life expectancy at birth averaged 70 years and adult literacy was almost universal. In common with other countries of the former USSR, the health care system – based on the Semashko model – was characterized by universal entitlement to a comprehensive and free, but inefficient, health care system, with an excess human and physical infrastructure (Saltman & Figueres, 1997). Health care utilization rates were high and differences in access to health services across socioeconomic groups were negligible (World Bank, 2000). Since achieving independence, Tajikistan has experienced a major reversal in both economic and social development.

The economic upheaval that accompanied the transition from a planned to a market-led economy and the disruption of traditional trading partnerships and the withdrawal of subsidies from Moscow following the break-up of the USSR have resulted in a dramatic drop in GDP and central government expenditures. Also, the country experienced a civil war in 1992-1993, followed by a long period of civil unrest.

Using the World Bank's recommended benchmarks to measure absolute poverty in Europe, a household survey in 1999 found 92.9% of the Tajik population living on US$ 4.30 per day or less, with 58.6% living on US$ 2.15 per day or less (State Statistical Agency, 1999). By 2003, the latter had decreased to 42.8% (State Statistical Agency, 2005). The latest available Gini index for Tajikistan is 34.7 for 1998, where 0 represents perfect equality and 100 represents perfect inequality (WHO Regional Office for Europe, 2006).

In the face of severe financial constraints, exacerbated by extensive damage to the infrastructure during the civil war, health services have deteriorated rapidly since independence. Health care expenditure as a percentage of GDP dropped from 6.4% in 1994 to 1.5% in 1999, and real spending on health care is now less than a tenth of its pre-independence level. Although reliable dollar conversions are difficult, the health budget in 1999 was perhaps only about 5% of its 1990 value (Ziglio et al., 2003). Currently, government expenditures for health are insufficient, consisting of 5.7% of state expenditures or 1.7% of the GDP in 2008 (Salokhiddin Miraliev, Advisor to the Minister of Health of the Republic of Tajikistan, personal communication, 2008). The decline in government expenditure has been accompanied by a reduction in hospital beds and personnel, and administrative data points to a significant fall in health care utilization.

The precipitous decline in real government expenditures has eroded the capacity of the health system to provide effective and accessible medical care to the public. As a result, primary health care in Tajikistan has been adversely affected, and much of the physical infrastructure has been destroyed (Ziglio et al., 2003). After salaries are paid, few resources remain for drugs and food, let alone maintenance or reconstruction (Falkingham, 2004). The recent WHO and Ministry of Health of Tajikistan analysis of pre-hospital and hospital facilities revealed that the majority of them lack hot water, experience interruptions in cold water supply and electric power, have no heating in winter, and lack sanitary and hygienic facilities or have only unsatisfactory ones (WHO Regional Office for Europe, WHO Country Office for Tajikistan & Ministry of Health of Tajikistan, unpublished observations, 2008). Also, medical and diagnostic equipment is either obsolete or in disrepair, and the situation is especially serious in rural areas, due to the lack of resources and medical staff.

Officially, the health care system in Tajikistan is funded primarily by the state through tax revenues, although major health care budget shortfalls are partially offset each year by international aid. The largest source of health care financing, however, is thought to be payments from patients, and the Tajikistan Living Standards Survey for 2003 (State Statistical Agency, 2005) suggests those payments constitute over two thirds of all health spending (see Table 21.1).

Alongside official charges, which are a relatively new development, there is a more common culture of informal payments (Falkingham, 2004). Although in principle medical supplies and drugs required as part of inpatient treatment remain free (in non-guaranteed benefit package pilot programmes), the scarcity of such items in medical facilities has led to an increasing number of patients having to purchase them. Also, local budgetary constraints and petrol shortages have eroded the capacity of the ambulance service, and often patients have to provide their own transportation to emergency medical facilities. Most importantly, informal user charges for consultations are frequently being imposed to help subsidize salaries, despite such consultations being free of charge officially.

In 2007, the average monthly salary for doctors and nurses in the health sector was US$ 17 and US$ 11, respectively, compared with the workforce average of US$ 53 (State Committee on Statistics of the Republic of Tajikistan, 2008). Given this and knowing from the baseline survey for the evaluation of the introduction of the guaranteed benefit package (GBP)

of health services (Public Foundation Panorama, 2007) that informal payments and in-kind gifts from hospitalized patients were reported to be on average SM 130 (about US$ 40) per hospitalized patient and SM 32.90 (about US$ 10) per patient for ambulatory patients, one may conclude that out-of-pocket payments are the main source of income for many physicians and nurses and are an integral part of their survival.

Table 21.1. Spending on health by source, lowest and highest consumption quintile groups, 2003

Type of service and source of spending	Total spending (in million SM)	
	Lowest quintile	Highest quintile
Outpatient services by:		
Government	0.5	1.5
Household	13.7	40.7
Donor	1.1	3.3
Subtotal 1	15.3	45.5
Inpatient services by:		
Government	2.4	9.1
Household	3.2	12.1
Donor	2.0	7.6
Subtotal 2	7.6	28.8
Total health services by:		
Government	2.9	10.6
Household	16.9	52.8
Donor	3.1	10.9
Total (subtotals 1 + 2)	22.9	74.3

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Until recently, official user charges existed for only a limited range of services in Tajikistan – in specialized so-called self-financing clinics, mainly located in urban centres. However, more than 98% of hospitalized patients and more than 70% of ambulatory patients surveyed by Public Foundation Panorama (2007) in the GBP baseline survey reported paying cash or providing gifts (such as food and services) either to a provider as a consultation/prescription fee or for drugs and medical supplies. In this situation, patients could no longer separate official and unofficial charges, although the majority of these payments were unofficial (only 2% of those surveyed received a receipt for their payment).

Although the existence of substantial out-of-pocket payments for health care in Tajikistan is widely acknowledged, very little is known about how this has affected access to health care. Access to health care is multidimensional and may be affected by geographical location (physical access), costs incurred (economic access) and cultural factors (social access). But it is widely recognized that spending on health is a heavy burden on poor households, causing *catastrophic* economic situations for some families.

The need to legitimize informal payments and to incorporate them into the formal health care financing stream is now recognized by the Government of Tajikistan. It may be, however, that user charges discourage both inappropriate and appropriate use of services. A review of the effect of user charges on utilization of health services (Creese, 1991) found that the poor were more severely affected by price increases than were the rich.

Analysing the health status and health seeking behaviour

In response to the 2003 Tajikistan Living Standards Survey (State Statistical Agency, 2005), more than 75% of respondents stated health to be their major concern. Tajikistan copes with a double burden of disease, inflicted by both chronic noncommunicable diseases (a profile similar to that of high-income countries) and infectious diseases (where the profile is closer to that of low-income countries). Cardiovascular and pulmonary diseases – which are strongly associated with such health risks as alcohol, tobacco use and stress – account for more than 50% of mortality. Infectious diseases, however, disproportionately affect young children.

Health-seeking behaviour can be analysed through hospitalization rates. Results from the 2003 Tajikistan Living Standards Survey (State Statistical Agency, 2005) show that hospitalization rates fell for all groups, except women aged 65 years and

more (who comprise a relatively small part of the overall population), which reinforces the conclusion that utilization of health care services has decreased since the Soviet era.

The main barrier to health care access is the financial burden it entails: out of those who reported in 2003 (State Statistical Agency, 2005) that they needed medical assistance but could not *seek* such care, the majority of respondents reported that affordability was the main reason for not seeking medical attention. This contrasts with the position in 1999 (State Statistical Agency, 1999), where self-medication was cited as the most common reason for not seeking care. Thus, it proves that, over time, financial barriers to access have increased, rather than decreased. The 2003 Tajikistan Living Standards Survey revealed about 60% of the poorest people and over 30% of the richest reported affordability to be the main reason for not seeking health care (State Statistical Agency, 2005). This is not surprising, given the proportion of the population paying for services during hospitalization (see Table 21.2).

Table 21.2. Proportion paying for services during hospitalization (per case)

Services during hospitalization	Poorest 20%		Richest 20%		All of Tajikistan	
	Per cent paying	Mean (median) payment [a]	Per cent paying	Mean (median) payment [a]	Per cent paying	Mean (median) payment [a]
Medicine	82	59.64 (40.00)	82	104.83 (50.00)	81	76.06 (50.00)
Food	36	27.54 (12.00)	45	64.83 (50.00)	46	40.02 (25.00)
Other supplies	81	11.95 (10.00)	78	18.54 (10.00)	76	14.58 (10.00)
Hospital charges (including laboratory)	90	6.84 (5.00)	90	13.97 (7.00)	91	10.14 (5.00)
Physician charges	65	27.48 (10.00)	66	68.06 (30.00)	66	48.03 (20.00)
Ancillary staff charges	62	8.19 (5.00)	61	16.81 (10.00)	60	12.10 (8.00)
Other payments, including gifts	17	39.73 (25.00)	24	72.04 (15.00)	20	55.57 (20.00)

[a] Values are expressed in somoni (SM). In June 2003, US$ 1.0 = SM 3.1.

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The relationship between economic status and the type of health care used also sheds light on the affordability of (and access to) such care. The level of unofficial fees imposed rises as the level of specialization increases; hospitals charge more than primary health care facilities, which receive only nominal payments or gifts, if anything (Public Foundation Panorama, 2007). Thus, the poor tend to use primary care facilities and providers more frequently than do the non-poor, who are better able to afford the higher costs of polyclinic and hospital care.

Although, with the start of health reforms, there has been a tendency to treat the primary health care level as the most important one (Government of Tajikistan, 2002), current government spending on health still favours tertiary care, with hospitals accounting for the major share of government health expenditure. Given the differential use of hospital services by poor and rich groups, as well as the decline in hospitalization rates for all groups, it appears that there are opportunities to further analyse and redirect government resource allocations to ensure that the needs of the poor and most vulnerable are met.

Prescriptions and medications

If the 1999 Tajikistan Living Standards Survey showed prescription rates in Tajikistan were relatively low (State Statistical Agency, 1999), these rates (and the number of drugs prescribed) now show a steady increase. The GBP Baseline Evaluation Survey (Public Foundation Panorama, 2007) revealed that 94.5% of ambulatory patients had been prescribed drugs. Of these patients, 90.9% purchased all prescribed drugs, 8.5% purchased some prescribed drugs and 0.6% purchased no prescribed drugs.

With the economy of Tajikistan growing and small and medium regional trading activities increasing, there is a worrisome tendency for low-quality and counterfeit drugs to be imported into the country (State Scientific Center for Drug Expertise, 2008). Another worrisome tendency is overprescription of drugs, so there might be 3–4 antibiotics and other drugs, mainly non-essential, prescribed for a treatment – for example, of a simple cold. These practices could significantly affect a household's

economic status, leading to catastrophic health expenditures. But it has also been noted that (less than in other groups), when individuals from the poorest households receive a prescription from a physician, the majority of them are unable to buy it. This finding underscores the importance of establishing careful exemption policies that protect the poor – especially children and women, who are the most frequent consumers of essential pharmaceuticals – and ensuring affordability and, eventually, accessibility of health services. In parallel, there is a need to activate measures that prevent overprescription of drugs and the importation of low-quality and counterfeit drugs.

Utilization of reproductive health services

Women, in particular, have been affected by changes in the health care system and by the erosion of access to adequate basic services. This is particularly true of the availability of pregnancy, delivery and contraception services for women in the poor segment of the population.

Providing the assistance of skilled attendants during delivery can greatly improve the outcomes for mothers and infants, through the use of technically appropriate procedures, speedy diagnosis and treatment of complications. During the Soviet era, over 90% of deliveries were performed at no charge to the patients at hospital facilities by doctors (I. Sheraliev, Deputy, Republican Medical Statistics Center, personal communication, 2007). Nowadays, the situation has changed significantly, and the Ministry of Health of Tajikistan struggles to ensure that deliveries are served by skilled personnel at medical facilities.

The Multiple Indicator Cluster Survey (MICS) 2005 data show that about 83% of births that occurred in the two years prior to the Survey were delivered by skilled personnel (State Committee on Statistics of the Republic of Tajikistan, 2007). Also, the presence of skilled personnel was higher in urban areas (89%) than in rural areas (81%). Moreover, the woman's age and the wealth of her household were important factors in the provision of skilled assistance at delivery. The numbers for the presence of skilled personnel decrease gradually from 94% of women 15–19 years of age to less than 75% of women more than 40 years of age. Only 69% of women from the poorest quintile had skilled assistance at delivery, while in the richest quintile this number was 91%. Doctors assisted with the delivery of 61% of births, and 20% of the births were assisted by a nurse or midwife. Overall, about 9% of births were delivered by traditional birth attendants, and less than 1% of births took place with no one in attendance.

Contraceptive use (in general and by different methods) is another indicator of access to health care and services for poor women. The following table, from MICS 2005, is self explanatory.

Table 21.3. Percentage of Tajik women aged 15–49 years currently married or in nonmarital union who use (or whose partner uses) a contraceptive method, 2005

Category	Do not use any	Any modern method	Any traditional method	Any method
Poorest (%)	66.6	28.2	5.2	33.4
Richest (%)	56.4	39.0	4.5	43.6

Source: Adapted from State Committee on Statistics of the Republic of Tajikistan (2007). Reproduced with the permission of the copyright holder..

While recognizing that level of education and health literacy influence the choice of having skilled assistance at delivery and using modern contraceptive methods, we believe that poverty level is a significant factor when a woman (or her family) makes a choice. Findings on assisted deliveries highlight that there are significant differences in rates of health service utilization across socioeconomic groups within Tajikistan. These differences are particularly evident when comparing rates during the Soviet era, when services were free of charge, to those identified through MICS 2005, which reflect a household's ability to pay for services. Official and informal payments act to both deter people from seeking medical assistance and, once advice has been sought, deter them from receiving the most appropriate treatment.

Children's health, nutrition, and mortality

Children, more than other population groups, suffer from poverty (Saifuddinov, 2007). Being born into poor families, they have limited access to health care services and lack timely and appropriate development and educational opportunities. Also, they are more likely to be in ill health, be underweight, lack immunization and face other serious problems.

According to Ministry of Health of Tajikistan reports and data from the State Committee on Statistics of the Republic of Tajikistan, diseases of the respiratory system account for 30–40% of infant mortality in Tajikistan (Saifuddinov, 2007). Also, diarrhoea was the most common childhood disease in summertime. Therefore, MICS 2005 focused special attention on children's nutrition: three MICS standard indicators were used to assess the nutritional status of children (weight for age, height for age and weight for height) and two additional indicators were used (the mid-upper arm circumference and the presence of oedema). The aim of including these extra indicators was to assess the presence of global acute malnutrition in children aged 12–59 months (as determined by weight for height below two standard deviations and mid-upper arm circumference below 12.5 cm or oedema). Countrywide, 11% of children aged 12–59 months were exposed to global acute malnutrition. The highest rate was observed in Khatlon Province (14%), and the prevalence of global acute malnutrition was higher in children from the poorest quintile (13%) than in children from the richest quintile (10%) (State Committee on Statistics of the Republic of Tajikistan, 2007).

Educational level of the mother and household wealth quintile also produce significant differences in child mortality rates. Rates are almost five times higher in children born to mothers with little or no secondary education than in children born to mothers with higher levels of education. Children born into households from the 60% poorest wealth index quintiles are more likely to die during their first five years of life than those from households in the 40% richest wealth index quintiles (State Committee on Statistics of the Republic of Tajikistan, 2007). Table 21.4 shows infant and under-5 mortality rates for 2005.

Table 21.4 Infant and under-5 mortality rates (per 1000 births) for Tajikistan, 2005

Category	Infant mortality rate	Under-5 mortality rate
Sex		
Male	75	92
Female	54	66
Average	65	79
Region		
Dushanbe	50	59
Khatlon	81	102
Sughd	61	73
Districts of the Regions of Republican Subordination	47	57
Gorno–Badakhshan Autonomous Oblast	46	54
Residence		
Urban	58	70
Rural	68	83
Women's education		
None/primary	75	95
Incomplete secondary	73	91
Completed secondary	63	76
Secondary special (vocational)	56	67
Higher education	13	14
Wealth index quintiles		
Poorest 60%	78	98
Richest 40%	48	57

Source: State Committee on Statistics of the Republic of Tajikistan (2007). Reproduced with the permission of the copyright holder.

Taking into account all the points made in this section, ensuring access to health and other public services for children from poor families has both political and economic implications for the present and future of the country.

Implementing the GBP to improve access to health care

Developing a system of official user charges for the health sector has become an important part of health care financing policy, due to the low level of funding for the health sector, salaries below subsistence and widespread evidence that patients make unofficial payments for supplies and to staff for health services.

After the referendum that took place on 22 June 2003, a change in Constitution Article 38, which concerns the right to health care in Tajikistan, was passed (Government of Tajikistan, 1994). This change modifies the population's universal access to "free medical assistance in state medical establishments" (Government of Tajikistan, 1994). The constitutional change passed means that Article 38 of the Constitution of Tajikistan now states: "free medical assistance in state medical establishments" will now be provided "within the framework defined by the law", which frees the government to introduce charges and explore new opportunities to start health financing reforms by introducing the GBP and other fee-for-service schemes.

The GBP is basically a list of health care services, mandated by the Government of Tajikistan, that are required to be covered, through cost sharing (co-payment) or full-payment. The GBP also includes exemption of coverage for certain groups within the population or certain services and procedures. The number of categories exempted and the share of co-payments depend on the funds available to the health system – that is, the government budget.

The first attempt to introduce the GBP (2005) had several shortcomings in design and implementation, such as the following.

- It was introduced at the national level, without being preceded by a pilot project.
- It lacked a single price list – every facility developed a separate price list and service costs were different in each facility.
- It lacked preparatory activities, resulting in a low awareness among health care providers and public community members.

Therefore, two months after being implemented, it was suspended.

Nevertheless it produced some important lessons and experiences. For example, implementing the GBP did not immediately and significantly increase the overall level of resources in the health system or the official salaries of medical staff – two major issues in the health sector.

Lack of a good campaign to raise awareness about the GBP and the long, very detailed price list of different diseases and conditions caused misunderstanding and dissatisfaction in the population. Although official charges in the form of co-payments were introduced, there was also evidence that informal payments continued alongside the official co-payments, resulting in higher costs for some groups, especially those for which affordability was already a major issue, thus exacerbating existing inequities in access to health care.

The failure in the first attempt to introduce the GBP raised the important question: What is needed to effectively design and implement the GBP and avoid discouragement from the introduction of user charges for the use of health services?

In June 2007, the Government of Tajikistan, supported by the international community, again introduced the GBP, but this time by implementing pilot projects in four districts of Tajikistan. The lessons learned from the first attempt and technical advice from international donors and agencies (such as WHO, the World Bank, USAID, the Asian Development Bank and Project Sino) contributed to the planning and implementation of the second attempt to introduce the GBP. The result was:

- serious analysis and detailed design before the start of the pilot projects
- gradual, step-by-step implementation, accompanied by monitoring
- broad awareness campaigns for decision-makers, health professionals and the public.

Needless to say, the civil war in 1992–1993, followed by a long period of civil unrest, further weakened social protection schemes damaged after the collapse of the USSR. Designing the programme, the Government of Tajikistan and donors faced the challenge of how to provide poor groups with better access to health services and how to accurately identify these groups. The state, however, still lacks reliable tools and instruments to calibrate populations/households by their income/welfare level. On the other hand, given the high level of poverty countrywide, the Government of Tajikistan assumed that the most vulnerable groups in need of exemptions were the elderly, pregnant women, children under 5 years of age, orphans and disabled people. The following social groups and health groups have been exempted from co-payments (Government of Tajikistan, 2007):

> veterans of the WWII, disabled, orphans, children under 1 [year old], retired people over 80 [years old], elderly on institutional care (social groups) and myocardial infarction patients (first month following the infarction), TB patients, cancer (terminal stage), [people with] diabetes, schizophrenia, hemophilia, congenital syphilis, leprosy, HIV/AIDS, malaria, rabies, meningococcal meningitis, diphtheria, acute respiratory infections and diarrhea (children under 5 [years old]), pregnant women, if registered and followed up properly on [the] antenatal level.

Also, to achieve better public understanding and to simplify cost calculations, for the second introduction of the GBP, eight co-payment categories, based on diagnosis and the health interventions needed, were identified. For each category, the average amount a patient would contribute is significantly lower than that reported for under-the-table payments for the same health intervention. Also, a 30% (for patients referred from the primary health care level) and 70% (for self admission, without any referral) co-payment differential has been introduced. This differential co-payment is intended to strengthen the role of primary health care and to initially direct the flow of patients to primary health care units (where a case might be managed and where health care services are comparatively low cost), instead of hospital care units.

Lessons learned

Poverty is a multidimensional problem that results in (and is a consequence of) inequitable access to many physical and social resources, including health care. Although publicly funded health care is based on the principle of equal access for all citizens, not all have equitable access to these services. The result is that those living in poverty are more likely to suffer from ill health.

People living in poverty have a great need for programmes that improve access to health care services and that improve their health status. However, working towards reducing poverty – thereby avoiding its negative health outcomes and, ultimately, rendering poverty-alleviating services unnecessary – is strategically more appropriate and efficient. Indeed, one should see poverty as a complex phenomenon rooted in a multiplicity of causes and conditions, many of which extend beyond the control of the health sector. But still, the health care system can contribute to alleviating poverty by:

- designing programmes to improve access and needed services for the poor;
- advocating for cross-governmental policy changes to improve the lives of those living in poverty;
- performing research and expanding knowledge of the negative effects of poverty on health and ill health on poverty; and
- ensuring that poverty is considered when creating or reviewing policies for the health care sector.

Developing the best strategies to establish such a national health care system requires focusing on three major criteria for evaluating system performance:

1. equitable access to quality care services
2. affordability for most vulnerable and poor groups
3. financial sustainability.

One effective way to increase demand for beneficial services is to improve affordability – that is, reduce the out-of-pocket cost of care that low-income patients face. Among other alternatives, direct public sector provision of subsidized and free services could play a role. These efforts, however, will not be sufficient to guarantee a sustainable national health care system, unless there are well-defined and broadly accepted techniques for efficiently allocating resources to meet health-outcome and social-equity objectives.

In the case of Tajikistan and thus far, the user charges and exemptions introduced are mainly universal. Although they exist on paper, they have rarely been applied in practice (Community and Basic Health Project & Health Research for Action, 2007) and are not flexible enough to fully respond to the individual patient's circumstances. This leads to questions of how this should be done and whether there are appropriate administrative infrastructure and capacity within the current health sector to achieve this. Observations by the study's authors suggest the following.

1. Unequal and inequitable funding across geographic areas jeopardizes the ability to provide equal GBP coverage for all Tajik citizens.

2. A critical next step in implementing the GBP is to develop some arrangements or mechanisms for pooling funds, to ensure equity and equal financial risk protection and coverage under the programme. If pooling and equitable resource allocation can be combined with the increased allocation of health budgets by the Ministry of Finance of Tajikistan, the result could drive successful GBP implementation.

3. The budget and hospital payment mechanisms can be improved to match the hospital budget to the GBP, and the development of a strategy and implementation plan would help carry this out.

4. Although the health sector is underfunded, it is also possible to improve the efficiency of the health delivery system, and maintaining restructuring linked to health financing reform as a priority would help improve efficiency.

5. The central district hospitals showed the ability to manage the GBP and to handle greater management autonomy. It is a priority to continue to support this management autonomy, as well as the continued development of improved management systems at all levels, including the primary health care level.

6. It definitely takes time to educate all stakeholders (health officials, health professionals and the public) about the GBP and to develop the systems and human capacity to manage it.

The year-end analytical survey to be conducted in late 2008 will evaluate the one-year experience of GBP re-implementation in pilot districts, will further explore these six points, identify patient and staff attitudes towards the GBP, assess appropriate allocation of public expenditure, and identify the implications of the programme for access to health care. The survey will help develop and redesign future interventions. The challenge facing policy-makers will be how to take all of the above into account and to ensure that equity in access to health care is achieved. What is clear is that the poor can no longer afford the so-called free health care being offered.

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22. United Kingdom: tackling health inequalities for families, mothers and children in England

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Summary

This case study focuses on child poverty and efforts to tackle health inequalities of families, mothers and children in England through the health inequalities infant mortality target and the national health inequalities strategy: Tackling Health Inequalities – A Programme for Action. It also explores the balance between upstream action on the broader social determinants of health and downstream action driven by interventions through the health care system and health improvement.

Between the mid-1970s and the mid-1990s, health inequalities widened and child poverty increased in England. Relatively little attention was paid to these issues, despite recognition that health inequalities constituted a major challenge to society. Reducing the gap in health inequality since the late 1990s has proved challenging, despite substantial reductions in child poverty. In 1997, a change of government brought a new focus to economic and social policy with health inequalities a key theme. This resulted in the establishment of the Independent (Acheson) Inquiry into Inequalities in Health. It was followed by the establishment of a national target and the adoption of the national strategy. This strategy identified families, mothers and children as a key theme to be implemented through a range of programmes, including poverty, taxes and benefits, education and child care, and infant and maternal welfare services.

These programmes shared some common characteristics, such as:

- a high level of political support and a high profile – led by ministers;
- a national focus, with a cross-government policy perspective that provides a wider policy framework – even if delivery was through a single department;
- a long-term, sustainable approach, often backed by substantial resources and support – for example, the Sure Start local programmes; and
- an emphasis on disadvantaged groups and areas, including low-income working families, and not just the most socially excluded groups.

Reducing health inequalities in infant mortality remains a significant challenge. These inequalities have widened since 1997, despite overall improvements in health for almost all groups and real improvements in the wider determinants of health, including those that affect child poverty. The gap in infant mortality has, however, started to narrow again after peaking in 2002–2004. The approach adopted to narrowing the gap included:

- recognizing that tackling health inequalities in infant mortality is part of the broader effort of addressing child poverty and extending and improving services for families, mothers and children in disadvantaged groups and areas;
- formulating the issue to make it amenable to action, by establishing a national target that has provided a focus for action and by supporting the target with a cross-government strategy that combines both upstream and downstream components; and
- managing the process by developing mechanisms of measurement, audit and review, to assess progress and develop programmes in line with evidence and experience.

The interaction of these factors has sustained the momentum of the national health inequalities strategy and helped renew interest in health inequalities, despite the persistence of the gap. This case study will show how these lessons were learned through the *Review of the health inequalities infant mortality PSA target*, with reference to disadvantaged children and their families.

Socioeconomic and policy context

England is part of the United Kingdom, which also includes Northern Ireland, Scotland and Wales. England is the most populated part, with 51 million of the United Kingdom's 61 million inhabitants. The population of the United Kingdom grew slightly at the end of the last century, from 567 million in 1981 to 57 million in 1991 (Office for National Statistics, 2001).

Since 2002, the social characteristics of this population have been described by an eight-point scale that reflects occupational status. This scale is summarized by a three-stage hierarchical classification:

1. managerial and professional (groups 1 and 2) – about 8% of the population
2. intermediate (groups 3 and 4) – about 27% of the population
3. routine and manual (groups 5–7) – about 56% of the population.

The routine and manual group is the focus of the infant mortality target and provides a classification based on the father's occupation. A fourth group, designated other (group 8), represents about 10% of the population and includes people who have never worked and unemployed people. This group was outside the scope of the target, though the strategy included a commitment to monitor developments in this group and in sole registrations – that is, births registered by the mother alone. During the period from 1997 to 2006, unemployment in the United Kingdom fell from 7.2% (2.2 million people) to 5.3% (1.7 million people) (Office for National Statistics, 2008).

During the period 1998/1999, 14 million people lived in poverty (below 60% median income in the United Kingdom after housing costs), of whom 4.4 million were children (34% of all children). By 2006/2007, 13.2 million people were living in poverty, of whom 3.9 million were children (30% of all children) (DWP, 2008). For 2005, the GDP per person for England was US$ 32 900 (€26 532) (Office for National Statistics, 2008).

Health trends

General health trends show a steady improvement. Over the past few years, mortality rates for a number of important causes have fallen, including those for lung cancer (for men only), coronary heart disease and stroke. The fall in mortality rates for some of these so-called big killers has accelerated, and the gap in health inequality has narrowed, partly because of the extra investment and improvements in health services in recent years. For cancer, the mortality rate fell from 141 deaths per 100 000 population under 75 years of age (1995–1997) to 117 deaths per 100 000 population under 75 years of age (2004–2006), with a reduction in the gap in health inequality in absolute terms of about 11%; this reduction was assessed on an area basis, between the spearhead group – the 70 local authority areas with the worst health deprivation indicators, covering 28% of the population – and the whole population. For circulatory diseases, the mortality rate fell even more steeply, from 141 deaths per 100 000 population under 75 years of age (1995–1997) to 84 deaths per 100 000 population under 75 years of age (2004–2006), with an almost 32% reduction in the gap in absolute terms (DH, 2008).

Life expectancy has improved for all groups. For the period 2004–2006, the average life expectancy for men was 77.3 years, and for women it was 81.6 years, compared with 74.6 years for men and 79.7 years for women during the period 1995–1997 (DH, 2008:33). These improvements conceal social, geographical and other differences. While life expectancy at birth has

improved for England as a whole and for the spearhead areas, it has improved more slowly in the spearhead areas than in England overall. There is an almost 10-year difference in life expectancy between a boy born in Manchester (one of the poorest areas in the country, located in north-west England) and a boy born in Kensington and Chelsea (the most prosperous borough of London) (DH, 2006b).

The infant mortality rate in England and Wales fell from 5.8 deaths per 1000 live births (1995–1997) to 4.8 deaths per 1000 live births (2004–2006). Again, all groups have benefited from this decline, including the routine and manual group for which the rate went from 6.6 deaths per 1000 live births for the period 1995–1997 to 5.6 deaths per 1000 live births for the period 2004–2006. Although the rate of decline was in the whole population until 2002–2004, since then there has been a slight reduction of the gap in successive years, from 19% to 17% (DH, 2008). There are also substantial differences in infant mortality across the population. For example, babies of mothers who themselves had immigrated to the United Kingdom from the Caribbean and Pakistan had infant mortality rates of 9.4 and 9.0 deaths per 1000 live births, respectively, during the period 2004–2006.

Public services and policies

Health care is provided through a national health service (NHS) founded in 1948 and funded by general taxation – free to all at the point of service. The NHS Plan (DH, 2000) sought to modernize the service and provided extra investment, raising significantly the proportion of GDP devoted to health – from about 5% to about 8%.

In the United Kingdom, health policy is devolved to each of the four home countries. For England, decisions about health policy and the NHS fall to the Westminster (United Kingdom) Parliament. The Secretary of State for Health is the minister responsible for the overall health policy and the NHS and is supported by other ministers, each with a specific remit.

Welfare policies are not devolved, but are administered through the United Kingdom Parliament. These policies affect such programmes as child benefits and child tax credits and are delivered as a mixture of universal and means-tested provisions. Benefit status can also affect entitlement to some services.

A focus on social justice: health inequalities and child poverty

Both health inequalities and child poverty increased in England between the mid-1970s and mid-1990s. Relatively little attention was paid to these issues, despite recognition that health inequalities constituted a major challenge to society (Black et al, 1980). Sir Donald Acheson – using an earlier social class scale - concluded that "the mortality rate among men of working age was almost twice as high for those in class V [unskilled] as for those in class I [professional]" in the early 1970s, but by "the early 1990s, it was almost three times higher" (Acheson et al., 1998:11). For child poverty, about one child in three lived in a low-income household (after deducting housing costs) during the period 1996/1997 – compared with about one child in seven in 1979. According to the Department for Work and Pensions (DWP, 2006), "real incomes for the poorest families with children had barely changed despite substantial improvements in average living standards".

The change of government in 1997 resulted in a stronger focus on social justice. An inquiry into health inequalities was established. Acheson, a former chief medical officer was asked to review the state of health inequalities and identify priorities for action. In his report (Acheson et al., 1998), he made clear the need to intervene on a broad front if health inequalities were to be tackled effectively, which reflected the "scientific evidence that health inequalities are the outcome of causal chains that run back into and from the basic structure of society. Such an approach is necessary because many of the factors are interrelated." This meant action on both upstream and downstream determinants of health. The report was also wary of the unintended consequences of policies that improved the overall position but ended up widening the gap in health.

The Acheson report recommended that priority be given to supporting mothers and children. Childhood was identified as a critical and vulnerable stage where poor socioeconomic circumstances had lasting effects. Equally, the importance of a mother's health was crucial, given the effects of a mother's nutrition on her child's later health. According to the report, "As the two principal determinants of a baby's weight at birth are the mother's pre-pregnant weight and her own birth weight, the need for policies to improve the health of future mothers and children is obvious."

This focus on families, mothers and children was reinforced by the announcement of the first national health inequalities target in the NHS Plan (DH, 2000). The aim of the target was, "by 2010, to reduce the inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth." This target was supported by a more detailed objective on

infant mortality, namely "…to reduce by at least 10 per cent the gap in mortality between the routine and manual group and the population as a whole" (DH, 2008).

The infant mortality target focused on the routine and manual group, composed mainly of low-income working families, but it was acknowledged that action on the target also affected vulnerable and disadvantaged groups more generally. Without broader action, the aim of a long-term and sustainable reduction in health inequalities would be difficult to realize. This was stated explicitly, but the focus on the routine and manual group, rather than disadvantaged groups more generally, has remained an issue.

The need to deliver the target shaped the development of the national health inequalities strategy (DH, 2003). This strategy sought to reconcile the target with longer-term aims underpinned by four themes, one of which was supporting families, mothers and children. This theme covered maternal and child health and child development, improved chances in life for children and young people, reduced teenage pregnancy, and support for teenage mothers. It covered a range of services, such as the Sure Start local programmes, neighbourhood nurseries in disadvantaged areas and free nursery education for all 3- and 4-year-olds.

Programmes to reduce health inequalities and tackle child poverty

During the past decade, programmes that addressed the needs of mothers, families and children living in poverty covered action on health inequalities, taxes and benefits, education and training, child care, and maternity services. These programmes shared some common characteristics:

- a high level of political support and a high profile – led by ministers;
- a national focus with a cross-government policy perspective that provides a wider policy framework – even if delivery was through a single department;
- a long-term, sustainable approach, often backed by substantial resources and support – for example, the Sure Start local programmes; and
- an emphasis on disadvantaged groups and areas, including low-income working families, and not just the most socially excluded groups.

In terms of improving health, these programmes were characterized by a focus on the upstream, wider economic and social determinants of health and were backed by significant action on the downstream determinants, including behavioural risk factors.

This section reviews the development of relevant programmes on child poverty, health inequalities, and improving services for children during their early years.

Child poverty strategy

Child poverty – as identified in *Tackling health inequalities: a programme for action* (DH, 2003) – is a key determinant of poor health. Children in poverty live in households where the level of income is at or below 60% of the median household income in the United Kingdom. Addressing child poverty requires improving the financial situation of disadvantaged families and creating better opportunities for work. Addressing child poverty also has an effect on health inequalities, since it can help narrow the gap in health between disadvantaged groups and areas and the rest of the country.

The aims of the child poverty strategy (DWP, 2006) were:

- to provide work for those who can, thus helping parents participate in the labour market;
- to provide financial support for families, with more support for those who need it most, when they need it most;
- to deliver excellent public services that improve poor children's chances in life and help break cycles of deprivation; and
- to provide support for parents in their parenting role, so they can confidently guide their children through key transitions in life.

Some measures to support families – such as the introduction of the national minimum wage and changes in tax and national insurance contributions – affect all low-income workers. Other changes have targeted working families with children, including the working tax credit and the child tax credit. For example, the Sure Start maternity grant supports low-income mothers in disadvantaged areas. Other policy changes have affected all families, such as the increases in the child benefit paid to all families.

These changes have had a significant effect on the household incomes of poorer families, reducing the number of children in poverty by any measure and halving the proportion in absolute poverty from 26% in 1998/1999 to 13% in 2005/2006 (DH, 2008).

Developing services for children in their early years

Changes in the way the government worked have also had an effect on the development of services for children in their early years. These changes included a greater emphasis on evidence (as in Acheson et al., 1998) and more attention to cross-government cooperation – for example, through the series of cross-cutting reviews launched by the Treasury, which cut across traditional departmental boundaries. The Sure Start local programmes for children during their early years were among the first programmes for review. The review showed (Cabinet Office, 1999):

> … [that] services for children under four years old are patchy and fragmented. Research demonstrates that early intervention and support is important in reducing family breakdown; in strengthening children's readiness for school; and in preventing social exclusion and crime. The aim is to work with parents and children to improve the physical, intellectual, social and emotional development of young children.

By 2004, there were 524 Sure Start local programmes that reached 400 000 young children (4 years of age and younger) in disadvantaged areas and also reached their families (DH, 2005). All programmes provided core services: support for parenting, outreach and home visits, good quality play and child care, health care, and advice and support for children and parents with special needs. Many local NHS health centres also provided community-based antenatal care services and other health service advice – for example, on smoking, nutrition and breastfeeding.

Related programmes included the neighbourhood nursery initiative, which provided over 45 000 day-care places for children in the most disadvantaged parts of the country. Since April 2004, all 3-year-olds have been entitled to a free, part-time place for nursery education – following the earlier provision of free nursery education for all 4-year-olds.

The umbrella for the improvements in services was provided by the cross-government Every Child Matters programme, led by the Department for Education and Skills. It aimed to maximize children's opportunities and minimize their risks with respect to five key outcomes:

1. being healthy
2. staying safe
3. enjoying and achieving
4. making a positive contribution
5. achieving economic well-being.

Many local services for children were brought together under this umbrella programme in a national network of centres for children, including centres for health, social care, education, child care and the Sure Start programme (Department for Education and Skills, 2004).

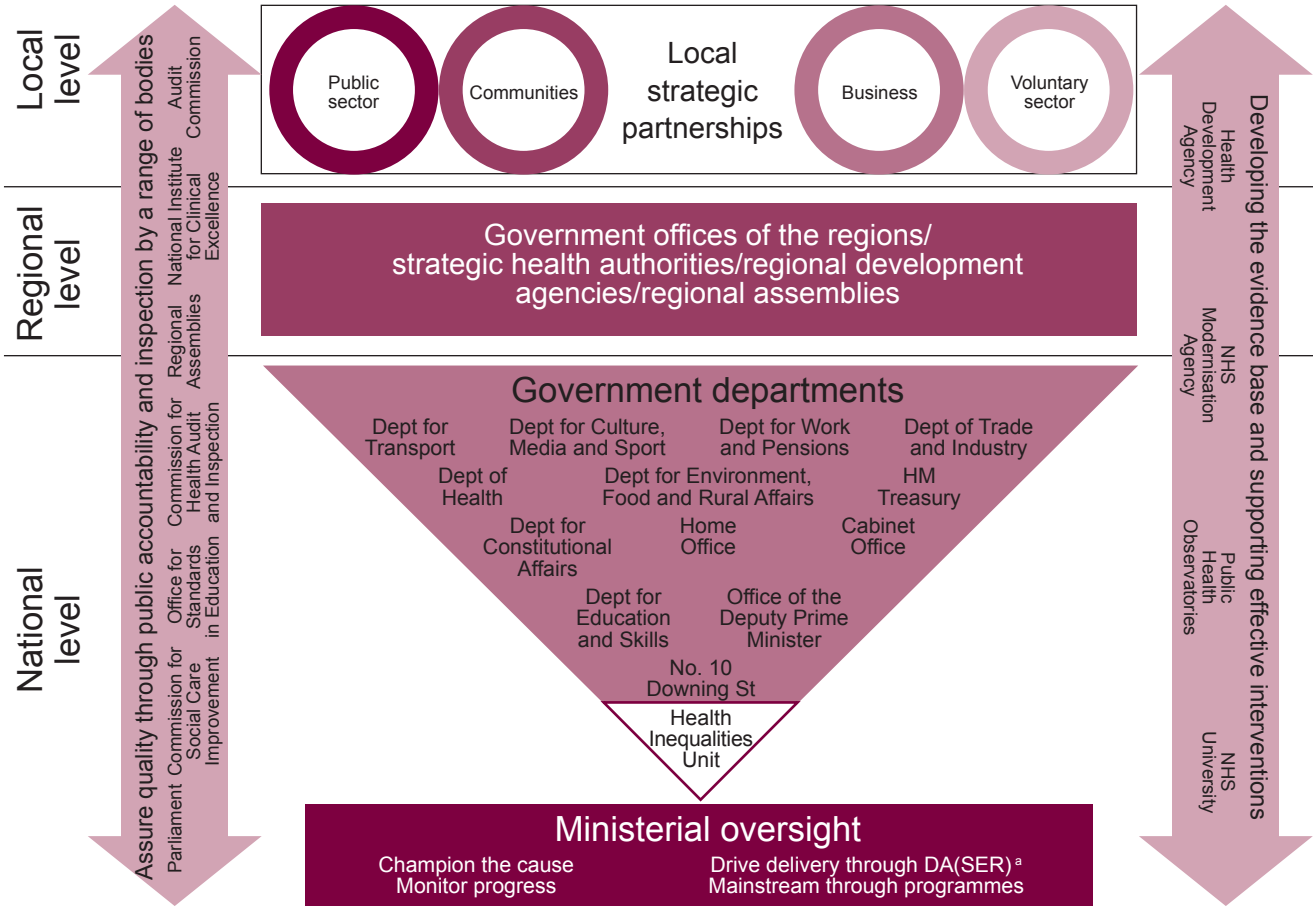
Health programmes were also directed through the NHS to meet the needs of pregnant women, mothers and young children in disadvantaged areas. These included general improvements to the access and quality of NHS services, as well as additional efforts to improve health and prevent illness, such as:

- action to reduce smoking, including smoking during pregnancy;
- improving maternal and child health services through a national service framework for maternity and child health, which set minimum standards, and more recently through the Maternity Matters framework (DH, 2007b); and
- action on obesity, with the setting of a national target on childhood obesity, where the prevalence of obesity among children (2–10 years of age) has risen from 9.6% (1995) to 15.5% (2002), with higher rates in lower social groups (DH, 2007a).

Building partnerships across the programmes

The work on health inequalities – both through the national target and through the families, mothers and children theme of the strategy – also contributed to the broader efforts to address child poverty. Recognizing the wider importance of health inequalities required cross-government cooperation. This was facilitated by the Treasury-led cross-cutting review of health inequalities (HM Treasury & DH, 2002). This review laid the foundation for the cross-government national strategy (DH, 2003) and helped crystallize the relationships between the players. While the names of some of the departments and agencies have changed since 2003, these links – as they appeared in the Programme for Action – are set out in Fig. 22.1.

Fig. 22.1. A framework for tackling health inequalities



[a] DA(SER) = Domestic Affairs Cabinet Sub-committee on Social Exclusion and Regeneration.
Source: DH (2003). Reproduced with the permission of the copyright holder.

The breadth of the strategy encouraged action on a broader basis by building links between relevant programmes, including those on child poverty. From the start, the strategy acknowledged the importance of recognizing the wider socioeconomic dimensions of health inequalities as a key to delivering the target and sustaining long-term developments. The strategy assigned roles and responsibilities for action to the NHS, to health and other professionals, and across government departments. This approach – called mainstreaming – was one of five principles on which the strategy was built. It recognized the need for (DH, 2003:10):

> … *working through the mainstream* – these [public] services are often worst in the most disadvantaged areas and have not always been able to respond to the diversity of need. The scale of change required to achieve the national target will only come about if mainstream services become more responsive to the needs of disadvantaged populations, as exemplified by Sure Start.

Facilitating local action

To make any difference to disadvantaged groups and areas, the national strategy needed to be matched by local action that engaged health and other professionals and secured the support of local communities. Local strategic partnerships were one mechanism for bringing together local government, the NHS and other local organizations. These partnerships were charged with developing an approach to health inequalities that was in line with local needs and priorities. They were encouraged to identify these needs by a health-equity audit. The audit developed an equity profile from an assessment of local health needs; from this profile, priorities for action and investment were developed. Together with others tools, this audit used local evidence and data to guide NHS planning and delivery of services. More recently, a health-inequalities intervention tool has also helped local areas assess the nature of their local gap in health and the effect of interventions on the gap. Engaging professionals and local communities has been an integral part of this process of local delivery (DH, 2001), including the development of such initiatives as locally recruited health trainers (DH, 2004).

Lessons learned

Health inequalities are stubborn, persistent and difficult to change. The data on the target for health inequalities in infant mortality and life expectancy show a widening gap over the established baseline, with some signs of improvement in the wider, social determinants of health. The results (and lessons learned) in tackling health inequalities include:

- recognizing that the issue of tackling health inequalities in infant mortality is part of a broader effort of addressing child poverty and extending and improving services for families, mothers and children in disadvantaged groups and areas;
- formulating the problem to make it amenable to action through a national target that has provided a focus for action and by supporting the target with a cross-government strategy that combines both upstream and downstream components; and
- developing mechanisms of measurement, audit and review to assess progress and develop programmes in line with evidence and experience.

This section reviews developments and shows how a process of audit and review can reinvigorate a national strategy and guide local action.

Results so far

The national target is subject to annual review through a published status report. This report assesses developments against the target and wider criteria. The Department of Health's Scientific Reference Group on Health Inequalities, which is comprised of leading academics and experts and is chaired by Sir Michael Marmot, oversees the development of the report. Publication ensures transparency and provides an opportunity to improve delivery against the target through a process of audit and review.

The report assesses developments against the target goals for life expectancy and infant mortality, 12 cross-government headline indicators identified in the national strategy, including child poverty, and departmental commitments designed to narrow the gap in health. The 2007 status report found:

- a further slight narrowing of the infant mortality gap to 17% for the period 2004–2006, compared with 18% for the period 2003–2005, but it was still wider than the 13% at the 1997–1999 baseline;
- an encouraging picture on the headline indicators, with long-term progress in reducing child poverty and narrowing inequalities in housing quality, educational attainment and flu vaccinations;
- a clear narrowing of the absolute gap in mortality caused by circulatory (heart) disease, cancer, child road-accident casualties and teenage pregnancy; and
- almost all (75 of 82) Department of Health commitments set out in the Programme for Action and due for delivery at the end of 2006 have been wholly or substantially achieved.

Audit and review

The stubbornness of the gap prompted further reflection and an audit and review of developments against the target goals for life expectancy and infant mortality. The review of the infant mortality aspect of the target was overseen by a cross-government steering group – which included representatives from the Treasury, the Department for Children, Schools and Families, the Department for Communities and Local Government, and the Office for National Statistics. The review found that action at the local level needed sharpening, not least because of a lack of awareness of the target and supporting systems and processes. It recommended a range of actions to improve delivery, by:

- promoting coordinated service delivery to the target group
- encouraging ownership of the target, through effective performance management
- sharpening and raising awareness of the target at the local level
- improving the quality of data and strengthening the evidence base.

The target was based on socioeconomic differences but the review recommended a complementary area approach that focused action on the areas with the highest numbers of infant deaths in the target group. Of local areas, 43 of 354 were identified in this category.

The review also modelled a range of interventions, based on evidence that indicated them to be most likely to contribute to the target. These interventions were intended to reduce the incidence of: teenage pregnancy, smoking during pregnancy, sudden and unexplained deaths in infancy, and maternal obesity. Subsequently, interventions intended to reduce the incidence of child poverty and of overcrowding in housing were identified as contributing to achieving the target (DH, 2007c). Early antenatal booking was also identified as likely to have an effect on the target. The results of the review – *Review of the health inequalities infant mortality PSA target* (DH 2007a) – were published in February 2007.

Renewal and sustainability

Although tackling health inequalities in infant mortality is a major challenge, the review showed the value of effective coordination and communications between the different players, including the NHS – not least through its performance and planning system - and other government players. The process of audit and review provided a means to focus on the steps needed to improve the prospects of meeting the 2010 target. The publication of the results of the review has also provided an opportunity to renew attention on the national health inequalities target, to reinvigorate the national strategy and to rebuild links with the wider aspects of child poverty and the strategy for children in their early years.

The national strategy helped reach relevant players at the national, regional and local levels. It assigned roles and responsibilities and identified specific commitments – with a time scale – across 12 departments (see Fig. 22.1). This has enabled action on upstream and downstream determinants of health to be developed in parallel – seen most clearly in the modelling of key interventions in the review.

Such a sustainable approach needs partners to understand the part they have to play to help meet the target. Targets and programmes need to engage the systems and processes available if they are to deliver change. This means working within the mainstream public services, sharing good practice and identifying opportunities for developing evidence on what needs to be done. The health inequalities intervention tool, by assessing the effect of key interventions at the local level, has promoted local planning and partnership.

The author of the present case study proposes that there is still much to be done in tackling the health inequalities that affect families, mothers and children in England. This will need continued commitment to meet the target and the delivery of effective local services to the target group. This offers the likeliest route to narrowing the gap in infant mortality and laying the foundation for a long-term sustainable reduction in health inequalities.

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Part II. Background papers on the health of select groups disproportionately exposed to poverty and social exclusion

23. Roma health

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Summary

Demographic synopsis

Roma and Travellers in the WHO European Region are vulnerable to deep, long-lasting poverty and ill health. Their status is shaped by a variety of factors, especially high unemployment, substandard housing conditions, poor access to health services, and direct and indirect discrimination.

Roma live in almost all European and central Asian countries. Population figures and other data on them are scarce and controversial. The European Parliament has estimated there are between 12 million and 15 million Roma and Travellers, with between 7 million and 9 million living in the EU.

Roma in eastern Europe and central Asia are primarily settled, while some in western Europe continue to pursue a nomadic lifestyle. Many Travellers also move around. Due in part to changing economies and deepening exclusion in eastern Europe, rural-to-urban labour migration and economically motivated immigration also occur – frequently from eastern to western Europe.

Health risks correlated with social conditions

Poverty rates are noticeably higher in Roma communities, shaping access to health care, education and good housing. Roma have lower rates of educational enrolment, as evidenced by data from England, France and Serbia that reveal large disparities in enrolment between Roma and major ethnic populations.

In urban and rural areas of western, central and eastern Europe, many Roma live in very unhealthy conditions. Living spaces are cramped, increasing the chances of spreading infectious diseases and contributing to stress among family members. Not only are houses often substandard, but they may also be located in unhealthy areas, such as garbage dumps or isolated rural areas far from primary health care. Roma living in houses that are illegally constructed are vulnerable to forced eviction and its associated physical and mental health outcomes. If they lack a legal address, Roma families that live in informal housing may also have trouble enrolling their children in school and accessing health and social services.

Health care access

These social conditions contribute to inequities between Roma and other populations in health system use and health outcomes. Lack of documentation underlies a substantial part of the discrepancies in health system use. Many Roma may lack citizenship,

personal identification or health insurance, limiting their access to health and social services.

Because of past negative experiences, Roma may also choose not to access health services. A high percentage of Roma report having experienced discrimination in health facilities, and research conducted among medical providers confirms that many hold prejudicial beliefs about Roma. The most frequently reported manifestations of discrimination include: general practitioners refusing to register Roma clients on their rosters, emergency services not responding to calls from Roma communities, health services refusing to treat them, verbal abuse, denial of access to medical records and segregated maternity wards of inferior quality.

Also, Roma may not seek health care due to the costs anticipated. The cost of visiting a health care facility or obtaining social assistance might include the price of public transport, lost wages, legitimate co-payments, out-of-pocket payments, payments for documents and payments for drugs.

Due to the factors noted above and to generally low health literacy within poor Roma communities, some Roma do not seek adequate preventive care. Surveys of knowledge about health suggest that excluded Roma have less knowledge about health. As a result of limited access to health care and poor awareness of health, Roma too frequently resort to costly emergency services or suffer from preventable illnesses.

Health outcomes

Lower rates of vaccination – as well as cramped living conditions, malnutrition and, in some cases, poor sanitation – mean that Roma are particularly vulnerable to communicable disease. There have been outbreaks of measles reported among Roma in Germany, Greece, Italy, Portugal, Romania and Serbia, as well as among Traveller populations in the United Kingdom. Other communicable diseases more prevalent among Roma include hepatitis A and TB. Discrepancies in rates of active TB suggest that Roma are more vulnerable to TB infection and disease, as well as to diagnostic delay, thus furthering the spread of the TB bacillus in the community.

There is very little information about noncommunicable diseases among the Roma, but existing data suggest that noncommunicable health issues and unhealthy behaviour affect Roma communities. Among some Roma, nutrition is inadequate. Also, in some Roma communities, tobacco use among men is alarmingly high. Maternal smoking may contribute to adverse effects on children's health, and low birth weight has been found to occur more frequently among Roma infants than among infants of other ethnicities – that is, the national non-Roma population comprising the majority ethnic population and other minorities). Both tobacco consumption and poor eating habits contribute to heart disease, which appears to be more prevalent in Roma communities, though there are few data to substantiate this connection.

Additional health concerns that can be assessed through surveys and other forms of self-reporting appear to be problems, such as domestic violence and mental health. Both issues, however, are somewhat contested within the Roma community. Some Roma health and rights advocates do not prioritize either issue, believing that they are not significant problems or that open discussion of domestic violence and mental health concerns will only reinforce prejudicial beliefs about the Roma. Despite these limitations, data indicate that violence against Roma women and anxiety and depression are problems.

Roma infants suffer disproportionately from many of these same communicable and noncommunicable health problems. In part, this may be due to maternal smoking and poor nutrition (mentioned earlier), to low use of antenatal care and to difficult births. Studies have documented higher rates of admission to neonatal units, higher perinatal death rates and higher rates of sudden infant death among Roma.

Poor maternal health is significant not only for what it implies about infant health, but it is significant also for what it implies about women's reproductive health more generally. While Roma women often bear responsibility for the health of other family members, they may neglect their own health, because they are unaware of the importance of preventive care or because they are ashamed to seek care, especially if it entails breaking traditions related to purity and modesty. In some Roma communities, a high symbolic value is placed on virginity, which inhibits unmarried women's efforts to obtain family planning or other reproductive health services. Among other factors, emphasis on virginity contributes to early marriage. Early marriage makes young women more vulnerable to high-risk pregnancies, and the likelihood of becoming pregnant at a young age is exacerbated by the low use of contraception.

Finally, while social and health care system exclusion, poor living conditions, poverty, and low education contribute to the health care concerns noted above, they also contribute to a higher risk of accidents. Roma have explained that hazardous

living conditions predispose their children, in particular, to accidents. Economic exclusion further exposes Roma to dangerous working conditions and a higher risk of workplace accidents or work-related health problems, and Roma who are engaged in the informal labour sector usually do not have access to health insurance and social protection. Others may have informal or formal jobs that pose health hazards, such as street cleaning and scrap metal or refuse collection.

While socioeconomic vulnerability to ill health is often highlighted, there are some health assets within Roma communities. It is difficult to make generalizations about such a heterogeneous ethnic group, but some aspects of Roma culture have been repeatedly highlighted as promoting better health and social care. Most importantly, strong norms of behaviour for family and community support may mitigate isolation and provide needed emotional and physical support during periods of illness. Moreover, a strong sense of group identity provides a firm foundation for community-led and -implemented programmes to improve health.

Initiatives to improve Roma socioeconomic status and minimize health risks

International and national governmental and nongovernmental actors have created funding streams and policy frameworks to remedy Roma marginalization. Relevant international organizations and intergovernmental bodies involved in efforts to improve the livelihoods and inclusion of Roma include: UNDP, UNICEF, EC, CE, OSCE, and the World Bank.

In general, these entities take two distinct approaches to Roma exclusion. The first is a legal approach based on human rights and antidiscrimination statutes, and the second is a policy approach based on emerging Europe-wide strategies on employment and social exclusion. Much of their work integrates both approaches. Also, most European countries, particularly those in eastern Europe, have a specific governmental entity assigned to minority or Roma inclusion, or both.

The Decade of Roma Inclusion 2005–2015 is an initiative that includes these intergovernmental organizations, as well as participating governments in central and south-eastern Europe, and NGOs. Launched in 2004 to address inequities in four sectors – education, employment, health and housing – the Decade is sponsored by governments, CE, the CE Development Bank, EC, the Open Society Institute, OSCE, UNDP and the World Bank. Also, each of the participating governments has developed a national action plan to address inequities in the four sectors.

Emerging know-how and policy implications

Before examining specific programmes, it is important to describe a broader debate on the approach to priority health concerns and health system access – the need for special measures. Special measures could include positive action, preferential treatment or quota systems. International governmental organizations and other international agencies agree that special measures (particularly positive action) are necessary, while a few government officials maintain that since Roma have equal access to health care according to the law, no such measures are required. After extensive analysis, both UNDP and WHO have provided evidence supporting group-specific strategies to remedy long-standing gaps and facilitate inclusion. Such measures should be complementary and synergetic, with policies and interventions promoting health equity across the social gradient.

There is no substantial body of so-called best practices for improving Roma health. In part, this is because the issue was only added to some government agendas in the past 10 years. Also, because of the lack of disaggregated data on health, measuring success is difficult. With these caveats in mind, some common challenges and opportunities do emerge from an analysis of governmental and nongovernmental programmes that address Roma health.

The priority given to public health issues varies widely by country. Vaccination and reproductive health are frequently identified, and most Decade of Roma Inclusion 2005–2015 and other national action plans that cite particular health areas mention vaccination and reproductive health more frequently than other health concerns.

Vaccination campaigns have been successful in increasing the number of Roma vaccinated in multiple countries. However, simply going to a community with large quantities of vaccines is not enough. It is important that vaccination campaigns be preceded by efforts to sensitize the community to the benefits of the proposed activities, to gain community support. It may also be both pragmatic and cost effective to pair vaccination with other interventions that have immediate, concrete benefits, such as assistance in obtaining documentation or insurance.

As in the case of vaccination, reproductive health can be a sensitive issue at the community level, particularly in areas that

maintain traditional gender norms of behaviour. For this reason, successful governmental programmes entail a partnership with Roma communities or organizations and integrate an understanding of gender dynamics.

Interventions in these and other health areas should try to address the broader issue of exclusion from the health system and should facilitate continued access. While targeted mobile projects may make needed improvements in rates of coverage for key health services, these services should attempt to ensure continuity through the establishment of accessible service points in Roma communities. Also, complementary programmes that address factors that underlie poor access to health services are also required.

Sensitivity to costs is an issue that repeatedly surfaces as a key determinant of Roma access to health care and social protection. Decreasing health care costs is not easily achieved, particularly in eastern European countries that are in the midst of health reform, but identifying concrete solutions for low levels of insurance coverage and for prohibitive health care costs will remove significant barriers to health care access.

In addition to the importance of addressing cost limitations, many policy analysts and programme implementers have concluded that specific programmes are required to mitigate poor health and health system knowledge among Roma and to mitigate prejudicial beliefs and lack of understanding of Roma culture among health providers. If Roma are still treated poorly when they try to obtain health services, removing bureaucratic and logistical barriers to access to health care will not result in sustained increases in the use of these services.

Within a country, coordination between the health ministry and other ministries will enable programmes that address the seemingly intransigent merging of health and social risks. Mediation is one of the most widely employed programmes to improve Roma access to health care and social protection services; it entails training, usually of a member of the Roma community, in mediation between Roma clients and services provided by the state. Mediation programmes have successfully increased access to health services in several countries.

Conclusion

Action to improve the health of Roma populations requires a commitment to the shared values of solidarity, equity and participation. These values should be manifested in health policies, resource allocation and other actions, ensuring due attention is paid to the needs of the poor and vulnerable groups, including the Roma. This was emphasized in the Tallinn Charter, endorsed at the WHO European Ministerial Conference on Health Systems in June 2008. Ample opportunities exist for governments to integrate such actions as those outlined in the preceding sections into health system stewardship, financing, resource generation and service delivery functions, thus improving their ability to pro-actively address the health status of Roma populations. It is time to move from a fragmented to a transformative approach. Health systems can remedy some of the social, economic, and political issues that predispose Roma to exclusion and ill health; and they can provide services that appropriately respond to morbidity.

Demographic synopsis

Roma and Travellers in the WHO European Region are vulnerable to deep, long-lasting poverty and ill health. Their status is shaped by a variety of factors, especially high unemployment, substandard housing conditions, poor access to health services, and direct and indirect discrimination (European Monitoring Centre on Racism and Xenophobia, 2006:6).

The encompassing term Roma is often used to describe various communities who identify themselves as Sinti, Ashkalia, Egyptians, Roma, gens de voyage, Yenish, Kale, Gypsies and Manouch, among other things, although those identifying themselves as Egyptians explicitly reject that their origin is Indian. Together, they comprise an ethnic population that is made up predominantly of communities of commercial and nomadic groups from India (Liégeois & Gheorge, 1995:6).

Because they are thought to share challenges of exclusion and a culture distinguished by nomadism and self-employment, Travellers are often included in policy discussions about Roma (Liégeois & Gheorge, 1995:6). However, some question whether this is valid. The OSCE Office for Democratic Institutions and Human Rights, for example, notes on its web site that Roma and Sinti are "Often linked together pejoratively under the term *Gypsies*, alongside ethnically unrelated groups" (OSCE Office for Democratic Institutions and Human Rights, 2007). Others have questioned the purported homogeneity of experiences of Roma and Travellers (Martin McKee, London School of Hygiene and Tropical Medicine, personal communication, 29 August

2007). Despite these concerns, this chapter will keep to the CE convention and use the term Roma to refer to both Roma and Travellers. Cases where only Travellers are involved will be noted as such. Readers should be cognizant of the debate and consider for themselves whether grouping Travellers with Roma is appropriate from an anthropological and/or a public policy perspective.

According to the World Bank, Roma live in almost all European and central Asian countries. CE reports that there are Roma communities in almost all CE member states, with the exception of Armenia and some of the smallest states, such as Liechtenstein, Luxembourg and Monaco, where they report that there are no Roma communities (CE, 2007a). Roma in eastern Europe and central Asia are primarily settled, while some in western Europe continue to pursue a nomadic lifestyle. Many Travellers also move around. Due in part to changing economies and deepening exclusion in eastern Europe, rural-to-urban labour migration and economically motivated immigration also occur – frequently from eastern to western Europe.

Population figures and other data on Roma are scarce and controversial. In 2005, the European Parliament estimated that there were between 12 million and 15 million Roma and Travellers, with between 7 million and 9 million living in the EU which, at the time, did not yet include Bulgaria and Romania (European Parliament, 2005). CE estimates that between 8 million and 10 million Roma live in Europe (CE, 2007b). Roma comprise a substantial percentage of the population in some countries; the World Bank states that Roma make up between 6% and 11% of the populations in Bulgaria, Romania, Slovakia and the former Yugoslav Republic of Macedonia (Ringold, Orenstein & Wilkens, 2005:4). Table 23.1 summarizes estimates from various sources. It is important to note that census data are generally believed to undercount the number of Roma, as data are based on self-identification.

The data in the last column of Table 23.1 come from a Minority Rights Group International report by Liégeois & Gheorghe (1995), and it contains some of the most widely cited Roma population estimates. The figures are from the Gypsy Research Centre at René Descartes University in Paris. Table 23.1 provides: "stable numbers more indicative of the long-term picture than of recent population movements" (Liégeois & Gheorge, 1995). For this reason, the figures for some countries that have experienced substantial population movements since 1995, namely some areas of the former Yugoslavia, are not included in the table (Liégeois & Gheorge, 1995).

Table 23.1. Estimates of Roma population

Country	Census figure (year)	Percentage of population from census	Other estimate (source)	Percentage of population from other estimates	Liégeois & Gheorghe [a]
Romania	535 140 [b] (2002)	2.5	1.45–1.59 million [c]	6.7	1.8–2.5 million
Bulgaria	365 797 [d] (2001)	4.7	600 000–750 000 [d]	7.7–9.6	700 000–800 000
Hungary	189 984 [*] [e] (2001)	1.9	400 000–600 000 [f]	3.9–5.9	550 000–600 000
Slovakia	89 920 [g] (2001)	1.7	360 000–400 000 [h]	6.6–7.4	480 000–520 000
Czech Republic	11 718 [i] (2001)	0.1	150 000–300 000 [j]	1.5–2.9	160 000–300 000
The former Yugoslav Republic of Macedonia	55 000 (2004)	2.7		5.0–6.0 k	
Serbia	108 193 [l] (2002)	1.4	~ 500 000 [m]		
Croatia	9 463 [n] (2001)	0.2	30 000–40 000	0.7–0.9	
Montenegro	2 601 [o] (2003)	0.42			

Sources: [a] Liégeois & Gheorghe (1995); [b] Ciocoiu (2006); [c] ECMI (2001:3); [d] UNDP (2003:25); [e] Hungarian Central Statistical Office (2001); [f] Ministry of Foreign Affairs for the Republic of Hungary (2004); [g] UNDP (2003:25); [h] OSI (2002:576); [i] UNDP (2003:25); [j] OSI (2002:172); [k] Roma Education Fund (2007:9); [l] Republic of Serbia Republic Statistical Office (2002); [m] UNDP (2006):4; [n] Croatian National Programme for Roma (2007); [o] Yugoslav Survey (2007).
[*] Of those asked about their ethnicity, 543 000 did not respond. It is reasonable to assume that a significant percentage of these non-responders may be Roma (who may also self-identify as Hungarian).

This chapter discusses the health status of Roma communities and, more particularly, the ways in which socioeconomic factors influence access to health care and health status. Many of the health problems Roma face are similar to those faced by the poor of any ethnicity. As this chapter will show, however, some key elements that shape their socioeconomic status, access to health care and health status are indeed specific to Roma ethnicity. The role of transnational policy and funding mechanisms, including the Decade of Roma Inclusion 2005–2015, the CE Council of Ministers Experts' Committee on Roma, Gypsies

and Travellers, and the OSCE Office for Democratic Institutions and Human Rights Contact Point on Roma and Sinti Issues, among others, will be examined as well. Particular programmes that have been shown to improve the state of Roma health or to address the wider context of social exclusion will be highlighted. Finally, as the development of integrated social and health strategies is fairly new to the field of Roma health, this chapter aims to contribute to the growing area of background data and policy know-how.

In the interest of drawing conclusions and highlighting widely applicable policy responses to Roma exclusion, this chapter makes many generalizations. Roma are a very heterogeneous group, in which Roma Muslim, Eastern Orthodox, Protestant, Pentecostal and other religious communities exist. Some Roma speak the national language of the country in which they reside, some speak a minority language (such as Turkish-speaking Roma in Bulgaria) and others speak Romanes, the Roma language. An important number of Roma speak primarily Romanes; about half the Roma in Bulgaria speak Romanes at home (Ringold, Orenstein & Wilkens, 2005:11). As will be explored further in the following section on data, Roma are also heterogeneous in level of education, socioeconomic status and degree of integration with the major ethnic community.

Data on Roma communities

As already indicated, there are few reliable data about Roma communities. Some figures cited in this chapter have been collected by local governments or NGOs and apply only to small geographic areas. There are generally more data about Roma living in countries with larger Roma populations and/or in countries whose governments have initiated some data collection. So, while these countries are mentioned more frequently here, this is not meant to imply that the status of Roma is any better or worse than in countries for which data are scarce.

Lack of data at the national level on Roma is part of the overall lack of ethnically disaggregated data in the European Region. Some governments do not collect such data because they believe it is unnecessary or illegal, because they fear the revelation of ethnic disparities, or because ethnic minority communities are opposed (Ramsay, 2006:2). In the past, data on ethnic groups were seldom used to bring about lasting changes in Roma communities, and they may have been collected and used in both an offensive and fatal manner (Greenfields & Home, 2006:120). For example, the use of data by the Nazis to implement genocidal policies is widely known in Roma communities, giving rise to deep suspicion about official data collection (Claude Cahn, Centre on Housing Rights and Evictions, personal communication, 8 August 2007). When international organizations or other entities that collect data enquire about ethnicity, some Roma identify themselves as another ethnic group, to avoid being stigmatized. A comprehensive 2002 UNDP/ILO survey in five eastern European countries showed that the more affluent Roma were less willing to classify themselves as such (UNDP, 2003:23).

Because of reluctance to identify themsleves, Roma ethnicity is often assigned by outside interviewers who may use skin colour or living situation as an indicator of it. As a result, much of the data cited below applies more to identifiable Roma settlements – so-called compact communities. These communities often do not include the more educated or wealthy Roma who dwell within the major ethnic populations. So, the data cited should not be understood to describe the Roma population as a whole, but should rather be understood to describe the relatively high percentage of the population that lives in Roma settlements. Also, some data collection is not grounded in ethnicity at all, but instead focuses on people associated with excluded Roma-like settlements, which includes non-Roma in these situations (Babusik, 2007).

Much of the so-called health data on Roma focus on priorities articulated by the major ethnic communities, rather than the Roma themselves. A Roma health literature review conducted in 2000 (Hajioff & McKee, 2000) found that much of the literature at the time addressed reproductive health and/or contagious disease, reflecting a concern for the ways in which Roma health can negatively impact the major ethnic communities, rather than a concern for Roma health as such. Another review (Zeman, Depken & Senchina, 2003) concluded that much of the current scholarship sought to find the locus of responsibility for Roma ill health within the community itself. So-called data analysis can be similarly oriented, where numerous studies have attributed low rates of health care access to Roma culture.

Additional health and social data – particularly data that illustrate differences among Roma, the poorest segments of the overall population and the overall population in general – are required to design and monitor programmes and to evaluate existing policies and their effect. Many policy-makers assert that disaggregated data collection is illegal, but this is generally not the case. With very few exceptions, national legislation does not formally prohibit ethnic data collection, but makes it conditional on the respect of certain safeguards (CE, 1981: article 6; Simon, 2007:68–70). The CE Committee of Ministers (2006a: para. 7.1) requested that member states develop strategies that allow for appropriate data collection on health needs, health determinants and health care received by so-called multicultural populations.

While additional data are needed for optimal programme design and evaluation, many advocates have pointed out that sufficient data exist for programme development, so lack of data should not serve as an excuse for inaction (CE Specialist Group on Roma/Gypsies, 2000). The data summarized in the following sections illustrate the need for increased attention to Roma health and socioeconomic status.

Roma demographic and population statistics

There are ample data to discern some demographic trends of the Roma population. Roma populations across Europe are younger than national populations as a whole. While noting the problems related to the designation of Roma identity, the UNDP/ILO survey (UNDP, 2003:26), which was done in Bulgaria, the Czech Republic, Hungary, Romania and Slovakia, revealed that the median age for Roma was 19.3 years, compared with 33.6 years for the overall population. Overrepresentation among the young is due in part to higher birth rates; in the Czech Republic, Hungary, Romania and Slovakia, Roma households averaged three to four children (UNDP, 2003:25).

The youth of Roma communities is also partly attributable to the younger average age at death. A 1993 report commissioned by the United Nations High Commissioner for Refugees stated that Roma live 10 years less than majority ethnicity communities (Ringold, Orenstein & Wilkens, 2005). Data available for Bulgaria, the Czech Republic and Romania show similar shortfalls in Roma life expectancy. A World Bank analysis of poverty among the Roma summarized a study of life expectancy done in the Czech Republic in the 1990s, which discerned a 12-year gap between Roma men and men of the major ethnic group and a 14-year gap between Roma women and women of the major ethnic group (Ringold, Orenstein & Wilkens, 2005). Using data on people who reported their ethnicity as Roma in the Bulgarian censuses of 1992 and 2001, UNDP extrapolated this information and concluded that the life expectancy of Bulgarian Roma was on average five to six years lower than that for other groups (UNDP, 2003:64). UNDP also developed an estimate for Romanian Roma life expectancy – this time using infant mortality rates as a base – and concluded that a "realistic estimate" for the average Romanian Roma life expectancy was between 63 and 64 years, compared with an overall Romanian life expectancy of 70 years (UNDP, 2003:17).

These life expectancy differences suggest greater morbidity among the Roma and are a proxy for social exclusion in general. Social exclusion of some groups, including the Roma, has deepened in both western and eastern Europe over the last 20 years. Also, social inequities have increased, and the gap in health between the top and the bottom of the social scale has widened (CE Committee of Ministers, 2001a:23; Costongs et al., 2007:6). Health care reforms in eastern Europe and the former USSR have created new structures, including semi-autonomous funding bodies and private health care delivery (Fuenzalida-Puelma, 2003:6). The accompanying health care processes have often selectively excluded Roma (Shakarishvili, 2003:4). Social dislocation, changing social protection systems and ethnic polarization in some countries have also contributed to increasing exclusion of Roma. Roma in the five countries covered in the UNDP/ILO survey believe that their life has deteriorated since the inception of the transition from socialism to capitalism (UNDP, 2003:17). Existing data support this perception. For example, in 1993, 13.9% of Hungarian Roma lived in segregated areas, called colonies, under unfavourable housing conditions. By 2000, about 20% lived under such conditions (Ministry of Health, Family and Social Affairs, 2003:13).

While living conditions and health care access have worsened, the transition has placed the status of Roma in eastern Europe and the former USSR higher on the international policy agenda. Also, EU expansion, the Decade of Roma Inclusion 2005–2015 and other policy mechanisms have created new opportunities for policy analysis and transnational action. It is in this wider context that this chapter examines the social determinants of Roma health.

The correlation between health risks and social conditions

Poverty and health

Poverty – and its multiple determinants and manifestations – is germane to Roma access to health services and to Roma health status. Such factors as discrimination and social exclusion make Roma more vulnerable to behaviour and conditions that effect health negatively, such as high rates of tobacco consumption, low educational attainment, substandard housing, lack of personal documentation and unhealthy working conditions. These conditions result in ill health that deepens poverty.

Roma disproportionately live in poverty throughout the WHO European Region. For example, the World Bank reported that, in 1997, 84.3% of Bulgaria's Roma were poor (Ringold, Orenstein & Wilkens, 2005:ii). Those living in Roma settlements are

the poorest, with women and children being especially vulnerable. In Serbia, 67% of children living in Roma settlements were classified as poor, and 62% of Roma households with children live under the poverty line (UNICEF, 2006:25); Roma are also concentrated among the poorest groups. When multiple levels of poverty were established among groups surveyed in Bulgaria, Hungary and Romania, Roma were overrepresented in the poorest groups (Ringold, Orenstein & Wilkens, 2005:29–31).

Analyses of household expenditures illustrate the depths of poverty in some Roma households. In Serbia, for example, the poorest Roma households with children spend over 60% of their income on food. Expenditures for education are barely more than 1% (UNICEF, 2006:26).

Income poverty may undermine pro-health behaviour. In a survey conducted among Roma and poor ethnic Romanians in Romania, only 68% of the Roma said they would go to the doctor after coughing for three weeks, compared with 99% of the ethnic Romanians. Compared with 22% of poor Romanians, 47% of the Roma said they would not go because of concerns about cost (Schaaf, 2007:19).

Poverty influences behaviour and access to health care, but experiencing inequality may also shape health among such marginalized communities as Roma. Michael Marmot, Chairman of the WHO Commission on the Social Determinants of Health, and others have suggested that experiencing unfairness may independently predict poor health outcomes – that is, even after controlling for unhealthy behaviour, being at the bottom of the social hierarchy may likely lead to adverse health events (Marmot, 2005; De Vogli et al., 2007). Thus, the low socioeconomic status experienced by many Roma may contribute to poor health, independent of poverty-related conditions and behaviour, such as smoking, poor nutrition and substandard housing. Further research is warranted on the effects of experiencing inequality within Roma communities, particularly since the perception of unfairness may be acute in the case of an ethnic group that is consistently disadvantaged in relation to the overall population. Some data support this proposition: a multivariate analysis of poverty demonstrated that Roma identity, as an independent factor, significantly influences welfare levels in south-east Europe (Milcher, 2006).

As a field of study, the subjective experience of inequality and its influence on health is still at a formative stage, so this chapter focuses primarily on social factors that directly and obviously influence health, such as housing, education, violence and sanitation. However, some analyses, such as those that focus on discrimination in health care settings, vulnerability to violence and mental health, encourage further thinking on the ways in which Roma identity may lead to negative outcomes, independent of other factors. This chapter tries to elucidate the need for further analysis by comparing data available on the Roma with data on the poor among the overall population. Programme planners should seek to discern and then consider, in subsequent strategies and programmes, how being Roma and the experience of exclusion influences health behaviour and directly contributes to health inequities.

Educational attainment and health

Disproportionately low educational attainment limits health literacy – that is, the capacity to understand and act on health information – and also further contributes to the poverty that underlies ill health. Roma have low rates of educational enrolment, and preliminary data from a MICS survey in Serbia show that 76% of Roma go to primary school, but only 13% complete it (UNICEF, 2006:28). In contrast, 96% of the Serbian school-age population overall completes primary school (UNICEF Strategic Information Section of the Division of Policy and Planning, 2007). Among Travellers surveyed in England, only 44% had received regular formal education after primary school, compared with 85% of a comparison group comprised of poor people living in different conditions and other ethnic minorities (Parry et al., 2007:200). School attendance rates in France are similar: the French Ministry of National Education reported in 2001 that about 15–20% of so-called Gypsy children of secondary-school age attend (ERRC & Númena, 2007:38).

For several reasons, Roma have lower rates of school attendance and completion. Among the most important reasons are the inability of many Roma children to adequately speak the language spoken at school, the inability to pay for school supplies or appropriate clothing, the fear of losing Roma culture to the national identity transmitted in school, and actual or perceived discrimination (Ringold, Orenstein & Wilkens, 2005:11–12).

In cases where Roma children do attend school, segregation may lessen the effect of education on social mobility. Although, segregation is certainly not policy in any country, it occurs (directly and indirectly) in many regions. First, residential segregation may result in school populations being entirely Roma students. Second, in some countries, Roma are disproportionately placed in classes for children with intellectual disabilities. This has occurred in some EU countries, including the Czech Republic, Hungary and Slovakia (European Monitoring Centre on Racism and Xenophobia, 2006:8). The UNDP/ILO survey showed

that, on average, 19% of children in the households surveyed attended classes comprised mostly of Roma students (UNDP, 2003:3). Educational segregation is not simply a matter of decision-making by educational authorities; the CE Commissioner for Human Rights reported that desegregation efforts have at times met with resistance from non-Roma parents (Gil-Robles, 2006a: para. 54).

Housing and living conditions

Housing is cited as frequently as education as a key social determinant of Roma health. Poor housing may directly harm health. Also, isolation and housing insecurity limit access to health care and may contribute to mental and physical distress.

In urban and rural areas of western, central and eastern Europe, the conditions under which many Roma live are very unhealthy. Living quarters are cramped, which increases the chances of spreading infectious illness and contributes to stress among family members. The European Centre for Minority Issues (ECMI) conducted a survey among 400 families in 10 cities in the former Yugoslav Republic of Macedonia, and 69% of them reported that they shared a space of between 10 m^2 and 50 m^2 with three to five other inhabitants (ECMI, 2005:109). Similarly, a significant majority of those surveyed by the Impreuna Agency in rural Romania shared one room with four to seven people (Impreuna Agency for Community Development, 2005:40). Also, houses may be built of scrap materials and may lack basic hygienic amenities. A survey conducted by UNICEF in the areas of the former Yugoslavia highlights the disparity between Roma and other marginalized groups: 70% of Roma households surveyed lacked a toilet or indoor bathroom, compared with 27% of poor households from the major ethnic population and 27% of refugee households (Milcher, 2006:24).

Housing standards are one element of poor living conditions. Location is another. Sites for shelter that are dangerously situated expose Roma communities to direct health risks. In the United Kingdom, many of the 350 public Gypsy sites (places where Travellers can legally stop with caravans) are located in unhygienic areas deemed unsuitable for other development, such as old waste dumps (Van Cleemput, 2000:33). A particularly dangerous incident occurred in Kosovo [1], where 700 internally displaced Roma were living on the site of an abandoned mine. After having tested the soil, WHO concluded: "The Roma case is urgent. … Children's lives and developmental potentials are at risk" (McWeeney, 2004).

Geographic isolation creates indirect health risks, as Roma often live disproportionately far from health and other services. A 2005 Sociological Investigation Team (EDIS) survey of 1200 Roma families from nine marginal neighbourhoods in Madrid, Spain, indicated that physical distance and lack of public transport hindered access to health services (ERRC, 2006b:37). In 2003, Delphoi, a Hungarian consulting firm, found that 5.9% of the country's overall population (excluding Budapest) live in settlements without a local general practitioner. The firm discovered that, in contrast (again excluding Budapest), 18.6% of the country's Roma live in settlements without a local general practitioner (ERRC, 2006b:36).

Inadequate political will has been found to underpin continued deficiencies in housing conditions. In some cases, activities normally assumed by the state, such as garbage removal, can be irregular. In other cases, entities with a legal mandate to monitor have explicitly highlighted state failures. For example, the CE Commissioner for Human Rights and the European Committee on Social Rights – the body given the task of monitoring compliance of the states that are parties to the European Social Charter, a CE Treaty – both investigated the Roma housing situation, and they both proclaimed poor living and housing conditions in segregated Roma communities to be human rights concerns (CE Committee of Ministers, 2005b; Gil-Robles, 2006b: para. 344).

At times, Roma communities do not benefit from state services, because some or all of their houses may not be legally owned or constructed. In Romania, in 1998, 21% of the Roma surveyed reported that they lived in a house for which they did not have title of ownership, meaning that the house itself was illegal or they were squatters (Impreuna Agency for Community Development, 2005:24–25). Even higher rates of squatting prevail in other countries – for example, between 50% and 70% of the Roma in Bosnia and Herzegovina live in informal housing (ECRI, 2005a:62). Also, some countries require a legal address to access educational, health, social and other services.

Moreover, many Roma communities in informal housing are susceptible to forced evictions, which may interrupt health care or even involve violence. A survey on forcibly evicted Travellers by Save the Children Scotland and Dundee University Law School shows that 43% of families were receiving health care at the time they were forcibly moved. For half the respondents surveyed, treatment subsequently stopped completely, and for the other half treatment was interrupted or delayed (Aspinall,

[1] Reference to Kosovo in this publication, including in the bibliography, should be interpreted as: Kosovo (in accordance with Security Council resolution 1244 (1999)).

2005:32). The CE Commissioner for Human Rights reported that evictions in some countries are frequent. These evictions can be violent, with force and sometimes tear gas being used and caravans being towed away (Gil-Robles, 2006b: para. 350).

In some countries where Roma and Travellers maintain a nomadic lifestyle, eviction or other housing (and concomitant cultural) changes may contribute to poor health outcomes. The often involuntary move to housing for Travellers has been described as responsible for breakdowns in mental health and child coping mechanisms. In one case, failure rates for placements in public housing were reported to be as high as 50% (Greenfields & Home, 2006:112). Also, as part of a survey in England, Travellers who rarely travelled reported worse health status than their travelling peers (Parry et al., 2007:201).

Vulnerability to violence

In addition to forced eviction, Roma could also be vulnerable to other types of violence perpetrated by the state or other actors. Attackers may be family members, racists or police, among others. In the case of family members, whether Roma suffer disproportionately is not known (see section on "Domestic violence and mental health"). Since Roma are targeted because of their ethnicity, they presumably suffer from racist attacks more than people in the major ethnic group. The CE Commissioner for Human Rights and the European Commission against Racism and Intolerance (ECRI) have expressed concern about continuing reports of violence against Roma, in some cases by the police (ECRI, 2004: para. 68; Gil-Robles, 2006a: para. 76–79).

Health assets

In summary, Roma ethnicity correlates with a range of direct and indirect health risks. However, while socioeconomic vulnerability to ill health is often highlighted, there are some health assets within Roma communities. While it is difficult to make generalizations about such a heterogeneous ethnic group, aspects of Roma culture have been repeatedly highlighted as promoting better health and social care. Most importantly, strong norms of behaviour for family and community support may mitigate isolation and provide needed emotional and physical support during periods of illness. Also, Roma in hospitals are often supported by an extended family (Koupilová et al., 2001:1194; Kemp & Rasbridge, 2004:32–33; FSG & Ministry of Health and Consumer Affairs, 2005:24), and those who are chronically ill are institutionalized at a much lower rate than adjacent populations (FSG & Ministry of Health and Consumer Affairs, 2005:24). Moreover, a strong sense of group identity provides a firm foundation for community-led and -implemented programmes to improve health. Other oft-cited customs that benefit health include emphasis on hygiene and the prohibition of some practices, such as tobacco and multiple sexual partners for women (FSG & Ministry of Health and Consumer Affairs, 2005:25). However, as will be shown later, existing data show that tobacco use can be quite high among some Roma women. When considering Roma women, the extent to which particular prohibitions on them helps or harms their overall well-being is unclear.

Inequities in health system usage and health outcomes

The social determinants of health outlined in the previous section increase the need for health and social care, but also limit access to these crucial services. Additional structural and poverty-related factors specific to the health and social protection system further curtail access. This section will cover documentation and health system access, discrimination in health care setting, costs related to health care, low demand for preventive care, inequities in communicable diseases and inequities in noncommunicable diseases.

Documentation and health system access

Lack of documentation underlies a substantial part of the discrepancies in health system use. Roma may not access health or social services because they lack the citizenship, personal identification or health insurance required. In general, one document is required for the next – for example, identification is required for health insurance. Lack of documents is a particular problem in Bulgaria, Romania and the areas of the former Yugoslavia. In the former Yugoslav Republic of Macedonia, 30% of the Roma in Skopje's largest Roma community are uninsured, while 90% are uninsured in the smaller city of Stip, and up to 100% are uninsured in isolated settlements (Zoon, 2001:97). Also, a third of the children visited as part of a vaccination campaign in Serbia had no health card (Langevin-Falcon, 2005). Moreover, the UNDP/ILO survey found that 37% of the Romanian Roma and 46% of the Bulgarian Roma surveyed claimed not to have health insurance (UNDP, 2003:4).

Roma may not have one or more of the documents required to receive health care because of:

- lack of knowledge of procedures
- arbitrary refusal by local authorities
- laws that indirectly discriminate against Roma
- loss of citizenship following border changes (such as the former Czechoslovakia, Yugoslavia and USSR)
- inability to cover related costs (such as travel and contributions to health insurance)
- failure to meet prerequisites to qualify for non-contributory health insurance.

Moreover, because of their disproportionate involvement in informal sector employment, Roma disproportionately lack access to benefits based on social insurance contributions.

A few illustrative examples follow. In Bulgaria, individuals must declare their income when requesting health insurance provided by the state; some Roma report being denied coverage when they state their income is zero, (ERRC, 2006b:28). Also, laws can indirectly discriminate when an apparently neutral provision unduly affects a group of people in light of their particular situation. For example, in Romania, non-contributory medical insurance is available only to the legal wife or husband of an insured person (ERRC, 2006b:30). In particular, this may affect Roma couples, to the extent that they may be more likely to live in common law marriages (Impreuna Agency for Community Development, 2005:12). In France, Roma immigrants who have the legal right to use state medical aid are in some cases unable to access services because they may not have proof of a legally registered address, a prerequisite to access (ERRC, 2006b:34). Again, this may have a disproportionate effect on Roma, to the extent that they may be likely to live in a caravan, which in France cannot have a legally registered address.

Discrimination in health care settings

Regardless of their legal status or health insurance coverage, Roma may avoid health services because they have experienced or heard about discrimination in health care settings. A few negative interactions can have a ripple effect in the community, as experiences are told and retold to others. There are no data on this in the Roma community, but data from the Afro-American community in the United States show that memories of past discrimination can erode trust and engagement in the health care system (Friemuth et al., 2001; Shavers, Lynch & Burmeister, 2002). Moreover, discrimination, when manifested in such behaviour as refusal to diagnose or treat Roma, can cut off urgently needed medical services.

The OSCE High Commissioner on National Minorities (2000) *Report and recommendations on the situation of Roma and Sinti in the OSCE area* identified discrimination and prejudicial attitudes as key factors underlying the poor socioeconomic status of Roma, limiting access to public services, among other things. The EC also has stressed this matter in its regular reports on EU candidate countries (CE & European Monitoring Centre on Racism and Xenophobia, 2003:94).

A high percentage of Roma report having experienced discrimination in health facilities. Of 237 Roma women responding to a 2005 survey in the former Yugoslav Republic of Macedonia, 113 reported having experienced discrimination in access to health care or other forms of abuse by health care workers (ERRC, 2006b:41). In Romania, 23% of 717 Roma women responding to a survey believed that they had suffered discrimination in access to health care because of gender, while 70.7% stated that Roma suffer discrimination based on ethnicity (Surdu & Surdu, 2006:57–58). Also, research among medical providers in Hungary confirmed that many hold prejudicial beliefs. A survey of general practitioners, health visitors and medical students by Delphoi Research found that 14% of them held strongly negative attitudes towards Roma, meaning that they engaged in negative stereotyping, approved of discrimination and felt marked emotional distance. The survey also found that an additional 30% tend towards anti-Roma attitudes (Delphoi Consulting Research Group, 2004).

One regularly reported discriminatory behaviour is general practitioners refusing to register Roma clients on their rosters. In Romania, 90% of Caldarari – a subgroup of Roma – surveyed reported that they were not registered with a family doctor. The most frequent explanation provided was that family doctors refused to register Roma (Impreuna Agency for Community Development, 2005:33). This problem is not unique to eastern Europe; for example, a London survey revealed that 10% of general practitioners do not accept Travellers (Feder, 1989). Other frequently cited rejections by the health system include emergency services not responding when the call comes from a Roma community (Center for Reproductive Rights & Poradña, 2003:16; ERRC, 2006b:50–52), refusal to treat (ERRC, 2006b:52–55), verbal abuse (OSI, 2005:47), denial of access to

medical records (OSI, 2005:47), and segregated maternity wards that are of inferior quality (Center for Reproductive Rights & Poradña, 2003:15).

Costs related to health care

People in Roma communities may not seek health care due to the costs anticipated. As mentioned earlier, the cost of visiting a health care facility or obtaining social assistance might include public transport, lost wages, legitimate co-payments, out-of-pocket payments, payments for documents, and payments for drugs. In Romania, county health professionals responding to a Ministry of Health survey identified insufficient financial resources as the second most important determinant of Roma health (OSI, 2007:49). Acknowledging these constraints, physicians have said that they are more likely to prescribe less effective, but less expensive medication to Roma patients (OSI, 2005:49), while Roma are more likely to avoid going to the doctor for financial reasons (Schaaf, 2007:19).

Low demand for preventive care

Due to the factors noted above, as well as to generally low health literacy within poor Roma communities, some Roma do not seek adequate preventive care. Surveys on knowledge about health suggest that Roma excluded from health care services have poor knowledge about health. For example, in a Doctors of the World knowledge, attitudes, behaviours and practices survey conducted among Roma and poor Romanians in Romania, 88% of the Romanians had heard of TB, a major health concern for their community. Only 60% of the Roma had heard of it. Of those who had heard of it, 56% of the Romanians knew it is a lung disease, compared with 34% of the Roma (Schaaf, 2007:20–21).

As a result of limited access to health care and poor awareness about health, Roma may too frequently resort to costly emergency services or suffer from preventable illnesses. For example, 73% of Roma respondents to a UNDP Bulgaria survey reported that they only look for health information when they have a sick relative (OSI, 2005:30). Many Irish Roma report that they have their so-called own ways of dealing with illness, and Roma affairs experts engaged by the European Parliament Directorate-General of Internal Policies, Citizens' Rights and Constitutional Affairs reported that Turkish Roma often medicate themselves until they urgently require medical care (Berliner Institut fur Vergleichende Sozialforschung, 2006:45, 172–173).

Inequities in communicable diseases

Vaccination

Limited health system access and the socially determined health risks described earlier contribute to higher rates of communicable disease among the Roma. While existing data are generally drawn from surveys and local-level assessments, a disparity in the trend in vaccine coverage emerges. For example, coverage of preschool Roma children in Slovenia against poliomyelitis, diphtheria, tetanus, pertussis, mumps, measles, and rubella is significantly lower than that of the national average (Kraigher et al., 2006:794).

Measles

Lower rates of vaccination, cramped living conditions, malnutrition and, in some cases, poor sanitation mean that Roma are particularly vulnerable to communicable diseases. Because WHO aims to eliminate measles and rubella in Europe by 2010, there are ample data on these particular diseases. The WHO Regional Office for Europe Targeted Diseases and Immunization Team, Communicable Diseases Unit, reported that a 2004 measles outbreak in Romania in which 14 people died and 6000 were infected – 90% of whom were Roma – led the Immunization programme to focus on reaching the Roma as being crucial to meeting their elimination targets (Loewenberg, 2006).

Measles outbreaks in Roma settlements have also occurred in Germany, Greece, Italy, Portugal and Serbia (Seguliev et al., 2007), as well as among Traveller populations in the United Kingdom (Loewenberg, 2006). An investigation into a measles outbreak in Greece revealed that 55% of the cases involved Roma. Among those whose vaccination status was known, 89% were unvaccinated (Georgakopoulou et al., 2006).

Hepatitis A and TB

Other pertinent communicable diseases include hepatitis A and TB. Data from a 1992 study in Spain highlights the discrepancies between Roma and other poor groups: 63% of Roma children (1–14 years old) had antibodies to hepatitis A, compared with 46% of the children living in a nearby orphanage and 23% of non-Roma families in the overall population (Morales et al., 1992).

Differences in active TB rates suggest that Roma are more vulnerable to TB infection and disease and to delayed diagnosis, thus furthering the spread of the TB bacillus in the community. A retrospective study of the Romanian town of Ciurea revealed that the incidence of TB among Roma in 1995 was 1379 cases per 100 000 people, more than seven times greater than the incidence among non-Roma (Ionita, Nastase & Mihaescu, 2001:S323). Research in a Serbian Roma community revealed a prevalence rate of active TB of 1767 cases per 100 000 people among the approximately 4000 people screened. This rate was more than 2.5 times the overall national rate of prevalence of the disease (Schaaf, 2007:16). Some studies suggest that once diagnosed with TB and treatment is begun, Roma are more likely to discontinue treatment. In part, this is likely because Roma face considerable financial and other barriers to following a 6-month drug-treatment regimen that entails transport and out-of-pocket costs, among other factors (Schaaf, 2007:17).

HIV/AIDS

Scattered data suggest that, due in part to social exclusion and limited opportunities for income, Roma are disproportionately represented in so-called risk groups, making them more vulnerable to HIV infection. According to the World Bank, female sex workers are believed to be disproportionately Roma in Bulgaria and the Czech Republic (Kelly et al., 2004:233). While knowledge about HIV is fairly good among Roma men living in urban areas, their behaviour may still put them at risk. In Sofia, Bulgaria, 77% of 324 Roma men surveyed reported that they did not use a condom during their most recent vaginal intercourse (Kabakchieva et al, 2002). Finally, while data are lacking, there is sufficient evidence on the global level that HIV/AIDS follows dislocation and exclusion. For this reason, particular efforts should be put into assessing and addressing HIV in Roma communities. At the national level, AIDS control programmes should have (as a minimum requirement) linguistically and culturally appropriate services and HIV prevention resources, such as brochures, posters and radio spots.

Inequities in noncommunicable diseases

Very little information exists about noncommunicable diseases among Roma (Koupilová et al., 2001:1197). This buttresses the point that much of the health analyses of the Roma community focus on them as a source of contagion rather than on the most important causes of ill health. For example, an extensive review of the literature on Roma health published in 2005 found only one article related to cancer – a 1981 summary of a study (Aspinall, 2005:28). However, even while data are sparse, they suggest that noncommunicable diseases, inadequate nutrition, and substance abuse are problems.

Nutrition and hunger

Of the 400 Roma families responding to a survey in 10 cities of the former Yugoslav Republic of Macedonia, 30.5% reported that they did not buy fruit and 20.2% reported eating dough-based meals every day (ECMI, 2005:108). A 1997 survey in the Czech Republic showed similar results, with only 19% consuming the equivalent of the United States recommended daily allowance of vegetables. They reportedly ate 4.5 times the recommended dietary allowance of snack foods (Koupilová et al., 2001:1198). Hunger is a problem in the poorest Roma communities. Of the Roma surveyed by UNDP in south-eastern Europe, 53% reported going hungry in the past month, compared with 7% of the non-Roma living in close proximity to these Roma settlements (Ivanov et al., 2006:57).

Tobacco use

Tobacco use among men is alarmingly high in some Roma communities, particularly in urban and periurban areas. Most of the existing data come from eastern Europe. A WHO study of Roma teenagers in Hungary found that 69% of females and 71% of males were smokers; 71% of all youths surveyed said they smoked daily (CE & European Monitoring Centre on Racism and Xenophobia, 2003:17). A population-based study in the Czech Republic revealed that Roma women smoked much more than women in the main ethnic group. At some stage of life, 42% of women in the main ethnic group smoked, 16% in the third trimester of pregnancy. In contrast, 78% of Roma women smoked at some stage of life, 63% during the third trimester (Bobak et al., 2005). Maternal smoking may contribute to adverse effects on children's health – for example, low birth weight

occurs six times more frequently among Roma infants in Serbia than among infants of other ethnicities (UNICEF, 2006:47). Tobacco consumption and poor eating habits both contribute to heart disease, which appears to be more prevalent in Roma communities (Aspinall, 2005:27), though there are few data to substantiate this belief.

Domestic violence and mental health

Other health issues that can be assessed through surveys and other forms of self-reporting, such as domestic violence and mental health, appear to be concerns. Both domestic violence and mental health issues, however, are somewhat contested within the Roma community. Some Roma health and rights advocates do not prioritize either issue, believing that they are not significant problems or that open discussion of domestic violence and mental health concerns will only reinforce prejudicial beliefs about Roma. Moreover, when asked what they perceive as their own health priorities, marginalized Roma women may not identify either issue, especially domestic violence. Roma women's advocates explain that women from patriarchal societies may assume that failure to adhere to one's socially imposed roles as a woman justifies violence against them (CE & European Monitoring Centre on Racism and Xenophobia, 2003:59). Of 160 Roma women interviewed for a NGO report on Serbia's adherence to the Convention on the Elimination of All Forms of Discrimination against Women, 79 declined to answer questions about violence against women (ERRC et al., 2006: para. 6.6–6.8).

Despite these limitations, some data indicate that violence against Roma women is a problem. Of the 81 women who did answer questions about domestic violence, 63 stated they suffer or had suffered violence (ERRC et al., 2006: para. 6.6–6.8). Roma women's advocates identified concerns about money, unemployment, the future, forced settlement, insufficient food and alcohol abuse as contributing to men's anger and ultimately to violence against women (CE & European Monitoring Centre on Racism and Xenophobia, 2003: 59).

These same stresses and concerns may contribute to the most often-cited mental health challenges affecting the Roma community – anxiety and depression. The French NGO Médecins du Monde conducted research among Roma migrants from eastern Europe who live in France, and 12% of the men and 21% of the women were found to suffer from depression (CE & European Monitoring Centre on Racism and Xenophobia, 2003:18). They also found that the rate among women living in Belgrade, Serbia, settlements was found to be 11.4% (CE & European Monitoring Centre on Racism and Xenophobia, 2003:18). Moreover, a study in Sheffield, England, by the Gypsy and Traveller Mental Health Project, identified the rate of prevalence of anxiety among Travellers to be almost three times that of the general population, and the rate of prevalence of depression was almost seven times that of the general population (Aspinall, 2005:26).

Infant health

Infants also appear to suffer disproportionately from many of these same communicable and noncommunicable health problems. This may be due in part to the maternal smoking and poor nutrition described earlier, as well as to difficult births and low use of antenatal care. Studies have documented the rate of Roma admissions to neonatal units to be 3.5 times the rate of non-Roma children in Granada, Spain (Sastre Gussoni et al., 2000); Seres found the perinatal death rate to be 1.5–2.0 times the rate among non-Roma in a region of Slovakia (Koupilová et al., 2001:1195); and, according to data analysis by the Irish Sudden Infant Death Association, the rate of sudden infant death was 12 times the national figure among Travellers in Ireland (Aspinall, 2005:19).

Reproductive and sexual health

Poor maternal health is significant not only for what it means for infant health, but also for what it means about women's reproductive health more generally. While Roma women often bear the responsibility for the health of other family members, they may neglect their own health, because they are unaware of the importance of preventive care or because they are ashamed to seek care, especially if it entails breaking traditions for purity or modesty (CE & European Monitoring Centre on Racism and Xenophobia, 2003:51; ERRC et al., 2006: para. 9.18–9.19). A high symbolic value is placed on virginity in some communities, which inhibits unmarried women's efforts to obtain family planning or other reproductive health services (Surdu & Surdu, 2006:34). Among other factors, emphasis on virginity contributes to early marriage. According to the UNDP/ILO survey, 35% of Roma women were married when they were 16 years old, 17% when they were 17 or 18 years old, and 26% between the ages of 19 and 22 years (UNDP, 2003:27). The number of early marriages, however, is decreasing, with the average age of marriage increasing for both men and women (Surdu & Surdu, 2006:33).

Early marriage makes young women more vulnerable to high-risk pregnancies, and the likelihood of becoming pregnant at a young age is exacerbated by the low use of contraception. Roma men and women may not use contraception because of lack of knowledge or because of general problems with access to health care. Also, adherence to traditions that equate virginity with honour buttresses Roma reluctance to engage in community-level discussions or programmes on the subject of sexual health (CE & European Monitoring Centre on Racism and Xenophobia, 2003:58).

Data on contraceptive use illustrate the effect of these limiting factors. Research conducted in Romania in 1998 showed that 14% of Roma women of reproductive age used contraceptive methods, while four times that rate among women of the major ethnic group employed contraception. Of Roma women interviewed, 23% stated that they did not have the knowledge required to use contraception (Impreuna Agency for Community Development, 2005:14). Similarly, almost half the Travellers interviewed for the "Travellers' Health Project" reported so-called problems with family planning (CE & European Monitoring Centre on Racism and Xenophobia, 2003:17). In keeping with the theory that knowledge, access to health care and gender-related norms of behaviour are key determinants of contraceptive use, low use of contraception in Romania is more common among those with little education and those living in rural areas (Surdu & Surdu, 2006:55–57).

Because of poor access to contraception, Roma women are more likely to experience unwanted pregnancy. Some women may rely overly on abortion, which can have negative health consequences, including haemorrhaging, infection and sterility (Klima, 1998; Parfitt, 2003). Frequent use of abortion is seemingly a concern in eastern Europe only, which historically has had much higher rates of abortion overall (Jacobson, 1990; Parfitt, 2003). Abortion rates are falling throughout the Region, but exclusion from education and persistent traditions for women's roles may slow this trend among some Roma communities. Almost half the Roma women surveyed by the Autonomous Women's Centre, in a settlement in Belgrade, Serbia, had undergone an abortion in their lifetime. Of these, 83.5% had between 1 and 5 abortions, 9.1% had between 6 and 10 abortions, and 7.4% had over 10 abortions (CE & European Monitoring Centre on Racism and Xenophobia, 2003:18). One cannot draw conclusions about overall abortion trends from this survey; however, since this and other data are not disaggregated by age and report on lifetime abortions, it is impossible to know if abortion rates are changing.

There have been reports of coerced, unsafe abortions performed by medical professionals (ERRC, 2006a:37). The CE Commissioner for Human Rights visited Slovakia in 2003 and found that Roma women in Eastern Slovakia were at "particular risk" of forced or coerced sterilization (CE Commissioner for Human Rights, 2003: para. 51–52), and an investigation undertaken by the Czech Public Defender concluded that physicians specifically targeted Roma women for sterilization (ERRC, 2006b:47). In August 2006, the Convention on the Elimination of All Forms of Discrimination against Women condemned Hungary for violating the Convention in connection with the non-consensual sterilization of a Roma woman in 2001 (ERRC, 2006b:45). Given indications of pre-existing distrust of the health care system and the already low use of reproductive health services and antenatal care, the ramifications of these reports raise concerns regarding erosion of access to reproductive and maternal health care, particularly in countries where this is already a problem.

Accidents and injuries

Finally, while social exclusion and exclusion from the health system contribute to the health concerns elaborated above, they also contribute to the higher risk of accidents. The Roma have explained that hazardous living conditions predispose their children (in particular) to accidents. For example, 60% of mothers interviewed in a study conducted by Pahl & Vaile on Travellers identified problems in caring for children, including dirty environments, lack of safe play areas and proximity to fast traffic (Aspinall, 2005:25). There is evidence of higher rates of childhood injury because of these conditions (Aspinall, 2005:23), including burns, falls, pedestrian traffic accidents, bone fractures and cuts (Fundación Secretariado Gitano & Ministry of Health and Consumer Affairs (2004:15).

Economic marginalization further predisposes Roma to dangerous working conditions and a higher risk of accidents in the workplace or to work-related health problems. Also, Roma engaged in informal labour usually do not have access to health insurance and social protection. Others may have informal or formal jobs, such as street cleaning and scrap metal or refuse collection, that pose health hazards. Women may engage in jobs where they have little ability to negotiate their own safety, such as sex work. Children too may be forced to work in irregular circumstances or (even) be trafficked (ECRI, 2005b: para. 111–112), which entails social exclusion and exclusion from health and educational services, as well as direct injury.

Initiatives on Roma socioeconomic status and minimizing health risks

International governmental organizations and national governments have created programmes and legal and funding initiatives to improve Roma health. There are six major relevant intergovernmental organizations – CE, EU, OSCE, UNDP, UNICEF and the World Bank. Also, the Decade of Roma Inclusion 2005–2015 is an initiative that includes these intergovernmental organizations, as well as participating governments and OSI.

In general, these agencies take two approaches to Roma exclusion. The first is a legal approach, based on human rights and antidiscrimination norms, and the second is a policy approach, based on emerging Europe-wide strategies on employment and social exclusion (Kostadinova, 2006:1). Some programmes integrate both approaches. Most European countries, particularly those in eastern Europe, have a specific governmental entity that is given the task of minority and/or Roma inclusion. For example, Romania's National Agency for Roma is an independent agency of the government that coordinates, monitors and evaluates governmental activities that address the Roma (National Agency for Roma, 2007). Also, many governments have developed national Roma strategies; at present at least 18 western and eastern European governments have done so (Hollo & Quinn, 2006:33).

It is important to note that countries not already in the EU or described as a candidate or potential candidate are generally not included in the most robust initiatives – namely all of the countries of the former USSR (with the exception of Estonia, Latvia, and Lithuania). These countries are members of CE and OSCE, but they do not participate in the Decade or benefit from EU membership or accession-related funding and policy mechanisms.

Human rights/antidiscrimination approach

The legal approach to improving Roma health is reflected in the antidiscrimination elements of the *acquis communautaire*, the body of EU legislation and policies that all candidate EU countries must integrate into their national legislation. The EU provides technical assistance and monitors the extent to which law, policy and practice reflect these antidiscrimination norms via the EU Agency for Fundamental Rights, formerly the European Monitoring Centre on Racism and Xenophobia. In the past, the European Monitoring Centre on Racism and Xenophobia researched and published reports about Roma and Travellers that covered public education, ethnic minorities and housing, and racist violence. The EU Agency for Fundamental Rights also publishes an annual report on racism and xenophobia in the EU, which generally examines socioeconomic deprivation among Roma (EU Agency for Fundamental Rights, 2007).

CE maintains several agencies for (and programmes on) the human rights of ethnic minorities. First, ECRI was established in 1993 by the heads of CE member sates as an independent human rights monitoring body. The Commission issues regular reports on member states, and while none of these have addressed Roma health as such they have examined social conditions that pose health risks to Roma, such as vulnerability to violence, domestic and international trafficking, and forced or coerced sex work (ECRI, 2005b: para. 111–112). In 1998, ECRI also issued a general policy recommendation on combating racism and intolerance against Roma/Gypsies (ECRI, 1998).

In partnership with a key Roma rights NGO (the European Roma Rights Centre, ERRC), CE organizes study sessions for lawyers, where lawyers from member states learn about how European human rights conventions can be used as a basis for cases involving Roma. The CE Human Rights Commissioner has also focused specifically on the human rights of Roma, including their health. He has reported on housing conditions, forced evictions, and violence against Roma, among other issues (Gil-Robles, 2006a).

Social exclusion and integrated approaches

The social exclusion approach to improving Roma health is reflected primarily through EU funding mechanisms that target candidate countries and EU Structural Funds, which are available to all EU Member States. The European Social Fund is the most relevant stream for Structural Funds; it emphasizes EU employment and inclusion priorities and has been used to fund Roma health projects in western and eastern Europe (OSI, 2005:33–34).

CE, EU, OSCE, UNDP and UNICEF have several initiatives that incorporate policy approaches to both human rights and social exclusion. Recommendations issued by the CE decision-making body, the Committee of Ministers, cite both human rights norms and developing consensuses on European employment and social inclusion policy. Recent relevant

recommendations include: *Recommendation Rec(2006)18 of the Committee of Ministers to member states on health services in a multicultural society* (CE Committee of Ministers, 2006a); *Recommendation Rec(2005)4 of the Committee of Ministers to member states on improving the housing conditions of Roma and Travellers in Europe* (CE Committee of Ministers, 2005a); and *Recommendation Rec(2006)10 of the Committee of Ministers to member states on better access to health care for Roma and Travellers in Europe* (CE Committee of Ministers, 2006b). The last recommendation, in particular, reflects emerging know-how in terms of legislative, policy and programme responses to the human rights and socioeconomic factors that shape Roma access to health care. The content of most of these recommendations are discussed in the section on "Emerging know-how and policy implications".

To gain additional insight into (and expertise about) how the Roma community envisions progress towards greater inclusion and fulfilment of rights, the CE Council of Ministers established an Experts' Committee on Roma, Gypsies and Travellers in 1995. The Committee is responsible for regularly reviewing the situation of Roma and Travellers in Europe and, to that end, has held regular discussions during which key policy concerns were discussed. In the past, the Committee has discussed data collection, housing, access to social rights for nomadic groups, and employment (CE Roma and Travellers Division, 2005, 2006). These discussions guided the Committee recommendations noted above, as well as other CE activities that relate to the Roma community.

CE and other international governmental organizations operate according to the state-centric model, according to which national governments are expected to represent their citizens' interest in international forums. Roma advocates have argued that Roma political and policy participation is limited by this model, as the Roma are marginalized from the national governments in states in which they live and because they are an ethnic group without a state of their own. The European Roma and Travellers Forum was thus established in 2004 to bring Roma representation to international governmental forums, particularly the CE. The Forum has an explicit human rights and inclusion mandate: "[The Forum] shall promote the struggle against racism and discrimination and facilitate the integration of these populations into the European societies and their participation in public life and in the decision-making process" (European Roma and Travellers Forum, 2006b). Within the framework of an official partnership, the Forum has advised CE bodies on health-related issues, including social-cohesion-promoting housing policies and lead poisoning among Roma refugees in Kosovo. While relations are not formalized with other entities, the Forum has advised the EU, OSCE, United Nations and governments, among others (European Roma and Travellers Forum, 2006a).

For its part in the initiatives, the OSCE has taken on the role of information gathering and coordination, within the larger framework of the 2003 Action Plan on Improving the Situation of Roma and Sinti in the OSCE Area. The Action Plan recommends that OSCE member states take action in several health-related areas, such as housing, discrimination, education and employment. Health-specific recommendations include: sensitizing health authorities to the health needs in the Roma community; policies to ensure equal access and utilization; and programmes that address malnutrition, disease, and the health concerns of women and children (OSCE Ministerial Council, 2003:9–10). The OSCE Contact Point on Roma and Sinti Issues has gathered policy information relevant to key underlying issues, such as lack of registration among Roma. To realize the Action Plan, the Contact Point has also coordinated information sharing about state activities. OSCE maintains an online Tolerance and Non-Discrimination Information System (TANDIS), which contains a searchable database of OSCE, governmental and NGO reports, and guidelines and handbooks related to Roma integration (OSCE Office for Democratic Institutions and Human Rights, 2007). It is a solid source of best practices and policy debates that can be used to discern emerging knowledge about inclusion. The TANDIS web site has few health-specific resources, but many of the social determinants of health, such as housing, political participation, human rights and education, are addressed.

Finally, as noted, the United Nations agencies UNDP and UNICEF have gathered and analysed some of the most comprehensive data that exist on Roma health and exclusion. In addition to the UNDP/ILO multi-country vulnerability study cited repeatedly in this chapter, UNDP has conducted another vulnerability survey of Roma and the displaced in south-east Europe (the areas of the former Yugoslavia). This report is particularly useful in that it compares self-reported indicators of Roma health with self-reported indicators of surrounding populations and the displaced, giving a picture of how Roma ethnicity shapes their perceived health status (Ivanov et al., 2006). UNICEF's most recent report, Breaking the cycle of exclusion, also focuses on south-east Europe (the areas of the former Yugoslavia and Romania) (UNICEF, 2007). The report does not contain original research, but summarizes a lot of relevant data that have not received wide dissemination previously. The World Bank has also collected, analysed, and disseminated data relating to Roma vulnerability, particularly in the context of EU expansion (Ringold, Orenstein & Wilkens, 2005). All of these documents and reports provide nuances of information about employment and other important issues not discussed in this chapter. These reports also contribute to the growing body of knowledge about the state of Roma health and possible policy responses.

The Decade of Roma Inclusion 2005–2015

The Decade of Roma Inclusion 2005–2015 is a major effort to improve Roma inclusion in Europe. It involves most of the agencies noted above, as well as national governments. The Decade was launched to focus donor funds on Roma issues in particular – in part, because the accession process in the EU did not result in adequately improving the state of Roma. Launched in 2004 to address inequities in four sectors – education, employment, health and housing – the Decade is sponsored by governments, CE, the CE Development Bank, EC, OSI, OSCE, UNDP, UNICEF and the World Bank. Participating governments include Albania, Bulgaria, Croatia, the Czech Republic, Hungary, Montenegro, Romania, Serbia, Slovakia and the former Yugoslav Republic of Macedonia. Slovenia holds observer status, and Bosnia and Herzegovina and Spain are expected to join shortly (Decade of Roma Inclusion 2005–2015, 2007d). Current member governments have voluntarily committed themselves to improving the state of Roma in the four key sectors. To that end, each government has developed a national action plan for the respective areas of focus. These action plans are intended to mainstream concerns about gender, poverty and discrimination (Decade of Roma Inclusion 2005–2015, 2007c).

The action plans for health emphasize the resolution of core issues (such as lack of documentation) and specific health priorities (such as vaccination and reproductive health). Particular methods of intervening are also foreseen, such as health mediation, which will be discussed in the following section on "Integration of health and social protection systems". Most action plans include an initial data collection phase, as the baseline state of health is not known. Few of the data collection activities, however, allow comparison between Roma and non-Roma populations, which is a key indicator of programme success in lessening inequality.

Acknowledging the interrelated causes of poor health among the Roma, some health action plans seek to address broad social determinants of health. The Serbian action plan, for example, includes activities to improve living conditions in Roma settlements and the integration of health into antidiscrimination policy discussions (Government of Serbia, 2004). Other action plans are less robust; one, for example, contains only one activity to improve Roma health (Decade of Roma Inclusion 2005–2015, 2007a).

Roma participation in action plan development, implementation and evaluation is a key element of the Decade. As the Vision and Values Statement of the Decade of Roma Inclusion 2005–2015 asserts (Decade of Roma Inclusion 2005–2015, 2007f): "Nothing about us without us: Roma participation will make or break the Decade. Roma representatives and civil society organizations are involved in every stage of the Decade. … Roma participation will be central to regular oversight and monitoring of the process over the next ten years."

Emphasis on participation is consistent with many international agency recommendations; the OSCE High Commissioner on National Minorities, CE and the European Monitoring Centre on Racism and Xenophobia have all emphasized the importance of Roma participation in policy-making and implementation (CE & European Monitoring Centre on Racism and Xenophobia, 2003). Roma advocates enlisted to observe Decade of Roma Inclusion 2005–2015 action plan development and implementation – as part of DecadeWatch, a monitoring project funded by the World Bank and OSI – have stated that their voices are indeed being heard more than they were prior to the Decade, but further progress is needed (DecadeWatch, 2007). One indicator of the progress made thus far is that civil society groups in some countries are submitting the DecadeWatch report to legislators and policy-makers. In Serbia, for example, the report was formally presented and discussed with ten parliamentarians (Decade of Roma Inclusion 2005–2015, 2007b).

Existing frameworks: critical assessment

National-level best practices and lessons learned through existing transnational frameworks are discussed in the section on "Emerging know-how and policy implications". To guide this later discussion, it is important to mention a few critiques that have been made of the structure of current international legal, programme, and funding frameworks and the ways in which these weaknesses may be reflected in strategies and programmes at the national level.

First, the Decade of Roma Inclusion 2005–2015 and EU funding and social-policy coordinating mechanisms have at times been described as fragmented. The EC itself has acknowledged pervasive opinions that EU funding is "fragmented, complex … and very difficult to access" (EC Directorate-General for Employment and Social Affairs, 2004:44). This fragmentation may be reflected at the national level; country researchers for DecadeWatch have similarly explained that "most governments think about Roma inclusion in terms of projects and sporadic measures, but not programmes or integrated policies" (OSI, 2005:18).

Also, the respective country secretariats responsible for Roma inclusion are not sufficiently integrated with line ministries and lack decision-making power (OSI, 2005:18–19).

Second, many have criticized international and national governmental frameworks and action plans for lacking clear benchmarks, thus compromising monitoring and evaluation at the national level. The European Roma Information Office, ERRC, OSI, and the EU Roma Policy Coalition, among others, have advocated the creation of European frameworks for Roma integration that contain clear benchmarks (Hollo & Quinn, 2006; EU Roma Policy Coalition, 2008). Similarly, in their concept paper for the Decade, the World Bank asserted that benchmarks "must be clear, monitorable [sic], and challenging… they [should also] focus on improving outcomes for Roma in order to reduce disparities between outcomes for Roma and non-Roma" (World Bank, 2004b). So, while many key institutions agree that action plans should be specific, some advocates assert that existing international action plans lack sufficient details. For instance, the Secretary General of the association European Roma Grassroots Organisations explained that among the "real problems [are] no mechanism to implement the [OSCE] Action Plan, [and a] lack of benchmarks, timeframes, budgets and indicators" (Nicolae, 2005). Also, a Roma women's rights activist asserted that the gender elements of country-level Decade of Roma Inclusion 2005–2015 action plans constitute "weak and unmeasurable actions" (Bitu, 2005).

Fragmentation and lack of benchmarks may result in incomplete programmes. For example, some countries have designed projects to increase Roma access to health care by educating members of excluded Roma communities about the importance of preventive care. If, however, the country implements a fragmented programme and undertakes this activity alone and fails to address the lack of identification or insurance required to go to a doctor, then the effectiveness of health education in improving Roma health will be diminished. Also, if the programme has no benchmarks or indicators to measure changes in health knowledge or behaviour, then programme weaknesses or failures may never be identified and rectified. In short, international and national frameworks should better ensure that programmes comprehensively address the multiple determinants of a particular health concern and that these programmes have robust benchmarks and are evaluated. Otherwise, activities undertaken to rectify Roma exclusion may not achieve their full potential.

International NGOs have sought to remedy some of these shortcomings by advocating for comprehensive programmes with benchmarks and by providing concrete materials that can be used by programme planners and Roma health advocates. The OSI's Public Health Programme has assessed specific Roma health concerns (such as TB) (Schaaf, 2007), specific kinds of programmes (such as health mediation) (OSI, 2005) and specific funding mechanisms (such as the Global Fund to Fight AIDS, Tuberculosis and Malaria) (OSI, 2007). OSI has also convened international-level meetings with governmental and nongovernmental partners – including many of the governmental organizations noted above – to discuss key underlying issues, such as data collection. ERRC and Minority Rights Group International, among other international NGOs, have produced reports and information brochures that focus specifically on discrimination, including discrimination in health care settings. A comprehensive ERRC report on the extent and effect of discrimination in health care was an important source of information for this chapter (ERRC, 2006b).

International and national NGOs that operate at the country level have also worked to disseminate to other countries and to international actors the lessons they have learned. The Romanian Roma organization CRISS and the Centre on Housing Rights and Evictions worked with OSCE to organize an international event on forced evictions (OSCE, 2007), while Pavee Point (an Irish Traveller NGO) has organized international study visits for Traveller and Roma advocates (Pavee Pont Travellers Centre, 2007). Several other international and national NGOs and individual advocates have supported comprehensive, accountable programmes through advocacy and the development of media material. These experiences and materials are an important source of guidance for governments that seek to develop Roma-specific (or broader) health equity programmes.

The success of targeted health initiatives depends in part on the targeted group wielding real political power. A review of health programmes that address particular groups found that separate services work best when the group that has lower health status has a definitive role in designing and implementing such service programmes (Healy & McKee, 2004:367). Thus, it is hoped that the existence of the European Roma and Travellers Forum, the development of Roma NGOs and statements of commitment to Roma participation in international frameworks will translate into a strong role for Roma representatives in shaping ongoing international and national efforts. The outcome could be programmes that avoid some of the pitfalls described above, that correspond well to the actual needs and that build further public health capacity within the Roma community.

Emerging know-how and policy implications

There is no substantial body of best practices for improving Roma health, in part because the issue was only added to some government agendas in the past 10 years (Koupilová et al., 2001:1194–1195). Also, because of the lack of disaggregated health data, measuring improvements in Roma health or decreased health disparities is difficult. In many cases, projects are evaluated by using process indicators or opinions expressed by programme implementers or beneficiaries (Aspinall, 2005).

With these caveats in mind, some common challenges and opportunities emerge from an analysis of governmental and nongovernmental programmes to address Roma health. This section will outline emerging know-how in three important and interrelated areas:

1. addressing priority public health conditions among the Roma
2. accessing health services
3. integrating health and social protection systems.

However, before examining specific programmes, it is important to describe a broader debate on the approach to priority health concerns and health system access – the need for special measures.

The efficacy and appropriateness of special measures are often debated in policy discussions about Roma health. Special measures could include positive action, preferential treatment or quota systems (United Nations Committee on the Elimination of Discrimination against Women, 1988). International governmental organizations and other international agencies agree that special measures (particularly positive action) are necessary, while a few government officials maintain that since Roma have equal access to health care according to the law, no such measures are required (ERRC, 2005a). After assessing the data gathered in their exhaustive survey of Roma exclusion, UNDP concluded that simply including Roma in existing health programmes is not sufficient; emergency measures should also be pursued (UNDP, 2003:6). In a discussion paper on health inequities in Europe, prepared by health equity experts and the WHO European Office for Investment for Health and Development, the authors (Dahlgren & Whitehead, 2007:104) contend that "group-specific strategies" are needed to "improve the [Roma's] chances to return to a healthier life." Also, ERRC publishes a journal, *Roma Rights Quarterly*, dedicated to the need for positive measures to address entrenched Roma marginalization (ERRC, 2005b). Moreover, Romania, among other countries, has started to institutionalize this approach: the Romanian Ministry of Health has a budget line for Roma-specific activities (Bercus & Radulescu, 2007). Most of the activities described in the section on "Addressing priority public health issues among the Roma" address only the Roma, as do many of the activities foreseen in the Decade of Roma Inclusion 2005–2015 health action plans.

To avoid the misinterpretation that special measures provide an unfair advantage, the CE Committee of Ministers (2006b) recommended that member states:

> take appropriate measures to make the wider population aware of the need of effective special measures intended to reach equal access to health care for Roma and Travellers, [and that] special attention should be paid to the education of the general population and to the elimination of existing anti-Roma and Traveller prejudices, which seriously hinder normal access to health care of Roma and Travellers.

Public discussion is needed to lessen widely held negative views of Roma-specific programmes; recent public opinion research by the World Bank in Decade of Roma Inclusion 2005–2015 countries revealed that the majority of the populations expressed "deep opposition to any government funding targeting only the Roma" (World Bank, 2006).

While there is broad agreement that special measures are needed and that such measures must be accompanied by awareness raising among the general population, it is also crucial that Roma health priorities are simultaneously incorporated into the mainstream of ongoing health and social service strategies and programmes. Targeted programmes can address immediate needs, but addressing Roma health in national-level efforts that target the entire population will decrease the need for special measures in the long run. Vaccine campaigns are a useful example: while a targeted campaign can improve coverage among the Roma, it may do little to improve a vaccination programme's capacity to reach Roma and other excluded groups in the future. So, national vaccine programmes should include specific activities to ensure that Roma are vaccinated at the scheduled time – and not as part of an emergency catch up programme. Similarly, Roma women's vulnerability to domestic violence should be considered in national-level gender equity programmes, and social mores about tobacco consumption among Roma men should be considered in national antismoking efforts, and so on.

Moreover, since health disparities between Roma and the overall population are part of a trend of increasing health inequities between the rich and the poor in most of western and eastern Europe (Costongs et al., 2007), other groups (such as the rural poor and immigrants) also experience unequal access to health care. Although governments might design special measures for particular groups, ongoing health disparities signal an acute need for robust efforts at the national level to ensure that health and social services are equally accessible to all and that these services actively remedy inequality. In particular, since there are some middle class and wealthy Roma, geographic or socioeconomic class-based interventions may be equally important in improving the health of Roma, as well as the health of other disadvantaged populations.

Addressing priority public health issues among the Roma

Priority public health issues vary widely by country. Vaccination and reproductive health are frequently identified, and reproductive health in particular is regularly noted by Roma women's advocates in their assessments of Roma marginalization (ERRC et al., 2006; Surdu & Surdu, 2006). Also, most Decade of Roma Inclusion 2005–2015 and other national action plans that cite particular health areas mention vaccination and reproductive health more than other health issues.

Vaccination campaigns

These campaigns can be successful in increasing coverage rates. A 2002–2004 Institute of Public Health and UNICEF vaccination campaign in Serbia identified and immunized 16 000 unimmunized children, most of them Roma (Langevin-Falcon, 2005). Similarly, a campaign among Roma children in Rome decreased the percentage of Roma children never vaccinated from 40% to 9% (Baglio et al., 2005). These examples suggest that relatively common public health interventions can make measurable improvements; they require merely the will and resources to implement them.

However, simply going to a community with a large quantity of vaccines is not enough. It is important that vaccination campaigns be preceded by efforts to sensitize the Roma, as there have been reports of Roma communities refusing vaccination because of distrust or lack of information (OSI, 2005). For example, prior to implementing the campaign in Serbia, health officials met with community leaders to explain the utility of vaccination. They also used media to raise awareness and developed Romanes-language brochures (Corrigan, 2006a:16, 17, 33).

It may also be both pragmatic and cost effective to pair vaccination with other interventions that have immediate, concrete benefits, such as assistance in obtaining documentation or insurance. Combined activities provide an additional incentive to participation and make optimal use of human, financial and logistical resources that have already been committed to Roma health. During the vaccination campaign in Serbia, service providers also registered about 1350 Roma children, facilitated health insurance coverage for about 4700, and helped about 410 to enrol in school (Corrigan, 2006b).

Reproductive health interventions

These health interventions, employed by governments and NGOs, include community-based health education on family planning methods (CE & European Monitoring Centre on Racism and Xenophobia, 2003:55–56; OSI, 2005:19–20), screening for cervical cancer, Roma health mediation (discussed in the following section on "Health system access"), and community campaigns to increase the use of antenatal care and family planning services. As in the case of vaccination, reproductive health can be a sensitive issue at the community level, particularly in areas that maintain traditional gender norms of behaviour. For this reason, successful government programmes entail partnership with Roma individuals or organizations and integrate an understanding of gender dynamics. For example, gynaecologists in Romania reported they brought a mobile Pap smear unit to a Roma community and were disappointed by very low attendance rates. Following the suggestion of Roma community health workers, the gynaecologists recognized that Roma men had important decision-making power about the use of gynaecological care and held educational sessions with Roma men about the health benefits of Pap smears. Subsequently, Roma women came forward for services in greater numbers (Babăn et al., 2004:63).

Interventions and other initiatives

Interventions in these and other specific health areas should try to address broader Roma exclusion from the health care system and facilitate continued access. The Serbian vaccination campaign, for example, did not include follow-up activities, so the extent to which the campaign increased subsequent vaccination uptake or health system use in the community is unknown. Similarly, a mobile Pap smear unit is less effective if those with irregular smear results lack the resources or the health literacy

to obtain follow-up care. In short, while targeted mobile projects may make needed improvements in the rates of coverage for key health care services, these services should attempt to ensure continued care. Also, complementary programmes might address the social service and health service factors that underlie poor access to essential health care in the first place.

A later section (on "Integration of health and social protection systems") will discuss some ways to address these underlying factors through programmes that integrate health and social protection systems. It is important to note, however, that given the broad spectrum of health risks correlated with social conditions, activities in fields not directly related to health care can improve health. For example, some governments have created specific programmes to decrease violence against Roma. In particular, the Serbian Ministry of the Interior and a public company initiated a programme to identify and bring charges against Skinhead groups that had committed violence against the Roma (Ministry of the Interior of Serbia and Montenegro, 2004). Also, the Hungarian government developed a programme that would increase trust between the police and the Roma community by training the police in Roma culture and conflict management, thereby decreasing the likelihood of police violence against Roma and other conflicts (Police Headquarters of Pest County, 2004). Other initiatives have tried to increase formal employment among the Roma, as opposed to so-called grey- or black-market employment. For example, the Croatian Employment Service has started public works programmes in Roma communities, thus increasing both formal employment and living conditions in Roma settlements (Croatian National Programme for Roma, 2008). This chapter will not explore emerging know-how in these areas, but programme planners can find relevant materials in some of the reports already noted.

Health system access

Financial barriers have emerged repeatedly as major obstacles to access to health care and social protection for the Roma (OSI, 2005:40). FSG, a Spanish NGO that cooperates with health authorities to address Roma health, states: "the first step to improving Roma health is ensuring free access to health services" (World Bank, 2004a). Decreasing health care costs is not easily achieved, particularly in eastern European countries that are in the midst of health reform and have limited health budgets. Bulgaria and Romania, among other countries, have created new social insurance systems that (in theory) provide universal coverage, but many poor Roma reportedly fall through the cracks (OSI, 2005:49).

Official and unofficial out-of-pocket payments, which affect the poor disproportionately, have increased in many east and south-east European countries (Dahlgren & Whitehead, 2007:50). Roma health mediators (discussed in the section on "Integration of health and social protection systems") have helped to decrease the frequency of unofficial payments. Mediators are generally trained in the policies that pertain to health care system use and payment, and when they are present physicians are less likely to request out-of-pocket payments from Roma patients. Apart from mediation programmes, few countries seem to have concrete Plans for addressing this issue; only one of the countries participating in the Decade of Roma Inclusion 2005–2015 has activities that seek to increase health insurance coverage among Roma (DecadeWatch, 2007).

Identifying concrete solutions to low insurance coverage and high health care costs will remove one of the most significant barriers to health care access for Roma, as well as for other poor groups. One possible intervention might include targeted subsidies, to boost enrolment of this group. Another possibility is developing health financing mechanisms based on ensuring universal access to an essential package of health services, including those that can be financially catastrophic for the patient. However, given that insurance coverage alone does not ensure usage of health services, other measures will be necessary to ensure health needs are met. Covering some or all of the indirect costs incurred when using health services may also help to meet the health care needs of the Roma community.

In addition to the importance of addressing cost limitations, many policy analysts and programme implementers have concluded that specific programmes are required to mitigate poor knowledge and prejudicial beliefs among health care providers (CE & European Monitoring Centre on Racism and Xenophobia, 2003; OSI Public Health Program, 2007). This is important because removing bureaucratic and logistical barriers to health care access will not result in sustained increases in use if Roma are treated poorly when they visit a health facility (OSI, 2005:61–62). Many governments have recognized the primacy of lack of knowledge about Roma culture among health care workers and the discriminatory treatment that may follow. To improve cultural literacy about Roma among health care providers, the Finnish National Board of Education has developed a guide to be used by health care professionals. The guide outlines aspects of Roma culture that may influence the way Roma patients act in health care settings (OSI, 2005:18). Similarly, the Bulgarian Decade of Roma Inclusion 2005–2015 action plan foresees providing training on Roma culture and health care priorities in medical universities and health care facilities (Decade of Roma Inclusion 2005–2015, 2007e).

Given the importance of discrimination in forming a negative view of the overall health care system for many Roma, the

perceived quality of the interaction with a service provider may be more important to Roma patients than to patients in the major ethnic group. In addition to its links with health service usage rates, the quality of patient–provider communication has been linked to several valued health outcomes in many settings (Cooper, Hill & Powe, 2002:479; Ashton et al., 2003). Roma surveyed in Spain stated that their assessments of quality are based primarily on the length of the visit, how they felt they were treated as a person, perceived empathy and non-verbal communication. For their part, physicians expressed reluctance to fulfil these expectations and thus take on *extra work* to deal with Roma patients (FSG & Ministry of Health and Consumer Affairs, 2005:18). Further assessment of the role of patient–provider interactions, as well as training for physicians in this area, might complement initiatives to reduce discrimination in health care settings. Moreover, approaching many of the issues commonly described as *discrimination* (such as ethnic stereotyping and brusqueness) from a quality of care perspective might lessen resistance to training and practice changes within the medical community.

Finally, in settings where Roma and/or Travellers are migratory, health policy-makers have sought to improve access to health care by instituting patient-held records. These mobile records increase access to quality health care insofar as migrating patients can visit a doctor wherever they are and have key elements of their medical history with them. The Scottish Parliament recommended in 2001 that a pilot scheme be scaled up throughout the country to better continuity of care for Traveller patients, and the Irish Department of Health and Children has included patient and family-held records in their national Traveller Health Strategy (Aspinall, 2005:40). According to the Irish plan, the records should include such information as medical history, previous medical consultations and obstetric history (Aspinall, 2005:41). While there has yet to be a strong evaluation of such an intervention, it is often included in discussions on best practices, as it is one of the few models that have been tried in several countries with migrating Roma and/or Traveller populations.

Integration of health and social protection systems

Coordination between health and social protection/inclusion services will enable development of programmes that tackle a number of the seemingly intransigent confluences of the social determinants of health. An approach that aims for health and equity in all policies can remedy the consequences to health of vulnerability and try to address some social factors that give rise to health inequities. Some countries have undertaken data collection initiatives to provide baseline information to guide the development of integrated health and social protection strategies. The Spanish Ministry of Health and FSG are analysing the health of the Roma population, and they will leverage the results to promote more active social policies (Ministry of Health and Consumer Affairs, 2004).

Ministries of social affairs in some countries have planned activities that address fundamental factors that shape Roma health. The Romanian Ministry of Labour, Social Solidarity and Family envisions the creation of a national programme to solve "problems related to the lack of identity cards" (Ministry of Labour, Social Solidarity and Family, 2006), which will facilitate access to both health and social assistance. The City of Ostrava in the Czech Republic has already initiated a programme to train Roma to provide assistance to fellow community members in attending school, in accessing medical and social services, and in creating social housing (Ministry of Labour and Social Affairs of the Czech Republic, 2006:78–80). This second example is part of a broader approach to health and social inequities between the Roma and the overall population – that is, instituting liaisons between the Roma community and local government entities. Many of these programmes take an integrated approach to health and social concerns, and the liaisons are often referred to as mediators.

Mediation is one of the most widely employed programmes for advancing Roma access to health care and social protection and addressing some of the underlying factors that determine inequities. Usually, it entails training a member of the Roma community to mediate between Roma clients and state-provided services. Mediators generally have intersectoral responsibilities and thus can address several of their clients needs.

The Navarre Public Health Institute, for example, has employed Roma mediators in health and social service facilities, schools, and Roma associations. As a result of their work with communities and individual clients, attendance at primary care, family planning and gynaecological services has increased. The mediators also refer clients to substance-abuse and smoking-cessation services and follow up on cases of school truancy (Navarre Public Health Institute, 2004).

Mediators in Romania, who are employed by the Ministry of Health, also tackle both health and social protection concerns. They provide health education, accompany patients to the doctor, facilitate access to the birth registration and documentation that is required to receive social assistance and non-contributory health insurance, and refer families with children not in school to a social worker (OSI, 2005:235). In the first two years of the Romanian mediator programme, mediators helped 108 632 children to register, 40 015 people to obtain health insurance and 1180 people to obtain identity documents. They also facilitated registration with general practitioners for 3521 women, 12 836 child vaccinations and 4259 health education

sessions (OSI, 2005:42–43). In Finland, mediators assist individuals with their housing, educational, health and employment needs (OSI, 2005:17).

In Serbia, mediators (Roma Coordinators) are housed in local municipal assemblies; these mediators determine the priority of health, social and other problems in their communities and then spearhead the drafting of the local action plan. As part of this process, Roma Coordinators are responsible for facilitating regular communication between the Roma community and the local administration (ECMI, 2007:15).

Mediator programmes thus have the potential to:

- increase access to health care, as well as improve the quality of care provided
- increase access to services that could lessen social inequality, such as education
- facilitate Roma political participation at the local level.

Apart from mediation and the identity-card initiatives noted above, there are few known examples of government programmes that address the social determinants of Roma exclusion. Most of the national-level government bodies responsible for Roma inclusion have the capacity to create such programmes, as they have multisectoral responsibilities. Some have planned comprehensive health and social programmes as part of the Decade of Roma Inclusion 2005–2015, but are just starting these activities.

The Finnish government is unique in that it has a long history of mechanisms that integrate the health- and social-sector priorities of the Roma community. In 1956, the government created an Advisory Board on Romani Affairs that: reports to national authorities on the living conditions of the Roma; implements initiatives to improve the economic, educational, social and cultural conditions in the Roma community; works to end discrimination; and furthers the culture of the Roma (OSI, 2005:17).

Further empowering national Roma agencies in other countries with financial resources and decision-making abilities will advance our policy know-how.

Discussion points and questions

Action to improve the health of Roma populations requires a commitment to the shared values of solidarity, equity and participation. These values should be manifested in health policies, resource allocation and other actions, ensuring due attention is paid to the needs of the poor and vulnerable groups, including the Roma. This was emphasized in the Tallinn Charter, endorsed at the WHO European Ministerial Conference on Health Systems in June 2008 (WHO Regional Office for Europe, 2008). Ample opportunities exist for governments to integrate such actions as those outlined in the preceding sections into health system stewardship, financing, resource generation and service delivery functions, thus improving their ability to pro-actively address the health status of Roma populations. It is time to move from a fragmented to a transformative approach. Health systems can remedy some of the social, economic, and political issues that predispose Roma to exclusion and ill health; *and* they can provide services that appropriately respond to morbidity.

Data indicate that, due to long-standing exclusion and discrimination, among other factors, Roma are more likely to be poor, more likely to be sick, and less likely to access the very health and other services needed to redress the resulting inequitable health outcomes. Moreover, policies and programmes should address – head on – discrimination and exclusion. At the same time, emphasis should also be placed on building and maintaining inclusive, proactive health systems that respond to the needs of all constituents, Roma and others. Ignoring the role of ethnicity will result in ineffective programmes, but focusing exclusively on it may create parallel systems and divert attention away from the health system reaching everyone.

The following 10 questions explicitly lay out some of the discussion issues that will invigorate strategy development and programme implementation throughout Europe.

1. International agencies, advocates and governments have underscored the importance of Roma participation at all levels of the health system. In practice, however, participation is lacking. How can governments, advocates and donors work together to ensure that members of the Roma community are capable of participating and that their participation is meaningful?

2. There are some examples of special targeted projects that have addressed key Roma health concerns, such as vaccination. While these measures may be required in the short term, how can governmental programmes be strengthened so that special programmes for Roma are no longer required?

3. How can dedicated individuals within health ministries work together with advocates to move Roma health further up the agenda? While particular individuals may understand the costs of ill health to the Roma community, as well as to the country as a whole, recognition of this may be insufficient within the government and/or the public at large. Therefore, what kind of data, arguments, and case studies would convince finance ministries and others of the importance and benefits of addressing Roma health?

4. Action plans that emanate from ministries of health and social affairs, as well as from the national entities responsible for Roma integration, often cite the key role played by underlying factors, such as poor housing and lack of documents. Sometimes, remedial actions to address these problems are contained in action plans. However, because they generally require more funding and cooperation from other government actors, these activities are rarely undertaken. Therefore, how can policy discussions and financing (at the national or international level) be approached to better ensure the capacity to address larger determinants of Roma health? Furthermore, how can Roma concerns be included in broader anti-poverty strategies?

5. Many Roma health issues are not purely within the purview of the health ministries, such as documentation, education and the legal status of their housing. Some of these issues concern ministries that are not generally oriented towards the needs of the vulnerable, such as the interior ministry. Given this, how can interministerial efforts be facilitated and implemented? Also, what strategies can health ministries adapt to convince colleagues in other ministries of the need for cooperation?

6. Roma live in almost every European country. Some of these countries have more experience than others in implementing Roma health programmes. Some also have stronger partners from Roma civil society. EU funding schemes try to facilitate cross-border information sharing, but intensified efforts are needed. How can governments better learn from one another? Also, many of the international conferences that consider the Roma only target eastern Europe. How can western European experiences be better communicated at these forums?

7. Given the larger context of decentralization (particularly in eastern Europe), how can ministries ensure that policies and programmes are implemented at the local level? Also, how can finance and monitoring mechanisms be improved to facilitate participation by municipalities that may be less interested in Roma health?

8. Low health literacy in Roma communities is a root cause of poor health system use and unhealthy behaviour. How can programmes better increase Roma health literacy in the long term, rather than just providing needed medical or social services in the short term?

9. Many of the current model programmes for addressing Roma health focus on increasing demand for health care within the Roma community, usually by removing bureaucratic barriers to access or providing health education. However, it is clear that demand for health care may be low because of concerns about the quality and/or appropriateness of the care provided. How can programmes address important – but difficult – supply side problems, such as low cultural literacy of health care providers, poor knowledge about how to treat illiterate patients, prejudicial beliefs, and so on?

10. How can we better understand and address the ethnic and poverty-related elements that shape Roma vulnerability to ill health? Being of Roma background is an independent risk factor for poor health, but many of the obstacles Roma face are problems for all poor people. How can strategies identify and address problems that are specifically ethnic, as well as those that are not?

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24. Migration and health of migrants

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Summary

This study aims to provide an overview and analysis of migration and health in the WHO European Region. As migration becomes an ever greater aspect of the European experience, the health implications associated with migration will assume greater importance. Just over 64 million (or 34% of the global population of) migrants reside in Europe.

Migration in Europe today involves a diverse group of people, including migrants in a regular and irregular situation, victims of human trafficking, asylum seekers, refugees, displaced persons and returnees. For ease of reference, they are all referred to as migrants. The majority of migrants in Europe are young adults. Women make up half of all migrants and are often overrepresented in vulnerable groups, such as victims of human trafficking for sexual exploitation. In terms of regular migration to Europe, family reunification remains the primary source of intake, but migration for employment is expanding and is expected to become more important.

Migrants experience unique influences linked to the four phases of migration: pre-migration, movement, arrival and integration, and return. The health conditions and environment, both physical and socioeconomic, at the migrants' place of origin (the pre-migration phase) determine many of the baseline health parameters and determinants of health in migrants. The migratory journey itself (the movement phase) can affect the health of migrants, with increased health risks most often observed among migrants in an irregular situation, refugees and displaced persons. During the arrival and destination-integration phase, poverty and social exclusion exert their greatest effect on health outcomes, with the health of migrants being influenced by the availability, accessibility, acceptability and quality of services in the host environment. Services that promote health or prevent illness may not be accessible or acceptable, because of linguistic or cultural barriers, as they may not recognize migrants as groups with different risks. Also, poverty and social isolation may limit the use of health services that prevent illness by those most vulnerable, particularly migrants in an irregular situation. For situations and conditions where the patterns and determinants of health differ between locations, return travel can be associated with significant health risks.

All phases of the migration process can affect communicable and infectious diseases in migrants. TB, AIDS, vaccine preventable diseases and several parasitic diseases are unevenly distributed across the globe. Many of these infectious diseases have a higher prevalence and incidence in regions of the world where migrants destined to Europe originate. European countries take different approaches to assessing the presence of disease in migrants. Some European countries require mandatory health assessments prior to departure or upon arrival; other countries arrange for voluntary evaluation after admission.

The migration process can also affect the evolution of infectious diseases, as is the case with multidrug-resistant TB, which can be linked to migrants not completing their TB treatment before travelling to the destination country, to increased immigration from countries with unsuccessful TB control, and to migrants having poor access to health care in destination countries.

In a similar manner, non-infectious diseases and illnesses, such as certain malignancies, diabetes and mental conditions, may be inequitably distributed among migrants. Prior to migration, access to medical services may have been limited or unavailable, which makes certain conditions that are easily managed in high-income countries more advanced or less effectively treated in migrants.

At the same time, for several conditions and illnesses, migrants display better health indicators than local or host populations, which is known as the healthy migrant effect. Examples of these better health indicators include body mass index, dietary practices, some sexually transmitted infections, the use of health services and self-reported health status. Longitudinal studies in some major immigrant-receiving countries suggest that over time these positive advantages decrease and migrants begin to assume the characteristics of the host populations.

Mental and psychosocial illness is a health concern for many migrants in Europe and includes high rates of alcohol and drug abuse, depression, and anxiety. Traumatic experiences prior to departure or during the migration process, such as armed conflict, hunger and physical or sexual abuse, can be a heavy burden on a migrant's mental well-being. Upon arrival, a variety of factors may increase psychosocial vulnerability and hinder successful integration, such as cultural differences, language barriers, racism and unemployment. Migrants in an irregular situation, some of them living in detention and risking deportation, live in a state of uncertainty about their fate and have limited access to services.

Gender-specific challenges also confront migrants. Maternal and child health, reproductive health and sexual health represent important challenges for some migrants. Accessing prenatal care for migrants, especially migrants in an irregular situation, is a major public health issue. Ensuring that migrants have early access to reproductive health services, preventive health services and health promotion, screening and diagnostic care, as well as prenatal and obstetrical services, will reduce the risks of adverse outcomes. Special attention should be paid to women and girls who have been trafficked, have fled from conflicts or have been displaced, as they have often been subjected to gender-based violence.

Cultural and ethnic reproductive and sexual health practices and norms of behaviour among certain migrant groups, such as female genital mutilation and the use of contraception, may challenge or conflict with those in the host community. Recognition and management of reproductive and sexual health issues requires cultural competence in health care providers. Such cultural competence, however, may not be part of current medical education programmes in Europe.

Migrants are often placed at increased risk of work- or occupation-related illness, injury or even death. New arrivals frequently gain employment in the so-called 3-D category of dirty, dangerous and degrading work, where the baseline risk of occupational injury is elevated. In an irregular situation, migrants and those trafficked for forced labour are also frequently subject to violence and accidents. Moreover, migrants' limited language skills and lack of knowledge of (or experience with) occupational health and safety practices can affect their workplace health.

The right to health applies to every human being, regardless of their immigration status. The Member States of the WHO European Region have ratified various international and regional legal instruments that aim to ensure, among other things, equitable access to health services of appropriate quality in accordance with the person's medical needs. Nevertheless, health inequalities persist in the Region, both in migrant health status and access to health services. Many measures can be taken to ensure the enjoyment of the right to health for all. For example, the right to health should be formally recognized in national laws, and the practical obstacles to its enjoyment by all migrants should be eliminated.

Because migration is increasingly fluid and because migrants themselves are increasingly diverse, the effects of migration-associated health challenges and the local capacities to recognize and meet those challenges will be shared unequally in Europe. Social exclusion and poverty-related adverse health outcomes, while sharing some basic characteristics, will manifest population- and location-specific elements that differ between countries and may differ between regions of the same country (rural–urban differences, for example). Attempts to introduce or replicate specific programmes and policies designed for (or resulting from) specific migratory flows may not be equally effective at other locations or for future arrivals of migrants.

To compensate for this diversity, programme and policy development at the regional level will need to reflect the basic principles of modern migration and draw on aspects of successful programmes that can be applied locally. Accomplishing this will require carefully constructed systems that gather and analyse standardized and comparable information and data on socioeconomic issues in specific migrant groups. Also, longitudinal monitoring of migrant health indicators and characteristics will be required. Together, the resulting information can be used to identify trends, to indicate areas of successful intervention and support and to define the principles that can be applied regionally. An important aspect of this activity will be the recognition that many of the health and socioeconomic challenges associated with migrants are the product of global inequity. Local and

regional endeavours that focus solely on issues in countries that receive migrants will be less effective than integrated globally focused programmes designed to mitigate the factors at both the country and region of origin and destination.

The need for coordinated and sustained action to address migration-related health challenges in Europe and globally is increasingly being considered in policy-relevant processes. Migrant health was addressed in the exploratory opinion of the European Economic Social Committee in July 2007, and this was followed by the Health and Migration in the EU: Better Health for All in an Inclusive Society Conference, convened in Lisbon in September 2007 through the Portuguese EU Presidency. Conference recommendations underscored the need for coherent immigration policies that incorporate the health dimension at both the EU and Member State level. In November 2007, in Bratislava, migrant health was once again highlighted during the Eighth Conference of European Health Ministers of the 47 member states of the CE on people on the move: human rights and challenges for health care systems. During this event, the CE member states signed the Bratislava Declaration on Health, Human Rights and Migration.

Options for action to improve migrant health were further covered in the Employment, Social Policy, Health and Consumer Affairs Council conclusions in December 2007. At the request of Member States, the WHO secretariat helped produce a report and a draft resolution on the health of migrants for submission to the 122nd session of the WHO Executive Board in January 2008. The World Health Assembly resolution WHA 61.17 – which was recommended to (and then endorsed by) the Sixty-first World Health Assembly in May 2008 – urges Member States and WHO to promote the inclusion of migrants' health in regional health strategies; to develop/support assessments and studies and share best practices; to strengthen service providers' and health professionals' capacity to respond to migrant needs; to engage in bilateral and multilateral cooperation; and to establish a technical network to further research and enhance the capacity to cooperate.

Demographic synopsis and socioeconomic status of target group

Any consideration of the relationship between the determinants of health and the process of migration must include the diversity of and differences in the nature and concepts of the modern migratory process in Europe. Regional, national and temporal differences complicate the collection, reporting and comparability of information, programmes and outcomes. Regional and international generalizations are possible, but they must also recognize that several local factors differ between areas.

Definitions

Migration can be defined as "A process of moving, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, uprooted people, and economic migrants" (IOM, 2004). Migration in Europe today involves a diverse group of people, including people moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family, victims of human trafficking, asylum seekers, refugees, displaced persons and returnees.

Driven by a combination of social, economic, geopolitical, demographic and environmental factors, the scope and scale of migration have evolved rapidly and continue to do so. That evolution is accompanied by changes in the number, nature and diversity of those who migrate. Each of these variables may be subject to poverty. Concomitantly, patterns of migration – in terms of the origin and destination – of those who migrate have changed and continue to do so.

For the definitions of all those involved in migration, see the *Glossary on migration*, which gives the following definition for the term *migrant* (IOM, 2004).

> At the international level, no universally accepted definition of migrant exists. The term migrant is usually understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of "personal convenience" and without intervention of an external compelling factor. This term therefore applies to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family.

However, for ease of reference in this chapter, the terms migrant and migrant population are used to describe all those who have migrated and have found themselves in the WHO European Region. As a result of historical and sociopolitical factors, the migration experiences of European countries differ. As a consequence, the demography of migrants and the ability of some countries to accept and manage migration vary (Spencer et al., 2007). It is important to note that there may also be considerable

variation of migrant populations within individual countries, which reflects the speed with which migration is evolving.

Many sources, including published literature, reports and statistics, commonly refer to immigrants or migrants as if they were a uniform population of non-nationals that reside within or attempt to enter a European country. In both practice and reality, however, the demographics have become much more complex, particularly during the past two decades. Many of the health issues and concerns of this target group are directly and indirectly related to that demographic complexity.

Efforts to measure international migration have also been hampered by the lack of agreement at the global and (even) regional levels about a common concept for defining it (United Nations, 2002). For example, when collecting data, many countries commonly apply their own definitions, without making adjustments that allow for international compatibility. Also, while some countries consider nationality as the decisive factor in defining a person as a migrant, others use variable concepts of residency (ECLAC, 2005; Parsons et al., 2007). Moreover, when population-based statistics are based on nationality, those people who have acquired host-country nationality might not be reported as migrants. This lack of consistency and conformity badly affects the ability to obtain accurate measurements. Therefore, representing population statistics by country of birth, rather than nationality, can be a metric that offers a more complete picture of the demographics and effect of migrant populations.

The method of counting migrants is an important issue when the relationships between health and poverty are considered in the context of migration. Depending on location, migrants who obtain permanent residence or nationality are frequently included in administrative and health statistics as a part of the national population. However, several migration-related economic and social factors, including aspects of migrant behaviour, and many health-related influences associated with migration can persist long after permanent residence or nationality is attained (Landman & Cruickshank, 2001). Also, some biological and genetic determinants of health, as well as certain behaviourally influenced determinants, may extend over generations (Sharareh, Carina & Sarah, 2007). In this context, monitoring and studying the health implications and consequences of migration require a focus that goes beyond the legal boundaries of nationality and residence.

Any regional approach to dealing with the health challenges related to socioeconomic status must take into account the wider determinants of migrant health. In terms of health and poverty, functional classifications of migrants, which recognize the great diversity among them, may be more applicable between countries and across the Region.

Demography

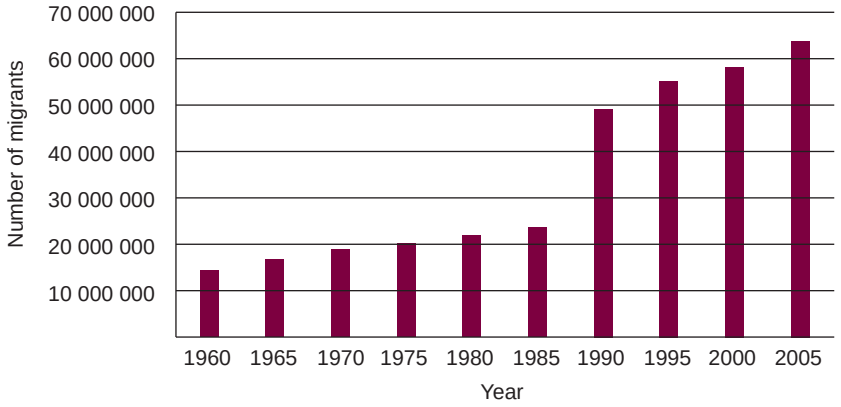
Providing an overview of the demography of migration in Europe is complicated by the above noted variability in data and definitions. Some statistics are based on nationality, others on location of birth and still others on legal status. However, no matter how the data are reported, it is clear that the number of migrants in Europe is large and is growing.

Using international definitions, the United Nations estimated that in 2005 there were more than 190 million global migrants (United Nations Population Division, 2006). This is an increase of about 50 million people since 1950. Of that total, just over 64 million (or 34% of them) resided in Europe (see Fig. 24.1). The enlarged EU was home to 44.1 million international migrants, some 70% of the total in Europe. Migration in the EU has been strongly affected by geographic proximity, with 30% of the migrants living in the EU originally being from other EU countries (IOM, 2008). Also for 2005, the 53 Member States of the WHO European Region were home to 72 million international migrants (United Nations Population Division, 2006).

When migrant numbers are based on nationality, national statistics (Eurostat, 2006) suggest that the total number of non-nationals that reside in the EU is lower, in the range of 25 million; non-nationals refers here to people who are not nationals of the country in which they reside, including people of unknown nationality and stateless people (Eurostat, 2006:3). This disparity in migrant numbers exemplifies the need to ensure data are defined and comparable denominators are used (Caritas Europa, 2006).

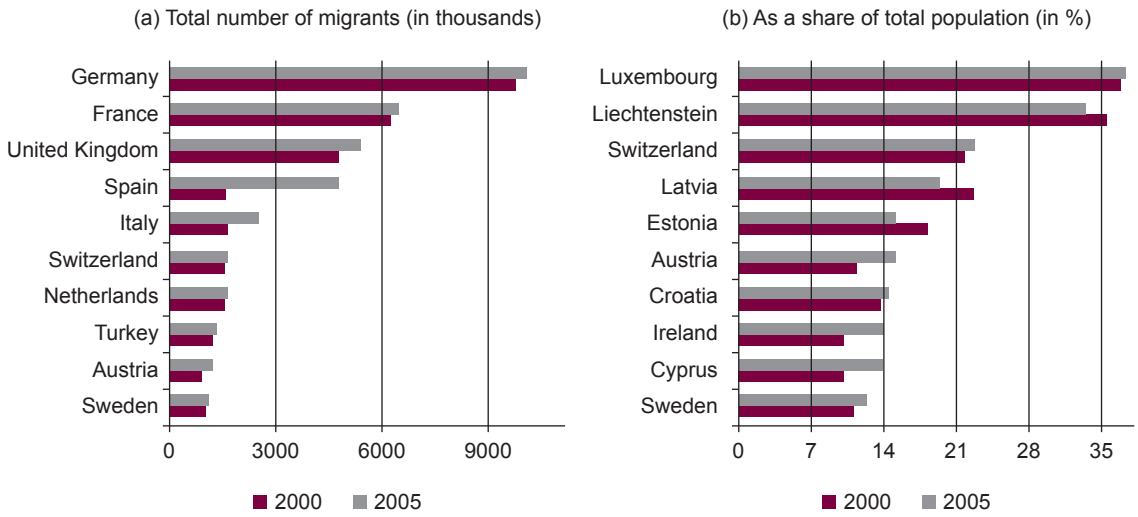
Substantial variability in the size and diversity of migrants extends across Member States of the WHO European Region. The proportion of migrants in the European population was estimated to be 8.9% in 2005. In 1960 it was 3.4%. The percentages, however, vary by European region, with western European countries reporting levels of 10–15% of the total population (Muenz, 2006). In some countries, the percentage of migrants is as low as 1%, while nearly 40% is reported as the highest proportion of migrants in one EU country. In terms of numbers, the largest populations of migrants are found in five countries: Germany (10.1 million), France (6.5 million), the United Kingdom (5.4 million), Spain (4.8 million) and Italy (2.5 million) (see Fig. 24.2).

Fig 24.1. Migrants in Europe, 1960–2005



Source: Adapted from United Nations Population Division (2006). Reproduced with the permission of the copyright holder.

Fig 24.2. Stock of migrants in western and central Europe: top ten destination countries, 2000 and 2005



Source: IOM (2008). Reproduced with the permission of the copyright holder.

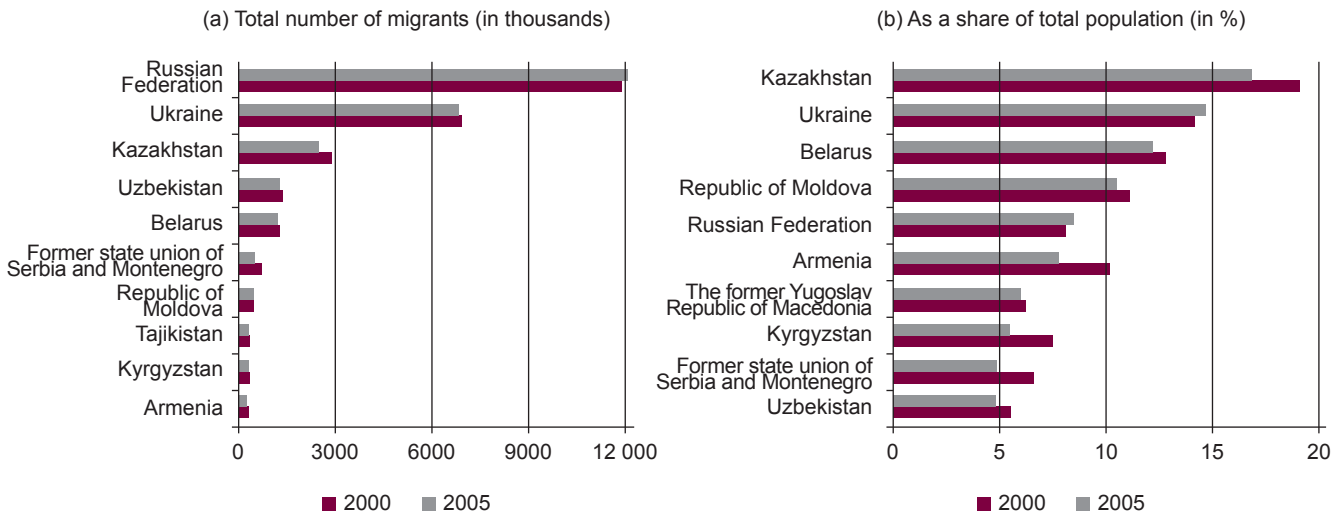
In nations with small populations, relatively small numbers of migrants can produce significant effects on the percentage of total population, generating influences that may not be observed in larger nations, even though the migrant populations themselves may be numerically larger.

In eastern Europe and central Asia, the Russian Federation was the top country of destination in 2005, hosting 12 million migrants, followed by Ukraine (6.8 million migrants) and Kazakhstan (2.5 million migrants) (see Fig. 24.3). Except for the Russian Federation, with a 1.6% increase in the stock of migrants from 2001 to 2005, the region experienced a decrease in immigration over the period. Most migrants from the CCEE moved to western Europe and the majority of migrants from central Asia travelled to the wealthier NIS countries.

Refugees and asylum seekers are an important component of those migrating in Europe and may have specific and important health concerns. In 2006, according to the United Nations High Commissioner for Refugees (UNHCR, 2007a), refugee populations in Europe numbered 1.7 million people, which represented about 18% of the global refugee population of 9.9 million people.

Examining asylum seekers in Europe, which receives the majority of global asylum claims, provides a concise example of the variability in migration and subsequent effects on population demography in the Region. In Europe, total claims,

Fig 24.3. Migrants in 10 leading destination countries in eastern Europe and central Asia, 2000 and 2005



Source: IOM (2008). Reproduced with the permission of the copyright holder.

which peaked in 1992, have slowly decreased. In 2006, in Europe, 223 990 claims were made for asylum, a decrease of 16%, compared with 2005 when there were 265 500 claims. A similar decrease was noted for the aggregate figures for the 25 Members States that were part of the EU on 1 May 2004, where the levels fell by 17%. Of those 25 EU Member States, however, there was a noticeable divide between the 15 old and 10 new countries. While the former recorded a 15% fall in the number of asylum seekers during 2006, the latter experienced a much larger drop of 31%. The Nordic countries, however, reported a 17% increase in 2006, primarily due to the arrival of new asylum seekers in Sweden, where numbers increased by 39% (from 17 530 in 2005 to 24 320 in 2006). At the same time, six nations in southern Europe (Cyprus, Greece, Italy, Malta, Portugal and Spain) had a sustained increase in the number of asylum claims (UNHCR, 2007b). The countries that were major sources of asylum seekers in Europe in 2006 were, in descending order: Iraq, Serbia and Montenegro, the Russian Federation, Turkey, Afghanistan, and the Islamic Republic of Iran.

Recent years have experienced a large increase in the number of international students in high-income European countries. From 1998 to 2003, the increase was about 38.5%. The countries that were the top destination were, in descending order, the United Kingdom, Germany and France

Irregular migrants are people who, owing to illegal entry or the expiry of their visa, lack legal status in a transit or host country. The term applies to migrants who infringe on a country's admission rules and any other person not authorized to remain in the host country (IOM, 2004). Irregular migrants are also referred to as clandestine, illegal, undocumented migrants or migrants in an irregular situation. However, the terms irregular or undocumented are preferable, because the term illegal often has a criminal connotation and is seen as denying migrants' their humanity.

By definition, irregular migration is difficult to measure; however, estimates show that irregular migration in the Region accounts for an important part of total migration. In 2006, there were more than 3 million undocumented migrants in the EU and between 1.3 million and 1.5 million in the Russian Federation. Other estimates of the stock of migrants in an irregular situation in Europe vary between 2.6 million and 6.4 million people, with nearly 400 000 border apprehensions each year in the 25 Member States that were part of the EU on 1 May 2004 (IOM, 2008).

Currently, young adults have large representations in migrant populations in Europe. The proportion of migrants in the cohort of 20–40-year-olds is greater than that of the host population. In global terms, women make up half of all migrants. They are often overrepresented in particular groups of vulnerable groups, such as victims of human trafficking for sexual exploitation (O'Neil, 2001).

In the area of immigration, family reunification remains the primary source of intake of migrants who obtained permanent residence permits, but labour migration is expanding and is expected to become more important as Europe continues to create jobs (EurActive.com, 2007). In many European countries, much of this migration consists of free movement of workers within the EU (OECD, 2007).

Socioeconomic status

In Europe, access to employment is a major aspect of social and economic inclusion. Levels of poverty are noted to be higher in the unemployed and other inactive members of society. In common with other statistics on migrants in Europe, the specific statistics on migrants in the workforce are not consistently reported by all countries. Rates of employment and unemployment vary by country, but there is evidence to indicate that employment income is reduced in migrant populations, particularly those of irregular migrants (Van Liemt, 2004; Malpani, 2006).

It has also been observed that employment rates for migrants are influenced by their place or region of origin. Migrants from low- and middle-income countries have lower rates of employment than those from high-income countries (European Monitoring Centre on Racism and Xenophobia, 2003). In some countries, asylum seekers may not be eligible for employment or may be subject to other work restrictions (Norredam, Mygind & Krasnik, 2006).

Migrants in an irregular situation with work are often underpaid (Gibney, 2000). For regular migrants, their legal status may not always be associated with an income at the same level as that of the host population. Language and education qualifications, or lack of portability of educational or professional certification, often limit employment, thus reducing household income. Also, ethnic and cultural factors, particularly for those newly arrived, may preclude the regular employment of some migrant populations, depending on their beliefs and religious practices.

Unemployment is not the only factor associated with poverty. Working people whose income is less than 60% of the median national income are at greater risk of poverty-associated outcomes. While it is suggested that many migrants fall into the category of working poor, corroborative data is limited. Also, as noted by Caritas Europa (2006:30), "poverty is generally measured at the household level, while employment relates to individuals". This makes the comparison between levels of employment and the impact of poverty difficult, but it is clear that simply being employed may not remove all the risks or implications of being poor. Moreover, national and regional studies that define the effect of working for low wages in migrant communities are scarce.

Despite the limits in baseline information and the challenges present in comparing data from different national sources with varied demographic definitions, there are some generally accepted conclusions. Some migrant populations are at particular risk of poverty. Those at risk include: migrants in an irregular situation; asylum seekers; single-parent migrant families, specifically those headed by women; those traumatized or tortured during the migratory process; and the victims of human trafficking.

The size of some of these at-risk populations is small in comparison with the host population and the larger migrant or foreign-born cohorts present in Europe. As such, without specific attention or monitoring, the indicators and significance of their needs may be obscured by the larger number of people less at risk used as denominators. Specific programmes for those at risk and more detailed information are required to better define and meet their needs.

Health risks in the context of socioeconomic status

A number of health risks correlate with social conditions. Among these conditions are exclusion, housing, nutrition, education, access to health care, isolation and separation, and occupational health concerns and risks.

Exclusion

Social exclusion, the process by which inequality limits the ability of individuals and communities to fully participate in the host society, is a determinant of health. Through institutionalized or functional processes, people, communities and populations may be prevented from accessing or utilizing social, educational, economic and political systems (Public Health Agency of Canada, 2004). As a consequence of this limited access to resources and services, migrant health is adversely affected (Bos et al., 2005).

Poverty is both a cause of social exclusion and a self-perpetuating consequence of the process. The effects of poverty on health are extensive and well documented (Wilkinson & Marmot, 2003).

As described above, many migrants are vulnerable economically and have less wealth than the host population. This is particularly true for such vulnerable groups as refugees, asylum seekers, migrants in an irregular situation and migrant workers defined in the preceding section. Examples of the health consequences of social exclusion are elaborated below.

Housing

Lack of housing and access to housing is an important consequence of poverty and social exclusion (Harrison, Law & Phillips, 2005). Lack of an accommodation, a substandard accommodation, overcrowding and homelessness influence health outcomes. Accommodation structure and design alone have been associated with adverse health outcomes and morbidity related to accidents and injury and to exposure to pollutants, toxins and thermal health risks (from excessive cold and heat). Overcrowding and poor sanitation and housing design can be associated with the increased risk of respiratory, gastrointestinal and dermatological diseases. Also, mental and psychosocial health risks are influenced by the quality and environment of housing (WHO Regional Office for Europe, 2007).

Migrants, particularly migrants in an irregular situation, are frequently inadequately housed or have difficulty in locating an adequate lodging. Considering that access to housing for migrants often occurs in the context of a predominantly private organized housing market, discriminatory regulations and practices may exclude them from certain sectors of that market, even if they have the financial means (Bosswick, Heckmann & Lüken-Klaßen, 2007). Also, it should be noted that the principal problem with housing in Europe concerns the availability of generally poor social housing. Inadequate living conditions of irregular migrants are therefore closely connected with problems of supply in social housing. Indeed, it is not unusual for public authorities to spend a lot of money on the provision of hotel accommodation for undocumented or irregular migrants when these funds would be better spent on constructing social housing (Cholewinski, 2005:34). Common to the majority of migrant-related health factors, the effect on health of housing and accommodation varies across the migration spectrum (Van Parys & Verbruggen, 2004). Regular migrants, such as migrant workers and members of their families who are in a regular situation, frequently acquire an adequate accommodation on arrival and experience fewer housing-related health risks than do irregular migrants.

For more disadvantaged migrants, particularly those in an irregular situation, the picture is less favourable. Following arrival, irregular migrants may be housed in holding centres. Large or unanticipated flows of arriving migrants, however, may exceed the capacity of such centres, forcing them to use other services for the homeless, such as hostel or shelter services (European Federation of National Associations Working with the Homeless AISBL, 2006). Depending on their status and location, some migrant populations enter the ranks of the urban homeless. Single-parent families and those headed by women are particularly vulnerable. In some European locations, migrants in an irregular situation are very poorly housed, and some experience conditions that are barely at a subsistence level (Caritas Europa, 2006).

Nutrition

Adequate nutrition is a fundamental determinant of health. Nutritional status is a consequence of amount and quality of food consumed, which itself is dependent on factors related to income and wealth. Inadequate or poor nutrition is associated with a myriad of adverse health outcomes, such as those observed in mother-and-infant health. Also, migrants may experience additional nutritional risks in situations where their traditional foodstuffs may be unavailable or very costly at their new destination.

Not all risks associated with nutrition are related to reduced nutrition status (Dubowitz et al., 2007). Some are related to poor dietary choices. The process of acquiring some of the behavioural patterns of the host population can extend to food and nutrition. As a consequence, the adoption of new dietary and physical-activity habits following migration can be associated with health risks related to poor diets, caloric overconsumption and obesity-related illness. Poverty may accentuate these adverse outcomes due to the prohibitive cost of accessible foods that are more nutritionally appropriate.

Education

Level of education is associated with the individual- and population-based level of health (Marmot & Wilkinson, 2006), as well as with the use of health care services (Schnittker, 2004). The latter includes the awareness and adherence to activities that promote health and prevent illness (Erikson, 2001). Migrants, particularly migrants in an irregular situation, may not have full access to educational services at their new residence (Cholewinski, 2005:36). Asylum seekers, refugees and temporary

migrant groups are often overrepresented in this category. Even if access to services is provided, there may be functional limits, created by the lack of capacity of the educational system to accommodate those with language abilities different from those of the host population. Migrants who lack sufficient or adequate education are expected to be associated with future downstream adverse health outcomes.

In some European and other locations, educated and well-qualified migrants may not be able to acquire employment commensurate with their education. Many of these migrants are forced to accept employment below their level of qualification and live on reduced or marginal income (European Foundation for the Improvement of Living and Working Conditions, 2007). As such, they may also experience limits in their ability to access some health services or to maintain lifestyles that support good health. Independent of low level of educational, low occupational level has been associated with poor health (Volkers, Westert & Schellevis, 2007).

Access to health care

Access to health care – which includes services that promote health, prevent illness and provide diagnosis and therapeutic care – is fundamental to maintaining and improving the health of migrant populations (Davidson et al., 2004; Pace, 2007). Those at greatest disadvantage continue to be migrants in an irregular situation (Romero-Ortuño, 2004). Depending on location, services may be limited by a migrant's status.

Additional important factors that affect access to health care are related to poverty and social exclusion. Some of these factors are shared with other groups affected by poverty and some are specifically associated with the migratory process. Also, low level of employment may be associated with limited sick or illness leave, and the working poor may find themselves in situations where they may not be able to access care during regular working hours and must seek it in after-hour clinics or services, the availability of which varies across Europe. Moreover, linguistic and cultural competence has a major effect on access and adherence to health care recommendations (Bischoff et al., 2003).

Not only do linguistic and cultural barriers affect a migrant's access to health services, but often there are other barriers that affect access. One such barrier is a lack of awareness of available services, due to the absence of information about the health care system in host countries. This, in turn, is compounded by a lack of awareness (and training) on the part of health care officials about migration health issues. Another such barrier is a lack of understanding of the specific needs and expectations of migrants, together with a lack of trust on the part of migrants (Pace, 2007). Moreover, the increasing diversity of modern migrants often exceeds the capacity of health care delivery systems (Betancourt, 2006).

Delayed or deferred care is associated with the progression of disease and illness and the subsequent need for more extensive treatment and intervention (Wang et al., 2007). Also, limited access to services that promote health and prevent illness increases the risks of (and demands resulting from) illnesses and conditions that can be successfully mitigated – often at reduced cost or complexity of service. This can be very important in situations that involve mother-and-child health and the management and control of some communicable diseases of public health importance.

Isolation and separation

Depending on their status, many migrants are separated from their families, some for extended periods of time. Isolation and separation are more common in irregular migrant communities, but temporary migrant workers also share these conditions (Latin American Research Group, 2005). Prolonged separation from loved ones is associated with mental and psychosocial illness as well as with risk taking behaviour that results in an adverse health outcome (McGuire & Martin, 2007). Among migrants exposed to long periods of separation or isolation, substance abuse, high-risk sexual activity and violence may occur with greater frequency (International Centre for Diarrhoeal Disease Research, Bangladesh, 2005). Women and girls, particularly if they are separated from family support structures and safe environments, may be subject to gender-based violence (UNFPA, 2006: 20–41).

Occupational health concerns and risks

Migrants are often placed at increased risk for work-related or occupational illness, injury or (even) death. New arrivals frequently gain employment in the 3-D category of dirty, dangerous and degrading work (International Textile, Garment and Leather Workers' Federation, 2007), where the baseline risks of occupational injury are elevated. For these migrants, limited language skills can affect training and uptake of occupational health information, while employment in informal situations may pose additional risks. In this latter category, victims of human trafficking and smuggled migrants are also exposed to violence, trauma and restricted access to health care services (Gushulak & MacPherson, 2000). Also, female migrants trafficked or coerced into situations of forced labour or sexual exploitation may be at increased risk of work-related illness and injury, due to their vulnerability and exposure to gender-based violence (UNFPA, UNIFEM & OSAGI, 2005).

Inequities in health behaviour, outcomes and health care system use

As with host populations, inequities in health behaviour and outcomes for migrants are relative indicators created by the interaction of three basic variables: the person, place and time. The health behaviour and characteristics of younger Europeans, for example, frequently differ from those of the more elderly, who may have experienced different exposures to risks and availability of therapeutic or preventive interventions (Martínez, 2000).

Migration, however, introduces specific and separate influences that uniquely affect migrants. These influences are the consequences of four functional components of the process of migration. Each component influences health status and risk and also affects health outcomes and characteristics, as well as access to (and use of) health and medical services. Using a functional framework to approach the health of migrants allows for a uniform and integrated comparative analysis of migrant groups that initially appear to be diverse and different (Gushulak & MacPherson, 2006). A functional framework also provides a consistent method of quantifying differences between migrant and host populations. The four functional components are: the pre-migration phase, the movement phase, the arrival and integration phase, and the return phase, which are described below.

Phases

Pre-migration phase

Health conditions and environment – both physical and socioeconomic at the migrant's place of origin – decide many of the baseline health parameters and determinants of health in migrants. Exposure to disease and illness, as well as the capacity of local health care systems and the associated infrastructure, allow the development of health characteristics in migrants that differ from the host population in their new home. It is important to note that these differences may have connotations that are positive (for example, in the case of body mass index and cardiovascular diseases) or negative (for example, in the case of the prevalence of some infections and limited access to treatment). Migrant populations that arrive from low-income regions of the world and populations of poor or otherwise vulnerable at their place of origin are at higher risk for these pre-migration effects.

Refugees and those displaced from areas of conflict or a natural disaster are often fleeing persecution, violence and the collapse of local services and civil society (Toole & Waldman, 1997). Their health and subsequent need for health care on arrival will reflect conditions at their place of origin (O'Dempsey & Munslow, 2006).

Movement phase

The migratory journey itself may be an experience that directly affects the health of the migrant. The health risks of this phase of the migration process are most often observed in migrants in an irregular situation, refugees, and displaced people. Physical and environmental threats, lack of access to basic services and health care, and exposure to violence and trauma frequently accompany the movement of irregular migrants. Not surprisingly, the most vulnerable – women and girls, victims of human trafficking and smuggled migrants, and the economically disadvantaged – suffer the most (UNFPA, 2006). For vulnerable populations, this phase of migration is associated with high risks of death and serious morbidity. The morbidity and mortality associated with attempts to illicitly enter southern Europe by sea exemplify these health risks (EuropaWorld, 2007).

Arrival and integration phase

Following arrival at their destination, the health of migrants is influenced by the presence, accessibility and capacity of services in the host environment. The presence of culturally and linguistically appropriate therapeutic and health care services can affect health outcomes, as can the capacity of the health sector to provide services that prevent illness and promote health among diverse populations. It is at this phase that poverty and social exclusion exert their greatest effect on health outcomes.

Return phase

Sustained increased mobility of migrant populations sets modern migration apart from historical migrations. Globalization and the greater ease and affordability of international travel, in addition to returning geopolitical stability in areas of the world from which people were previously displaced, facilitate return travel. For situations and conditions where the patterns and determinants of health differ between locations, this travel can be associated with significant health risks (Wilson, 2003).

Migrants returning to visit friends and families are at increased risk of acquiring travel-related disease and illness (Angell & Cetron, 2005). This is particularly true for children born to migrant families in the EU who return to tropical and low-income regions. While their parents may have acquired local or herd (whole population) immunity to diseases as a consequence of exposure during their pre-migration residence, children born in locations where the incidence of these diseases is low lack this protection, and parents may not recognize the need for preventive actions to protect their children (van Gorkom et al., 1998). Also, there is increasing evidence that migrants who return to their places of origin for extended visits may be at increased risk of infection and subsequent importation of important infectious diseases, such as HIV (Sinka et al., 2003) and TB (Broekmans et al., 2002). International surveillance and monitoring programmes in the EU are documenting the increased risk of migrants acquiring and importing disease (Pistone et al., 2007).

Communicable diseases

All phases of the migration process influence the presence of communicable and infectious diseases in migrant populations. TB, AIDS, vaccine-preventable diseases and several parasitic diseases are unevenly distributed across the globe, and many of these infectious diseases have a higher prevalence and incidence in regions of the world where migrants destined for Europe originate. At the same time, public health practices and control measures in the EU have significantly reduced the prevalence of infections that still occur in the low-income regions of world. Screening for infectious diseases in migrants arriving in Europe varies according to national practice. Some countries require mandatory health assessments before departure from the country of origin or on arrival; others arrange for voluntary evaluation after admission (IOM, 2001). Also, screening protocols differ widely among European countries (Coker et al., 2004, 2006).

Vulnerable populations, such as migrants in an irregular situation, may be exposed to an increased risk of some infections during the movement phase of migration. This exposure may complicate recognizing and managing infections after arrival (Stauffer, Kamat & Walker, 2002).

The migration process can also influence the evolution of infectious diseases. For instance, there is evidence that multidrug-resistant TB can be linked: to incomplete treatment, as some migrants may return to their countries of origin for treatment and then not fully complete it before going back to the destination country; to increased immigration from countries with unsuccessful TB control; and to poor access to health care for some migrants in destination countries (Laserson & Iademarco, 2000; Menzies, 2000; Cox et al., 2004; Coker et al., 2004, 2006; Winje, Heldal & Pettersen, 2004; Infuso & Falzon, 2005; Faustini, Hall & Perucci, 2006; Munro et al., 2007). Finally, migrants may be exposed to an increased risk of infectious disease following arrival, particularly in situations of poor housing, overcrowding and where limited or restricted access to health care delays recognition, diagnosis and treatment of the disease.

As a consequence of these factors, several infections are overrepresented in foreign born populations in some EU countries, and because of differences in the pre-migration risk and exposure patterns of migrants, there are differences between EU Member States. For example, the risk of Chagas disease, a chronic, parasitic blood-borne infection common in parts of Central America and South America, is a more substantial issue in Spain than in other countries (Schmunis, 2007).

In global terms, the absolute numbers of some of these infections are low, but when they occur in locations where they are very rare or uncommon in the host population they can generate significant public health concern. Also, managing these infections in environments where their incidence is low can require extensive training and support for health care and

social sectors no longer familiar with them. Finally, in a global environment that has been sensitized recently to some of the dramatic consequences of infections of epidemic potential (such as severe acute respiratory syndrome and avian and pandemic influenza), the increased frequency of infectious diseases in foreign born populations can generate or support disproportionate concern that may further stigmatize some communities.

Poverty and socioeconomic exclusion play a great role in the natural history of these infections. Exposure and transmission is accentuated in the poor, those who live in crowded and substandard housing, those with nutritional imbalances and those with limited education or access to preventive measures.

Noncommunicable disease and illness

Similarly, non-infectious diseases and illnesses can be inequitably distributed among migrants. Prior to migration, access to and use of preventive or therapeutic medical services may not have been available to poor or otherwise vulnerable migrants in low-income regions of the world. As a result, conditions easily managed in high-income countries may be more advanced or less effectively treated in migrant populations. For example, screening for some malignancies may not have been accessible or available prior to migration for many migrants.

When compared with the host population, genetic and biological factors can result in some migrant populations being at higher risk of chronic diseases and illnesses. If these maladies have been historically rare or uncommon in the host population, their significance may not be appreciated or there may not be diagnostic or therapeutic intervention services that are available, or both.

Following arrival, health services that promote health or prevent illness may not be available or accessible, because of linguistic or cultural barriers, as they may not recognize migrants as groups with different risks. Also, poverty and social isolation may limit the use of preventive health services by those most vulnerable, particularly irregular migrant communities.

As noted in the above paragraph on the pre-migration phase, not all situations where the health characteristics and health determinants of migrants differ from those of the host population represent events where the migrants have negative or less desirable indicators. For several conditions and illnesses, for example, many migrants on arrival display better or more positive health indicators than those observed in the local or host population. Situations where migrants are noted to have more advantageous health indicators than those of the host population are known as the *healthy migrant effect* (Kennedy, McDonald & Biddle, 2006). Examples of this effect include positive advantages in body mass index, dietary practices, some sexually transmitted infections, the use of health services and self-reported health status (Hyman, 2001). Longitudinal studies in some countries that received a major influx of immigrants suggest that over time these positive advantages decrease and migrants begin to assume the characteristics of the host populations. Studies to this effect in Europe are limited, but there is growing evidence of the healthy migrant effect in several conditions (Darmon & Khlat, 2001).

Mental and psychosocial health concerns – including high rates of alcohol and drug abuse, depression, anxiety, and schizophrenia – are important and have been reported for certain migrant populations (Claassen et al., 2005). Traumatic experiences prior to departure or during the migration process, such as armed conflict, hunger and physical or sexual abuses, can pose a heavy burden on a migrant's mental well-being and may modify their way of experiencing exile. Once uprooted from their culture, migrants may suffer a sense of loss – loss of home, separation from family and community networks, and loss of sense of belonging – particularly in the case of forced migration. Following arrival, a variety of factors may increase psychosocial vulnerability and hinder successful integration. These factors include cultural differences, language barriers, racism and unemployment. Migrants in an irregular situation often live for prolonged periods in a state of uncertainty about their fate and have limited access to services (Martínez Moneo & Martínez Larrea, 2006). Some may even live in detention. These factors combine to make mental and psychosocial illness a major health concern for many migrants in Europe (Claassen et al., 2005).

It is important to note that the recognition, diagnosis and management of mental illnesses and psychosocial problems is highly dependent on the linguistic and cultural competency of the health care sector and that locations where these services are deficient or lacking may significantly underreport the true incidence of the problem (Bhugra, 2004). Studies on service utilization of mental health services by migrants demonstrate variations in service provision between European locations (Salvador-Carulla et al., 2005).

Child and adolescent health

Poverty and socioeconomic exclusion are among the most important influences on adverse outcomes in children. Poor health, educational shortcomings and diminished opportunities all show high correlation with poverty. Unique among health risks, poverty begins to exert its harmful effects before children are born, thus setting the stage for physical and neurological impairment, increased educational demands, and increased morbidity and mortality (Cook & Brown, 1993). Access to adequate health care for children is essential to support their growth and development. The early identification of the presence of abnormalities is crucially important to ensuring that treatment and interventions are introduced early to mitigate and prevent subsequent adverse effects. Childhood and adolescence are also the time when activities that promote health and prevent illness produce maximum results – when interventions can significantly affect risk taking behaviour, such as smoking, substance abuse and high-risk sexual activity.

Migrant children and children born into migrant families are at increased risk of several adverse health outcomes. The stresses of migration and seeking asylum, particularly in communities that have been traumatized or displaced can result in the early development of mental and psychosocial illnesses. Many adverse health outcomes are related to lack of access to services that promote health, prevent illness and provide dental care, while others result from poverty and exclusion. Once again, the most vulnerable are migrants in an irregular situation and those in single-parent families, particularly single-parent families headed by women. As noted in the section on the "Return phase", children born to migrant families from the tropical and low-income regions of the world are at increased risk of travel-associated disease and illnesses when they travel to their place of origin to visit friends and families.

Reproductive and sexual health

Mother-and-child health, reproductive health and sexual health represent important challenges for some migrant populations. For migrants in an irregular situation and other vulnerable groups, accessing prenatal care is a major public health issue. Studies in some EU countries indicate divergent outcomes for pregnancy and the first few weeks of postnatal care for some migrant populations (Troe et al., 2007). In some locations, their outcomes are similar to those observed in the host population, while in other locations the complications of pregnancy occur more frequently among some migrant communities (Yoong et al., 2004).

Poverty and marginalization can limit access to reproductive health services for migrants. Ensuring that migrants have early access to these services – which include those that promote health and prevent illness, screening and diagnostic care, and prenatal and obstetrical services – will reduce the risk of adverse outcomes (Gagnon, Merry & Robinson, 2003).

As noted elsewhere in this chapter, migrant women and girls, particularly those trafficked, forced to flee from conflicts or displaced, are often subject to gender-based violence. In this context, it is important to note that not all gender-based violence is sexual (Heise, Pitanguy & Germain, 1994).

Sexually transmitted infections, including HIV infection, are of concern in some migrant populations in some EU countries. Migrants originating from global regions with a high prevalence of HIV may represent populations at increased risk of the disease after arrival. Due to migration-associated vulnerabilities, migrants can also be at increased risk of exposure to HIV infection after arrival in their host country (Matic, Lazarus & Donoghoe, 2006).

Migration also creates situations where cultural and ethnic reproductive and sexual health practices and norms of behaviour may challenge or conflict with those in the host community. One well-recognized example is female genital mutilation (Finke, 2006), but there are other more subtle situations that have importance as well. Access to and use of contraception in the new community may differ significantly from patterns at the place of origin (Adamson et al., 2003). Also, migrants arriving from religious or culturally conservative environments may find traditional approaches to sexuality and behaviour challenged by their new place of residence. All of these factors may affect stress and family health in some migrant communities, in both adult and parent–child relationships (Blizzard, 2006).

In recognizing and managing reproductive and sexual health issues, health care providers require a level of cultural competency that may not be provided by current medical-education programmes in Europe (Dickenson, 1999).

Accidents, injuries and occupational health

As noted above (in the section on "Occupational health concerns and risks"), migrants may experience an increased risk of work-related injury and death for a number of reasons. Migrants in an irregular situation, including those smuggled into the EU, often work in informal arrangements that comply poorly with national and international labour standards. Working conditions are often poor, and the 3-D nature of much migrant work is associated with elevated risks of occupational injury and death (Trade Union European Information Project, 2004). Migrants in an irregular situation and the victims of human trafficking for forced labour are also frequently subject to violence and accidents.

For all migrants, limited language skills and lack of knowledge of (or experience with) occupational health and safety practices can affect health risks in the workplace. Some evidence indicates that foreign-born workers are at greater risk for on-the-job injury than host population workers. If they are injured at (or because of) work, migrants (particularly irregular migrants who work informally) may not be aware of the requirements of injury reporting to occupational health authorities. Also, they may be unaware of or may not have access to care, compensation or rehabilitation. As such, occupational health injuries in migrants may be significantly underreported.

Policy frameworks to address target-group socioeconomic status

International legal framework: international migration law instruments

WHO European Region Member States have recognized the right of everyone to attainable standards of physical and mental health. The right to health is not only the right to health care but includes the right to such preconditions for health as: adequate nutrition, housing and safe food; access to safe and drinkable water and adequate sanitation; safe and healthy working conditions and a healthy environment; and access to education and information related to health, including sexual and reproductive health.

Article 12 of the International Covenant on Economic, Social and Cultural Rights – ratified by all WHO European Region Member Sates, except Andorra – and Article 25 of the Universal Declaration of Human Rights are only two examples of articles recognizing the right to health at an international level (Pace, 2008). They are both provisions of international instruments that recognize the right to health as a fundamental human right and extend protection to non-nationals, as well as nationals. In particular, the Committee on Economic, Social and Cultural Rights, which supervises the implementation of this Covenant, emphasized in its General Comment on Article 12 that "… states are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services …" (Committee on Economic, Social and Cultural Rights, 2000).

Other international instruments that are spread across different branches of laws – such as human rights law, refugee law, international humanitarian law and labour law – address the right to health for specific categories of people involved in migration. An example of a core human rights instrument is the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. The Convention provides for the right to equal treatment of access to social and health services among regular migrant workers (Article 43) and members of their family (Article 45) and nationals. Its Article 28 recognizes the right to emergency medical treatment for all migrant workers and members of their families, regardless of whether their stay or employment is irregular or not (OHCHR, 2003; Schoukens & Pieters, 2004:12; Cholewinski, 2005:46; CE Parliamentary Assembly, 2006a,b).[1] In recognizing only necessary emergency medical treatment, however, the Convention fails to guarantee access to preventive medical treatment, such as early diagnosis and medical follow-up, not to mention that few countries in the WHO European Region have ratified it; among the Member States of the WHO European Region, ratification or accession has occurred only in six countries: Albania, Azerbaijan, Bosnia and Herzegovina, Kyrgyzstan, Tajikistan and Turkey (MacDonald & Cholewinski, 2007).

[1] In the CE Parliamentary Assembly (2006a) document Human rights of irregular immigrants: report of the Committee on Migration, Refugees and Population, the Rapporteur notes that "access to emergency health care is a minimum standard to be applied". This is in line with the right to life protected under Article 2 of the European Convention on Human Rights. However, there is no common understanding as to what urgent or emergency health care entails. A shift, however, can be noted from a strict interpretation of urgent care (essential treatment, which can not reasonably be delayed) to a more flexible one evolving "necessary care" on the basis of which doctors consider regular follow-ups and vaccinations also to be part of "urgent treatment" (Schoukens & Pieters, 2004:12).

Certain authors and policy-makers have argued that the present state of human rights law focuses on nationals and tries to be accommodating to non-nationals, as long as they are present lawfully; they have used Article 8 of the Declaration on the Human Rights of Individuals Who are not Nationals of the Country in which They Live to support their views. This Article states that only aliens lawfully residing in the territory of a state may enjoy the right to health protection and medical care. Nevertheless, Article 8 of the Declaration cannot supersede the interpretation of the International Covenant on Economic, Social and Cultural Rights, which accords economic, social and cultural rights to all people, regardless of legal status. The right to health as a fundamental human right certainly does not apply only to WHO European Region Member State nationals.

European legal framework: European Community law and CE instruments

While European Community law is binding, the same cannot be said of all CE instruments. Some of these instruments, such as the Convention for the Protection of Human Rights and Fundamental Freedoms, are binding while the various recommendations and resolutions are so-called soft law only. The CE, established in 1949, is a different organization than the EU. Its membership is also different: while the EU has 27 Member States as of 1 January 2007, the CE has a membership of 47 countries. The CE and EU, however, have worked in parallel and on a comparative basis.

Important CE instruments, such as the European Convention on Social and Medical Assistance and the European Social Charter, explicitly require that nationals of one contracting party lawfully present on the territory of another be afforded medical assistance on terms equal to those of nationals of the second party. The European Committee of Social Rights, which monitors the application of the European Social Charter, found that, despite the focus on lawful presence, "legislation or practice that denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter" (CE, 2005a). This stresses, once again, that the right to health is not reserved for nationals or certain groups, but applies to all individuals, nationals and non-nationals alike.

Furthermore, the CE Convention for the Protection of Human Rights and Fundamental Freedoms recognizes, in Article 3, the right to be free from torture and degrading and inhuman treatment. The Case Law of the European Court of Human Rights outlined that the denial of health care to migrants in an irregular situation may also amount to an infringement of this right. Article 3 has also been invoked to prevent migrants who are ill from being deported to countries of origin or third countries with inadequate health care facilities, as in the case of D. v. the United Kingdom (1997) and the case of B.B. v. France (1998), but the more recent decision under Article 3 in the case of Arcila Henao v. The Netherlands (2003) also has to be taken into consideration. Additionally, according to the Case Law of the European Court of Human Rights, a state's failure to provide effective access to health care for migrants in an irregular situation could also potentially result in a violation of Articles 2 (right to life) and/or Article 8 (right to respect for private and family life).

The CE Parliamentary Assembly has denounced the current unclear situation that results in irregular migrants "falling outside the scope of existing health and social services", stating that this represents "a major problem in the area of health care provision that requires close examination" (CE Parliamentary Assembly, 2000a, 2000b, 2001). In the EU, the EC has further stated that "illegal immigrants are protected by universal human rights standards and should enjoy some basic rights e.g. emergency healthcare and primary school education for their children" (EC, 2003). In practice, however, the irregular migrant is not granted a complete right to health in EU Member States. Some Member States grant limited rights to migrants in an irregular situation. In contrast, other Member States have various obstacles that obstruct the implementation of national legislation that guarantees irregular migrants' right to health. Health service providers should be prohibited from reporting the presence of irregular migrants to the authorities, and barriers to the enjoyment of the right to health should be addressed (PICUM, 2007).

Victims of human trafficking are also a vulnerable category. Council Directive 2004/81/EC, adopted by the EU in 2004, obligates all EU countries to provide by August 2006 a reflection period and residence permit to victims of human trafficking under limited circumstances (Malpani, 2006). Also, the CE Convention on Action against Trafficking in Human Beings (CE, 2005b) would require member states, if they ratified it, to provide a reflection period of 30 days to victims of human trafficking and, thereafter, to issue a renewable residence permit to victims of human trafficking if "the competent authority considers that their stay is necessary owing to their personal situation" or "the competent authority considers that their stay is necessary for the purpose of their co-operation with the competent authorities in investigation or criminal proceedings". With regard to the length of the reflection period granted, however, broad differences exist among countries. Moreover, to grant them such a permit, countries mostly require the victims to cooperate with law enforcement and criminal investigations. A longer reflection period that gives the victim the possibility to recuperate and to make an informed consent should be granted. Furthermore, assistance and protection should be provided, regardless of the trafficked person's willingness or capacity to testify against

his/her traffickers.

Finally, CE's non-binding instruments, such as recommendations and resolutions, also stress the importance of addressing migrants' health, recognizing the inequalities in health status and access to health services for people involved in migration (CE Parliamentary Assembly, 2000a, 2000b, 2001). The need for health care services to respond to the demand of people in marginal situations is also considered, in view of ensuring "equal access to social and health systems for everybody whatever his/her economic and legal status" (CE Committee of Ministers, 2001). Last, but not least, a recent recommendation focuses on health services in a multicultural society (CE Committee of Ministers, 2006); in it,

> The Committee of Ministers … recommends that the governments of member states: … promote an intersectoral and multidisciplinary approach to health problems and health care delivery in multicultural societies, taking into consideration the rights of multicultural populations; …embed health issues of multicultural populations in the legal framework as an integral part of the general health system; …

During the Eighth Conference of European Health Ministers, in 2007, health ministers of the 47 CE member states signed the Bratislava Declaration. This states that "Someone's health should not be a ground for any exception to the principles and standards embodied in international migration law" (CE, 2007). With regard to the enjoyment of the right to health of migrants in an irregular situation, the Bratislava Declaration highlights that: "The member states will ensure that irregular migrants are able to access health care services in accordance with international treaties as may be in force at the time and national laws and policies" and that the member states "encourage host countries to consider the invitation of the Parliamentary Assembly in the Resolution 1509 (2006) to eliminate any requirement on health service providers and school authorities to report the presence of irregular migrants to the authorities" (CE, 2007).

General policy framework

Policy frameworks specifically designed for and directed towards migrants in Europe generally reflect the temporal evolution of migration on the continent. In some instances, they address issues of adaptation, integration and accessibility of health services for migrants. Finally, the newly created European Centre for Disease Prevention and Control can be expected to deal with and address several issues about the public health of migrants. The new Centre will also play an important role in assisting in the application of migration-relevant aspects of the International Health Regulations and other global disease management activities.

Much of the legal and policy framework that has direct or indirect application or relevance to migrant health and socioeconomic status has been developed through addressing the needs of specific migrants. This reflects traditional approaches to historical patterns of migration, as well as the belief that the majority of challenges that result from migration are a consequence of regular or irregular movements, or both. Dealing with those groups is intended to address the greatest and most immediate needs. Cohesive, integrated approaches to the process of migration that encompass the general aspects of modern population mobility remain in their infancy, however.

Also, the competence to act in the field of public health and health care services is still primarily a national matter (Pace, 2007). Moreover, the responsibility for ensuring access to quality health care in the EU lies with the Member States, in line with the principle of territoriality. Nevertheless, direct EU influence is increasing. There have been efforts within the EU to mainstream health issues for such policy areas as social protection and employment, in line with the provision of Article 168 of the Consolidated Version of the Treaty on the Functioning of the EU (EU, 2008). Furthermore, there have been attempts to extend the EU's influence over health services and social regulation for the European single market and for trade issues. Additionally, the European Court of Justice has had various cases brought before it that relate to the four freedoms of the single European market (people, goods, services and capital) and decided that health issues are not exclusively national matters. Finally, Article 153 of the Treaty (EU, 2008) also acknowledges direct Union competence within the field of health, although it only allows for action that supports or completes that taken by Member States.

At the national level, health service demands posed by new arrivals vary between countries. Those receiving large numbers of new arrivals are faced with two sets of health and disease challenges. The first is managing the consequences of diseases that are imported with newly arriving migrants. While often limited in number, they may significantly affect local public health. Examples include the provision of adequate services to address: mother-and-child health; respiratory infections, such as TB; blood-borne pathogens, such as Chagas disease; and HIV and AIDS. In this context, exclusion and limits to access to care make for poor public health logic.

The second set of challenges involves maintaining the health of new arrivals. It is often more difficult to mobilize resources or provide services for these challenges than it is for the challenges of diseases already present in migrants when they arrive. This difficulty results from the benefits of health maintenance and promotion being evaluated in terms of reduced ill health and lower demands for health services in the future. Investing in future risk reduction can present political and programme hurdles. On a population basis, however, the increasing number of migrants in Europe will mean that activities directed towards preventing illness and promoting health will have increasing importance and relevance. For this reason, coordinated policies and programmes that focus on the long-term implications of health in migrants and that take into account the principles of migration will need to be developed.

Emerging know-how and policy implications for ensuring health

The Health and Migration in the EU: Better Health for All in an Inclusive Society Conference, held in Lisbon in September 2007, outlined the key emerging issues for EU Member States in this field. The Conference aimed to identify the main health problems that affect migrants in the EU, together with the determinants of their health status and ways to respond to their health needs. Underscoring the Conference proceedings were the ideas that access to health care by everyone must be seen as: a prerequisite to public health in the EU; an essential element of its social, economic and political development; and central to the protection of human rights.

The Conference recommendations underscored the need for coherent immigration policies that incorporate the health dimension at both the EU level and the Member State level. The recommendations maintained that the "health in all policies" approach should also be applied to migrant health and that the forthcoming European health strategy (Together for Health: A Strategic Approach for the EU 2008-2013) and European framework for health services should address migrant health issues. Also, Conference recommendations stated that "Health should also be considered a key component of integration and cooperation for development with the countries of origin", in an effort to strengthen the health systems of these countries (Ministry of Health, 2007).

The sections that follow cover the consideration, relevant to Member States throughout the WHO European Region, to support the recommendations that emerged from the Conference. These sections cover health system access, integrating health and social protection systems, addressing priority public health conditions among migrants, and areas that require further research and study.

Health system access

As noted, one of the characteristics of social exclusion is limited or restricted access to services, including health care. These obstacles to access may be administrative – for example, where city councils demand documents the migrants lack (but need) for registering within the municipality and obtaining services they are entitled to, such as health services. Also, administrative procedures for refunding the cost of treating an uninsured person, regardless of residence status, can be complex, expensive and lengthy (Pace, 2007). In Europe, the legal status of the individual does affect access to the health system of the receiving country. Other restrictions are functional, as exemplified by the lack of culturally or linguistically appropriate services. Fees for services delivered, including the provision of pharmaceuticals, are problematic for migrants affected by poverty, as well as for the working poor. Lack of adequate access can actually be associated with the need for increased health service utilization: migrants who are unable to access preventive or health promotional services may develop advanced or more serious illnesses and progress to levels of care that could have been prevented or managed with reduced cost had they been able to access care earlier. Moreover, early access to regular care and preventive care can reduce the use of hospital services (WHO Regional Office for Europe, 2006)

Because the issue of access within Europe is not uniform and because this non-uniformity arises for a variety of historical and legislative reasons, solutions and policy developments may not be equally applicable across the Region. Among other things, the diversity among migrant populations and their distribution across European countries presents differing location-specific challenges, and further complexity is introduced by immigration policies being national concerns.

Despite limited comparable data, the following generalizations are possible.

- Migrants in an irregular situation have limited or no access in practice to care.

- Regular migrants, however, may still require programmes and policies that improve access and sustain health, depending on specific population characteristics.
- Improving or granting access to care and services improves the health of these communities and prevents the progression of disease and disability.
- Denying or deferring care or access on the basis of immigration status only results in diminished health outcomes and greater long-term cost and service demands as diseases and illness progress to levels where emergency or urgent care is required.

All migrants, including regular migrants, can face functional limitations, which are often exacerbated or generated by poverty and social exclusion. In this situation access to care, while technically available, reflects service delivery patterns, programmes and policies designed for the host or mainstream population. Also, migrants with limited resources or who lack social mobility may not be able to travel to access care services. Moreover, specific issues related to the country of origin of migrants or the nature of being a migrant may not be integrated into the health sector.

As migrant populations grow, their demands will increase. As migrant populations in Europe grow, they further the case for pan-European collaboration on health issues in these communities. This collaboration will allow for the sharing of policies, standards and instruments required to support the health of migrants. Necessary instruments include: methods for assessing needs, service standards, education, and information strategies and materials; and methods for evaluating service delivery. Meeting these challenges requires policies to ensure:

- improved understanding of population diversity and greater recognition that health is a matter of the person, including their background and history of mobility, as opposed to nationality only;
- inclusion of migrant community participation in health service planning, programme design and delivery;
- more detailed epidemiological monitoring of health indicators, to identify regional and local areas of risk and/or needs for mitigation;
- adequate regionally and globally integrated health management strategies that bridge the needs between communities in the four phases of migration: source, transit, destination and return;
- introduction of global and migrant health curricula into training and continuing medical education programmes for the health care sector, including modules on the right to health and how it applies at the national level to migrants;
- education of researchers, policy-makers and those involved in social and economic planning on the health issues associated with migration; and
- investment and support of existing facilities to meet the needs of an expanding and diversifying patient population.

Integrating health and social protection systems

Studies of migrants have indicated that meeting the complex challenges of the populations affected requires coordinated multisectoral approaches from the large number of parties and stakeholders involved and also requires the multifaceted need profiles of migrants (Charles Watters, European Centre for the Study of Migration and Social Care, personal communication, April 2007). These integrated programmes and policies are based on the following principles.

Access and promotion

Migrants must have easy access to services, and the use of these services by migrants must be advised, recommended and supported by all the agencies, organizations and groups involved.

User involvement

Migrant communities themselves must be involved at all levels of programme planning and delivery, and health care providers from the communities should be actively recruited.

Multi-agency linkages

The complicated interrelationships between the multiple agencies, organizations and governments (regional, national, municipal and civic) involved require close and integrated working relationships. Also, many health issues have a social and/or economic basis and cannot be adequately managed by the health sector alone.

Continuity of service

Programmes for migrants require long-term sustainability. Short-term funding or service provision cannot be expected to produce long-term results.

Cultural sensitivity

Cultural and linguistic competence is an essential component of programmes and policies relevant to migrants.

Advocacy

Overcoming the limitations present in some migrant communities (such as financial and linguistic limitations as well as insufficient information on the existence of rights) often requires social advocacy, to build awareness and ensure that decision-makers appreciate the issues.

Evaluation

The diversity of migrant populations and the ongoing evolution of migration itself necessitate the ongoing evaluation of migrant-oriented programmes. Those designed for a particular community at a particular time may not be applicable to other locations or migrant groups, and outcome-based evaluation is required to demonstrate effectiveness.

Addressing priority public health conditions among migrants

Addressing public health conditions in migrants often requires examining the issue through a different lens than that normally used for host populations. Because many of the health concerns about migrants result from the effects of functional influences created by the process of movement between disparate health and social environments, planners and developers of national and regional approaches to dealing with conditions of public health importance for migrants need to take into account not only local epidemiology and demography, but also need to take into account the context of the condition, in terms of global factors (Schwartzman et al., 2005). Understanding these relationships is essential to developing health services specific to migrant communities.

Traditional approaches to public health in European countries are based on the use of education and information-dissemination programmes that promote health and prevent illness. These programmes are coupled with specific health interventions, when required, to reduce risk. The epidemiological basis for these undertakings is usually statistics for national health and disease. The same principles are often applied to migrants, who are frequently offered programmes and interventions designed for host populations. In the case of migrants, however, populations often originate in areas of the world where the risk factors, incidence of illness, or both are currently different from those of the host population or were different at the time migrants were born or resided there.

As a consequence of migrants originating from regions of the world where the prevalence of disease or health risk is (or was) elevated or reduced in comparison with the host population, they may require additional consideration. As noted earlier, while migrants now share the risks and exposure experienced by the host population, they also carry the legacy of risks of their previous life in locations of different health characteristics. Some of these imported risk factors, if they are of low prevalence in the host population, may be of great public health importance in migrant communities. This risk imbalance has significant implications for programmes based on host population epidemiology that have been (or are being) designed or delivered. For example, early screening and therapeutic intervention for some conditions, while of limited use in the host population, due to low prevalence (such as TB, anaemia, post-traumatic stress disorder and tropical infections), may be important aspects of programmes intended to improve and sustain the health of migrants and reduce secondary effects on health service utilization and resource allocation. The effects of poverty and social exclusion will complicate a migrant's need and capacity to access

and utilize services and programmes, and the implications of these important cofactors must be integrated into any migrant-specific programme.

When conditions are significantly different between locations of migrant origin and destination, the risk-imbalance analogy can be applied across the spectrum of conditions and situations of public health importance. Areas of current interest include both infectious and non-infectious public health matters, such as mental and psychosocial health, diet and obesity, the use of tobacco, preventive screening for malignant and nonmalignant disease (Modell et al., 2007), occupational health, mother-and-child health, reproductive health, and the approach to some infections – for example, hepatitis B, Chagas disease, TB, leishmaniasis and HIV infection.

Areas requiring further research and study

This short review, while outlining the basic issues related to health, poverty and migration in Europe, also reveals several areas where further investigation and analysis are required. International and regional comparisons and collaborative study into aspects of migrant health will require standardized data on (and definitions of) populations at risk.

Collaborative studies on the medical screening and evaluation of migrants, including examination of the policy frameworks behind screening and service provision practices, will be essential to support the development of best practices and Region-wide standards. In that vein, examining the experiences of those currently providing health services for migrants will be useful. Local tools and strategies used to increase or improve access for at-risk migrant populations exist at the clinic level or metropolitan level in many locations, and there is a growing network of clinics and facilities that provide services for migrants. Pooling this knowledge and building on existing experience will assist others in facing the challenges of providing services for migrants.

Discussion points and questions

1. What can be done to ensure that the right to health is formally recognized in national laws and that the practical obstacles to its enjoyment by all migrants, including those in an irregular situation, are eliminated?
2. How can the health component of immigration policies be strengthened?
3. How can data- and information-collection systems (covering, for example, country of birth, country of origin and duration of residence) be improved and standardized? In addition, what are data issues for the so-called second-generation immigrants?
4. Are there sufficient operational and policy tools to effectively address the medical, social and ethical health issues of temporary migrants, such as temporary migrant workers?
5. What are the lessons learned for effectively building and supporting cultural and linguistic competency in the health care delivery sector?
6. How can medical evaluation and screening of new arrivals be improved? These processes continue to vary according to national standards.
7. What ways are there at the national level to address perceived competing needs between disadvantaged non-foreign-born populations and disadvantaged foreign-born populations?
8. How can the epidemiological consequences of global inequity be better addressed? For example, it may be more effective to deal with some diseases (such as TB) at the place of origin rather than following migration. How can bilateral cooperation facilitate this?
9. How can civil-society associations and migrant communities be more involved in the design, implementation and evaluation of interventions?
10. What are the capacity-building needs of health professionals and policy-makers with respect to addressing the health of migrants?

11. How can the socioeconomic determinants of the health of migrants (including labour, housing conditions and access to social services) be better addressed and what is the role of the health sector in addressing them?

Acknowledgements

The authors would like to acknowledge the comments contributed by: Barbara Rijks, Regional HIV and AIDS Coordinator, IOM, Pretoria; Janet Hatcher Roberts, Director Migration Health Department, IOM, Geneva; Jillyanne Redpath, Senior Legal Officer, International Migration Law and Legal Affairs Department, IOM, Geneva; and Roumyana Petrova-Benedict, Senior Migration Health Manager, IOM, Brussels.

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25. Poverty and child health

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Summary

Child poverty across the European Region

Rates of child poverty vary widely across the Region. Among high-income countries relative poverty rates (children living in households with incomes less than 60% of the national median) vary from more than 20% in Greece, Ireland, Italy, Poland, Portugal, Slovakia and the United Kingdom to less than 10% in Denmark, Finland, Norway, Slovenia and Sweden. Among low- and middle-income countries, absolute poverty rates (households living on less than $US 2.15 per person per day) vary from more than 50% in Armenia, Georgia, Kyrgyzstan, the Republic of Moldova and Tajikistan to less than 10% in Bosnia and Herzegovina, Bulgaria, Montenegro, Serbia and the former Yugoslav Republic of Macedonia.

Children are more likely than the rest of the population to live in poverty, and some children (such as those living in single parent households or in households with no working adult) are at increased risk. Children in ethnic-minority households are also more likely to be poor.

Poverty is dynamic, and children move in and out of it. Those in chronic, persistent poverty are likely to be at greatest risk of adverse outcomes for their health.

Health risks associated with child poverty

Poor children are likely to be exposed to a range of risks to their health, including: deprivation of food, water, sanitation, adequate shelter, education, health care and parental care; and increased exposure to environmental pollution, adverse health-related behaviour, racism and discrimination. Children in absolute poverty in the low-income countries of the Region are exposed to malnutrition, inadequate water and sanitation, environmental pollution, and poor housing conditions. They are also more likely than their more fortunate peers to be deprived of affordable health care and parental care. While not subject to the same level of risk as children in absolute poverty, children in relative poverty in the high-income countries experience increased risks – particularly from the obesogenic environment, poor housing conditions, adverse health-related behaviour and, in the case of ethnic-minority children, racism and discrimination.

Inequities in child health outcomes and health system use

Poor children are at increased risk of most, but not all, of the common adverse child health outcomes. Poverty plays a major role in pregnancy outcomes, such as preterm birth and low birth weight, infant mortality, stunting and underweight in early

childhood, mental health disorders in later childhood and adolescence, and violence and accidents throughout childhood and adolescence. The greater risk among poor children relates to their greater exposure to the multiple risk factors for these outcomes.

Poor children in all countries of the Region are more likely to be born early, to have low birth weight and to die during the neonatal period. Mortality rates at all ages are higher among poorer children and young people, although the risk of fatal exposures varies with age – from preterm birth, low birth weight and inadequate prenatal care during the neonatal period to increased exposure to violence and road traffic in adolescence.

Tuberculosis and human immunodeficiency virus are increasing in some countries of the Region, notably the Russian Federation and Ukraine, and although data are limited on the association of child poverty with these diseases, evidence supports a link with increased poverty and social dislocation since these countries began the transition to a market economy.

Stunting and underweight remain common in the low- and middle-income countries of the Region, and children in the poorest fifth of the population in these countries are up to twice as likely to be stunted and wasted as those in the richest fifth. Also, obesity is becoming more common in most of the low- and middle-income countries although, currently, children in richer households are at greater risk. In contrast, there is evidence in high-income countries of increasing inequity in childhood obesity, with rates increasing faster among poor children. Data on other noncommunicable diseases that occur in childhood because of social circumstances are limited, but data available from the United Kingdom and the Nordic countries indicate that chronic physical illness, mental illness, and accidents and injuries are more common among poorer children. Also, teenage pregnancy and birth rates are higher among girls in poor households across the Region.

In some of the low-income countries of the Region, affordable health care has declined since the transition to a market economy, as a result of health reforms. The expenditure on health care in these countries has shifted markedly from the public to the private sector. Some countries in transition, however, have maintained high levels of access to health care and have increased public expenditure on health.

Data on children's access to health care in the high-income countries of the Region are limited. There is, however, evidence for the whole population of a pro-poor bias in the use of primary care services in most countries, alongside a pro-rich bias in the use of specialist services.

Existing policy frameworks to address child poverty and minimize risks to health

Among high-income countries, tax and social transfer policies are the most important factor that determines the level of relative child poverty. No country devoting 10% or more of its GDP to social transfers has a child poverty rate above 10%, and no country devoting less than 5% of its GDP to such transfers has a child poverty rate below 15%. Child poverty rates result from policy decisions and can be reduced by governmental action.

Benefits also have an important role in reducing child poverty in the low- and middle-income countries of the Region. However, rather than focusing on social protection, anti-poverty strategies have focused on economic growth and market reform in many transition countries. In many of these countries, market reforms have increased (rather than decreased) both poverty and health inequities.

Most EU countries have programmes aimed at addressing health inequalities. Programmes tend to focus on midstream and downstream interventions that aim to increase access to medical care and change behaviour, such as eating habits in poor communities, although some include upstream policies that aim to reduce poverty through redistribution and improved job and educational opportunities. Combining an upstream approach with midstream and downstream approaches is likely to be most effective in reducing inequalities. Also, health systems that ensure free health services for children – and special health promotion programmes that target disadvantaged communities and youth – play a role in reducing the adverse effects of child poverty on health.

Emerging know-how and policy implications

In March 2000, the Lisbon Special European Council: towards a Europe of Innovation and Knowledge identified key

policy priorities and challenges that address upstream determinants of health inequities, including increasing labour market participation, modernizing social protection systems, tackling educational and training disadvantages, eliminating child poverty, ensuring decent accommodation, improving access to quality services and overcoming discrimination. Also, among the low-income countries of the Region, the lessons of low-income countries that achieve good child health in other parts of the world could be applied to achieving high levels of maternal education, equitable distribution of the proceeds of economic growth and, for nutrition in particular, food subsidies.

The priority areas in which good evidence exists for effective interventions are nutrition, communicable diseases and accidents/injuries. Policy development to address these priorities is urgently needed in both the low-income and high-income countries of the Region. Finally, early childhood is a cornerstone of human development, and Member States need to continually improve the conditions for families to nurture their children, by addressing the need for economic security, flexible work, information and support, health, and quality child care.

Child poverty across the European Region

Definition and measurement of child poverty

Definitions of child poverty vary, but typically poverty measures use two types of poverty threshold: absolute or relative poverty lines (Bradbury & Jäntti, 2001). Absolute poverty lines define income thresholds below which people in specified family types are unable to purchase a bundle of goods and services thought to be an essential part of the basic necessities of life in the society in which they live. Relative poverty lines are ideally defined with reference to a measure of typical consumption level, but in practice they are usually set against household income. The final Copenhagen Declaration of the World Summit for Social Development in 1995 (United Nations, 1995) proposed a more comprehensive definition of absolute poverty and rejected the concept of relative poverty in favour of overall poverty. It also proposed that absolute poverty be defined as "a condition characterized by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to social services." Overall poverty was defined as "not having those things that society thinks are basic necessities or not being able to do things that most people take for granted".

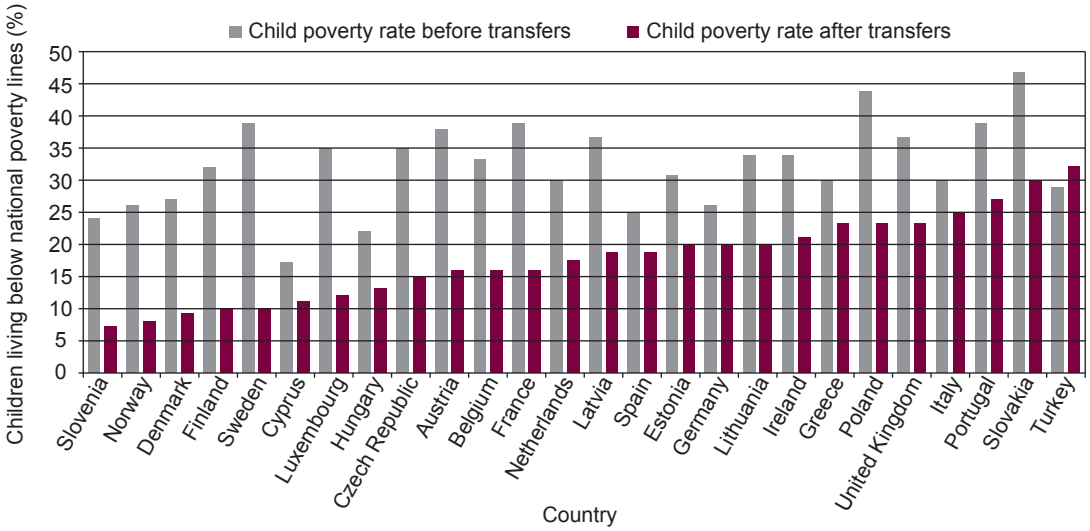
This chapter uses the specific absolute and relative poverty measures used for different countries and areas of the Region. For example, the measure of relative child poverty used across the EU is children aged 0–18 years living in households with incomes below 60% of the national median. In the low- and middle-income countries of the Region, measures of absolute poverty are used that are based on household incomes in dollars per day, analogous to the less than a dollar a day measure used in the world's lowest-income countries. For example, in Bulgaria, two measures of absolute poverty are used in a World Bank publication (World Bank, 2002): less than US$ 2.15 (adjusted for PPP) a day and less than US$ 4.30 (adjusted for PPP) a day.

The remit of this chapter is to examine the association between poverty and child health in the European Region. Where possible, comparisons are made between health outcomes of poor and non-poor children. These differences, characterized as inequities (inequalities that are unjust and unfair), are discussed for each group of health outcomes between and within countries. Although some data included in this chapter demonstrate stepwise gradients in child health outcomes across social groups, the significance of these gradients is not discussed specifically, as the chapter's main focus is the effect of poverty on children's health. Unless otherwise stated, the use of the word children refers to people aged 0–18 years.

National child poverty rates

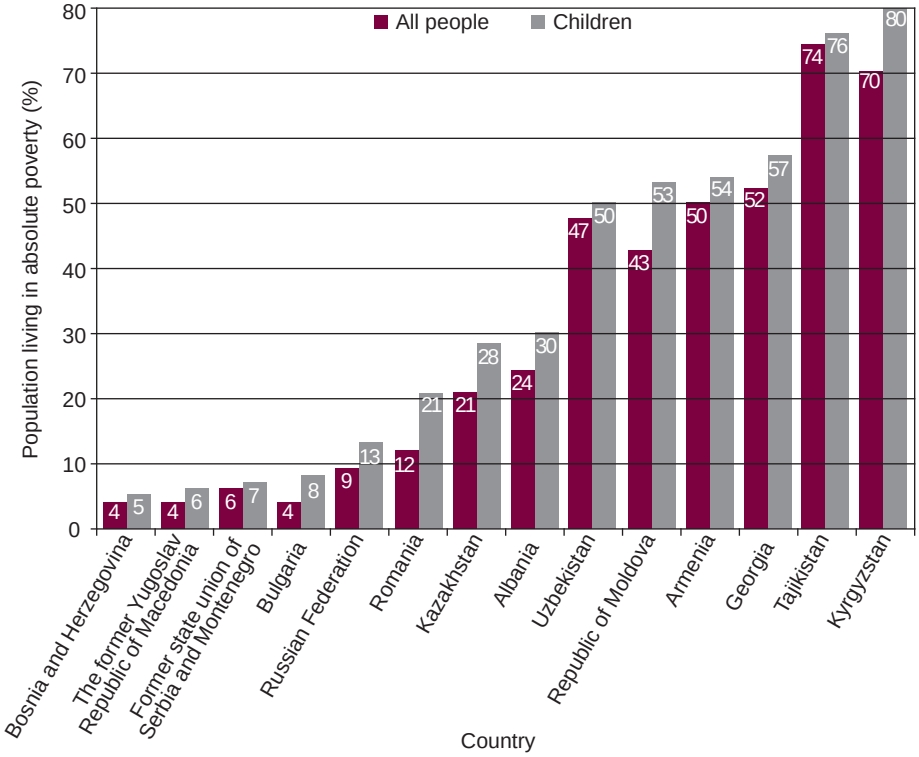
Fig. 25.1 shows the extent of relative child poverty (less than 60% of national median income) in countries of the European Region with very low child mortality and very low adult mortality (Sharma, 2007), and Fig. 25.2 shows the extent of absolute child poverty (less than US$ 2.15 (adjusted for PPP) a day) in countries of the Region with low child mortality and low or high adult mortality (Menchini & Redmond, 2006). The rates obtained by using relative and absolute measures are clearly not comparable in terms of living conditions, but they do demonstrate the extent of variation in child poverty across both the high- and low-income countries of the Region. Fig. 25.1 shows relative child poverty rates before and after cash benefits (transfers). The green bars (before transfers) represent the child poverty rates that would occur in these countries if no redistribution of income took place (see the section on "Existing upstream approaches"). The purple bars (after transfers) represent the actual

Fig 25.1. Relative child poverty rates before and after transfers in European countries



Source: Eurostat (2003a,b); Sharma (2007:10). Reproduced with the permission of the copyright holder.

Fig 25.2. Per cent of 0–15-year-olds and all people living in absolute poverty,[a] CCEE/NIS[b], 2002–2003



[a] Data refer to all persons and children aged 0–15 living in households where current household consumption is less than PPP $2.15 per person per day. Data are calculated from Household Budget Surveys and Living Standards Measurement Surveys.

[b] CEE/NIS is the term used by UNICEF for what WHO calls CCEE/NIS (as used by WHO throughout the report).

Source: Adapted from UNICEF (2006a:26). Reproduced with the permission of the copyright holder.

child poverty rate in 2003 in the countries included. Among the high-income countries, Ireland, Italy, Portugal, Slovakia and the United Kingdom have high levels of child poverty compared with the cluster of mainly Nordic countries (Denmark, Finland, Norway and Sweden) and Slovenia where, by the EU definition, few children live in poverty.

From Fig. 25.2, it is evident that the central Asian countries (such as Kyrgyzstan and Tajikistan) have very high rates of absolute child poverty, whereas rates are much lower in the Balkan states of Bosnia and Herzegovina, Montenegro and Serbia; these differences are likely due to greater economic development combined with more effective social protection measures in the Balkan states. These differences in child poverty rates are important to understanding the wide differences in health status between children across the Region. From Fig. 25.2, it is also evident that children are more likely to be living in absolute poverty than adults in CCEE and NIS countries (together: CCEE/NIS). The tendency for children to be more likely than other population groups to live in poverty is also seen in the high-income countries of the Region (UNICEF, 2005a).

Within countries, some children have higher risks of impoverishment than others. In all countries of the Region, children in single-parent households are at greater risk of impoverishment (UNICEF, 2005a, 2006a). Children in households characterized by no working adult (UNICEF, 2005a) or refugees, and children in some ethnic minority groups, are at high risk of impoverishment. In the United Kingdom, 58% of children of Bangladeshi and Pakistani origin lived in poverty, compared with 18% of children of European origin (Platt, 2007). In the CCEE, Roma children have a high risk of living in poverty – for example, in Bulgaria in 2001, the poverty rate among Roma was 61.8%, compared with 5.6% for ethnic Bulgarians (World Bank, 2002). In the low-income countries of the Region, children living in rural areas are more likely to be poor than children living in urban areas (UNICEF, 2006a).

Poverty is dynamic. Depending on changing social and economic conditions and parental employment, children can move in and out of poverty. Relative child poverty increased sharply in the United Kingdom during the 1980s, as a result of profound social and economic changes. In some of the former socialist countries, the transition to a market economy increased absolute child poverty rates (UNICEF, 2006a). In Belarus, poverty among children under 6 years of age rose to 55.3% in 1995 and to 61.3% in 1999, but fell again (to 28.6%) by 2004 (UNDP & Government of the Republic of Belarus, 2005). In Belarus, between 1995 and 2004, 61.5% of the child population that never lived in poverty experienced poverty that lasted 3 months on average; 7.7% experienced poverty that lasted at least 12 months; and the remaining 30.8% experienced transient poverty (UNDP & Government of the Republic of Belarus, 2005).

Movement in and out of poverty also occurs in more settled economies. A study in the United Kingdom (Magadi & Middleton, 2005), using data collected between 1994 and 2002, reported that: 53% of children were never in poverty during this period; 18% were in poverty for fewer than three years and had not suffered severe poverty (household income below 27% of the median household income); 4% were in short-term severe poverty, 18% experienced three years or more of poverty, but none in severe poverty; and 7% experienced three years or more of poverty and at least one year in severe poverty.

Health risks associated with child poverty

Historically and globally, poverty constitutes one of the greatest threats to the health of children (Spencer, 2000). Poverty exerts its effect on children's health through a range of risks to which children living in poverty are likely to be exposed. The major exposures associated with poverty that create risks to health can be defined as basic human needs that are not met (Gordon et al., 2003) and additional exposures. The basic human needs that are not met include:

- housing
- safe drinking water
- sanitation facilities
- food/nutrition
- education
- health care.

Additional exposures result from:

- environmental pollution
- adverse health-related behaviour
- deprivation of parental care
- racism and discrimination.

The type, extent and effect of exposures associated with poverty that create risks to health will vary between populations of children, between localities and between individual children. In this chapter, these exposures are discussed in relation to two broad groups of countries in the Region: the lower-income countries of central Asia, south-eastern Europe and the NIS (referred to collectively as CCEE/NIS in the remainder of the chapter) and the high-income countries of western and northern Europe, including the newest Member States of the EU.

Although the study of child poverty in low-income countries by Gordon et al. (2003) did not include any countries in the European Region, it contains useful definitions of deprivation, ranging from mild to extreme, of basic human needs (Gordon et al., 2003:8, Table 2.1). These definitions, with some modification, can be applied to children living in absolute poverty in the low-income countries of the Region.

Housing deprivation

Many children in the low-income countries of the Region experience significant levels of housing deprivation. For example, 39% of children in the poorest quintile of rural households in Albania live in houses with more than three people per room (UNICEF, 2006a:57, Table 3.16), which is consistent with the definition by Gordon et al. (2003) of moderate housing deprivation. The problem of housing deprivation is different in the higher-income countries. Levels of overcrowding may be less severe than in the low-income countries, but in relative terms poor children in the high-income countries tend to live in more crowded and poorer accommodations than their more advantaged peers. In a study of Britain's poorest children between 1994 and 2002 (Magadi & Middleton, 2005), poor children were found to be more likely to live in houses with damp walls, rot on the window frames and floors, and a shortage of space.

Homelessness also affects poor children across the Region. In the low- and middle-income countries, homelessness is likely to take a more extreme form, with children living on the streets. In Ukraine, 130 000 children are reported to be living on the streets (Sewall, 2007). In the high-income countries, few homeless children live on the streets, but they may be living in hostels, as a direct result of domestic violence or shortage of social housing. In the United Kingdom, this type of homelessness rose to 169 291 in 2002 (Bradshaw, 2005).

Water and sanitation deprivation

Moderate deprivation of safe drinking water, as defined by Gordon et al. (2003), applies to more than 80% of rural households in Azerbaijan, the Republic of Moldova and Romania (UNICEF, 2006a). Water deprivation is highest in the poorest fifth of the child population (UNICEF, 2006a). Also, fewer than 50% of rural households in Azerbaijan, Romania, Tajikistan and Uzbekistan have improved sanitation coverage, defined as connection to a public sewer or septic system or use of a pour–flush latrine, simple pit latrine or ventilated improved pit latrine (UNICEF, 2006a:58, Table 3.17). Although the definitions differ somewhat, children in these households would be defined as moderately deprived of sanitation facilities by Gordon et al. (2003). Poor children in the high-income countries of the Region do not tend to suffer water or sanitation deprivation.

Food/nutrition deprivation

Moderate to severe food deprivation, as defined by Gordon et al. (2003), affects many children in the Region. Stunting, one of the most significant consequences of chronic malnutrition, was found in more than 30% of children younger than 5 years in Albania, Tajikistan and Uzbekistan in 2002/2003 (UNICEF, 2006a:45, Table 3.4). Obesity is not established yet as a major nutritional problem in most low-income countries; but in those countries for which data are available, between 2% and 6% of children younger than 5 years are overweight, with Uzbekistan an apparent exception, with a higher level of 14.4% (UNICEF, 2006a) (for further discussion, see the section on "Inequities in noncommunicable diseases").

In the high-income countries of the Region, few children experience malnutrition, although children in British families that experienced long-term poverty were less likely than those in non-poor families to be able to afford meat, fish or chicken every other day (Magadi & Middleton, 2005). In contrast, obesity is a major public health nutritional problem in the high-income European countries, and there is increasing evidence that poor children and adolescents are more vulnerable to obesity (DH, 2003; Romon et al., 2005) (for further discussion, see the section on "Inequities in noncommunicable diseases").

Educational deprivation

Few children in the Region suffer from significant educational deprivation, as most countries have high levels of primary and lower secondary school enrolment for both boys and girls. Prior to the transition to a market economy, there were no gender differences in education in the CCEE/NIS, and the situation remains broadly the same except for evidence that families in rural Uzbekistan are reluctant to allow girls to travel unaccompanied to school (UNICEF, 2006a). Enrolment rates fall off sharply in some countries in the 15–17-year-old age group, with rural and poorer children less likely to enrol, particularly in the CCEE/NIS. Also, the availability of preschool facilities has declined in countries where it was high – such as the former Soviet republics, Bulgaria and Romania – and, as with higher secondary education, rural and poorer children are least likely to enrol (UNICEF, 2006a).

Enrolment rates in primary and lower secondary education are close to 100% in all the high-income countries of the Region. Enrolment rates among preschool children and young people 15–19 years of age, however, vary widely in these countries: rates of preschool enrolment are high in Denmark, other Nordic countries and France and, until recently, relatively low in the United Kingdom (Reale, 2005); in Belgium and the Czech Republic, more than 90% of young people aged 15–19 years were in full- or part-time education, compared with 75% in Austria and the United Kingdom (UNICEF, 2007).

Health care deprivation

The CCEE/NIS had a long tradition of delivering universal health care, and elements of this tradition remain intact, as witnessed by the high levels of immunization in all but a few of these countries (UNICEF, 2006a:46, Table 3.6). Health reforms and the transition to a market economy, however, have resulted in reductions in public expenditure on health care in some countries, with the result that many children in poor families now experience what the World Bank has termed "deprivation of affordable access to quality services" (UNICEF, 2006a:49). The impact of these reforms is further exacerbated by the increased health needs that result from social dislocation.

Children in high-income countries generally have access to quality health care, independent of income, so that poor children do not suffer health care deprivation although, as discussed below (in the section on "Integrating health and social protection systems"), access for marginalized groups (such as disadvantaged rural populations, ethnic minorities and illegal migrants) may be limited.

Environmental pollution

Underdevelopment and poverty are strongly related to the burden of disease attributable to environmental factors, and this is especially true for children (WHO Regional Office for Europe, 2004a). Children in the low- and middle-income countries of the Region are exposed to high levels of environmental pollution, particularly outdoor air pollution, indoor air pollution from indoor solid fuel use, and lead (Valent et al., 2004). Rates of air pollution, both outdoor and indoor, are particularly high in the Eur-B+C subregion reference group[1] that includes the central Asian countries and Turkey (Valent et al., 2004). Young children (including the fetus) are particularly susceptible to the effects of air pollution, and air pollution has been linked to impaired lung development, infant mortality, and increased upper and lower respiratory disease among children (WHO Regional Office for Europe, 2004b). Exposure to toxic substances in air, water, soil, and the food chain constitute an emerging (but relatively under-researched) threat to children's health, especially in areas already affected by underdevelopment and poverty (International Programme on Chemical Safety, 2006).

Although environmental pollution affects children in the high-income countries of the Region, outdoor and indoor air pollution levels and lead levels tend to be lower than in the low-income areas (Valent et al., 2004). However, injury rates related to exposure to traffic and other hazards are higher in the high-income countries of the Region than in the subregion that includes the central Asian countries and Turkey, but they are lower than those in the subregion that includes the Eur-B+C countries of the former USSR (Valent et al., 2004).

[1] WHO designated 25 countries with low child mortality and low or high adult mortality as the reference group Eur-B+C. This group comprises Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Poland, the Republic of Moldova, Romania, the Russian Federation, Serbia and Montenegro, Slovakia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine and Uzbekistan. Please note that the state union between Serbia and Montenegro ended on 3 June 2006 when Montenegro declared its independence.

Adverse health behaviour

Smoking

Smoking rates are generally high among men, but low among women in the low- and middle-income countries (Bozicevic, Gilmore & Oreskovic, 2004). Bosnia and Herzegovina, Montenegro, and Serbia are exceptions, with adult female smoking rates higher than the EU average (Bozicevic, Gilmore & Oreskovic, 2004:10). In contrast to the high-income countries of the Region, the evidence from a limited number of studies in Albania and Bulgaria suggests that smoking rates are higher among women with higher educational qualifications and among those in urban (compared with rural) areas (Bozicevic, Gilmore & Oreskovic, 2004). The pattern of smoking among women in northern European countries is strongly social, with smoking rates increasing with increasing material disadvantage (Graham, 1996). Until recently, in the high-income southern European countries, smoking rates were higher among more educated women, but there is evidence that the social patterning is changing towards that of the northern European situation (Graham, 1996; Schiaffino et al., 2003). The pattern of smoking during pregnancy is strongly social in most countries for which data are available, with disadvantaged women more likely to continue to smoke and smoke more heavily (Cnattingius, 2004).

In nearly all the 38 European countries included in the European School Survey Project on Alcohol and Other Drugs (ESPAD), over 50% of young people aged 16 years in 2003 had tried cigarettes at least once (Hibell et al., 2004). The highest rates were found in the Faroe Islands (83%), followed by Austria, Lithuania and the Czech Republic (all higher than 80%). The lowest rates (46–52%) were found in Cyprus, Greece, Iceland, Malta and Turkey (Hibell et al., 2004). The geographical pattern for lifetime consumption of 40 or more cigarettes is similar, with the highest prevalence being about 40% in Austria and the lowest being 13% in Turkey (Hibell et al., 2004). In most countries, prevalence rates were higher among boys.

Smoking rates among young people in those low-income countries for which data are available are similar to rates in the high-income countries of the Region, with some exceptions – girls (15–16 years) in Romania have lower rates (10%) and those in Bulgaria higher rates (38%) (Bozicevic, Gilmore & Oreskovic, 2004). Also, boys tend to have higher rates than girls, with the exception of Bulgaria (38% of girls versus 35% of boys) (Bozicevic, Gilmore & Oreskovic, 2004).

The social pattern of smoking among adolescents is not the same as that among adults. Data from Germany suggest that low family affluence affects regular smoking among young people aged 11–15 years (Richter & Leppin, 2007), but this is not a consistent finding across Europe (Hibell et al., 2004). Based on a Scottish study, Sweeting & West (2001) suggest that, although there are few social class differences in smoking rates among adolescents, if the quantity smoked and the frequency of smoking are taken into account, then lower social groups have heavier consumption.

Alcohol

The majority of adolescents 11–15 years in the 34 mainly European countries included in the Health Behaviour in School-aged Children study, a WHO collaborative cross-national study, reported never having drunk alcohol or been drunk (Elgar et al., 2005). Among those who had consumed alcohol, 19.9% reported drinking less than once a week, 8.6% once a week and 6.2% two or more days a week (Elgar et al., 2005). Also, 28.6% reported being drunk on at least one occasion (Elgar et al., 2005). In contrast, in the 2003 ESPAD study (Hibell et al., 2004), more than 90% of 15–16-year-olds in almost all countries were reported to have drunk alcohol at least once. The only exception was Turkey, with a lifetime use of alcohol of 45%. Rates of being drunk also tended to be higher in the ESPAD study. In eight countries (Austria, the Czech Republic, Denmark, Estonia, Ireland, Lithuania, Ukraine and the United Kingdom) and the Isle of Man, more than 75% of 15–16-year-olds reported being drunk at least once (Hibell et al., 2004). The different findings of these two studies are likely to reflect methodological differences and variations by age group.

The ESPAD study reported little change in rates of drinking alcohol and drunkenness among both boys and girls in Europe between 1999 and 2003 (Hibell et al., 2004), but other sources report increases (WHO Regional Office for Europe, 2006a). In the Baltic countries, over the 10-year period of transition from 1993–2002, alcohol drinking and drunkenness among adolescents 11–15 years of age doubled (Zaborskis et al., 2006). The evidence for a social pattern of alcohol consumption and drunkenness among adolescents is mixed (Hibell et al., 2004). For example, adolescent boys aged 11–15 years in low-income households in Croatia, Hungary, Portugal, the Russian Federation and Sweden were less likely to get drunk at least twice than their more privileged peers; but in Estonia, Germany, Latvia and Scotland, boys from middle-income households were the least likely to get drunk (Richter, Leppin & Nic Gabhainn, 2006). Moreover, family affluence had no effect on the likelihood of drunkenness among girls (Richter, Leppin & Nic Gabhainn, 2006).

Illicit drugs

Cannabis is by far the most common illicit drug used by young people aged 15–16 years in Europe (Hibell et al., 2004). In the ESPAD study (Hibell et al., 2004), rates of lifetime use varied from 44% in the Czech Republic to 3–7% in Cyprus, Greece, Romania, Sweden and Turkey. Use of cannabis in the preceding 30 days was used in the study to identify regular users: rates varied from 19–22% in the Czech Republic, France, the Isle of Man, Switzerland and the United Kingdom to 1% or less in Romania and Sweden (Hibell et al., 2004). Boys were more likely to use cannabis than girls in all countries studied. Ecstasy is the next most common drug that young people have taken, but levels of lifetime use are relatively low. There is no consistent pattern, however, of an association between poor social circumstances and illicit drug use. For example, in 22 of the countries included in the ESPAD study, the family economic situation was not associated with different rates of cannabis use; in 2 other countries in the study, poorer children were more likely to use cannabis, and in 7 other countries in the study, more-privileged children had higher rates (Hibell et al., 2004).

Deprivation of parental care

Children across the Region are vulnerable to deprivation of parental care, and poor children are the most vulnerable. In all countries, child abuse and neglect, marital conflict, and violence are important markers of deprivation of parental care. Many children that have experienced deprivation of parental care remain within the family home; all countries, however, have systems of state intervention to protect children. In the high-income countries, foster parents and adoption have replaced institutional care as the preferred means of social care for children deprived of parental care. In the low- and middle-income countries of the Region, rates of institutional care have remained high and are associated with lower levels of health expenditure (Browne, 2005). Across the low-income states of the CCEE/NIS, care in orphanages and institutions for disabled children is associated with poverty, social marginalization, single motherhood, migration of one or more parents, chronic illness and childhood disability (UNICEF, 2006a). Similar factors have been shown to influence admission to social care in the United Kingdom (Bebbington & Miles, 1989).

Racism and discrimination

There is increasing evidence that racism and discrimination have adverse effects on pregnancy outcomes and child health (Caughey, O'Campo & Muntaner, 2004; Mustillo et al., 2004). In many European countries, children in ethnic minority groups are more likely to live in poverty (see the section on "National child poverty rates"). The effect of discrimination is not only felt in relation to income (World Bank, 2002; Platt, 2007), but is also felt in many other aspects that influence child health and development. In the United Kingdom, children in ethnic minority groups, particularly those of Pakistani–Bangladeshi origin, are more likely than children of European origin to experience problems of overcrowding, substandard housing and social exclusion (Platt, 2007). In Portugal, school-aged children of migrant families experience high levels of discrimination that affect their well-being and mental health (Matos, Gaspar & Gonçalves, 2004). In Bulgaria, Roma children are more likely than non-Roma children to live in overcrowded conditions with no flush toilet; no wood, coal or kerosene for cooking and heating; and no telephone connection and no connection to public sewerage (World Bank, 2002:16, Table 25.10).

Inequities in health outcomes and health system use

Inequities in child health outcomes

As a result of increased exposure to health-related risks, poor children are much more likely to suffer a range of poor health outcomes. In addition to an increased risk of death throughout childhood, the health problems in which poverty plays a major role are low birth weight and short gestational age, communicable diseases (such as tuberculosis), chronic illness, disorders of growth related to poor nutrition (such as stunting, underweight and obesity), and exposure to injury and violence.

Inequities in birth weight and gestational age

Inequities at the country level

Weight at birth and duration of pregnancy are important determinants of infant mortality and morbidity, and they also have an effect on health in later childhood and adulthood (Barker, 1998; Spencer, 2003). Low-birth-weight rates (less than 2500 g) vary between and within countries. Data on duration of pregnancy and preterm birth are not readily available for most countries, but there are data from Sweden and the United Kingdom on the effect of low income on preterm birth (see the section on "Inequities within countries").

Low-birth-weight rates vary across the high-income countries of the Region, from 3.2% in Iceland to more than 8.0% in Greece and Hungary (UNICEF, 2007). The high-income countries with high levels of child poverty tend to be those with high levels of low birth weight (Pearson correlation coefficient $r = 0.48$, $P < 0.05$). Among the lower-income countries of the Region, rates vary from 5% in the Republic of Moldova to 16% in Turkey and 15% in Tajikistan (UNICEF, 2006b). Differences in the definition of live and viable birth may partly explain variations in rates across the Region.

Inequities within countries

Social gradients in pregnancy outcomes, including preterm birth (less than 37 weeks gestation), intrauterine growth retardation and low birth weight, have been reported in many European countries (see Table 25.1) (Sanjose, Roman & Beral, 1991; Arntzen et al., 1994; Olsén et al., 1995; Rodriquez, Regidor & Gutierrez-Fisac, 1995; Koupilová et al., 1998, 2000; Helweg-Larsen, Olsen & Madsen, 1999:41; Brundred et al., 2003; Grjibovski et al., 2003, 2005; Danishevski et al., 2005). In most of these studies, maternal education was used as the measure of social stratum, but in all these countries the group with the lowest level of education tends to be the poorest, and adverse outcomes were higher in these groups. Studies of mean birth weight by social group in England (Spencer et al., 1999; Brundred et al., 2003), Estonia (Koupilová et al., 2000), the Russian Federation (Grjibovski et al., 2003) and Sweden (Elmén et al., 1996) showed similar social gradients, with differences between the lowest and highest social groups of between 180 g and 200 g.

Studies in England (Brundred et al., 2003; Smith et al., 2007) have shown marked social gradients in very low birth weight (less than 1500 g) and very preterm birth (22–32 weeks gestation). These are the babies at greatest risk of death and disability. Babies born to mothers living in the most deprived decile were almost twice as likely to be born very preterm (Smith et al., 2007). There was no evidence of an increasing social difference in very preterm births during the 10-year period studied (Smith et al., 2007), but the study of very low-birth-weight babies (Brundred et al., 2003) suggested that the difference in rate between the least and most deprived quartiles increased between 1990 and 2001.

Table 25.1. Social gradients in pregnancy outcomes by socioeconomic status in selected countries

Country, year (source)	Measure of socioeconomic status	Preterm birth (% live births)	Intrauterine growth retardation (% live births)	Low birth weight (% live births)
Czech Republic, 1989–1991 (Koupilová et al., 1998)	**Maternal education**			
	Primary	8.4	ND	ND
	Vocational	4.4	ND	ND
	Secondary	3.6	ND	ND
	University	3.5	ND	ND
Denmark, 1991–1992 (Helweg-Larsen, Olsen & Madsen, 1999:41)	**Maternal education**			
	8 years	ND	ND	8.3
	9 years	ND	ND	6.4
	10–11 years	ND	ND	5.7
	> 11 years	ND	ND	4.0
Estonia, 1992–1997 (Koupilová et al., 2000)	**Maternal education**			
	Basic or less	7.8	ND	ND
	Secondary	5.2	ND	ND
	Higher	4.8	ND	ND
	University	3.9	ND	ND
	Unknown	8.3	ND	ND

Country, year (source)	Measure of socioeconomic status	Preterm birth (% live births)	Intrauterine growth retardation (% live births)	Low birth weight (% live births)
Finland, 1985–1986 (Olsén et al., 1995)	**Maternal education**			
	≤ 8 years	6.2	ND	ND
	> 8 years	4.3	ND	ND
	Occupational socioeconomic status			
	Unskilled manual	5.6	ND	ND
	Skilled manual	4.8	ND	ND
	Non-manual	4.2	ND	ND
Norway, 1978–1982 (Arntzen et al., 1994)	**Maternal education**			
	< 10 years	ND	ND	6.0
	10–12 years	ND	ND	4.4
	13–15 years	ND	ND	3.8
	> 15 years	ND	ND	2.9
Spain, 1988 (Rodriquez, Regidor & Gutierrez-Fisac, 1995)	**Paternal occupation**			
	Manual	3.4	ND	ND
	Non-manual	2.7	ND	ND
Sweden, 1989–1991 (Koupilová et al., 1998)	**Maternal education**			
	Primary	6.4	ND	ND
	Vocational	5.5	ND	ND
	Secondary	4.9	ND	ND
	University	4.5	ND	ND
Russian Federation, 1999 (Grjibovski et al., 2003, 2005	**Maternal education**			
	≤ Secondary	9.2	ND	ND
	Vocational	6.4	ND	ND
	Unknown	5.1	ND	ND
	University	1.1	ND	ND
Russian Federation, 2000 (Danishevski et al., 2005)	**Maternal education**			
	≤ Secondary	ND	ND	10.8
	Secondary general	ND	ND	6.9
	Secondary specialized	ND	ND	4.5
	Incomplete higher	ND	ND	3.7
	Higher	ND	ND	4.5
United Kingdom (England), 2001 (Brundred et al., 2003)	Small-area index of deprivation			
	Most deprived quartile	ND	7.0	ND
	Least deprived quartile	ND	3.5	ND
United Kingdom (Scotland), 1981–1984 (Sanjose, Roman & Beral, 1991)	**Maternal occupation**			
	Manual	5.6	6.3	ND
	Non-manual	4.6	4.6	ND
	Paternal occupation			
	Manual	4.8	5.1	ND
	Non-manual	3.9	3.4	ND

ND = not determined.
Source: Adapted from Spencer (2003). Reproduced with the permission of the copyright holder.

Inequities in mortality in infancy, childhood and adolescence

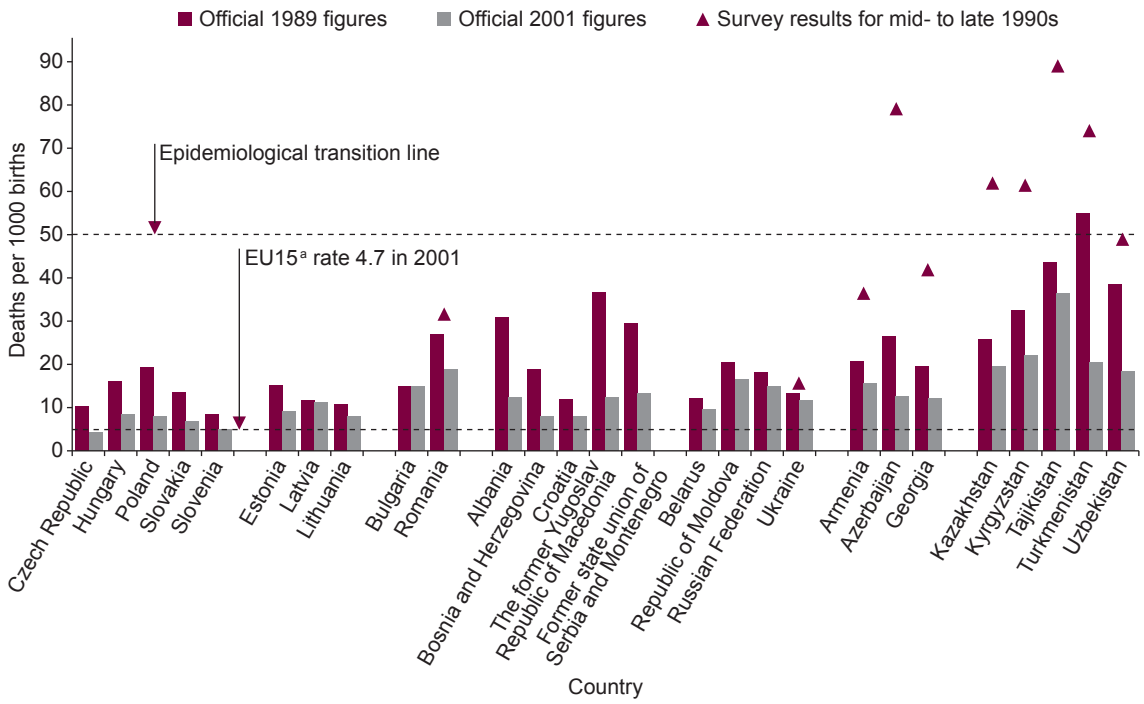
Given the effect of poor social circumstances on pregnancy outcomes, it is unsurprising that poor children are more likely to die in infancy.

Country level

At the country level, there is a weak correlation of relative child poverty with the infant mortality rate in high-income countries of the Region ($r = 0.47$, $P < 0.05$). Fig. 25.3 shows that, among the low-income countries of the Region, official figures for the infant mortality rate are likely to be underestimated; however, even when the official 2001 figures are used, there is a strong correlation ($r = 0.71$, $P < 0.01$) of absolute poverty rate for children in each country (see Fig. 25.2) with the infant mortality rate.

Among the high-income counties of the Region, Italy and Portugal have better infant mortality rates than would be predicted from their relative child poverty rates, and the Netherlands performs worse than expected. These exceptions may be due to other factors that confound the relationship between poverty and infant mortality rate. In the central Asian republics, the infant mortality rate is high, as would be predicted from their high absolute child poverty rates. Fig. 25.3 also shows the difference between official and survey estimates in some states of the CCEE/NIS for which independent survey data are available. The official figures for all states show falling infant mortality rates between 1989 and 2001. Between 1989 and 1995, the infant mortality rate increased in a number of states of the CCEE/NIS, with the largest increases in those countries with the largest falls in economic output (UNICEF, 1997).

Fig 25.3. Infant mortality rate (per 1000 live births) in the CCEE/NIS: official and survey estimates



[a] The countries belonging to the EU before May 2004.
Source: Adapted from UNICEF (2005b:xiv). Reproduced with the permission of the copyright holder.

The under-5 mortality rates in the low- and middle-income countries of the Region are strongly correlated with high absolute child poverty rates ($r = 0.78$, $P < 0.01$) (see Table 25.2). Despite a general reduction in under-5 mortality rates, some countries (such as Bulgaria and Turkmenistan) showed an increase between 2000 and 2003, and rates in a number of countries were static.

There are limited data on death in later childhood, adolescence and early adulthood by country. Data on mortality rates for young people aged 15–24 years in the CCEE/NIS (UNICEF 2000a) shows wide variation between countries but no country level correlation between absolute poverty levels and deaths in the age group 15-24 years (r=0.20, p=0.95). Boys are much more likely to die in this age group than girls.

Table 25.2. Under-5 mortality rate (per 1000 live births) and child poverty rates in the CCEE/NIS

	Under-5 mortality rates (per 1000 live births)				Child poverty rates (%)	Yearly average rate of change of under-5 mortality rates (%)	
	1990	1995	2000	2003	2001–2003	1995–2000	2000–2003
Turkmenistan	97	89	99	102	NA[a]	2.2	1.0
Tajikistan	119	113	101	95	76	-2.2	-2.0
Azerbaijan	105	98	93	91	NA[a]	-1.0	-0.7
Kazakhstan	63	67	73	73	28	1.7	0.0
Uzbekistan	79	75	71	69	50	-1.1	-0.9
Kyrgyzstan	80	74	70	68	80	-1.1	-1.0
Georgia	47	45	45	45	57	0.0	0.0
Armenia	60	49	37	33	54	-5.5	-3.7
Republic of Moldova	37	36	33	32	53	-5.5	-3.7
Albania	45	34	25	21	30	-6.0	-5.6
Russian Federation	21	22	21	21	13	-0.9	0.0
Romania	32	25	22	20	21	-2.5	-3.1
Ukraine	22	24	21	20	2	-2.5	-3.1
Belarus	17	18	17	17	3	-1.1	0.0
Bosnia and Herzegovina	22	19	18	17	6	-1.1	-1.9
Bulgaria	19	19	16	17	8	-3.4	2.0
Former state union of Serbia and Montenegro	26	19	16	14	7	-3.4	-4.4
The former Yugoslav Republic of Macedonia	33	25	14	7	6	-10.9	-7.7
Croatia	13	11	8	7	NA[a]	-6.2	-4.4

[a] NA = not available

Note. Child poverty rates refer to children aged 0–15 years who live in households with consumption lower than US$ 2.15 (adjusted for PPP) a day per person. Countries are ordered by decreasing level of under-5 mortality rate in 2003.

Source: Adapted from UNICEF (2006a:43). Reproduced with the permission of the copyright holder.

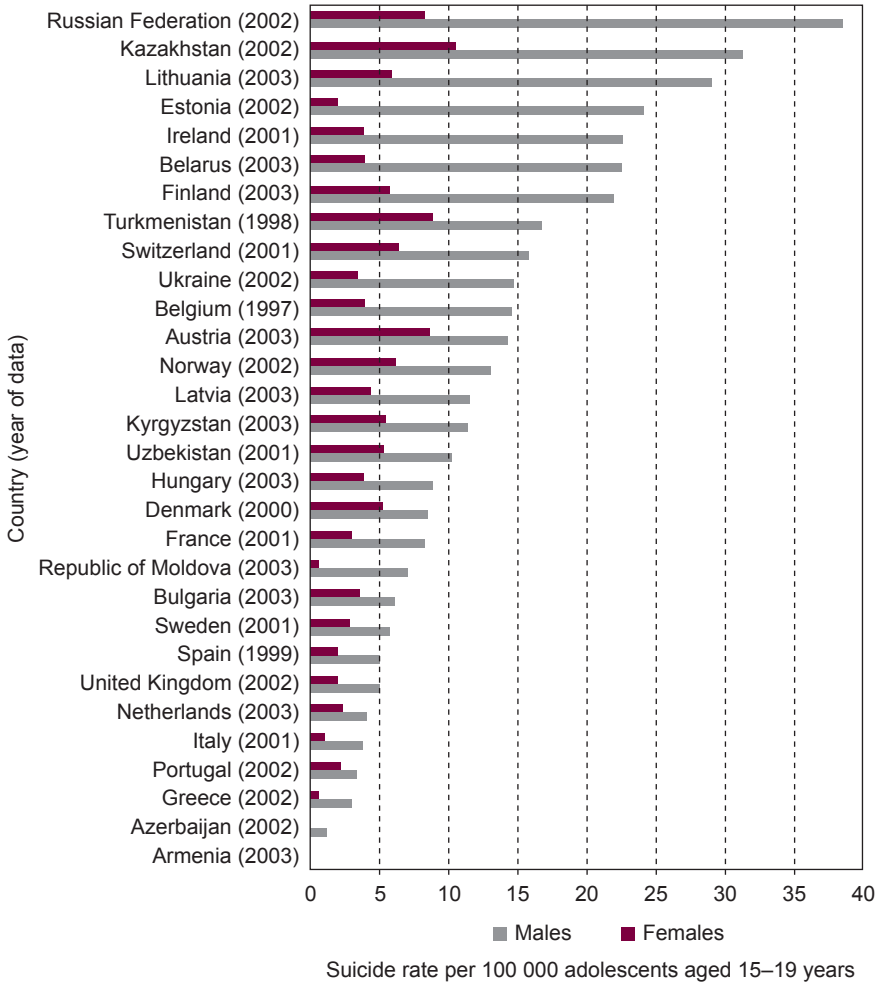
Suicides are an important cause of death in late adolescence and early adulthood. Rates vary widely across the Region, and there is little apparent association with poverty rates (Fig. 25.4). As Fig. 25.4 shows, rates tend to be higher in the higher-income states of the CCEE/NIS and many of the high-income countries of the Region, a reversal of the relationships seen with infant mortality rate, under-5 mortality rate and all-cause mortality in 15–24-year-olds. Also, boys are more vulnerable to suicide than girls. Across the CCEE/NIS, suicide claims the lives of 10 000 males and 2000 females annually (UNICEF, 2000a).

Within country inequities

Inequities in infant mortality rate have been reported in the high-income countries of the Region (Arntzen & Nybo Andersen, 2004; Mackenbach, 2005). Between 1980 and 1995, inequities in the infant mortality rate in Belgium and Hungary widened (Fig. 25.5). Also, since 1997, inequities in the infant mortality rate have increased in England and Wales (Dyer, 2005).

Regional differences in infant mortality rate have been reported in Germany, with a twofold difference between the federal states of Baden-Württemberg and Bremen in 2002 (Bertram, 2006). Such differences have also been reported in Bulgaria, with a threefold difference between the city of Sofia (9.7 infant deaths per 1000 live births) and the Burgas Region (27.4 infant deaths per 1000 live births) in 1997 (Gantcheva & Kolev, 2001:15, Fig. 8). The difference between the German federal states is likely to relate to variation in poverty levels. However, both Sofia City and the Burgas Region are relatively advanced urban areas of Bulgaria, and the reasons for the variation in infant mortality rate are unclear. Similar differences have been noted between Russian Federation *oblasts* (administrative regions): in 2003, the infant mortality rate was 27.6 infant deaths per 1000 live births in the Republic of Tuva, compared with 8.0 infant deaths per 1000 live births in the city of St Petersburg (UNICEF, 2006a:43, Table 3.2). Among the central Asian states and Turkey, there are marked differences in infant mortality between the richest and poorest families (see Table 25.3).

Fig 25.4. Suicide rates among 15–19-year-olds by gender in European countries, for the years indicated



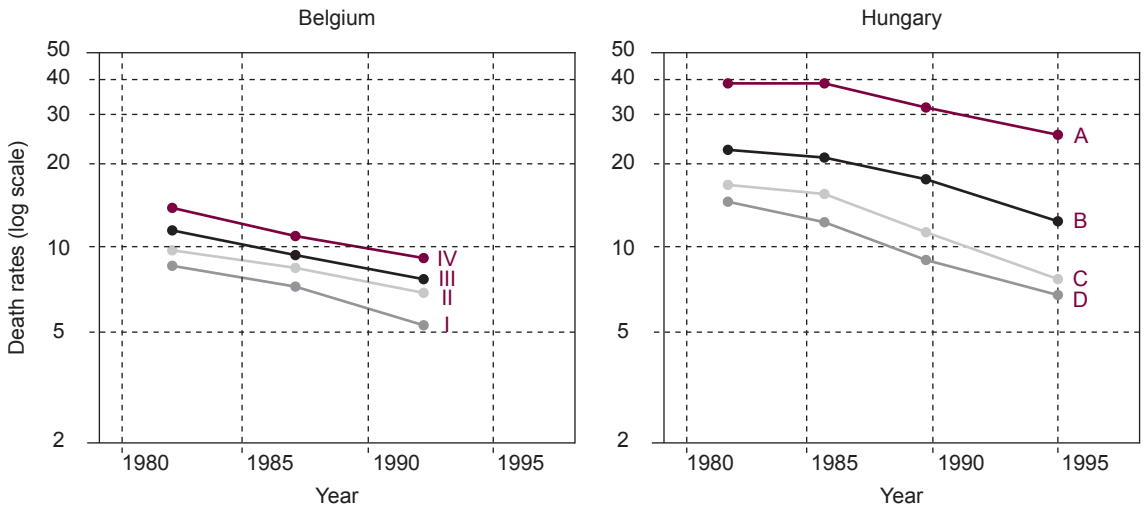
Source: Adapted from Mittendorfer-Rutz (2006). Reproduced with permission from Elsevier.

Turkey had the most striking inequities in 1995, with the poorest families experiencing three and a half times more infant deaths than the richest families and more than four and a half times more deaths before the age of 5 years. Uzbekistan demonstrated a relatively small difference in infant mortality rate and under-5 mortality rate between poor and rich. The rates themselves varied widely between these countries. Among the poor, Turkey and Turkmenistan had the highest rates, almost three times higher than the poor in Kazakhstan. Rich families in Turkey and Kazakhstan had the lowest rates of infant and under-5 mortality. In all these countries, boys are at higher risk of dying in infancy and before the age of 5 years than girls.

In the Czech Republic, Hungary and Slovakia, the infant mortality rate among Roma is twice as high as that for non-Roma (UNDP, 2003).

Mortality among older children and adolescents is less common than among infants, but the social gradient remains the same (Reading, 1997). Injury deaths, considered in the section on "Inequities in accidents and injuries", show the sharpest social gradient (Reading, 1997). Suicide among youth 15–19 years in Europe has a strong social pattern (Mittendorfer-Rutz, 2006), although this is most noticeable among males (Lorant et al., 2005). Social inequities in suicide among females are less marked and, in some countries (such as Denmark, Norway and Switzerland), women with a high level of education are at higher risk (Lorant et al., 2005).

Fig 25.5. Infant mortality by occupational group (Belgium) and maternal education (Hungary)



Note. Belgium: I–IV represent occupational groups, where I = highest and IV = lowest. Hungary: A–D represent maternal educational levels, where A = lowest and D = highest.
Source: Mackenbach (2005:11). Reproduced with the permission of the copyright holder.

Table 25.3. Inequities in infant and under-5 mortality rates in selected central Asian states and Turkey

Country (year)	Deaths per 1000 live births		Ratio of poor to rich
	Poorest quintile	Richest quintile	
Kazakhstan (1995)			
Infant mortality rate	35.1	29.1	1.21
Under-5 mortality rate	43.0	33.5	1.28
Kyrgyzstan (1997)			
Infant mortality rate	83.3	45.8	1.82
Under-5 mortality rate	96.4	49.3	1.96
Turkey (1995)			
Infant mortality rate	99.9	25.4	3.50
Under-5 mortality rate	124.7	27.1	4.60
Turkmenistan (2000)			
Infant mortality rate	89.3	58.4	1.53
Under-5 mortality rate	105.5	69.8	1.51
Uzbekistan (1996)			
Infant mortality rate	49.5	46.8	1.06
Under-5 mortality rate	65.8	50.8	1.30

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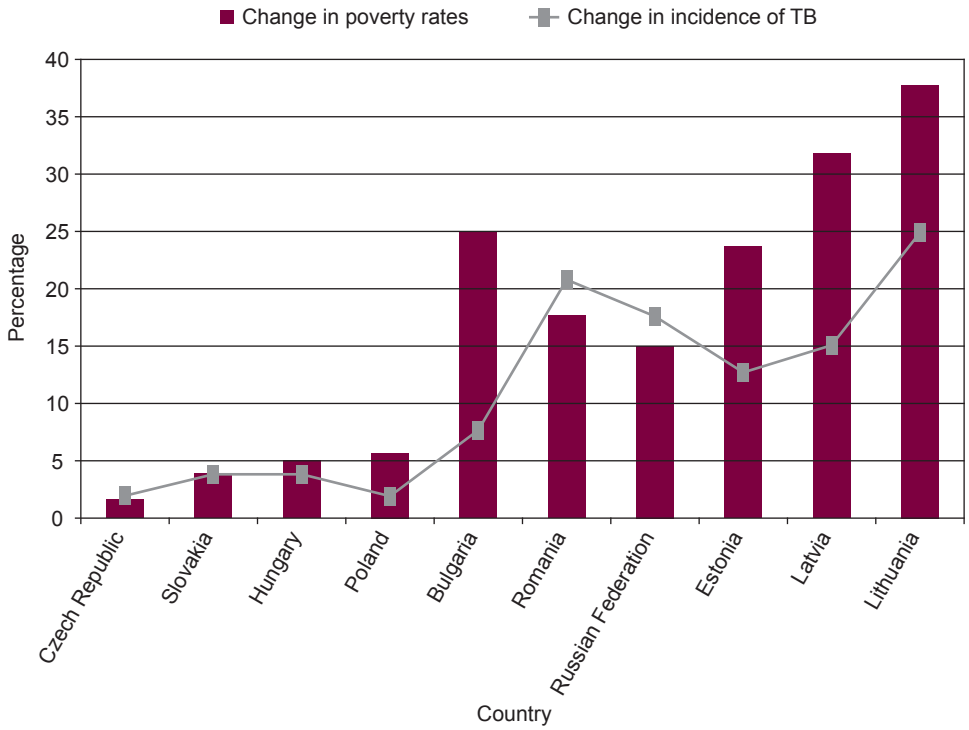
Inequities in communicable diseases

Inequities at country level

Globally, poor children are at high risk of such communicable diseases as TB, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and measles. The European Region has among the lowest rates of communicable diseases in children, particularly among the high-income countries, but these diseases are more prevalent in the low-income

countries of the Region, with evidence of rising rates (UNICEF, 1997). In some the states of the CCEE/NIS, TB rates have risen in areas where poverty has increased (Fig. 25.6).

Fig 25.6. Percentage change in extreme poverty and TB rates, 1989–1994



Source: Adapted from UNICEF (1997:7). Reproduced with the permission of the copyright holder.

Fig. 25.6 shows the incidence of TB for all age groups, but the rates among children follow the same pattern (UNICEF, 1997). The rate is particularly high in Azerbaijan, western NIS and Baltic countries, but it is low and stable in central Europe (UNICEF, 1997).

Rates of incidence of TB in children in western Europe decreased between 1995 and 2001 (Falzon, Infuso & Belghiti, 2003). Among the countries of western Europe, the rates vary from more than 6.0 cases per 100 000 population in Portugal and Spain to less than 2.0 cases per 100 000 population in Iceland, Ireland, Italy, Norway and Sweden (Falzon, Infuso & Belghiti, 2003). Children in migrant populations account for a high proportion of cases in many countries (Falzon, Infuso & Belghiti, 2003).

By global standards, HIV/AIDS rates across the Region are relatively low, but the rates of increase in some of the countries of the Region are among the highest in the world. Rates in the high-income countries among all age groups have risen slowly, but in some countries, such as the Russian Federation and Ukraine, rates have risen very sharply (UNAIDS, 2006). HIV spread by heterosexual contact and intravenous drug abuse constitutes the fastest growth of the disease in many European countries, with the result that women of reproductive age are becoming one of the largest groups affected. Rates among children are rising as a consequence, particularly through mother-to-infant transmission (UNDP, 2004).

Rates of deaths and infection from measles and other diseases of childhood preventable by vaccination are low in the Region, compared with global rates, but these illnesses remain a major threat in the low-income countries of the Region (WHO Regional Office for Europe, 2002). Immunization rates tend to be high in the high-income countries, and although rates fell in many of the states of the CCEE/NIS during the 1990s they generally recovered by 2004 (UNICEF, 2006a). However, rates in some countries – notably Armenia, Bosnia and Herzegovina, Georgia, Kazakhstan, and Tajikistan – have not reached levels where adequate immunity is guaranteed. Malnourished children are particularly vulnerable to measles, and if levels of immunization fall among these children they become highly vulnerable.

Inequities within countries

TB has long been recognized as a disease of poverty, and it affects poor children across the world (WHO, 2005). The association persists in modern European countries (Diaz de Quijano et al., 2001; Parslow et al., 2001; WHO Regional Office for Europe, 2002). Children and young people are particularly vulnerable to TB, and poor children are at increased risk (WHO, 2007). In the Balkans, the Caucasus, Tajikistan and the southern part of the Russian Federation, war and displacement of populations has contributed to the rise in TB in adults and children (UNICEF, 2001a). Also, Roma children in the CCEE have high rates of TB (Schaaf, 2007), as do ethnic minority children in the United Kingdom, although in both cases this may be related more to poverty than to ethnicity (Darbyshire, 1995).

Globally, HIV/AIDS is increasingly recognized as a disease of poverty that generates poverty, especially among children (UNAIDS, 2006). Increasing unemployment, poverty and rapid social changes in Bulgaria, Croatia and Romania have been implicated in the rise in HIV infections in these countries. (Novotny, Haazen & Adeyi, 2003). Similar social conditions are responsible for the epidemic in the Russian Federation, Ukraine and other states of the CCEE/NIS (UNDP, 2004). Infection rates are rising among young people in these countries, as a result of increased use of intravenous drugs (especially among

Table 25.4. Inequities in immunization rates between rich and poor in selected countries

Country (year) and vaccination	Immunization rates (%)			
	Poorest quintile		Richest quintile [a]	
	Male	Female	Male	Female
Kazakhstan (1995)				
Measles	(51.8)	(68.1)	(64.1)	(72.3)
DPT3 [b]	(40.9)	(33.3)	(43.9)	(47.0)
All	(13.2)	(24.8)	(27.8)	(24.3)
None	0	0	0	0
Kyrgyzstan (1997)				
Measles	80.0	84.9	(78.4)	(83.3)
DPT3 [b]	81.0	84.1	(84.0)	(90.4)
All	68.1	71.3	(72.6)	(73.8)
None	0	0	0	0
Turkey (1995)				
Measles	68.4	57.1	81.5	(89.7)
DPT3 [b]	53.0	61.3	96.4	(88.0)
All	39.5	43	79.9	(84.6)
None	9.9	3.6	0	(2.2)
Turkmenistan (2000)				
Measles	88.4	93.2	(78.4)	(80.8)
DPT3 [b]	98.6	95.8	(85.2)	(85.9)
All	82.8	87.1	(78.4)	(76.7)
None	1.4	1.3	(12.3)	(14.1)
Uzbekistan 1996:				
Measles	92.6	100	(86.9)	(92.4)
DPT3 [b]	91.7	88.7	(80.8)	(88.5)
All	80.6	84.9	(79.0)	(75.2)
None	0	0	0	0

[a] For Kazakhstan, data on richest refer to the fourth quintile.
[b] DPT3 = diphtheria, pertussis (whooping cough) and tetanus.
Note. Figures in parenthesis indicate a large sampling error due to a small number of cases.
Source: Compiled from Gwatkin et al. (2007a–e). Reproduced with the permission of the copyright holder.

street children), lack of knowledge about the dangers of unprotected sex and lack of ready access to condoms (UNICEF, 1997). Vertical transmission of HIV in high-income European countries tends to be associated with maternal intravenous drug abuse which, in turn, is associated with poverty and social exclusion (Thorne et al., 1996). In the United Kingdom, the highest rates of HIV infection among pregnant women are found among women of sub-Saharan origin (Cortina-Borja et al., 2004).

Against a global and regional background of falling rates of measles and other diseases preventable by vaccination (Elliman & Bedford, 2007), these infections remain most prevalent among poor children, particularly those in the low-income countries of the Region (WHO Regional Office for Europe, 2002). Roma children in European countries have high rates of infection, despite high official immunization rates (Loewenberg, 2006). It has been suggested that immunization rates among these marginalized groups are low as a consequence of long-term neglect of the needs of Roma populations (Loewenberg, 2006).

With the exception of Kazakhstan and Kyrgyzstan, immunization rates in central Asian countries tend to be higher in the poorer groups (Table 25.4), although the data should be interpreted with caution, because of the small number of cases in the richest quintile. Nonetheless, the figures suggest that in these countries immunization programmes have reached the poorest, in contrast to Turkey where the poorest groups are least likely to be immunized. Also, the gender differences in immunization rates in these countries appear to be small.

In the United Kingdom, vaccination in the first year of life is unequally distributed across the population. Children living in the most deprived areas are most likely to be incompletely vaccinated, and non-receipt of any vaccination is more prevalent among children in the least deprived areas – probably resulting from more affluent parents being influenced by media coverage of adverse events in immunization (Samad et al., 2006).

Inequities in noncommunicable diseases

Nutrition: inequities between countries

Stunting and underweight are globally recognized markers of undernutrition in childhood. Undernourished children are vulnerable to infection and are at high risk of death in early childhood (UNICEF, 2005b:12, Fig. 25.6). Undernutrition in early childhood is also a potent cause of suboptimal brain development, with adverse consequences for subsequent cognitive ability. Undernutrition is no longer a significant problem in the high-income countries of the Region, but many children in the poor countries are affected (UNICEF, 2006a). Between a third and a fifth of children younger than 5 years are stunted in the central Asian countries; and in these countries, a relatively high proportion of children is underweight or wasted (Table 25.5). These levels are equivalent to those reported in Asian countries known for high levels of undernutrition (UNICEF, 2005b).

Micronutrient deficiencies are highly prevalent in the central Asian countries (Table 25.5). Iron deficiency anaemia affects almost half the children younger than 5 years in Kazakhstan and Tajikistan, and vitamin A deficiency and iodine deficiency affect between close to a third and a fifth of children, respectively, in these countries (Table 25.5). Vitamin A deficiency affects growth and immune function, and deficiency of iron or iodine can lead to cognitive and educational impairment. As with stunting and underweight, the countries in the Region with high levels of absolute child poverty (see Fig. 25.2) are the ones most affected by micronutrient deficiencies.

In contrast to the prevalence of problems that result from nutritional deficiencies, obesity and overweight, tend to be more prevalent in the high-income countries of the Region although, as Table 25.5 shows, countries such as Uzbekistan have coexisting high rates of underweight and overweight. Many countries in the Region are experiencing a rapid rise in childhood obesity and overweight: prevalence rates of obesity in European children are ten times higher now than in the 1970s (Branca, Nikogosian & Lobstein, 2007a). Obesity and overweight combined increased more than fivefold in France between 1963 and 2000, rising from 3% to 16%; in the United Kingdom, rates doubled in the 20 years between 1974 and 1994 (Lang & Rayner, 2005). Poland, Germany and Spain have also experienced similar increases.

Nutrition: inequities within countries

Within the countries of the Region with high levels of stunting, underweight and micronutrient deficiencies, poor children are more vulnerable to the effects of undernutrition (Table 25.6) (UNICEF, 2006a).

In the United Kingdom, although levels of stunting and underweight are low, iron deficiency anaemia is common among children, and disadvantaged children and those from ethnic minorities are at high risk (Aukett & Wharton, 1995).

Table 25.5. Nutritional indicators for children under-5 in selected states of the CCEE/NIS

Country (year)	Per cent with given nutritional problem						
	Stunting	Underweight	Wasting	Overweight	Vitamin A deficiency	Iron deficiency anaemia	Iodine deficiency disorders (total goitre rate)
Tajikistan (2003)	36.2	NA [b]	4.7	NA [b]	18	45	28
Albania (2000)	31.7	14.3	11.1	NA [b]	NA [b]	NA [b]	NA [b]
Uzbekistan (2002)	31.3	18.8	11.6	14.4	40	33	24
Kyrgyzstan [a]	25.0	11.0	3.0	NA [b]	NA [b]	NA [b]	NA [b]
Turkmenistan (2000)	22.3	12.0	5.7	NA [b]	18	36	11
Azerbaijan (2000)	19.6	16.8	8.0	3.7	23	33	15
Ukraine (2002)	15.9	3.2	6.2	NA [b]	NA [b]	NA [b]	NA [b]
Armenia (2000/2001)	12.9	2.6	1.9	6.3	12	24	12
Georgia (1999)	11.7	3.1	2.3	NA [b]	11	33	21
Romania (2002)	10.1	3.2	2.3	2.3	NA [b]	NA [b]	NA [b]
Republic of Moldova [a]	10.0	3.0	3.0	NA [b]	NA [b]	NA [b]	NA [b]
Kazakhstan (1999)	9.7	4.2	1.8	4.3	19	49	21
Bosnia and Herzegovina (2000)	9.7	4.1	6.3	NA [b]	NA [b]	NA [b]	NA [b]
The former Yugoslav Republic of Macedonia (1999)	6.9	5.9	3.6	5.0	NA [b]	NA [b]	NA [b]
Former state union of Serbia and Montenegro (2000)	5.1	1.9	NA [b]	NA [b]	NA [b]	NA [b]	NA [b]
Croatia [a]	1.0	1.0	1.0	NA [b]	NA [b]	NA [b]	NA [b]

[a] Data for these countries are from UNICEF (2006c); the remainder are from the World Bank (2006).
[b] NA = not available.
Source: Adapted from UNICEF (2006a:45). Reproduced with the permission of the copyright holder.

Table 25.6. Stunting and underweight in children younger than 5 years by wealth quintile

Marker of undernutrition by country (year)	Wealth quintiles					National average	Low/high quintile ratio
	Lowest	Second	Middle	Fourth	Highest		
Stunting							
Armenia (2000)	19.0	15.5	11.9	7.4	9.3	13.0	2.04
Kazakhstan (1999)	15.3	7.7	8.3	6.1	7.5	9.8	2.04
Kyrgyzstan (1997)	33.9	30.2	20.6	18.6	14.3	24.8	2.37
Turkmenistan (2000)	25.1	24.6	23.5	19.5	17.1	22.4	1.47
Uzbekistan (1996)	39.6	29.5	29.5	24.5	30.5	31.3	1.30
Underweight							
Armenia (2000)	3.4	2.7	4.1	1.2	1.5	2.6	2.27
Kazakhstan (1999)	5.1	4.0	3.6	3.0	6.1	4.2	0.84
Kyrgyzstan (1997)	12.9	12.5	13.8	5.9	8.1	11.1	1.59
Turkmenistan (2000)	13.0	12.8	9.5	12.7	11.5	12.0	1.13
Uzbekistan (1996)	25.1	23.7	12.7	15.0	12.9	18.8	1.95

Note. The wealth quintiles are computed by using an asset index constructed on the basis of information on households' assets collected in the Demographic and Health Surveys (DHS).
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A systematic review of the literature (Parsons, Power & Logan, 1999) found strong evidence for a relationship between poor social circumstances in childhood and adult obesity, but not with childhood obesity. More recent studies, however, suggest a changing social pattern, with poor children showing higher rates (DH, 2003; Romon et al., 2005). Based on data from the 2002 Health Survey for England, the prevalence of obesity was 17.1% in children 2–10 years old in the lowest social group, compared with 12.4% in the highest group (Jotangia et al., 2005). Studies in Norway (Andersen et al., 2005) and France (Klein-Platat et al., 2003) show similar social patterns of obesity among older school-aged children and adolescents.

Disability and long-standing illness: inequities between countries

There are no reliable comparable data on childhood disability between countries (UNICEF, 2005b). Based on data from high-income European countries, the European Academy for Childhood Disability (2003) estimated a prevalence rate of childhood disability of 2.5%, 1% of which are serious conditions. The Academy estimates that a further 8% of children have learning or behavioural disorders. Official childhood disability rates have increased in the CCEE, but it is not clear if these increases are due to real increases in disability or improvements in recognition and reporting (UNICEF, 2005b). Data on children with disabilities in institutions in the CCEE and Baltic states suggest a continuing high rate of admission of disabled children to institutions in many of these countries (UNICEF, 2005b:16, Table 25.5). Institutional care is known to be detrimental to child well-being (Browne, 2005), and children tend to be institutionalized because of fear of disability and poverty (UNICEF, 2005b). Some countries, such as Romania, have reduced the rates of disabled children in institutions. However, some of the countries with the highest numbers of institutionalized disabled children, such as Bulgaria and the Russian Federation, have registered increases between 1990 and 2002 in their rates of institutionalization.

Disability and long-standing illness: inequities within countries

The relationship between childhood disability and poverty in high-income countries is well documented (Gordon et al., 2000). This results partly from the increased costs associated with caring for a disabled child, but poverty and social conditions also play a part in the etiology of disability (Burchardt, 2003; Preston, 2005). Evidence from different parts of the Region confirms that households with disabled children are more likely to be poor. In Romania, 25% of households with disabled children live in poverty, compared with the average for the country of 12% (UNICEF, 2005b). Disabled children in Armenia have a 60% probability of living in extreme poverty, and in Georgia 30% live in households in the lowest income quintile (UNICEF, 2005b). Ethnicity is also linked to disability in some countries: Roma children are overrepresented among disabled children in the CCEE, although this may result, in part, from diagnoses (such as learning difficulties) based on culturally biased assessment tools (UNICEF, 2005b).

Data from the United Kingdom show that children with disabilities live in households with a lower average total weekly income than that of the general public (£475 compared with £543), lower rates of home ownership (52.6% compared with 66.9%) and

higher rates of debt (26.5% with one or more debts compared with 16.2%) (Read, Blackburn & Spencer, 2007). In the Nordic countries, children from families with low levels of education or income had a higher prevalence of chronic illness than those from more advantaged families (Grøholt et al., 2001). Also, a study in Germany reported higher rates of lower airway resistance among poorer children, although it failed to show any other significant differences in chronic conditions (du Prel et al., 2006). Data from Sweden show an increased risk of asthma among children whose mothers have a low level of education (Hjern, 2006). However, data from the National Health Survey for Children and Adolescents in Germany show a reverse social gradient in allergic disease, with higher rates among children in households with above average income (Schlaud & Thierfelder, 2007).

Moreover, studies in England (Sundrum et al., 2005), Ireland (Dowding & Barry, 1990) and Malta (Sciberras & Spencer, 1999) have reported higher rates of cerebral palsy, one of the most important disabling conditions of childhood, among low-income households compared with high-income households. This association is partly, but not wholly, explained by social differences in birth weight and gestational duration (Dowding & Barry, 1990; Sundrum et al., 2005) (see the section on "Inequities in birth weight and gestational age" above).

Mental health: inequities between countries

Despite the increasing importance of mental health problems as a cause of chronic morbidity and apart from data on suicide rates presented above (Fig. 25.4), there are few comparative data on child and adolescent mental health by country. The WHO Regional Office for Europe (2003) estimates that 10–20% of children in the Region have one (or more) mental health or behavioural problem.

Young people's feelings about themselves are likely to reflect their mental health. Data from the Health Behaviour of School-aged Children study (UNICEF, 2007) show that a significant minority of children appears to feel awkward and out of place, with particularly high rates in Belgium (16%) and the Russian Federation (14%). There is, however, no correlation between the percentage of young people expressing negative feelings about themselves and child poverty rates in their countries of residence.

Also, children experiencing bullying may be more vulnerable to subsequent mental health problems. Rates of young people (11, 13 and 15 years old) who reported being bullied in the previous two months vary from 15% in Sweden to more than 60% in Lithuania (UNICEF, 2007). The relationship between bullying and levels of child poverty in their countries of residence, however, is unclear.

Mental health: inequities within countries

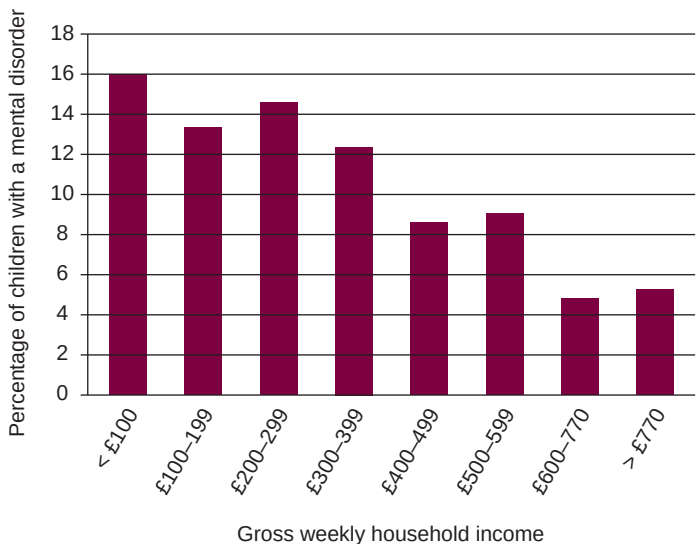
The United Kingdom Department of Health commissioned two major British surveys of mental health (1999 and 2004) among children and young people aged 5–15 years (Meltzer et al., 2000; Green et al., 2005). These surveys provide a rich source of data on social inequities in mental health in this age group.

Fig. 25.7 shows the striking gradient in mental disorders in the United Kingdom by household income. Children and young people in the lowest income group have a rate three times that of children and young people in the high-income group. All the common forms of mental health problems in this age group, including conduct disorder, attention deficit hyperactivity disorder and emotional disorders, occur more frequently among children in low-income households (Meltzer et al., 2000; Green et al., 2005). Autistic spectrum disorders and other less common disorders, however, do not show a social gradient, and children from ethnic minority families are at lower risk of mental disorders than those from ethnic majority families.

Between genders, boys have higher rates than girls of all types of mental disorder, apart from emotional disorders. In 2004, 6% of 11–15-year-old girls had emotional disorders, compared with 3.9% of boys, but for conduct disorders, boys in this age group had a rate of 7.8%, compared with 3.8% for girls (Green et al., 2005).

Studies outside the United Kingdom also show inequities. Swedish children and young people aged 10–18 years who live in poor households have higher rates of nervousness, psychosomatic symptoms and headaches than their more advantaged peers (Hjern, 2006). In a range of countries participating in the Health Behaviour of School-aged Children study (Belgium, Finland, Germany, Hungary, Ireland, Iceland, Portugal, Romania and Slovenia), adolescents in households with low family affluence scores reported higher rates of mental health problems and lower well-being than their more privileged peers (Mathieson & Koller, 2008).

Fig 25.7. Percentage of children 5–15 years with a mental disorder, by gross household income, 2004



Source: Adapted from Green et al. (2005:28). Reproduced under the terms of the Click-Use Licence.

Inequities in accidents and injuries

Inequities between countries

Death rates among children and young people 0–19 years from injury and accidents vary from less than 10 deaths per 100 000 children in Sweden to 60 deaths per 100 000 children in Israel (see Fig. 25.8). Among the high-income countries of the Region, there is no evident correlation between child poverty levels and injury death rates. However, Estonia, Latvia, Lithuania, the Russian Federation and Slovenia all exceed levels in the high-income countries. While overall injury-related death rates are falling in the high-income countries, they are rising in many of the lower-income countries in the Region and are associated with economic changes that have led to increased unemployment, income inequalities, increased traffic, reduced restrictions on alcohol and loss of social support (Sethi et al., 2006). Also, deaths related to road traffic accidents account for 41% of injury deaths in high-income countries (UNICEF, 2001b).

There are currently no reliable standardized data between countries on nonfatal injuries. Work from the Netherlands (Netherlands Consumer Safety Institute, 1997:6), however, suggests that for each injury-related death there are 160 hospital admissions and 2000 visits to emergency departments. Also, boys are 70% more likely to die from injury than girls (UNICEF, 2001b).

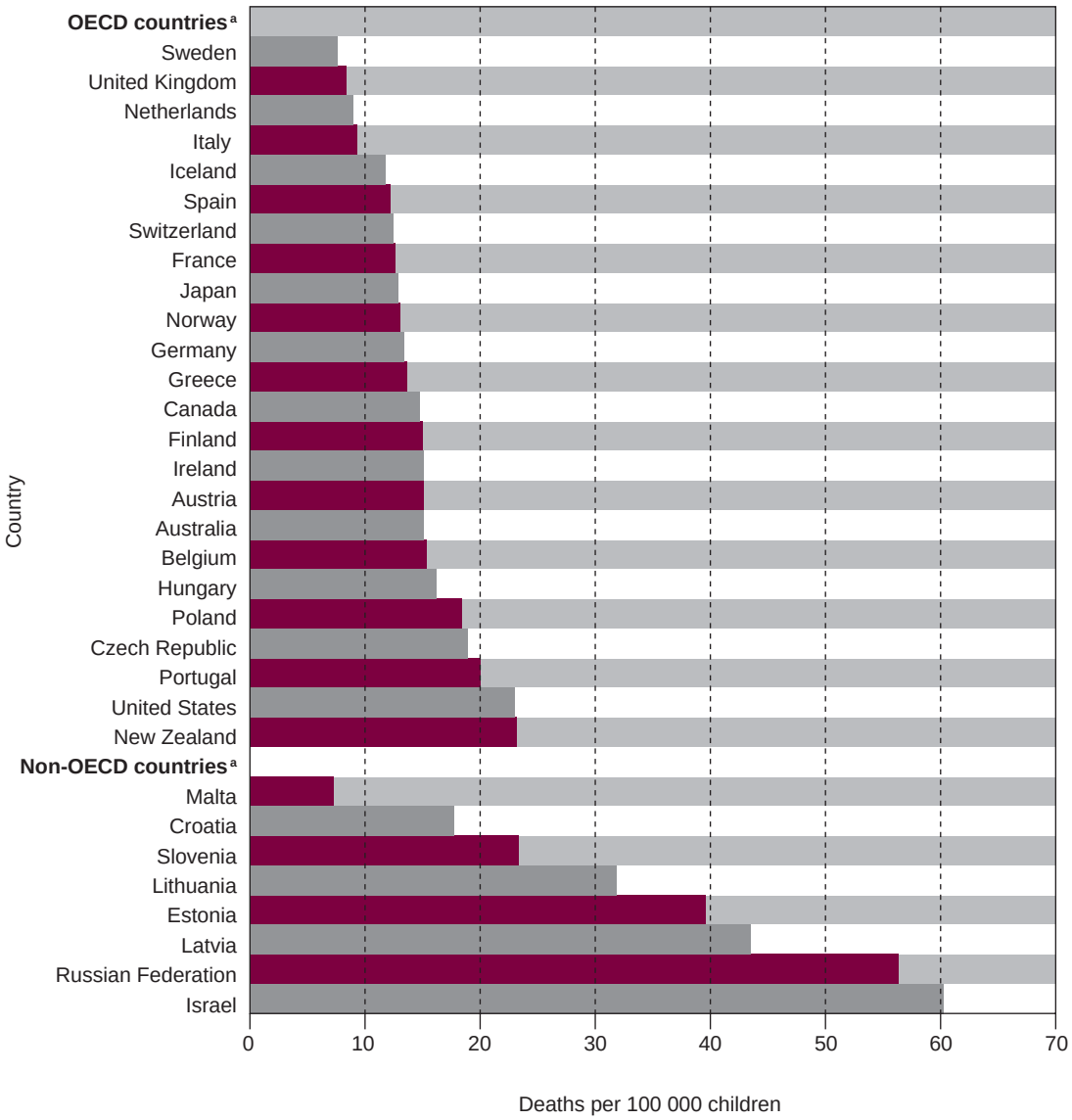
Intentional injury is a less common (but important) cause of death in childhood. Rates of death due to confirmed abuse and neglect and deaths of "undetermined intent" for which data are available vary across the countries of the Region (UNICEF, 2003). Greece, Ireland, Italy, Norway and Spain have low rates (0.3 death or fewer per 100 000 children), whereas the Czech Republic, France, Hungary and Slovakia have rates above 1.0 death per 100 000 children and Portugal has a rate of 3.7 deaths per 100 000 children, the highest in the high-income countries (UNICEF, 2003). Children younger than 1 year are three times as likely to die from maltreatment as children aged 1–4 years and six times as likely as those aged 5–14 years. As with injury-related deaths from all causes, deaths due to maltreatment are the tip of an iceberg. An Australian study (Australian Institute of Health and Welfare, 2001:46–47) calculated that for each death there are 150 substantiated cases of physical abuse.

Inequities within countries

The UNICEF publication *A league table of child deaths by injury in rich nations* (UNICEF, 2001b:14) concluded that:

> … whether the proximate cause be traffic accident, assault, drowning, fire or poisoning, the likelihood of a child being injured or killed appears to be strongly associated with such factors as poverty, single parenthood, low maternal education, low maternal age at birth, poor housing, large family size, and parental drug or alcohol abuse.

Fig 25.8. Death rates from injuries and accidents (per 100 000 population) in 0–19-year-olds



[a] OECD = Organisation for Economic Co-operation and Development.
Note 1. Rates are averages of the latest three years available.
Note 2. The following dates apply to the countries shown within parentheses: 1992–1994 (Malta, Croatia), 1993–1995 (Finland, Hungary, Iceland, Latvia, the Netherlands, Norway), 1994–1996 (Poland, Sweden), 1995–1997 (Australia, Belgium, Germany), 1996–1998 (Spain, United States), 1997–1999 (Canada, France, New Zealand, United Kingdom), 1999–2001 (Austria, Ireland, Italy, Portugal), 2000–2002 (Switzerland, Greece). Non-OECD: Israel (2003), Russian Federation (2000–2002), Lithuania (1995–1997), 1994–1996 (Estonia, Slovenia).
Source: Adapted from UNICEF (2007:16). Reproduced with the permission of the copyright holder.

Data from England and Wales for 1979–1983 and 1989–1992 (Fig. 25.9) show the extent of the social gradient in child injury deaths. Children in the most disadvantaged social group were five times as likely to die during the period 1989–1992 as those in the most privileged group, and although rates fell in all social groups between the two periods studied the gradient remained the same. When specific causes of injury-related deaths are considered, the differences between social groups become even more pronounced: for pedestrian deaths, the rates were 5 times higher in the lowest social group than in the highest; for fires, they were 16 times higher; and for homicide, 17 times higher (UNICEF, 2001b). A more recent study in England and Wales, covering the period 2001–2003, included the poorest social group, those whose parents had never worked or were long-term unemployed (Edwards et al., 2006). In this group, the rates of all injury-related deaths were 13 times higher than in the most

Fig 25.9. Injury deaths by parental occupational group in children aged 0–15 years, England and Wales

Note. The taller, lighter-coloured bars show rates in 1979–1983 and the shorter, darker bars show rates in 1989–1992. For the numbered occupational groups: 1 = professional; 2 = managerial/technical; 3 = skilled non-manual; 4 = skilled manual; 5 = partly skilled manual; and 6 = unskilled manual.
Source: Adapted from UNICEF (2001b:16). Reproduced with the permission of the copyright holder.

privileged group. When specific causes of death were examined, compared with the children of parents in the most privileged group, death rates among children in the poorest group were 20 times higher for pedestrian deaths, 27 times higher for deaths as cyclists, and 37 times higher for deaths due to fire. The very high injury-related death rates among the poorest groups are likely to result from much higher levels of exposure to environmental risk factors.

A similar influence of social factors is shown in violent deaths in a Swedish cohort aged less than 15 years in 1985 and followed up during 1991–1995, with 58% of homicides, 47% of motor traffic injuries and 30% of other traffic injuries explained by parental social determinants (Hjern & Bremberg, 2002). Nonfatal injury has also been shown to be more common in poorer children in Sweden and the United Kingdom, particularly among adolescents (Engström, Diderichsen & Laflamme, 2002; Kendrick et al., 2005). Moreover, nonfatal child abuse and neglect is known to be associated with poverty and social exclusion (Sidebotham et al., 2002), although care should be exercised in interpreting these data, as they are based on registration for child abuse and neglect, a process that may itself be socially biased.

Reproductive and sexual health

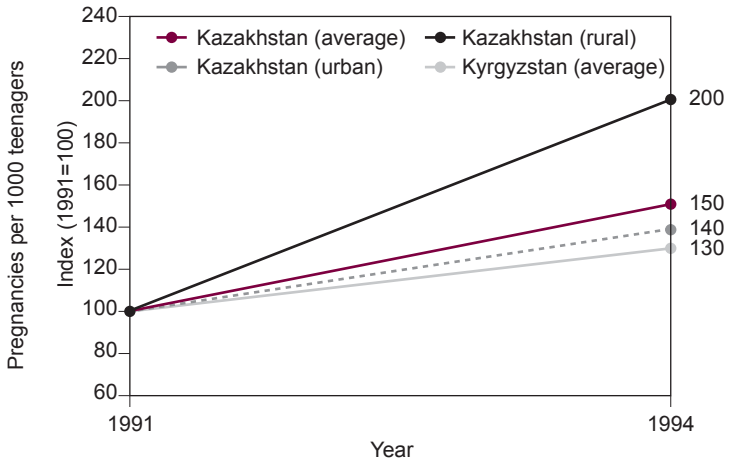
Inequities between countries

Teenage pregnancy and motherhood is associated with higher risks of long-term poverty for the mother and of poorer health and well-being for the child (UNICEF, 2001c). Teenage birth rates have fallen in the high-income countries of the Region over the last 30 years, as a result of rising levels of education, more career choices for women, more effective contraception and changing preferences (UNICEF, 2001c). Among the higher-income countries of the Region, however, teenage birth rates vary widely from 5.5 births per 1000 teenagers in Switzerland to 30.8 births per 1000 teenagers in the United Kingdom (UNICEF, 2001c). High-income countries with higher rates of teenage births tend to be those with high levels of income and educational inequality, in which young people are ill-prepared for a sexualized world (particularly in relation to contraception use) and feel that they have little expectation of reasonable education and employment (UNICEF, 2001c).

Among the low-income countries of the Region, there is evidence of increasing teenage births (Fig. 25.10). The rise in the two central Asian republics shown in Fig. 25.10 has been attributed to the impact of economic and social problems and of institutional upheaval associated with independence (Bauer et al., 1998).

HIV/AIDS is considered above, in the section on "Inequities in communicable diseases". Rates of other sexually transmitted

Fig 25.10. Rising teenage pregnancies in Kazakhstan and Kyrgyzstan, 1991–1994



Source: Adapted from Bauer et al. (1998:114). Reproduced with the permission of the copyright holder.

infections vary among different parts of the Region (WHO Regional Office for Europe, 2006b). In the western part of the Region, syphilis declined in the 1980s, remained stable in the 1990s and increased again after 1999. Gonorrhoea has declined since the 1980s in this part of the Region and is now confined to young homosexual men and socioeconomically deprived communities. In the central part of the Region, rates of syphilis fell in the 1980s and have remained relatively stable since. Gonorrhoea in this part of the Region has declined and, by 2005, was at very low levels. In the eastern part of the Region, there was a huge increase in syphilis between 1993 and 1998 but, since then, the rates have declined to pre-1993 levels. Gonorrhoea has undergone a decline in the eastern part of the Region, but at a slower rate than in the west and centre, and there was a slight upturn in 1993 and 1994.

Inequities within countries

Poverty is one of the underlying drivers of teenage pregnancy and birth. In the United Kingdom, the risk of becoming a teenage mother is almost 10 times higher for a girl in the lowest social group than for one in the highest (Social Exclusion Unit, 1999). Girls living in poor households are more likely to experience multiple risk factors known to be associated with teenage motherhood (Social Exclusion Unit, 1999). Using a meta-ethnographic method to systematically review qualitative literature related to the experiences of teenage mothers in the United Kingdom, Graham & McDermott (2005) argued that, despite facing material disadvantage and social disapproval, teenage mothers show resilience and strive to provide good mothering to their children.

Inequities in health care use

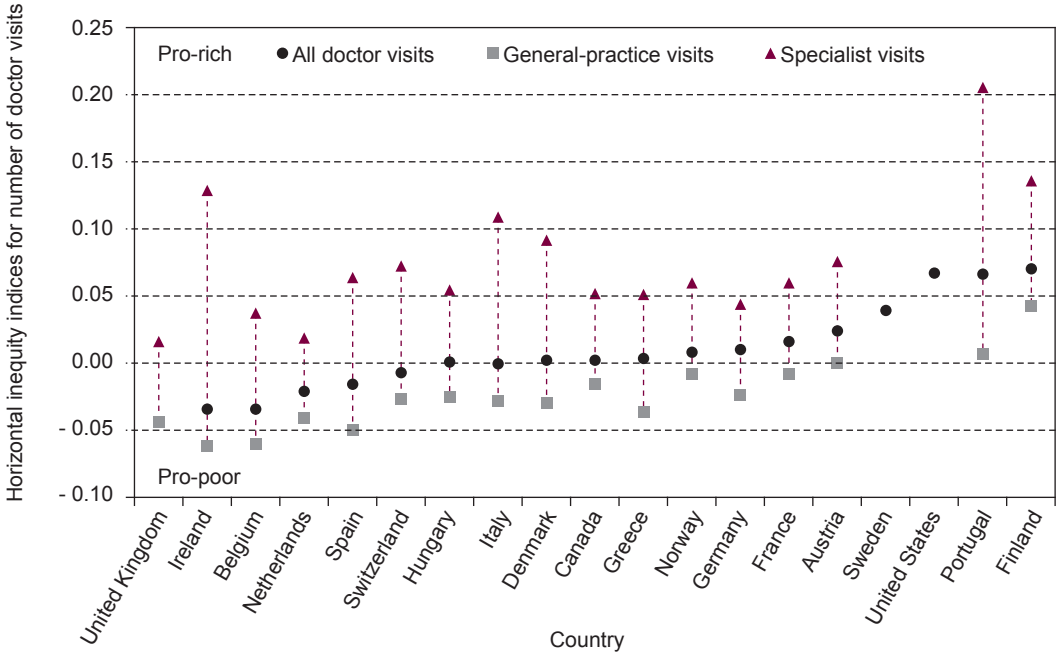
Inequities between countries

Data on inequities in health care use by children, in particular, are scarce. Data for the whole population, however, are likely to reflect the situation for children. Among the high-income countries of the Region, access to health care for children is generally free, although some countries link child benefits to the uptake of preventive child health services. Data for whole populations, however, suggest that there are marked inequities in the use of general-practice and specialist services (van Doorslaer et al., 2006). In all countries, with the exception of Finland, Portugal and Sweden, there is a pro-poor bias in the use of general-practice services, whereas in all countries there is a pro-rich bias in the use of specialist services (see Fig. 25.11).

The pro-rich bias in specialist usage is lowest in the United Kingdom and highest in Portugal. It is interesting that the pro-rich bias is relatively high among some of the most egalitarian countries of the Region, such as Denmark and Finland.

The inequities in specialist use appear to be related to a number of factors. Education and income contribute, as does proximity to hospitals (European Observatory on the Social Situation, 2005). In most countries, income makes a greater contribution to

Fig 25.11. Inequity in number of doctor visits between poor and rich people in OECD countries



Source: Reprinted from the Canadian Medical Association Journal, 17 January 2006 (van Doorslaer et al., 2006:182) by permission of the publisher. © 2006 Canadian Medical Association http://www.cmaj.ca/cgi/reprint/174/2/177. The Canadian Medical Association assumes no responsibility or liability for damages arising from any error or omission in the text or from the use of any information or advice contained in this material.

inequity in specialist use than does education, with the exception of Hungary. Inequity in proximity to hospitals is relatively low in many of the high-income countries, but reaches levels over 30% in some of the former socialist countries, such as Hungary and Slovakia. Part of the explanation for this might be the concentration of poorer households in rural areas.

Among the former socialist countries, the transition to a market economy and the accompanying reforms, such as reduction of state subsidies, deregulation, organizational restructuring, decentralization and privatization, have led to significant changes in health care expenditure and provision. These reforms, based as they are on marketization of health systems (the process that enables state-owned health systems to act like market-oriented enterprises) and the promotion of private providers, lead to what has been described as the "medical poverty trap" (Whitehead, Dahlgren & Evans, 2001), which further impoverishes poor people through such mechanisms as increased untreated morbidity and reduced access to health care. Particularly among the low-income countries of central Asia and the Caucasus, public expenditure on health has fallen as a percentage of GDP (see Table 25.7). As a consequence of lower public expenditure, private expenditure on health now dominates in these countries (see Fig. 25.12).

The increase in private out-of-pocket expenditure for health care has adversely affected access to, and affordability of, services that differentially disadvantage the poor (UNICEF, 2006a). As stated above (in the section on "Health care deprivation"), this has led to health care deprivation for poor children in the most vulnerable areas of the Region.

Inequities within countries

Inequities in access to specialist care between countries – due to education, income and proximity to hospitals – were considered in the preceding section. Inequities within countries are most striking in the low-income countries of the Region with high levels of child poverty. The findings shown in Table 25.8 indicate that the poorest groups are most likely to avoid medical contact because of lack of money. Also, they show that, even among the richest fifth of the population, lack of money can deter people from seeking medical help. In Armenia, Georgia and the Republic of Moldova, more than 50% of their populations were deterred from using medical services due to lack of money (Walters & Suhrcke, 2005).

Table 25.7. Trends in public expenditure on health as a percentage of GDP and per person in PPP$

Country	Public expenditure on health as per cent of GDP			Per person government expenditure on health in US$ (adjusted for PPP)
	1991	1998	2002–2004	2003
Bulgaria	6.4	3.4	4.4	312
Romania	3.3	4.1	3.7	340
Albania	4.8	1.2	1.8	153
Bosnia and Herzegovina	3.5	4.9 [a]	4.8 [a]	166
Croatia	NA [b]	4.6	6.5 [a]	701
The former Yugoslav Republic of Macedonia	NA [b]	5.0	5.4	329
Former state union of Serbia and Montenegro	4.8	5.3	7.2 [a]	282
Belarus	3.1	4.9	4.7	406
Republic of Moldova	3.9	4.2	4.4	96
Russian Federation	2.8	3.9	3.9	325
Ukraine	3.3	3.5	3.5	201
Armenia	3.2	1.6	1.4	61
Azerbaijan	4.3	0.9	0.8	33
Georgia	3.5	0.8	0.8	42
Kazakhstan	4.3	1.8	1.6	180
Kyrgyzstan	NA [b]	2.6	2.1	66
Tajikistan	NA [b]	1.1	1.0	15
Turkmenistan	NA [b]	3.6	2.9	149
Uzbekistan	2.9	3.3	2.4	68

[a] These data on public expenditure on health as a percentage of GDP were computed using statistics drawn from various editions of the World Health Report.
[b] NA = not available.
Source: Adapted from UNICEF (2006a:47). Reproduced with the permission of the copyright holder.

Table 25.8. Respondents who did not visit a doctor when ill because of lack of money by asset quintile

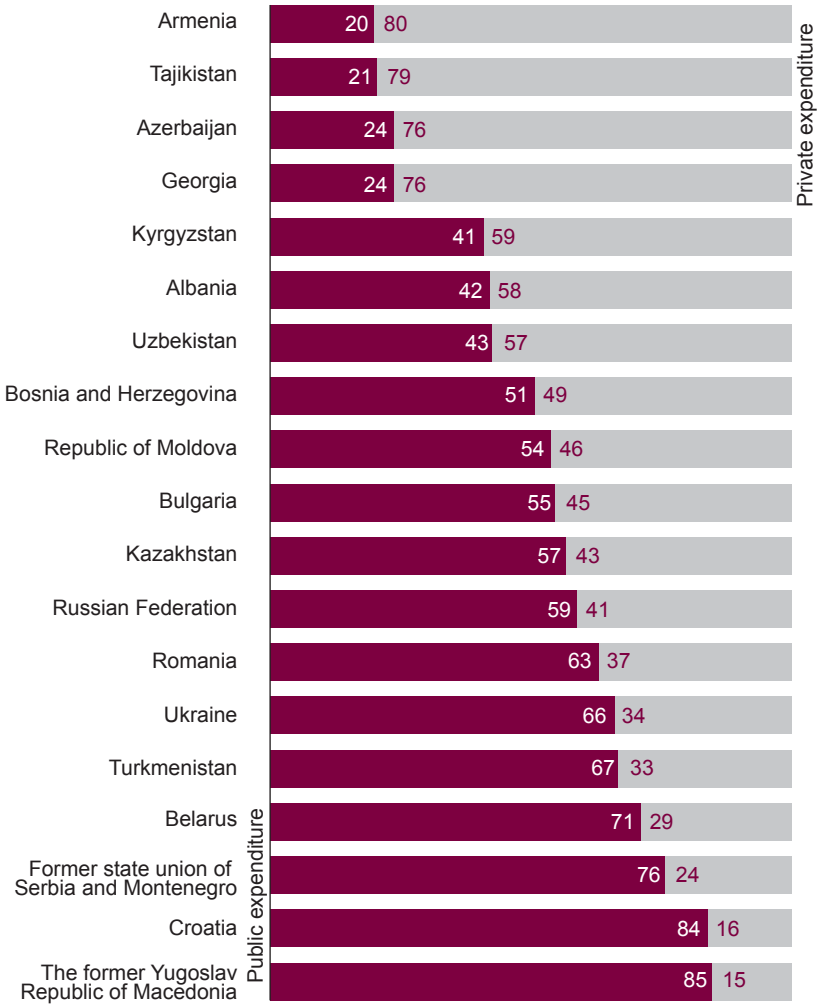
Country	Poorest quintile	Richest quintile	Ratio of poor to rich
Armenia	92.5	36.6	2.53
Georgia	78.9	38.1	2.07
Republic of Moldova	66.7	33.3	2.00
Kazakhstan	63.0	10.3	6.12
Ukraine	54.1	3.1	17.45
Kyrgyzstan	52.0	9.5	5.47
Russian Federation	13.1	2.2	5.95
Belarus	0.0	0.0	–

Source: Adapted from Walters & Suhrcke (2005:36).

Even in such countries as Belarus, which have maintained a health service that is free at the time of use, high-income households can afford medical services outside the public health care system (UNDP & Government of the Republic of Belarus, 2005). In Belarus, the richest 10% spent four times more that the poorest 10% on drugs and medical services in 2004 (UNDP & Government of the Republic of Belarus, 2005). In Turkey, the poorest fifth of the population is much less likely to receive medical treatment for an acute respiratory illness than the richest fifth (25.3% compared with 54.4%) (Gwatkin et al., 2001).

Ethnic minority groups, particularly Roma, may experience discrimination that limits their access to health care (Reading, 1997). Among Roma populations, barriers to treatment of TB, including cost and discrimination, ensure that levels of TB remain high (Darbyshire, 1995).

Fig 25.12. Proportion of private-to-public health expenditure in the CCEE/NIS



Source: Adapted from UNICEF (2006a:48). Reproduced with the permission of the copyright holder.

Existing policy frameworks to address child poverty and minimize risks to health

Policy approaches to child poverty and inequities in child health can be divided broadly into those that address the *upstream*, macroeconomic factors responsible for child poverty and those that aim to alleviate the *midstream* and *downstream* effects of child poverty. Upstream policy initiatives involve efforts to address the macroeconomic environment, including fiscal measures (such as tax and social transfers) to reduce child poverty and measures that increase employment and educational opportunities and ensure an adequate minimum wage. Midstream and downstream policy initiatives involve measures to reduce the consequences of unhealthy circumstances, including health care provision and health promotion, and measures aimed at changing lifestyle.

Existing upstream approaches

The variation in child poverty rates across the high-income countries of the Region (Fig. 25.1) are in large part explained by social policy differences among these countries (UNICEF, 2005a). Fig. 25.1 shows the extent to which tax and transfer policies in different countries reduce market child poverty rates – that is, the child poverty rate that would occur in the absence of redistribution through taxes and transfers. Child poverty rates in most countries would be greater than 20% without redistribution through taxes and transfers. The Scandinavian countries are the most successful at reducing child poverty

rates, although France has achieved a considerable reduction from a high market child poverty rate of 38%. Although child poverty rates have increased in many high-income countries in the last five years, countries such as Norway and the United Kingdom have succeeded in reducing rates – albeit from very different initial levels (UNICEF, 2005a). The United Kingdom government set itself the target of halving child poverty by 2010 and eliminating it by 2020 (Stewart, 2005). There has been some progress towards these targets, mainly through redistributive fiscal policies targeted at families with children. These policies include tax credits for working families with children and increases in the child benefit for the first child, increased allowances for younger children in non-working households, and increased maternity allowances (Stewart, 2005).

Besides tax and transfer policies, family structure, employment and wage levels, particularly at the lower end of the wage scale, are important determinants of child poverty in high-income countries (UNICEF, 2000b). In all countries, children in single parent households were more likely to live in poverty than those in families where both parents lived together. Also, the proportion of children living in households with no working adult and with the main breadwinner earning less than two thirds of the national median income accounted for the variation in child poverty rates among countries (UNICEF, 2000b).

Maternity and family allowances are important mechanisms through which redistribution to children takes place. In the CCEE/NIS, the levels of maternity allowances and leave entitlements vary, but are generally comparable to those in the high-income countries of the Region (Stewart & Huerta, 2006). For example, Croatia spends more on maternity leave benefits as a proportion of GDP (0.9%) than Norway (0.8%) and Sweden (0.75%) (Stewart & Huerta, 2006:13, Fig. 6). Also, family allowances in the low- and medium-income countries tend to be lower in proportion to GDP than in the high-income countries, although Belarus and Romania spend similar proportions to those spent by Denmark, Finland, Germany, Sweden and the United Kingdom (Stewart & Huerta, 2006). In Belarus and Romania, the family allowance is universal, as it is in the United Kingdom, but in most of the CCEE/NIS it is means tested (Stewart & Huerta, 2006).

The effect of family/child allowance and other benefits on poverty in the CCEE/NIS is limited (Stewart & Huerta, 2006). Table 25.9 shows the effect on the poverty rate and the poverty gap (the extent to which the average poor household falls below the poverty line of US$ 2.15 (adjusted for PPP) per person per day) in three countries for households with a child aged 0–6 years. The family/child allowance has little effect on the poverty rate, especially in Albania and the Republic of Moldova, but it has a greater effect on the poverty gap. Also, a powerful means of overcoming intergenerational poverty and promoting early child development is education, especially in the early years (Maggi et al., 2005).

Among the high-income countries, the provision of early child care varies, but many of them now have well-developed, high-quality systems of early child care and education that is accessible and affordable for all children, irrespective of income. These systems contribute positively to the development of less advantaged children, who gain most from them (Sylva et al., 2004), and also provide the opportunity for mothers and carers to seek paid employment, further enhancing the household income. For children younger than 2 years, child care may be detrimental to their development (Maggi et al., 2005), but above this age the benefits are widely accepted.

In Belgium, France and Italy, more than 90% of 3–6-year-olds were enrolled in universal, free day-care nurseries (part time in the case of Italy) in the mid-1990s. Denmark, Germany and Sweden also have high uptake rates of affordable preschool child care. In the United Kingdom, 96% of 3–4-year-olds now attend nursery part time as a result of a recent government commitment to provide a free part-time place for all children in this age group (Maggi et al., 2005). Also, the Sure Start local programmes in the United Kingdom, targeted at the most disadvantaged children, aim to provide a range of services for children and their carers (Belsky et al., 2006). These programmes are sensitive to local needs and are designed to overcome some of the early detrimental effects of social disadvantage. The initial national evaluation suggests that the programmes have been only partly successful and that some of the most disadvantaged children may have gained least from them or even become more disadvantaged following them (Belsky et al., 2006). So far, the reasons for this apparent effect on the most disadvantaged are unclear.

The former socialist countries have a long tradition of providing early child care, although the age groups covered and proportion attending vary widely (Stewart & Huerta, 2006). Providing money for parents to stay at home on extended leave has ensured that children younger than 3 years in many countries were not placed in nurseries. Belarus, Croatia, Romania, the Russian Federation and Ukraine have strengthened this provision since their transition to a market economy (Stewart & Huerta, 2006). In 1989, for children older than 3 years, preschool attendance was common, although rates varied from 70% in the Russian Federation to as low as 16% in Tajikistan. Since the transition to a market economy, rates have risen in many of the higher-income states of the CCEE/NIS, but have fallen in the lower-income countries of south-eastern Europe and central Asia (Stewart & Huerta, 2006).

Table 25.9. Effect of child allowance and other benefits on market poverty rate and poverty gap

Country	Measure	Income only (%)	Plus child allowance (%)	Plus other benefits (%)	Percentage fall after child allowance	Percentage fall after other benefits
Bulgaria	Poverty rate	32.9	30.6	21.3	7.0	30.4
	Poverty gap	15.3	13.6	9.7	11.1	28.7
Albania [a]	Poverty rate	43.5	42.7	37.1	1.8	13.1
	Poverty gap	16.7	15.5	13.1	7.2	15.5
Republic of Moldova	Poverty rate	60.4	59.7	55.6	1.2	6.9
	Poverty gap	23.7	23.0	20.2	3.0	12.2

[a] For Albania, the category of economic assistance is analysed in place of child allowances. The poverty rate is the share of households containing a child aged 0–6 years living below the US$ 2.15 poverty line.
Source: Stewart & Huerta (2006:38). Reproduced with the permission of the copyright holder.

Existing midstream and downstream approaches

Most EU countries have strategies for tackling health inequities (Costongs et al., 2007). In some countries, including Denmark, Finland, Sweden and the United Kingdom, strategies combine upstream approaches with midstream and downstream approaches. The combination of these approaches is most likely to be successful in reducing inequities in health (Costongs et al., 2007). For example, the United Kingdom government commissioned a report on health inequalities, the Acheson Report (Acheson et al., 1998); it made a series of recommendations that addressed both upstream factors and midstream and downstream factors. Since the Report's publication, United Kingdom government policy has been broadly guided by its recommendations, although the balance of government initiatives has recently shifted to midstream and downstream strategies (Dowler & Spencer, 2007).

In most countries, the strategies focus on midstream and downstream factors, such as health care access, health education and promotion, and lifestyle issues. Of four examples of good practice cited in Costongs et al. (2007), only one addresses both upstream factors and midstream and downstream factors that influence health in a disadvantaged neighbourhood in Madrid. This programme, based on an agreement between the government of the Community of Madrid and associations of residents, involves investment in education, health and youth services in the neighbourhood. The other three examples are concerned with supporting pupils missing school because of illness (Netherlands), family support through parenting programmes and counselling (Ireland), and improving uptake of services for early detection of health problems among disadvantaged children in Germany.

Emerging know-how and policy implications

Integrating health and social protection systems

Key policy priorities that address the upstream determinants of health inequities identified at the Lisbon Special European Council: towards a Europe of Innovation and Knowledge, in March 2000, are as follows (Judge et al., 2006:6–7).

- **Increasing labour market participation.** Seen as the most important priority by most Member States, this translates into expanding active labour market policies and ensuring a better linkage between social protection, lifelong learning and labour market reforms, so that they are mutually reinforcing.
- **Modernizing social protection systems.** This ensures that sustainable social protection schemes are adequate and accessible to all and that benefits aimed at those who are able to work provide effective work incentives and enough security to allow people to adapt to change.
- **Tackling disadvantages in education and training.** This lays emphasis on: preventing early departure from formal education and training; facilitating the transition from school to work, in particular for school dropouts with low qualifications; increasing access to education and training for disadvantaged groups and integrating them into the mainstream education system; and promoting lifelong learning, including e-learning (computer-enhanced learning), for all. Many recognize the need to invest more, and more efficiently, in human capital at all ages.

- **Eliminating child poverty.** This is seen as a key step in combating the intergenerational inheritance of poverty. Particular focus is given to early intervention and early education in support of disadvantaged children and to enhancing income support and assistance to families and single parents. Several countries also put increasing emphasis on promoting the rights of the child as a basis for policy development.

- **Ensuring decent accommodations.** In some Member States, attention is being given to improving housing standards; in others, it is being given to the need to address the lack of social housing for vulnerable groups. Several Member States are developing more integrated approaches to tackling homelessness.

- **Improving access to quality services.** This includes improving access to health and long-term care services, social services and transport; improving local environments; investing in adequate infrastructure; and harnessing the potential of new, accessible information and communication technologies for all.

- **Overcoming discrimination and increasing the integration of people with disabilities, ethnic minorities and immigrants.** The fight against high levels of exclusion experienced by such groups involves a mixture of increasing access to important services and opportunities, enforcing legislation aimed at overcoming discrimination and developing targeted approaches. In particular, the difficulties faced by Roma require special attention.

These policy priorities require action across sectors of government and are not the domain of the health ministries alone. Integrating policies with health service initiatives and interventions, to address these priorities, is essential. Integrating policies across government sectors is also stressed as a requirement for equity in the WHO European strategy for child and adolescent health and development (CAHD) (WHO Regional Office for Europe, 2005). Health-service-based interventions are necessary, but not sufficient, to tackle health inequities.

Integrating policies across governmental sectors will require the political will to overcome the barriers that exist between ministries and government departments. Essential to this integration process is high-quality data on the current situation and trends in health inequities. One lesson that comes from preparing this background chapter is that, although data are available on health inequities among adults within countries, there is a paucity of similar data on children.

Health system access

As discussed in the section on "Inequities in health care use: inequities between countries", children in high-income countries have good, broad access to primary care services, although children in low-income households may be less likely to use specialist services. The evidence available relates primarily to whole populations, and data specifically on inequities in children's access to health care services in EU countries are limited. Evidence from the United Kingdom suggests that the so-called inverse care law or inverse equity hypothesis, which states that those most in need of services are least likely to get them, operates in child health services in the United Kingdom, with the result that children looked after by the state, Roma children, refugee children and asylum seekers are underserved – even by health services that are free at the time of use (Webb, 1998). In EU countries, further studies are needed to address the issue of health care access for children, with particular emphasis on equity of access for all groups, independent of household income, ethnicity and disability.

In the low- and middle-income countries of the Region, rising out-of-pocket health costs and lower public expenditure on health care are a particular threat to poor children and their families. Urgent attention is needed in these countries to ensure universal access to affordable health care for all children. Special attention will need to be paid to Roma children, so that the effect of discrimination is minimized and special outreach services are established to address urgent health needs. Poor children in rural areas in the low-income countries of the Region are also likely to experience difficulties in accessing high-quality paediatric and child health care. Access problems can be overcome by providing good basic primary child health care services supported by specialist outreach services and emergency transport services from rural areas. Such measures will require a move away from the current health reform programmes that penalize the poor and a move towards (and in some countries, a return to) systems that pool risks across the whole population by redistribution from rich to poor (Whitehead, Dahlgren & Evans, 2001).

Addressing priority public health considerations for poor children

The CAHD (WHO Regional Office for Europe, 2005) identifies priority areas for intersectoral and health service action to promote and improve child and adolescent health across the Region. The strategy is guided by four principles:

1. a life-course approach that focuses on the most vulnerable periods in fetal, neonatal, early childhood and adolescent development;
2. equity that recognizes the need to explicitly take into account the needs of the most disadvantaged;
3. intersectoral action; and
4. participation of the public and young people themselves in planning, delivering and monitoring policies and services.

The priorities areas considered below are of particular importance for poor children.

Newborn health

As considered above, in the section on "Inequities in birth weight and gestational age", health inequities that affect poor children become established in the fetal and neonatal periods. Increased rates of adverse pregnancy outcomes, such as low birth weight and preterm birth, mean that poor children are more likely to die in infancy, suffer ill health in childhood and have poorer adult health outcomes. Policy approaches that ensure all pregnant women have adequate resources to afford a nutritious diet and have access to high-quality antenatal and perinatal care are of pivotal importance to overcoming these inequities. The CAHD (WHO Regional Office for Europe, 2005) recommends policies to achieve specific targets for preconception, pregnancy and delivery for all women, with priority being given to ensure services developed to meet these targets are affordable and accessible to the poor. These targets include: folate supplementation and genetic counselling in the preconception period; prevention, detection and management of anaemia and intrauterine growth retardation in pregnancy; safe delivery by a skilled birth attendant; and early mother–baby contact and initiation of breastfeeding in the perinatal period.

Nutrition

The CAHD (WHO Regional Office for Europe, 2005) identifies intersectoral and health service actions that can be taken to improve the nutritional status of children. These actions include food-fortification programmes, legislation to protect breastfeeding, and promotion and extension of the Baby-friendly Hospital Initiative. A particular priority in the Region is to address the problem of large numbers of malnourished children in the central Asian states and south-eastern Europe. To raise children out of poverty, this is likely to require macroeconomic policies aimed at promoting economic growth and equitable distribution of income.

Globally, over time, other poor countries have achieved high levels of child health and nutrition through a series of policy approaches that include achieving high levels of maternal education, distributing the proceeds of economic growth equitably and, specifically for nutrition, providing food subsidies (Mehrotra, 2000). To overcome the nutritional effect of absolute poverty, similar approaches are likely to be needed in the lowest-income countries of the Region.

In high-income countries, as well as in some of the low-income countries (such as Uzbekistan), obesity is becoming a priority. These countries want to ensure that the effect on public health of this new epidemic and its associated inequities are controlled and (where possible) reversed. As with many major threats to public health, the solutions are not confined to health services. Governments must address the obesogenic environments created by the food industry's promotion of foods high in sugar and saturated fats and the sedentary lifestyles induced by television viewing and home-based electronic entertainment systems (European Observatory on the Social Situation, 2005). In addition, there is limited evidence that school-based programmes and multifaceted interventions that promote healthy diets and physical activity are effective in reducing obesity in school children, particularly girls (European Observatory on the Social Situation, 2005). As recommended by the WHO European Ministerial Conference on Counteracting Obesity, in Istanbul, in 2006, a combination of macrolevel and microlevel policy interventions is required to address the complex interacting factors that drive the obesity epidemic (Branca, Nikogosion & Lobstein, 2007b).

Communicable diseases

TB and HIV constitute the most significant threats to health in most countries of the Region. The CAHD (WHO Regional Office for Europe, 2005) urges governments to enact reproductive rights legislation that includes access for adolescents to services and information, to ensure easy and free access to condoms for adolescents and to ensure the availability of essential drugs for HIV and TB to all, including poor and marginalized children. Special priority should be given to addressing endemic TB among Roma children in much of the CCEE. As indicated above, in the section on "Health system access", outreach services are needed that are specifically directed at case findings and treatment among these groups. As long-term courses of medication are required to treat TB, regular follow-up by outreach services will be needed to ensure compliance with treatment.

The rise in HIV in Ukraine and some other countries of the Region is fuelled by an increase in poverty, social exclusion and drug abuse. If the rise is to be halted, these social drivers will need to be addressed. Specific health care measures require the availability and affordability of antiretroviral drugs and the early identification of HIV infection in pregnant women, to minimize the chances of vertical transmission.

Measles remains a significant threat to child health, especially in countries in the Region with high levels of malnutrition. In particular, Roma children are vulnerable, as a result of low immunization levels. Where immunization uptake is below the level required to maintain community immunity, immunization campaigns (combined with general improvements in vaccination programmes) should be instituted to increase coverage. The CAHD recommends intersectoral action to enact legislation that makes the provision of recommended immunizations mandatory and free to all children.

Injuries and violence

For road accidents, there is good evidence that area-wide engineering schemes and traffic-calming measures reduce traffic injuries and that bicycle helmets offer protection from head and brain injuries. Educational campaigns and legislation can increase the use of car restraints for children and the use of bicycle helmets. Also, smoke detectors and child-resistant containers reduce injury among high-risk households, and home-based support can substantially reduce rates of accidental injury (Asthana & Halliday, 2006). Measures based on this evidence should be widely introduced to reduce inequities associated with accidents and injuries among children. The CAHD recommends legislation to ensure that these measures are introduced to protect children from unintentional injury.

Protecting children against violence within the family and within countries is a major challenge. The evidence available suggests that poor children may be more vulnerable to intrafamilial violence (see the section on "Inequities in accidents and injuries"), although it is important to note that the process of recognition and reporting of intrafamilial child abuse and neglect may be biased against poor households. Poor children, however, are more likely to be exposed to violence outside the home and to be affected by trafficking in children and by violent conflicts, such as gang conflicts and wars. The CAHD (WHO Regional Office for Europe, 2005) proposes actions that governments and health services can take to protect children against violence. These actions include comprehensive legislation on child protection, paedophilia and child trafficking, and specific child protection and psychosocial support programmes for children and adolescents in situations where they are highly vulnerable.

Environment and health

The Children's Environment and Health Action Plan for Europe (WHO Regional Office for Europe, 2004a) identifies four regional priority goals:

1. improve access to safe and affordable water and sanitation for all children;
2. promote safe, secure and supportive human settlements for children;
3. reduce outdoor and indoor pollution; and
4. reduce exposure to hazardous chemicals, physical and biological agents, and hazardous working environments during pregnancy, childhood and adolescence.

The Plan lays out specific actions that need to be taken to achieve these goals. Achievement of these goals would have a huge positive effect on the health of children across the Region, particularly those in low- and middle-income countries.

Mental health

Between 10–20% of adolescents in the European Region are estimated to have one (or more) mental or behavioural problem (WHO Regional Office for Europe, 2005), and these problems frequently start much earlier in life. As considered above, in the section on "Mental health: inequities within countries", poor children and adolescents are more vulnerable to mental health problems than their more privileged peers. Improving the early life circumstances and life chances of poor children are likely to be important to reducing inequities in child and adolescent mental health and CAHD (WHO Regional Office for Europe, 2005). These inequities highlight the need for investing in the most vulnerable households and giving priority to the periods of greatest vulnerability, including adolescence. With particular reference to policies, programmes and health systems that address adolescent mental health, the CAHD (WHO Regional Office for Europe, 2005) proposes, among other things, the following targets: protection from exploitation, control of inappropriate adolescent-centred marketing, youth-friendly counselling and mental health services, and healthy school environments that facilitate well-being.

Discussion points and questions

1. In contrast to data collected by the EU health inequalities network on social inequalities in adult health, there is a paucity of data on social inequities in child health in many European countries, which leads to the following question. How can more comprehensive data on child health inequities that covers the whole Region be developed?
2. What child health outcomes and poverty/socioeconomic status measures should be collected for a comprehensive Regional poverty and child health database?
3. Are different data collection strategies needed in different parts of the Region and, if so, what are they?
4. In the low-income countries of the Region (and those in transition), what are the priority areas for reducing risks to health among children in absolute poverty?
5. In the high-income countries of the Region, what are the priority areas for reducing risks to health among children in relative poverty?
6. What is the role of the health sector in reducing these risks and what are the benefits of intersectoral cooperation?
7. What are the barriers to the implementation of upstream policies aimed at reducing child poverty in the low-income countries of the Region? How can they be overcome?
8. What are the barriers to the implementation of upstream policies aimed at reducing child poverty in the high-income countries of the Region? How can they be overcome?
9. What are the barriers to short-term, midstream and downstream policies that could be implemented to reduce the effect of poverty on child health? How can they be overcome?

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Annex 2. Dedications and acknowledgements

Dedications

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"National health programmes in rich and poor countries alike are grappling with social factors, such as education, living and working conditions, and economics. However good a health technology is, it cannot work if people are denied access to it. Where health workers struggle blindly with these social factors their projects are liable to fail. Where they work with open eyes, using what is known and uniting their efforts with those of colleagues in other sectors, they can be highly effective. A great deal is known around the world about the social determinants of health, but that knowledge needs to be drawn together, more clearly understood and put more systematically to use."

- LEE Jong-wook at the inauguration of the Commission on Social Determinants of Health, 18 March 2005, Santiago, Chile

Dr Jo Eirik ASVALL

WHO Regional Director for Europe from 1985 to 2000

Dr Asvall championed and shepherded the development of the WHO European Health for All strategies and targets from concept to practical application in local communities and institutions across the now 53 Member States in the European Region. This approach, supported by a new database that compared health system performance in all WHO European countries on many common health indicators, inspired health systems to look beyond services and to tackle previously neglected social, lifestyle, and environmental determinants of health. He brought new resources and attention to tackle growing health inequities and gaps between and within all countries. Dr Asvall was a true leader in European health policy and public health. He was an extraordinary person, an inspiring, energetic and relentless public health advocate whose life's work has significantly improved the capacities of health systems across the Region to address health challenges and serve all people.[1]

Acknowledgements

This publication represents the outcome of a call by WHO to Member States in the European Region for case studies on how health systems can address poverty and health. The studies were elaborated by focal points nominated by their ministries and, in some cases, co-authors. In addition to the case studies, the report contains three background papers commissioned by WHO. A full list of authors is featured in Annex 1. WHO extends its sincere appreciation to all of the authors for their valued contributions. The production of this book also entailed a task force meeting and European consultation on poverty and health in late 2007, the latter convening over 100 representatives from 25 European Region Member States.

The production of this book was carried out under the overarching guidance of Erio Ziglio, Strategic Objective 7 focal point for the Regional Office for Europe and Head of the WHO European Office for Investment for Health and Development, in Venice, Italy. Editing of the text, design of the case study criteria, and coordination of this book's production—including overseeing the task force activities and European consultation—were conducted by Theadora Koller, technical officer. The administrative focal point for the book's production and all related events was Bianca Bortot, secretary. Budgetary oversight was provided by Simone Tetz, administrative officer.

The production of this book involved representatives from across the European Region, some of whom are listed below in groupings and in alphabetical order. It is impossible to feature all people who contributed, and we apologize in advance for omissions.

[1] Adapted from Apfel F. Jo Eirik Asvall: Refocused the World Health Organization in Europe on public health. *British Medical Journal*, 2010, 40:c1652.

The people below commented on one or more case studies or background papers, and/or had key roles in the task force meeting and European consultation where case study outlines or drafts were reviewed: Joseba Achotegui, Fiona Adshead, Enis Barış, Ben Barr, Claudio Beltrame, Rachid Bennegadi, Luigi Bertinato, Mats Bjurvald, Jonathon Bradshaw, Ģirts Briģis, Claude Cahn, Manuel Carballo, Francesco Castelli, Francesco Cicogna, Maria Grazia D'Aquino, Göran Dahlgren, Savelina Danova-Russinova, Peter Donnelly, Heather Doyle, Jon Friedland, Nicolae Gheorghe, David Gordon, Michele Gragnolati, Janette Gronfors, Sally Hargreaves, Christopher Heginbotham, Lucie Horvathova, David Ingleby, Lord Kamlesh Patel Obe, Hans Kluge, Lennart Kohler, Mihály Kokeny, Zemfira Kondur, Anton Kunst, Lennart Levi, Louis Loutan, Michele Maglio, Margareta Matache, Martin McKee, Azbija Memedova, Begoña Merino Merino, Marjan Muratovic, Clive Needle, Maria Nemenyi, Beata Olahova, Paola Pace, David Parker, David Pattison, Juergen Pelikan, Roumyana Petrova-Benedict, Alessandro Pigatto, Jan Pruessmann, Richard Reading, Benedetta Rotesi, Giancarlo Ruscitti, Alfons Schröer, Vittorio Silano, Fabrizio Simonelli, Andor Urmos, Denny Vågerö, Simone Weyers, Margaret Whitehead, Alexander Vladychenko, and Alberto Zanobini. WHO temporary adviser Marta Schaaf provided input to multiple case studies on Roma health, in addition to authoring the background paper on this topic.

The Italian National Institute for Health, Poverty and Migration, in addition to providing financial support to the production of this book, contributed to the task force meeting and European consultation. Established in Rome in 2006, the Institute works to promote health in populations experiencing social exclusion and to reduce poverty-related diseases. Particular gratitude goes to Aldo Morrone, head of the Institute, for his strong commitment to activities related to follow-up to resolution EUR/RC52/R7 on poverty and health. Further appreciation is extended to Raffaele Di Palma, who oversaw support for the publication of this report, as well as to Anna Lisa Marini and Roberta Calcaterra for their contributions to related activities.

Financial support and in-kind contributions (including of staff time and premises) were provided by other partners for the follow-up process to resolution EUR/RC52/R7. These partners/co-organizers included the Federal Ministry of Health of Germany; the Tuscany Region (Italy); the WHO Collaborating Centre for Health Promotion and Public Health Development (National Health Service, Scotland, United Kingdom); the Veneto Region of Italy; the Venice Local Health Unit Azienda ULSS 12 Veneziana; the WHO Collaborating Centre for Policy Research on Social Determinants of Health (University of Liverpool, United Kingdom); and the WHO Collaborating Centre for Health Inequities in Insurance-based Health Systems (BKK Bundesverband – Federal Association of Company Health Insurances, Germany). A special note of appreciation goes to the Istituto Veneto di Scienze, Lettere ed Arti, whose cooperation was essential for the European consultation.

WHO wishes to thank the Italian Ministry of Health and the Veneto Region for their longstanding support to the work of the WHO European Office for Investment for Health and Development.

Throughout the production process, essential inputs were provided by WHO staff from across the Regional Office for Europe. Particular gratitude is expressed to the following staff in WHO country offices, whose input and collaboration made this book possible: Nazira Artykova, Mina Brajovic, Cassandra Butu, Haris Hajrulahovic, Rusudan Klimiashvili, Geraldine McWeeney, Paulina Marianna Miśkiewicz, Mirza Muminovic, Barbora Neubauerova, Dorit Nitzan, Victor Stefan Olsavszky, Zsofia Pusztai, Darja Radonjic, Aiga Rūrāne, Darina Sedláková, Santino Severoni, Alena Steflova, Pavel Ursu, and Melita Vujnovic.

In addition, these WHO colleagues (some of whom are now former colleagues) provided technical, administrative, editorial and/or organizational input during the production of this book: Rasul Baghirov, Valentina Baltag, Chiara de Bastiani, Andrea Bertola, Antonella Biasiotto, Chris Brown, Mary Stewart Burgher, Pamela Charlton, Lisa Chen (intern), Pierpaolo de Colombani, Fabrice Danjou (intern), Gauden Galea, Egle Granziera, Tamás Evetovits, Matt Jowett, Eero Lahtinen, Evis Kasapi, Marija Kisman, Gudjon Magnusson, Åsa Hanna Mari Nihlén, Mikael Ostergren, Jeremy Veillard, Eugenio Raul Villar Montesinos, Dinesh Sethi, Sarah Simpson, Marc Suhrcke, Hayley Tangaroa, Isabel Yordi Aguirre, and Cristian Montaño Arevalo (intern).

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