

**IMPACT ANALYSIS OF THE HEALTH POLICIES ON THE
ACCESSIBILITY OF HEALTHCARE FOR THE ROMA POPULATION
IN SERBIA**

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Analysis of impact of public policies implemented in the period 2003-2007

Every responsible government bases its public policies on detailed analyses and information. International best practices show that the established system and regular public impact analyses contribute to enhanced transparency of Government work, development of more efficient and effective measures and better allocation of available funds and capacities.

Poverty Reduction Strategy Implementation Focal Point launched the Analysis of Impact of Public Policies implemented in the period 2003-2007 in order to establish how efficient had been certain measures implemented in that period. In this way we have sought to identify measures that led to improvement of the life of citizens in Serbia as well as those that are not cost effective and need to be made either more efficient or revoked.

The analysed measures were identified in cooperation with the colleagues from Governmental and non-governmental agencies.

We analysed the direct impact of active labour employment measures and their indirect impact on poverty reduction. We also analysed the links between employment and education of adults i.e. employment and the implemented additional trainings and re-trainings. Since lack of education has been identified as one of the key causes of poverty in Serbia, particular attention in the analysis was paid to educational interventions taken in the period 2003-2007 and their impact on poverty reduction. We analysed the impact of introduction of mandatory preschool education, examined the relationship between quality of education and poverty as well as impact and efficiency of affirmative measures implemented over the past four years. In the area of health, we analysed the impact of measures targeting the most vulnerable population with a special focus on Roma. In order to complete the image on the efficiency of State measures on the most vulnerable, we conducted a detailed analysis of impact of cash benefits received by the population in Serbia (MOP and child allowances). The impact of material subsidies that small and medium size enterprises were eligible for was also subject of analysis as was the impact of Government measures for agriculture development promotion.

The obtained results in the process of policy impact analyses were presented to relevant Government institutions and civil society. Future directions were agreed jointly. In this way, we enabled direct influence of results of analyses on defining measures for improvement of lives of the most vulnerable citizens of Serbia in the coming years. The process itself will influence development of capacities of Government institutions for regular analysis of impact of public policies and establishment of a continuous process highlighting commitment to development of democratic and accountable government.

The final versions of the above analyses are available at www.prsp.sr.gov.yu

Abstract

The impact analysis of health policy measures on the access of the Roma population in Serbia to healthcare is part of a broader analysis of the impact of the policies implemented in the period between 2003 and 2007, being part of the group of policies which the *Poverty Reduction Strategy* in Serbia is based on. For this reason, the strategic framework for the policies that are being implemented, and which especially target the Roma as a socially vulnerable category of the population, is precisely this strategy, but also the strategic documents of the Government of the Republic of Serbia such as *Health Care Policy of Serbia, Better Health for All in the Third Millennium, Decade of Roma Inclusion 2005-2015*, as well as the *National Health Care Action Plan for Roma*. All other endorsed strategies and action plans highlighting an integrated approach to health care of all vulnerable groups including Roma, are also of paramount importance.

In view of the fact that the health care system in Serbia is such that all the citizens are offered the possibility of using the health care services provided by state-owned health care institutions and that the laws regulating health insurance and health care single out the categories of the population which, on the basis of social care, realize their right to health insurance, especially emphasized are those solutions in the law which enable the socially vulnerable Roma to realize their right to access to health care, and the effects of their implementation were analyzed. This especially refers to the Law on Health Insurance and the article of the law which, apart from the other groups of the socially vulnerable population, also defines as insureds the Roma who, due to their traditional way of living, have no permanent residence in Serbia. However, the analysis of the law's implementation has shown that its effects are limited, primarily due to the short period in which it was implemented, since the implementation of the provisions of this law started in January 2007.

From all the above mentioned it is possible to anticipate the goal of this analysis, which is recognized in the identification of the results of the implementation of health policy measures in regard to the accessibility of health care services to the Roma population, but also the obstacles accompanying their implementation. Namely, based on the data from the 2007 Living Standards Measurement Survey it was assessed that 17% of the Roma in Serbia have no health insurance, which is more than double compared to the total population. The statistics referring to the health status of the Roma population are unfavorable to a far greater extent than is the case with the total population. However, when compared to the previous period, with all the limitations resulting from the lack of updated information about the Roma population in Serbia, these statistics show a mild improvement in access to health care.

The goal of the activities being carried out within the Decade of Roma Inclusion, by the Republic of Serbia's Ministry of Health, through public and civil sectors partnerships, is also to improve the access to health care for the Roma population in Serbia. Despite positive results, the impact of the implemented programs and projects is insufficiently pronounced, due to the small coverage of the targeted Roma population. Examples of good practices in the European Union point to the recommendations of the Council of Europe's Committee of Ministers whose goal is considerably to improve access to health care for the Roma and nomadic populations in Europe. However, it is not only Serbia but all the signatory countries of the Decade of Roma Inclusion that have achieved modest results in the previous period of the implementation of this document, syndicated by the reports of a group of Roma activists „*Decade Watch*".

The entire analysis presented in this study, has resulted in general conclusions and recommendations which should be borne in mind in order for the implementation of the previous measures, relating to access to health care for the Roma population in Serbia, to produce better results and open up possibilities for their revision.

First, the current health care policies are good, In order for them to have stronger effect on improvement of health status of the targeted population, their implementation needs to be intensified with greater involvement of the Ministry of Health and other relevant ministries as well as local authorities and the civil sector dealing with Roma problems, through implementation of partnership programmes and projects.

Second, the ministries of health, education, labour and social policy, youth and sports local self-governments and non-governmental sector should jointly develop programs for Roma population adjusted to their specific need. This would, in the long term, lead to them becoming part of the system of health care of population in Serbia.

Third, changes and addenda of the relevant regulations should be introduced to remove administrative barriers for accelerated issuance of a unique citizens' registration number and health cards for Roma who do not have habitual/temporary residence. To that effect, adequate campaigns should ensure better information of Roma on procedures and possibilities for issuance of health cards with a view to their enhanced inclusion into the health care system.

Fourth, a «door to door» information campaign targeting Roma families should be launched on their rights from the area of health insurance and ways to exercise these rights. This particularly refers to the rights of socially vulnerable Roma mentioned in Article 22 of the Law on Health Insurance.

Fifth, the Ministry of Health and the local self-governments should, in cooperation with non-governmental sector and with media support, launch a wide campaign to educate socially vulnerable Roma on responsibilities for their own and health of their families. This would help promote healthy life styles, care of health and importance of prevention.

Sixth, it is paramount importance to publish a tender for participation in projects early in the calendar year, and on the basis of funds established in the Law on Republican Budget. It should establish a team of experts to duly evaluate the offers submitted and decide on participation implementation of programs and projects in the current year. The team of the Ministry of Health should develop a reporting format and evaluate results to form basis of the next project cycle.

Seventh, on the basis of reports submitted in a given format, the Ministry of Health should secure establishment of electronic databases in order to provide for accurate impact evaluation and reduce risks to effective implementation or completion of projects.

Eighth, in order to provide accurate impact analyses on measures targeting Roma population to the decision-makers, the government statistics office i.e. the Republic Statistical Office, should take over the responsibility and an obligation to establish essential databases for monitoring and analysing inclusion of Roma into the health care system and utilization of health care services. The main criteria for evaluation of health policies endorsed through relevant strategies and laws by the Government should be borne in mind.

Ninth, with a view to extending life expectancy of Roma population and decreasing infant and child mortality, registers of Roma living in unfavourable hygienic conditions should be set up and immunisation and innoculation conducted.

Tenth, starting from the fact that almost 50% of Roma in Serbia live below poverty line, the cooperation between local non-governmental agencies dealing with health problems of Roma and local community institutions (health care institutions, public utility companies, sanitary inspections, etc) in order to reduce exposure of Roma to risks of contracting chronic contagious and non-contagious diseases, particularly those who live in unhygienic settlements and collecting scrap materials and having a monotonous diet.

1. INTRODUCTION

Poverty Reduction Strategy (PRS) Implementation Focal Point has initiated an analysis of the impact of the policies which the Government of the Republic of Serbia adopted and implemented in the period 2003 - 2007. The Living Standards Measurements Survey (LSMS) conducted in 2002 showed that vulnerable groups are more likely to fall sick or die of ordinary causes, including, tuberculosis, AIDS and malignant diseases. The activities within the PRS are primarily directed towards economic growth and development, as well as greater employment for the purpose of reducing the existing and preventing new poverty, and also towards the efficient implementation of programs for the poorest and socially vulnerable groups, which include the Roma as well. The PRS insists on the development of special national programs among which it also includes special programs of care for the health of Roma women. In this regard, one of the priorities of the PRS in the field of health care is to ensure access to health care services of adequate quality for the entire population, including vulnerable groups and Roma. The PRS emphasizes the importance of the better informing of these groups about the existing programs and services, as well as the possibilities for their use.

The Focal Point's initiative for doing the analysis of the impact of the adopted policies in the period 2003 - 2007 on the results achieved in the implementation of the PRS is part of the mentioned process and should provide a comprehensive assessment of the results of the process of implementing the PRS.

This study analyses the impact of the measures of health policies that enable the Roma in Serbia to have better access to health care, which is closely linked to the level of this vulnerable group's poverty. The social inclusion of the Roma represents an important aspect of the realization of their rights in the field of the health policy as well. It is on the basis of an analysis of the status of the Roma in Central and East European countries in 2002¹ that the "Decade of Roma Inclusion" initiative, the so-called Roma Decade, was adopted. The national action plans have encompassed four key fields: employment, education, health care and housing. The mentioned fields are mutually linked and they have a direct impact on increasing the social inclusion of the Roma as the basis for the reduction of poverty and the improvement of this vulnerable group's health.

The impact analysis of policies will focus on the measures being implemented as part of the Roma Health Care Action Plan which the Government of the Republic of Serbia adopted in 2005. Furthermore, Serbia has also adopted other policies pertaining to health care which are contained in several national strategies that have included sensitive groups as well: the Strategy for Youth Development and Health in the Republic of Serbia, the National Mental Health Protection Strategy, the National HIV/AIDS Strategy. The National Strategy for the Development of Social Welfare has devoted special attention to the problems of the Roma. However, it should be pointed out that, after the adoption of the Poverty Reduction Strategy in Serbia, an intensive process of the development of strategic planning at the local level started, and within it vulnerable groups were accorded a significant place.

¹ The regional report on the development of human rights and the social inclusion of the Roma in Central and Eastern Europe was made in 2002. This report analyses the status of the Roma in five countries (Bulgaria, the Czech Republic, Hungary, Slovakia and Romania) and it recommends the monitoring of the poverty of the Roma as a vulnerable group. See: "At Risk: The Social Vulnerability of Roma, Refugees and Internally Displaced Persons in Serbia", UNDP, 2006.

The goal of the analysis of the impact of the adopted strategic plans and laws, as well as the health policy measures implemented in the 2003-2007 period, directed towards the improvement of the accessibility of health care services to the Roma as one of the most important sensitive groups from the aspect of social inclusion, is to enable:

- The improvement of the process of planning and implementing planning documents in the field of the health policy aimed at improving the accessibility of health care services to the Roma, and which are based on facts and concrete information;
- The formulation of better decisions by the government within the health policies that would ensure the efficient allocation of resources for the implementation of programs for improving the health of the Roma;
- The provision of feedback on the efficiency of the implemented policies concerning the health of the Roma in Serbia and their impact on the development of future policies and programs.

1.1 Methodology of impact analysis of health policies on improvement of accessibility of health care services to the Roma in Serbia

The methodology of the impact analysis of adopted and implemented health policies on increasing the inclusion of the Roma in Serbia in the system of health care services for the purpose of improving their health is based on:

- The policies pertaining to the field of health care adopted by the Government of the Republic of Serbia, especially the Health Care Action Plan for Roma for the period until 2015 within the Decade of Roma Inclusion,
- The available information from the Living Standards Measurement Surveys for 2003 and 2007, which concern the inclusion of the Roma in the health care system and the use of health care services by the Roma,
- Available information from other surveys (UNICEF, UNDP, the Serbian Public Health Institute and others),
- Available information about the realization of projects in the field of health care for the Roma within the Republic of Serbia's Ministry of Health.

The methodology used for evaluating the implemented policies in the field of health care in the case of the Roma is based on the main criteria for evaluating the policies identified in practice, such as:

- The assessment of the priorities adopted within the analyzed policies,
- The assessment of the availability of the identified resources (budget), of how well equipped the institutions are, the technical assistance and other factors contributing to the realization of the priorities,
- The assessment of the supervision of the realization of projects concerning the implementation of policies directed towards improving the health of the Roma,
- Identification of the outcomes of the policies' implementation – the benefits,
- The possibility of identifying future effects of the policies aimed at increasing the inclusion of the Roma in the system of health care services –quantitative and qualitative effects,
- The possibility of isolating the difficulties that appear when measuring the impact of the policies that are to be implemented in the future,

- The assessment of the sustainability of the present policies aimed at improving the health of the Roma on a long-term basis.

The following techniques were used in the survey:

- In-depth (qualitative) analysis of the priorities in the adopted and implemented policies,
- A quantitative statistical analysis of the information about poverty, the health condition and the inclusion of the Roma in Serbia's health care system with all the relevant aspects,
- Interviews with the creators of health policies, experts, project managers, representatives of the Roma and the civil sector. Interviews carried out in direct conversations or by telephone. Interviews conducted on the basis of a questionnaire which the authors had created for the needs of this analysis, and which contains questions of relevance for doing an analysis of the impact of the implemented health policies,
- Analysis of the results of projects carried out in 2006 and 2007, linked to the implementation of the Health Care Action Plan for Roma for the period until 2015, within the Decade of Roma Inclusion, and on the basis of annual reports of the Ministry of Health,
- *Cost-benefit* analysis of the investments in programs for improving the health of Roma children and young people as the group with the largest share in the total Roma population in Serbia,
- Analysis of examples of best practices in the EU countries.

Based on the literature we have consulted, we have reached the conclusion that work on analyzing the impact of government policies on the final results, especially policies for the inclusion of the Roma, started recently in the world. Analyses of the impact of policies on the inclusion of the Roma mostly concentrate on specific narrow issues depending on the problems of importance for the Roma in certain countries. The common characteristic everywhere is that the Roma population has no permanent residence and that this population's inclusion in the social life is dealt with at the localities where it has registered residence. This is also the case with the Roma in Serbia. The creation of a methodology for making an analysis of the impact of health policies on the accessibility of health care services to the Roma is also hindered because of the difficulties in establishing reliable and continually comparable data and information used for this type of analysis. In our country there are surveys the results we have used, but it is difficult to establish a quality connection between the results of those surveys, since each of them was created according to the author's vision of the problem.

2. STRATEGIC FRAMEWORK FOR THE IMPLEMENTATION OF HEALTH POLICIES

A health policy directed towards improving the health of the Roma represents established strategic, medium-term and short-term goals whose realization, in a continual process, is linked to the improvement of the Roma population's health. At the national level, the goals, measures and activities are defined within government institutions as a response to the health needs of the Roma, whereby it is necessary also to pay attention to the available financial resources, available knowledge, as well as available health capacities. The establishment of partnership between national and local authorities, as well as between the civil and public sectors in the implementation of the health policy for the Roma, leads to the raising of the level of efficiency in satisfying their health needs i.e. the achievement of as large and as best a benefit for the Roma as possible compared to the funds invested in the implementation of programs intended for the resolution of this population's health problems.

The main goal of the reforms in the health care system, as defined in the Poverty Reduction Strategy, is to ensure access to health care services of adequate quality without financial barriers for the entire population, including vulnerable groups, which means the Roma as well.² This goal is being realized through the drawing up and implementation of national strategies in the field of health care, and under the framework of legislative solutions. Therefore, the two key strategic documents that are to improve access to health care services and to providers of health care services are the Poverty Reduction Strategy and the National Health Care Action Plan for Roma for the period until 2015 within the framework of the Decade of Roma Inclusion.

The creators of health policies, as well as representatives of medical institutions and the civil sector whom we have interviewed (a list of 23 participants in Annex 3), pointed to a large number of documents and laws that have been adopted at the national level, and which represent an institutional framework for the implementation of state health policies. There was not a single participant in the interviews who did not mention the importance of the Poverty Reduction Strategy in Serbia, the National Millennium Development Goals, the Decade of Roma Inclusion and the National Health Care Action Plan for Roma for the period until 2015, as well as the Law on Health Care and the Law on Health Insurance. The coordinators of the local projects of the Ministry of Health and local Roma non-governmental organizations and citizens' associations from the municipalities that have adopted the Local Action Plan for Children also mentioned it, stressing the importance of the realization of the goals related to the creation of equal conditions for providing a healthy and safe beginning of life for every child and for its further development. Furthermore, also mentioned were several examples of adopted local action plans for the improvement of the health of the Roma. At the level of two local units of self-government in Vojvodina, Novi Sad and Kikinda, where a large number of Roma - domicile, internally displaced and returnees, live in unhygienic settlements and slums, local action plans for improving the health of the Roma population have been developed. It should also be added that some attention has also been devoted to the health of the Roma through the development and implementation of local strategies for the development of social welfare, and two local units

² The first progress report on the implementation of the Poverty Reduction Strategy in Serbia, the Government of the Republic of Serbia, 2005. p. 64.

of self-government – Kragujevac and Svilajnac – have developed special action plans for sensitive and vulnerable groups, including the Roma.³

The main goal of the **Poverty Reduction Strategy** in the field of health care is the improvement of the entire population's health and the reduction of inequality in health by improving the health of vulnerable groups. The realization of this goal implies the development of health programs adjusted to vulnerable groups and a more just distribution of resources in health care. In this regard, emphasis was put on equal accessibility to the basic health care services for sensitive groups, which implies the additional allocation of funds from the Health Insurance Fund and the state budget.

The most important activities concerning the improvement of the health of the Roma in the PRS are directed towards:

- The adoption of programs facilitating the Roma's access to information and the possibility of using health care services;
- The recognition of special health care needs of the Roma, their linkage to welfare needs and synchronized action at all the levels of the community;
- Enabling medical services to recognize the needs of the Roma and to create conditions for the fulfillment of these needs;
- Special programs envisaging care about the health of Roma women;
- Integrating health care measures for the Roma into regular health care programs;
- The development and implementation of programs for protection from contagious diseases (which especially affect the Roma because of the conditions they live in, particularly if they live in unhygienic settlements⁴) – HIV/AIDS, tuberculosis;
- The realizations of actions promoting health, responsible behaviour and healthy life styles;
- Connecting institutions of primary health care – medical centers, with social welfare institutions, educational and other institutions for the purpose of the preservation, improvement and prevention of the health of the Roma as a vulnerable group;
- The drawing up and implementation of programs linked to the improvement of the health of young people and mental health;
- Increasing efficiency and effectiveness in the use of resources;
- The participation of the non-governmental sector in the creation and implementation of programs concerning the improvement of the health of the Roma;
- The introduction of a health care information system for the purpose of creating standardized and comparable data bases on the health condition of the Roma as a sensitive group and their constant updating, so as to make it possible to analyze the illnesses, deaths and use of health care services within this population;
- Changes in the legislative sphere that would enable the inclusion of the Roma in the overall health care system and would ensure adequate health care for this vulnerable group.

The Second Progress Report on the Implementation of the PRS defines the following short-term and medium-term priorities:

³ ESPI (2008), *Analysis of the Harmonization of the National and Local Strategic Framework in the Republic of Serbia*, study prepared by the Deputy Prime Minister's Poverty Reduction Strategy Implementation Focal Point.

⁴ Around 43% of the settlements where the Roma live are considered to be unhygienic as they do not possess the adequate infrastructure. – Jakšić (2002), quoted from "The Roma and the Right to Health Care in Serbia", Petar Antić, Minority Rights Center, Belgrade 2005, p. 6.

- The drafting of by-laws that will enable persons without permanent residence to have access to health care;
- The drawing up of health care programs for vulnerable groups at the level of local communities;
- The definition of mechanisms for including the Roma in programs for the implementation of national health policies defined by other strategies;
- Increasing the coverage of sensitive groups with health care and programs for the improvement of health;
- The development of inter-sector programs that would also imply the participation of the beneficiaries of these programs;
- The evaluation of the cost effectiveness of health care services for sensitive groups through the establishment of a system of national health care accounts.

As part of the **Decade of Roma Inclusion**, the Government of the Republic of Serbia adopted at the beginning of 2005 the **National Health Care Action Plan for Roma in the period until 2015**. Namely, the AP relies on the **Draft Strategy for the Integration and Empowerment of Roma** which is currently in the process of revision. The health care AP of the Decade of Roma Inclusion contains developed goals and measures in the field of the health policy for the Roma, primarily in the research for the purpose of identifying the health condition of the Roma and in the field of primary health care as the most important field for their effective inclusion in the country's health care system. Four strategic goals have been identified and within each of them the measures ensuring their realization were defined:

- Health care research with the goal of defining morbidity and mortality, as well as the main data bases on the health condition of the Roma population - 2005
 - A data base on households and household members
 - A minimal data base of indicators and data on the current health condition of the Roma population
 - An assessment of the health condition of the Roma population, as well as the primary samples for the morbidity and mortality of this population
- Ensuring the implementation of the present systemic laws pertaining to health care, with the goal of improving the realization of the right of the Roma, especially the high risk groups of the Roma, to health care – until the year 2010
 - Participation in a public debate on the Draft Law on Health Care
 - Lobbying for an increased allocation of funds for health care, for the preservation of health and the prevention of illnesses among the Roma population at the local and/or Republic level
 - The development of mechanisms that facilitate the registration of the Roma population for the purpose of realizing all the rights to health care under the Law
 - The education of medical staff and the Roma about the rights of the Roma to health care
- The improvement of health care for the entire Roma population – until the year 2015
 - Projects for the promotion of public health and their implementation
 - The drawing up of programs linked to reproductive health and the health of women
 - Acquainting medical staff with the specific needs, culture and differences of the Roma population
 - The work of mediators in medical teams
- The environment in which the Roma community lives – priority cases up to the year 2010, and the implementation of the general strategy until 2015

- An analysis of the hygienic and epidemiological conditions in Roma settlements
- The improvement of housing conditions in the sense of the supply of drinking water, sanitary devices and the keeping of domestic animals, through an evaluation of the present situation by a health care institute
- The Institute's proposals for the necessary resettlement of the settlements in which the conditions are extremely bad and which cannot be encompassed by the improvement process, following an Institute's evaluation.

Certain segments of the health policy are developed in another three national strategies:

- The Strategy for Youth Development and Health in the Republic of Serbia,
- The National Mental Health Protection Strategy,
- The National HIV/AIDS Strategy.

The first two mentioned strategies do not discuss separately problems linked to the health of the Roma, they rather refer to the entire population. Therefore, in the mentioned strategic documents the Roma are not recognized as an especially sensitive group. Since the young are prevalent among the Roma in Serbia, this means that, in the process of implementing the **Strategy for Youth Development and Health in the Republic of Serbia**⁵ it would be necessary to develop programs and projects that would enable the implementation of special measures referring to young Roma. As the current health problems within the population of the young in Serbia the Strategy mentions **psychological development** problems, problems of reproductive health, problems linked to sexually transmitted infections, addictions, abuse and neglect, injuries, physical inactivity, improper nutrition, factors from the environment that affect the development and health of the young, the organization of services for the young, the legislation, record keeping and reporting. The strategic goals in this document are developed through the general and specific goals that are defined as outcomes and monitoring indicators.

The **National HIV/AIDS Strategy**⁶ includes the Roma among vulnerable groups of the population to which preventive measures of protection from infections should be applied. The main strategic goal is directed towards reducing the damage of risky conduct, primarily by defining programs and carrying out education about HIV/AIDS, the increasing of the motivation to avoid risks, the use of one's own sterile instruments, the use of condoms, and also through the linkage of state and non-governmental capacities in the realization of damage reduction programs.

The **National Youth Strategy**⁷ adopted in the first half of 2008 and for whose implementation an Action Plan is only now being drawn up, devotes attention to issues concerning health care for young Roma through measures and activities intended for sensitive groups.

In the strategic framework for implementing health policies the goals and priorities directed towards increasing the inclusion of the Roma in Serbia's health care system are mutually harmonized and complementary. However, the strategies and action plans accompanying them have not been budgeted, so it is not possible to assess the financial coverage of the realization of the strategic goals and priorities which are the subject of this analysis on a long-term basis. Therefore, it is difficult to assess the long-term sustainability of the health policies related to the

⁵ Strategy for Youth Development and Health in the Republic of Serbia, Official Gazzet number 204/2006, page 51.

⁶ Source: Ministry of Health of the Republic of Serbia.

⁷ Government of the Republic of Serbia, *National Youth Strategy*, May 2008.

inclusion of the Roma in the system of health care services that contribute to the improvement of their health condition. The financial plans for the realization of certain programs and projects are adopted annually within the budget system. The long-term sustainability of health care policies aimed at increasing the accessibility of health care services to the Roma requires budgeting of the key goals and priorities on a long-term basis so as to ensure efficiency of their implementation. Furthermore, it is necessary to develop and clearly define the quantitative and qualitative indicators for monitoring the implementation of the adopted strategies, and to introduce mutually harmonized information systems in health care institutions that will enable the creation of the main data bases for calculating indicators on the basis of which it will be possible efficiently to monitor and evaluate the realization of the set strategic goals and priorities referring to the inclusion of the Roma in the health care system. The information systems of health care institutions, at the local and national levels, should be connected to the Statistical Office of the Republic of Serbia (RSO) as the main state statistical institution.

3. DATA ANALYSIS

In this part of the research we tried to unify as many quantitative indicators and analyses as possible, those we can use for adopting valid conclusions on whether the policies being conducted had led to changes in the picture of the health of the Roma population in Serbia, not only at the national level, but also at the local level through the realization of projects and programs. It is difficult to give an assessment of the health condition of the Roma without pointing to the problems that reduce the accessibility and coverage with health care services of the Roma population (Antić, 2005, 2006; Roma Rights Center, 2006, 2007, 2008; ESPI, 2007). Apart from the efforts that are being made by relevant state institutions through the **National Health Care Action Plan for Roma for the Period until 2015** within the framework of the implementation of the Decade of Roma Inclusion 2005-2015 (Government of the Republic of Serbia, 2005) and relevant strategic documents whose goal is to improve the accessibility of health care services to the Roma, it is also necessary to mention the endeavors to transfer the realization of the National Action Plan to the level of the local community as well (Jovanović, 2005; Red Cross of Serbia, 2008b).

Furthermore, when speaking of socio-economic factors or health risks, we cannot avoid mentioning poverty as a constant latent threat to the ruining of the health of every individual (Grozdanov, 2008; RSO, 2008) or the lack of adequate education (UNDP, 2006), the housing conditions of the Roma population and so on. Problems in the accessibility of health care to the Roma appear due to the social characteristics of this group of the population, but also because of the insufficiently implemented institutional solutions and migrations of the Roma population. These are problems that do not affect the Roma in Serbia only, but also in other countries in the region which have undertaken unconditionally to carry out the Decade of Roma Inclusion in the Period between 2005 and 2015 through four action plans, and this serious problem is also dealt with by the EU.

For the purpose of assessing the impact of the implemented policies on the accessibility of health care to sensitive groups, which also include the Roma, the EU has formed the European Policy Health Impact Assessment Project Group which relies on four groups of factors i.e. four groups of the main determinants of a health status which we will only enumerate here: individual factors resulting from differences in life styles, social influences and influences of the community, living and working conditions and the general socio-economic and cultural conditions, as well as the environment an individual lives in.⁸

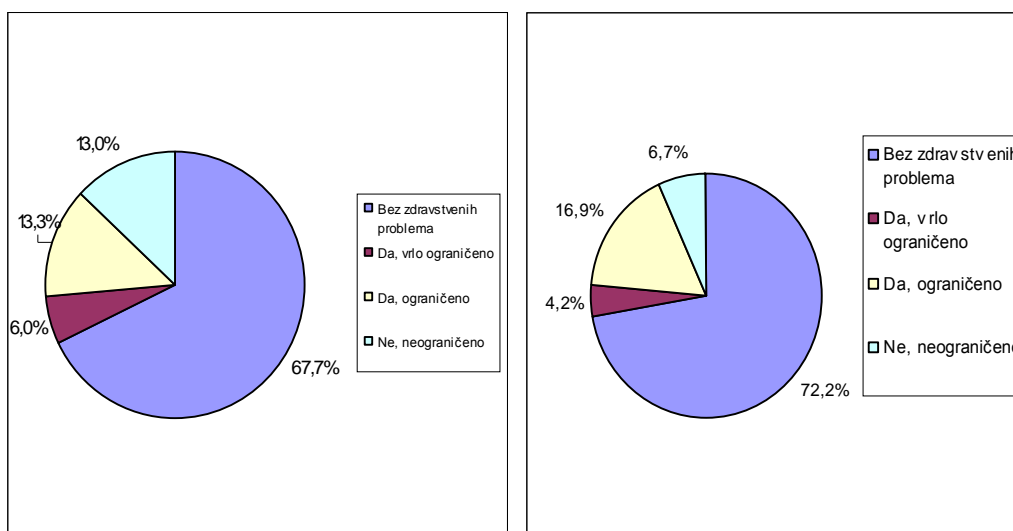
3.1 Health condition of the Roma population in Serbia

In the overall population in Serbia present is the trend of growth of the number of persons suffering from chronic diseases. If the results of two surveys on the standard of living, carried out by the Statistical Office of the Republic of Serbia are compared, one notices an increase in this type of disease, so that, in 2003, 27.1% of the total population in Serbia suffered from chronic diseases, only for this percentage to increase to 32.3% in 2007. A similar tendency is also present among the Roma population, although a smaller number of cases of chronic diseases were reported than was the case in the total population. Namely, while in 2003, 19.9% of the Roma suffered from these diseases, in 2007 the share of ill Roma increased to

⁸ European Policy Health Impact Assessment Project Group (2004), *European Policy Health Impact Assessment EPHIA – A Guide*, p. 4.

27.8%. A similar result was also obtained in the research on the presence of chronic diseases among the Roma refugees and internally displaced persons and domicile non-Roma carried out by the UNDP, and where the survey established that 19% of the Roma suffer from hypertension, 21% of the Roma from bronchitis and emphysema and 16% of the Roma from cardiovascular diseases. In the group of non-chronic diseases, the Roma population suffered the most from colds – 30% and the influenza – 12%, while only 2% of the interviewed Roma reported psychological disorders.⁹ According to an analysis of the ESPI Institute which covered the Roma population in the Jablanica district, in 27.9% of the polled Roma households there was at least one member suffering from a chronic disease, dominant among which were cardiovascular diseases – 38.7%, bronchitis and pneumonia – 21.3% and diabetes – 12.7% (ESPI, 2007).

Figure 1: The percentage of the citizens who had health problems over the past six months: the total population (left chart) vs. the Roma (right chart)



Source: Republic Statistical Office (RSO) (2008), Living Standards Measurement Survey 2007

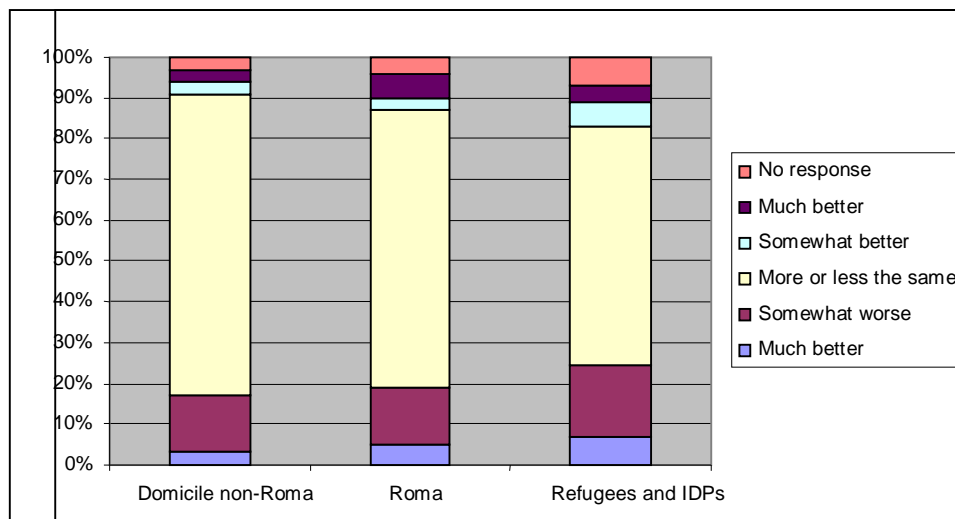
The UNDP survey showed that in the self-evaluation of the health condition, through interviews based on polls, individuals usually underestimate the importance of certain diseases, primarily chronic diseases, so they state that they have no major health problems compared to the actual situation (UNDP, 2006). In this spirit we could also interpret the results of the survey of RSO which showed that, in the total population, 67.7% of the inhabitants said they had no health problems, while this percentage is even higher among the Roma - 72.7%.

We will also corroborate the above mentioned results obtained by researchers of RSO, with the results of a UNDP survey which shows that, compared to the domicile non-Roma – 74%, as well as refugees and internally displaced persons – 58%, 68% of the Roma consider their health condition to be unchanged compared to the year before the survey was conducted. However, 19% of the Roma are of the opinion that their health deteriorated in the course of one year, while this opinion is also shared by 17% of the non-Roma population or by as much as

⁹ UNDP (2006), *At Risk: Social Vulnerability of the Roma Refugees and Internally Displaced Persons in Serbia*, p. 24.

24% of the refugees and internally displaced persons. The poorest perceptions regarding an improvement of their health are those of domicile non-Roma population -6%, while 10% of the Roma felt an improvement of their health condition, as did 11% of the refugees and internally displaced.

Figure 2: Subjective assessment of the health condition compared to the preceding year



Source: UNDP (2006), p. 24

The Roma are among the youngest populations in Serbia. The most numerous age group among the Roma are children up to the age of 14 (40.7%), while a fifth of the Roma are persons aged between 15 and 24, more than half of the Roma population in Serbia is below the age of 25 (62%), while the share of the elderly population is only 4.1%.¹⁰

Within the Roma population, especially vulnerable groups are children, women (especially pregnant women) and the elderly.¹¹ Already from their birth, Roma children have a much smaller likelihood of surviving compared to the overall population. According to the data of the Multiple Indicators Cluster Survey (MICS) 2005, the mortality rate of children up to the age of 5 is rising to 28 on 1,000 newborn babies.¹² The mortality rate of newborns and children below the age of 5 at the level of Serbia is 8 and 9.2 on 1,000 live born children, respectively.¹³ The mortality of newborn babies is larger in city unhygienic settlements (2829‰), among male children (32‰), in Central Serbia (29‰) compared to Belgrade (26‰) and Vojvodina (16‰), among children whose mothers have no education (29‰) and in the first two poorest quantiles (30‰).

¹⁰ Government of the Republic of Serbia (2003), *Poverty Reduction Strategy in Serbia – Annex*, p. 33.

¹¹ A very small number of the analyses point to the health condition and general living conditions of elderly Roma. However, due to all the reasons which we have mentioned a number of times, and which create difficulties in the lives of the Roma, very small is the number of persons belonging to this national minority whose life space is longer than 60 years, estimated at only 1% (Antić, 2005, p. 8).

¹² UNICEF (2007), *Multiple Indicator Cluster Survey MICS 2005*, p. 148-149.

¹³ UNICEF (2007), *The State of Children in Serbia 2006: Poverty and the Social Inclusion of Children*, p. 70.

Table 1: Mortality rate among children and indicators of the health condition and nutrition of children¹⁴

Indicator	General population		Roma in Roma settlements	
	2003	2005	Boys	Girls
			2005	
Mortality rate of children below the age of 5 (on 1,000 newborn children)	10.4	9.2	36	23
Mortality rate of children up to one year (on 1,000 newborn children)	9.1	8.0	32	20
Share of newborns with a small weight(<2.500g)	-	5.0%	9.3%	

Source: Government of the Republic of Serbia (2007), *Second Progress Report on the Implementation of the Poverty Reduction Strategy in Serbia*, p. 102.

The coverage of Roma children with immunization is considerably lower compared to the total population, but the Roma children who live in unhygienic settlements are in a much less favorable position compared to the national average. Namely, Roma children aged between 18 and 29 have received all the recommended vaccines in 47.7% of the cases, the average at the national level for children of the same age is 57.5%, while the average for children from Roma settlements is only 26.6%. In the same age group, only 59.9% of the Roma children from Roma settlements have been inoculated against tuberculosis, while 74.5% of the children have been inoculated at the national level. The new survey produced different indicators, since the calendar for the mandatory inoculation of children in Serbia was changed at the beginning of 2006, with new vaccines also having been introduced. Since the immunization of children is performed at maternity hospitals, medical centers and schools, the inclusion of Roma children in the health care and education systems represents one of the preconditions for improving the health status of this population group. In addition to this, one should mention the fact that 40.8% of the Roma children of this age on the whole i.e. 34.1% of the Roma children from unhygienic Roma settlements have no health card.¹⁵ On the poor coverage of Roma children with immunization, apart from the lack of personal documents, other factors have an impact as well. Let us mention a UNDP survey¹⁶ stating that the reason for the poorer coverage of children (children up to the age of 14 were observed) with inoculation is, in 23% of the cases, the lack of health cards, but that other factors also have an impact on this phenomenon, such as the lack of medical assistance – 15%, the fact that the parents are uninformed – 8%, as well as the stands of Roma mothers (and parents) that inoculation is not important – 12%, which only additionally confirms that efforts aimed at education the Roma are very important and topical.

¹⁴ The Government of the Republic of Serbia (2007), *Second Progress Report on the Implementation of the Poverty Reduction Strategy in Serbia*, p. 102.

¹⁵ UNICEF (2007), *Multiple Indicator Cluster Survey MICS 2005*, p. 157.

¹⁶ UNDP (2007), *At Risk: Social Vulnerability of the Roma Refugees and Internally Displaced Persons in Serbia*, p. 26.

Roma children aged between 0 and 59 months, primarily because of the conditions they live in¹⁷ and the lack of heating in the winter months, suffer much more frequently from pneumonia compared to the total population of children of the same age. Data from the MICS for 2005 show that as much as 10.4% of the Roma children who live in Roma settlements suffer from this disease while the average for all the Roma children is 7.7%, and the national average for children aged between 0 and 59 months is 3.4%.¹⁸ Only 45.1% of the Roma children suffering from pneumonia who live in Roma settlements are treated with antibiotics, the average for all the Roma children is 45%, while the national average is 56.8%.¹⁹ Furthermore, the incidence of skin diseases, as well as asthma is higher among Roma children.²⁰

Roma women of reproductive period (15-49 years of age) suffer from health problems, especially during pregnancy, which is later correlated with the high mortality of children and miscarriages. A Roma woman gives birth to five children on the average. However, the level of the Roma women's knowledge about protection from unwanted pregnancies, sexually transmitted diseases and the use of contraception is very low. As much as 71.9% of married Roma women who live in Roma settlements do not use any of the means of birth control, while the average for Serbia is 58.8%.²¹ Also, lower is the percentage of Roma women of reproductive age who live in Roma settlements, as who are under medical supervision during pregnancy – 88.9%, compared to the national average – 99%. It is also important to mention that only 26.7% of the Roma women have had the Papanicolaou test done during pregnancy, but at the national level as well, the rate of women who have done this test is quite low – 50.9%. As regards the number of births performed at home, according to the latest surveys carried out among young Roma mothers (15-25 years), the situation is changing in a positive direction, this also reducing the risk of the mortality of newborn children. Namely, around 98.4% of young Roma women who live in Belgrade have given birth at a hospital, while all the respondents in Vranje have given birth at a maternity ward.²²

Roma women get married at a very early age, even before they turn 15, which exposes their reproductive organs to additional risk. Namely, 12.4% of the Roma women who live in Roma settlements get married before the age of 15, while as much as 45.9% are married before they turn 18. The national average of married girls below the age of 15 is 0.8%, and for those under 18 it is 8.4%.²³

Furthermore, the level of the knowledge of Roma women in the reproductive period about the transmission of HIV from the mother to the child is also very low. Namely, 72.2% of the Roma women in Roma settlements have certain knowledge about HIV (at the national level – 97.7% of the women), while only 13.9% know that the transmission of HIV from mother to the child can be avoided through prevention.²⁴ Only 36% of the women in Serbia are familiar with the prevention of the transmission of HIV, so that the education of women, primarily young ones, regardless of their ethnic affiliation is desirable and necessary. This is all the more so, since

¹⁷ On the basis of data from the MICS 2005, it was estimated that, in Serbia, 63.2% of the Roma from Roma settlements live in slums without adequate hygiene and with the accommodation not being fit for living (UNICEF, 2007, p. 176).

¹⁸ UNICEF (2007), *Multiple Indicator Cluster Survey MICS 2005*, p. 162.

¹⁹ UNICEF (2007), *Multiple Indicator Cluster Survey MICS 2005*, p. 163.

²⁰ Government of the Republic of Serbia (2003), *Poverty Reduction Strategy in Serbia – Appendix*, p. 33.

²¹ UNICEF (2007), *Multiple Indicator Cluster Survey MICS 2005*, p. 177.

²² Ministry of Health and the Serbian Institute of Public Health (2008), *Surveys among populations exposed to a higher risk of HIV and among persons living with HIV*, p. 142.

²³ UNICEF (2007), *Multiple Indicator Cluster Survey MICS 2005*, p. 198.

²⁴ UNICEF (2007), *Multiple Indicator Cluster Survey MICS 2005*, p. 202.

16% of young Roma women in Roma settlements have sexual relations before the age of 15, while at the level of Serbia it is 1.1%.²⁵ However, a survey among the young Roma population (15-25 years of age) has pointed to even more unfavorable results about the knowledge of the proper ways to prevent the sexual transmission of an HIV infection. According to this survey, only 14.7% of young Roma in Belgrade i.e. 31.7% of young Roma in Vranje are familiar with the prevention of the transmission of HIV.²⁶

3.2 Accessibility of health care to the Roma population in Serbia and the use of services

In order to review the results of the activities accompanying the implementation of the Decade of Roma Inclusion 2005-2015 in the countries - signatory of this agreement, the progress of the social inclusion of the Roma is monitored at the annual level. With regard to the improvement of health care for the Roma in Serbia, the document of Roma activists "Decade Watch" for 2007,²⁷ says that the Ministry of Health of the Republic of Serbia, by allocating budget funds for the implementation of projects, is contributing to the realization of the Health Care Action Plan for Roma in at least two directions. The first direction is the realization of activities contributing to the improvement of the health of the Roma population in Serbia, and thus of the accessibility of health care services as well, while the second direction of the activities concerns the improvement of the hygienic conditions in the settlements where Roma live. However, the impact of the policies implemented within the Decade of Roma Inclusion, in all the countries, is modest according to the assessments of the "Decade Watch" for 2007.

Despite the problems the Roma face when realizing their right to health care²⁸ due to their frequent change of their permanent residence and the lack of personal documents (Antić, 2005, 2006), the situation concerning access to health care is changing towards improvement. Namely, the latest survey conducted by RSO through the Living Standards Measurement Survey for 2007 has shown that there are no major differences between the proportions of the sick who use health care services among the overall population and among the Roma population. In the total population 66.5% of the sick citizens used certain hospital services, while in the Roma population this percentage was 60.8%. Despite the fact that these results are overestimated to a certain extent due to the poorer coverage of persons who live in unhygienic settlements, these findings are very similar to the results of the UNDP's survey which confirmed that 57% of the Roma who had previously suffered from a certain disease sought the assistance of a physician.²⁹ Furthermore, among the Roma population, there is a trend of increase of the number of persons who regularly receive therapy for chronic diseases (65.5% in 2007 compared to 52.3% in 2003). Such a tendency is present in the total population as well, since the number of persons who regularly received therapy for chronic diseases in 2007 increased to 80.2% compared to 78.6% in 2003. For both the overall and Roma populations, the extension of the list of medicines that can be obtained with a prescription, has

²⁵ UNICEF (2007), *Multiple Indicator Cluster Survey MICS 2005*, p. 209.

²⁶ Ministry of Health and the Serbian Institute of Public Health (2008), *Surveys among populations exposed to a higher risk of HIV and among persons living with HIV*, p. 144.

²⁷ Decade Watch (2008), *Roma Activists Assess the Progress of the Decade of Roma Inclusion, 2007 Update*, Savelina Danova (ed.).

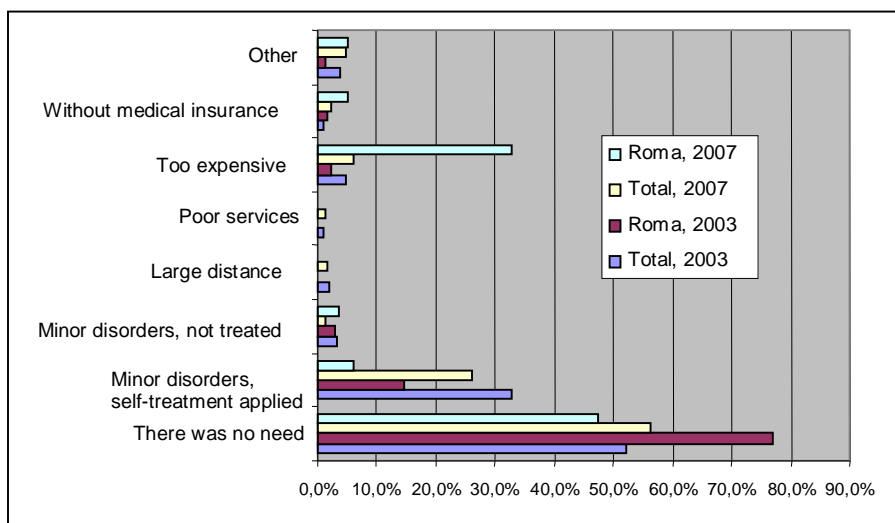
²⁸ The UNDP's estimate is that 10% of the Roma are unable to have access to health care because of the lack of personal documents, but that refugees and internally displaced persons are in an even more unfavorable position, since 12% of them, for the same reason, were unable to use the necessary health care services (UNDP, 2006, p. 24).

²⁹ UNDP (2006), *At Risk: Social Vulnerability of the Roma, Refugees and Internally Displaced Persons in Serbia*, p. 24.

contributed to an increase in the number of persons for whom it has been made possible to receive regular treatment, and this is the result of the improvement of the entire health care system in Serbia.

The ill who have not used health care services mention as the most frequent reason for this the self-assessment of their own condition, with the conclusion that there was no need to visit medical professionals, then that at issue were minor disorders that can be treated at home, and that health care services are too expensive for them to be adequately treated. Compared to the total population, the Roma more frequently mention this last reason as one of the crucial reasons for their failure to visit a doctor, 32.9% compared to 6.2% in 2007. The Roma are also inclined to underestimate the importance of health problems and, even though they feel difficulties, to take no steps that would lead them to a doctor, but less compared to the total population (47.5% compared to 56.4%). We also point out that, only 5% of the Roma in 2007, mentioned as an obstacle to visiting the doctor the lack of health insurance and that this number tripled compared to the year 2003 when only 1.6% of the Roma mentioned this as a reason.

Figure 3: Percentage of ill citizens who have not used health services, according to the most frequent reason: total population vs. Roma



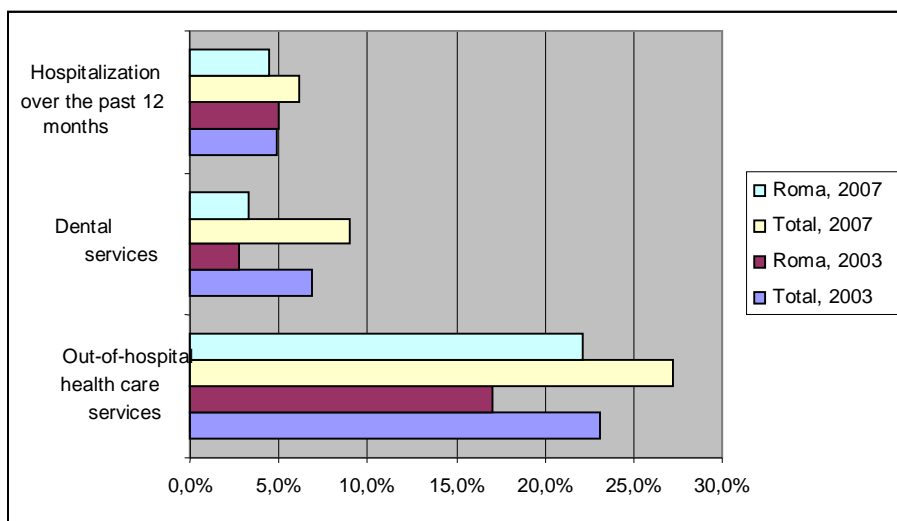
Source: Republic Statistical Office (RSO) (2008), Living Standards Measurement Survey 2007

On the other hand, if we wish to gain an idea about how the citizens care about their own health through regular visits to the doctor i.e. through the use of health care services at the monthly level, the differences between the overall population and the Roma population are larger. While in the total population 35% of the citizens use health care services at the monthly level, this is the case with only 1/4 of the citizens in the Roma population, which, of course, is no confirmation of the better health of this population group, but there is a certain improvement trend, since the situation has changed compared to 2003 when this number was small - 1/5 of the Roma citizens.

The Roma, as well as the total population, most often use out-of-hospital services at medical centers which imply visiting doctors for checkups, obtaining referrals, doing laboratory analyses

and so on. As regards the use of these types of health care services, as well as in the case of hospital treatment, the difference between the Roma population and the total population is not so pronounced. However, in the usage of dentist's services, the difference between the Roma and the overall population is more than double. Namely, in the overall population 9% of the population visits the dentist, which is two percentage points more than in 2003, while there were only 3.3% of the users of dentist's services among the Roma. In view of the traditionally poor dental hygiene, the acquired habits of this population still change very slowly, and this situation is also contributed to by the prices of dentist's services which, under the Law on Health Insurance, are not charged to the beneficiary's mandatory health insurance, with the exception of children, pregnant women, the elderly and in the case of urgent interventions, as well as the fact that most of the poor Roma cannot afford private dental services.

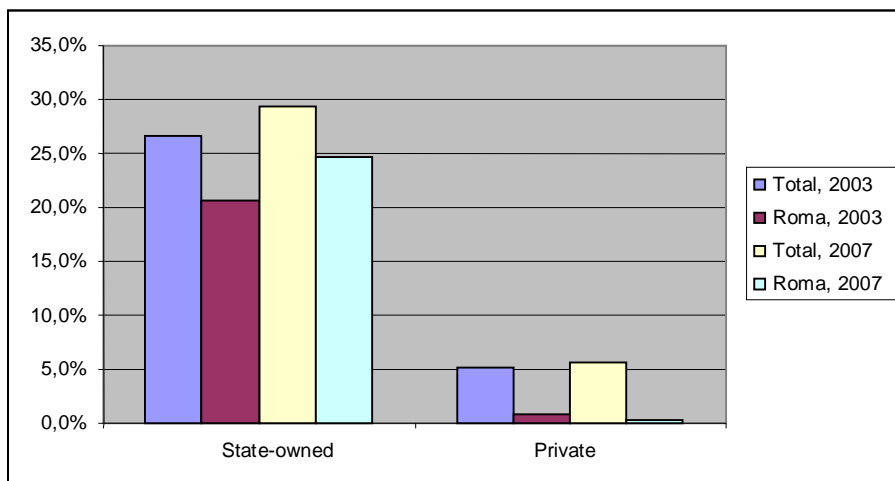
Figure 4: The percentage of the users of three types of health care services: total population vs. Roma



Source: Republic Statistical Office (RSO) (2008), Living Standards Measurement Survey 2007

Due to the increasing number and better accessibility of health care institutions owned by the state, and also because of the quality of the basic health care services which can be obtained through the basic health insurance, quite expected is for health care services in public institutions to be used more often than the services of private institutions. Another important element is also the greater confidence in state-owned health care services and the greater certainty of the collection of health insurance in the case of damage or undesired consequences. However, despite the existence of mandatory health insurance, for quite a long time now the users of health care services at state-owned institutions have additionally been paying for health care services, which not only directs the users towards the private sector – although the number of users of the services of private health care institutions in the total population is increasing (5.7% in 2007 compared to 5.1% in 2003) and in the Roma population this percentage is decreasing from 0.8% in 2003 to 0.4% in 2007 – but is increasingly directing them towards self-protection and alternative forms of treatment, which, as we will see below, is not a favorable tendency.

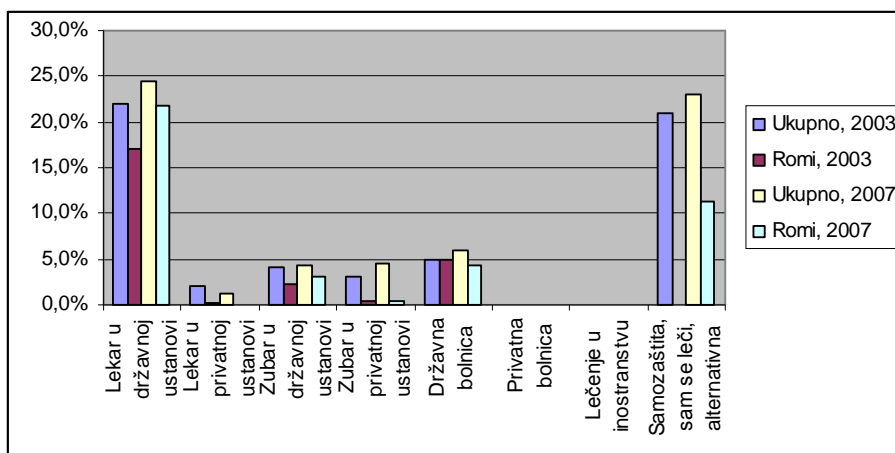
Figure 5: The percentage of the users of health care services according to the type of ownership over the health care institution: total population vs. Roma



Source: Republic Statistical Office (RSO) (2008), Living Standards Measurement Survey 2007

The Roma most frequently use the services of doctors at public health care institutions, and there is also an increase in the number of users of the services of doctors at state-owned institutions within both the total population and among the Roma. Among the Roma population, the number of users of these services in 2007 increased to 21.8% from the previous 17%. However, from the standpoint of receiving adequate health care one notices the unfavorable trend of an increase in the number of persons who resort to self-protection and other alternative forms of medicine, which confirms the conclusion that awareness about the importance of prevention is poorly developed among both the Roma and in the overall population. In 2007, 11.2% of the Roma resorted to self-treatment compared to 23.1% of the citizens in the entire population.

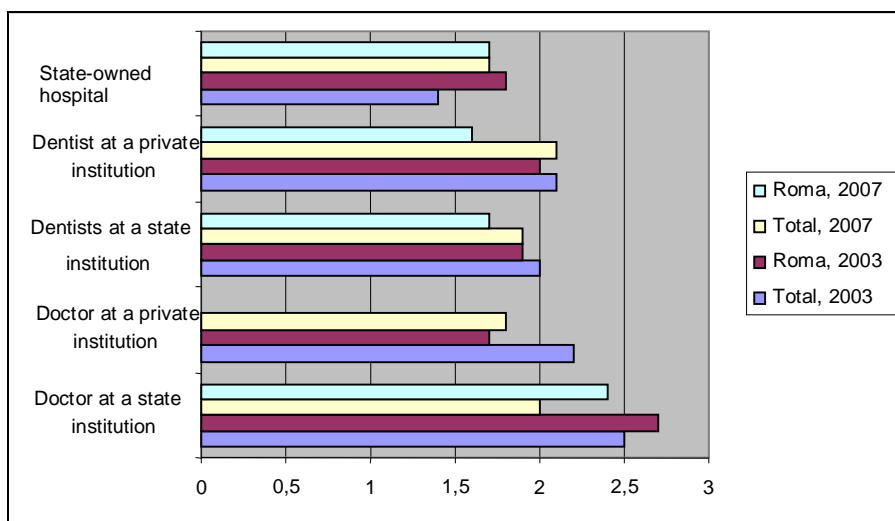
Figure 6: Percentage of the users of health care services: total population vs. Roma



Source: Republic Statistical Office (RSO) (2008), Living Standards Measurement Survey 2007

The average number of monthly visits to the doctor is higher among the Roma than in the overall population, but it has decreased compared to the year 2003 (2.4 in 2007 compared to 2.7 in 2003). A similar tendency is also present in the total population, and one of the possible reasons is the payment for health care services at state-owned institutions as well, regardless of the existence of health insurance. Cases of Roma going to private health care institutions for treatment have not been registered either, which is correlated with the price of health care services. As regards the use of dental services, a drop in the number of users among the Roma is present, in both private practices (1.6 visits on the average per month in 2007 compared to 2 times in 2003), and at state institutions (1.7 monthly visits to the dentist in 2007 compared to 1.9 in 2003). Therefore, we can conclude that the Roma most frequently go to state-owned institutions for medical assistance, not only because of the prices of health care services, but also because of the fact that state institutions are better equipped and have better quality services.

Figure 7: Frequency of the use of special types of health care services at the monthly level



Source: Living Standards Measurement Survey 2007

The costs of treating the Roma at state-owned out-of-hospital institutions are lower than the average for the entire population. However, in 2003, much higher expenditures of the Roma for treatments at private out-of-hospital institutions and at state-owned hospitals compared to the total population were noticed, which can also be the result of necessity in urgent cases when a certain health care service can be obtained only if one pays, regardless of whether the person possesses personal documents or not. As regards hospital treatment, the situation changed in 2007, since the Roma allocate a little less for treatment at state-owned hospitals compared to the total population, which is related to the fact that public health care services and system of health care are better equipped. However, in view of the financial position of most Roma – let us recall that around ½ of the Roma population lives below the poverty line – treatment at out-of-hospital institutions and private hospitals is inaccessible to this population group.

Table 2: Average monthly total expenditures for treatment at health care institutions, in RSD¹

	LSMS, 2003		LSMS, 2007	
	Total	Roma	Total	Roma
State non-hospital institution	1 033	429	1 040	867
Private non-hospital institution	2 998	4 014	4 831	-
State dentist	303	199	907	563
Private dentist	2 869	2 076	3 134	534
State-owned hospital	4 072	12 134	4 883	4 045
Private hospital	19 785	-	24 956	-
Alternative medicine	471	409	657	369

Source: Republic Statistical Office (RSO) (2008), Living Standards Measurement Survey 2007

¹ Including informal payments to the medical personnel. (-) No data.

3.3 Conclusions

- Summarizing the conclusions of this section we could single out the most important factors within the system of health care itself which have an effect on the coverage of persons with health insurance. The first factor is, quite certainly, the possession of a health card and, consequently, the possibility of receiving treatment in the public health care sector. Comparing the health condition of the Roma population and the total population, through the presence of chronic diseases and the self-assessment of the health status, we can conclude that the main trends that have been noticed in the total population are also followed by the health condition of the Roma. However, more profound analyses, which take into account the demographic and socio-cultural characteristics, point to a less favorable position of the Roma in the health care system compared to the total population. The lower coverage with health care is linked to the problems of migrants (in the country and abroad) and the legalization of their status in the country, to the poor coverage of children with immunization and inoculation, particularly poorer care of children not born in hospitals or have been excluded from the educational system. It is also connected to the low level of information of Roma women about the prevention and protection from unwanted pregnancies and infections, but also to the prices of health care services (out-of-hospital, hospital and dental) especially in the private sector, which most of the poor Roma cannot afford. Therefore, mid-term and long-term improvement of the overall health card of Roma population in Serbia must be accompanied by successful inclusion of the socially vulnerable Roma into the health insurance system, as well as the higher level of information on exercising the legal rights, the latter being a short-term measure.

4. IMPLEMENTATION OF HEALTH CARE POLICIES

As part of the Decade of Roma Inclusion, the Ministry of Health has realized 103 projects over the past two years, through partnerships with healthcare institutions and Roma nongovernmental organizations. The project activities included all groups of socially vulnerable Roma – children, women, the elderly, residents of insanitary settlements, and persons that have been denied access to public healthcare institutions because they do not have identification papers. The apparent trend to include Roma in certain activities has shown an increase in the number of persons that are beneficiaries of the implementation of project activities. The greater interest exists precisely for participation in activities that aim to protect the health of Roma women during the reproduction period, increasing inclusion of Roma children in immunization, increasing Roma awareness of prevention, protection and treatment of non-contagious illnesses and the risks that such illnesses entail, primarily shortening the life span and low productivity of the working-age Roma population.

Table 3: Projects within the Decade of Roma Inclusion and the included population

	Population inclusion					
	2006				2007	$\Delta 2007/2006$, %
	Children	Women	Men	Total	Total	
Child and youth health	1 267	372	184	1 823	1 777	-2.5
Reproduction health, family planning and prevention of malignancies (uterine and breast carcinoma)	215	1 011	381	1 607	4 308	168.1
Immunization	371	30	15	416	1 367	228.6
Dental care and oral hygiene	507	117	33	657	360	-45.2
Prevention and risk factors for chronic non-contagious conditions (CNC)	584	709	460	1 753	3 484	98.7
Healthcare and assistance for the elderly	-	151	82	233	244	4.7
Addiction prevention	-	15	53	68	-	-

The right to healthcare and health insurance	303	198	118	619	1 078	74.2
Health condition, behavior and use of healthcare	374	212	205	791	250	-68,4
Evaluation of hygienic and epidemiological conditions in Roma settlements	80	-	-	80	2 300	2 775.0
TOTAL	3 701	2 815	1 531	8 047	15 168	88.5

Source: Ministry of Health (2008), pg. 39-40. (-) Not available

As part of the implementation of the Action Plan for Improving Roma Health the following activities were realized between January and June 2008:

- Creation of a software for calculating the indicators and parameters for monitoring projects carried out within the Action Plan for Improving Roma Health
- Realization of the competition for selecting and educating 15 Roma healthcare mediators, as moderators between healthcare institutions and the Roma communities in 15 municipalities in the Republic of Serbia. Healthcare mediators will provide assistance and support to Roma in the exercising and regular use of their right to healthcare, to train them in skills for healthy lifestyles, etc. The Ministry is planning on increasing the number of mediators in the near future.
- Creation, publication and distribution of a Guide to the Procedures for Health Projects Included in the Decade of Roma Inclusion.
- Preparation of a competition for project for improving Roma health focusing on:
 - Increasing the immunization rate, improving reproductive and sexual health, addiction prevention, antenatal protection of Roma women, improving child health and nutrition, prevention and early detection of risk factors for chronic non-contagious illnesses, prevention, early detection and treatment of intestinal and other contagious diseases
 - Improving living environment conditions in the Roma community – assessment of hygienic and epidemiological concision, creating a safe environment, healthcare for Roma collectors of secondary raw materials
 - Monitoring and evaluating approved projects.
- Three workshops were held for healthcare institutions and Roma nongovernmental associations on the methods of reporting ongoing project realization, procedure for creating projects and introduction to the Guide.

Table 4. Projects within the framework of the Program for Roma Health Improvement from Roma Decade, number of beneficiaries and potential impact and risks.

List of projects /area	No of beneficiaries 2006	No of beneficiaries 2007	Planned impact	Current status	Risks
Health of children and youth	1,823	1,777	<ul style="list-style-type: none"> -Improvement of health of children and young people -Registries of children and young people in informal settlements -Increase of no. of children and young people maintaining hygiene regularly -Reduced no. of underfed children -Infant mortality rate in Roma settlements – 25% 	<ul style="list-style-type: none"> -Mortality rate of children up to 5 in Roma settlements – 28% -8% of children in Roma settlements is underfed -12.4% of Roma women in settlements married under the age of 15 and 45.9% under the age of 18 	<ul style="list-style-type: none"> -Lack of health insurance -Lack of personal documents -Exclusion from education system -Lack of information about damages from smoking at early age - Early marriages, poor living conditions (lack of heating, equipment, hygiene, potable water, adequate nutrition)
Reproductive health, family planning, prevention of malignant diseases (breast and cervix cancer)	1,607	4,308	<ul style="list-style-type: none"> -Education of Roma women on importance of reproductive health, protection from unwanted pregnancies and prevention of malignant diseases. -Development of programs for Roma women of reproductive age (higher coverage by gynecological checkups, lab testings, hospitalization, surgeries, incentives for giving birth in 	<ul style="list-style-type: none"> -71.9% of married Roma women living in settlements do not use contraceptives -88.9% of Roma women under medical supervision during pregnancy -93% of Roma children born under medical supervision -Case studies indicate denial of assistance to women not having health insurance, health cards; request to pay for services, deliveries, family violence, etc. 	<ul style="list-style-type: none"> -Lack of health insurance -Lack of medical assistance (refusal to assist Roma) -Lack of information about prevention of unwanted pregnancies -Lack of education on preventive measures -Discrimination on the grounds of ethnicity

			hospitals) -Creating social card for Roma women -Reduction of discrimination to Roma women		
Immunisation	416	1,367	-Public health promotion and education of parents -Increased capture of children, particularly in settlements; those who were not born in hospitals and those not attending schools -Increased capture of inoculated children -Register of children and monitoring (inoculation calendar)	-47.5% children 18-29 months fully inoculated -59.9% of children from settlements inoculated for tuberculosis -2/5 Roma children and 1/3 children from settlements do not have a health card	-Exclusion of Roma children from health care and education system -Lack of health card -Lack of medical assistance (refusal to assist Roma) -Ignorance of parents -Negative views of Roma mothers on inoculation
Dental protection and oral health	657	360	-Education of Roma pop, especially children in settlements on importance of oral hygiene and health to increase no of users of dental care services	-Only 3.3% Roma use dental care services	-Lack of health insurance -Ignorance of parents - Exclusion of Roma children from health care and education system -Low income of Roma families and low percentage of allocation for dental services
Prevention and risk factors for chronic non-contagious diseases	1,753	3,484	-Reducing no. of chronic patients -Public health promotion and implementation of local and regional projects on prevention	-2007LSMS: 277.8% of Roma chronically ill -UNDP: 19% Roma suffer from hypertension, 21% bronchitis and emphysema, 16% suffer from cardiovascular	-Lack of health insurance -Lack of medical assistance (refusal to assist Roma) -Lack of information -Lifestyle and living conditions

			and risk factors -Education of Roma pop. In settlements -Improvement of access to health care -Free medical treatment and provision of medications for elderly -Registration for exercise of right to health care	diseases	-Discrimination on ethnic grounds
Health care and assistance to elderly	233	244	-Improved access to health care of socially vulnerable Roma -Free treatment and procurement of medication for socially vulnerable persons	2007 LSMS: 17% Roma do not have health card. Breakdown of these persons per age group is unavailable - Only 1% of Roma is over the age of 60 -Life expectancy at birth is 58	-Lack of health insurance -Lack of money to purchase medication -Difficult socio-economic conditions -Short life expectancy
Prevention of addictive diseases	68	-	-Education of youth and children on problems resulting from abuse of psychogenic substances to reduce the number of drug addicts among Roma -Anti-smoking and anti-alcohol campaigns especially targeting young Roma and persons in settlements -Education on protection of Roma from exposure to sexually transmitted diseases due to alcohol and	-Lack of accurate data on no. of drug addicts among Roma population. NGO surveys show a large no. of addicts on the streets, a no. of them in jails (drug dealers and traders). Only a small no. in rehabilitation. -Survey of the MoH shows that 44% of young Roma (aged 15-24) in Belgrade used one of psychogenic substances. 20% of them in Vranje -55% and 34% young Roma (aged 15-24) in Belgrade and Vranje respectively are smokers. -14.7% and 31.7% of young Roma in	-Negative impact of alcohol and smoking on development of malignant diseases. -Easier access of children and young people to cheap drugs -Lack of information on detrimental effects of psychogenic substances on health - Increased risk of exposure to HIV/AIDS infections -Increase of crime, family violence

			drug abuse	Belgrade and Vranje respectively familiar with HIVprevention	
Right to health care and health insurance	619	1,078	<ul style="list-style-type: none"> -Introduction of Roma mediators - Implementation of item 11, para 1 Art.22 of the Law on Health Insurance through increase of Roma exercising the right to health care -Door to door information campaign, supported by media, targeting Roma to inform of possibilities of exercise the right to health insurance based on Art. 22 -Education of medical staff on the rights of Roma 	<ul style="list-style-type: none"> -2007 LSMS: 17% Roma do not have health cards -15 Roma mediators introduced in health institutions in 15 municip. Planned introduction of 120 mediators by 2012 -2,174 Roma insurees registered on the basis of Art.22 in the period 1 Jan 07 – June 08. 	<ul style="list-style-type: none"> -Lack of personal documents - Lack of information on legal bases for exercising rights to health insurance -Delays in legalization of illegal settlements and their relocation to better sites -Admin. Obstacles -Inconsistency of implementation of item 11, para 1 Art.22 of the Law on Health Insurance -Lack of medical assistance (refusal to extend it to Roma)
Health status, behaviour and utilization of health care	791	250	<ul style="list-style-type: none"> -Registration of Roma pop. With a view to exercising health care rights and establishing a minimum set of indicators of Roma pop. Health care and monitor changes. -Operation of Roma mediators in health care institutions. -Organising seminars within 	<ul style="list-style-type: none"> -108,193 Roma registered in 2002 Census. Estimated no. between 400,000-500,000 - Monthly health care services used by 25% of Roma – 2007 LSMS - Program of TB Control covering 181 Roma settlement. 13,644 inhabitants of slums examined 	<ul style="list-style-type: none"> -Lack of personal document and verified health card -Self-assessment of Roma on health status -Lack of information about the right to health care -Lack of funds for treatment.

			Program of TB Control and referral of cases to health care centres.		
Assessment of epidemiological conditions in Roma settlements	80	2,300	-Analysis of hygienic and epidemiological living conditions in settlements to establish and develop relocation solutions. -Reduced no of Roma families living in unhygienic conditions and slums.	-2005 MICS: 63.2% in Serbia live in slums; with 38% Roma households do not own formal ownership documents. Almost 30% of Roma do not have access to drinking water in their homes and 30% have no adequate sanitary facilities.	-Sluggish response of local self-government and relevant state institutions in resolving Roma problems. -Community unwilling to accept Roma
Total	8,047	15,168	-Improved access to health care and improved health status	-Setting up database with key indicators for monitoring health status	-Lack of information about exercise of right to health care -Socio-economic conditions -Living conditions -Lack of understanding in the community, discrimination, stigmatization

The competitions for the realization of projects for improving Roma health are carried out based on the procedure described in detail in the publication "Guide for competition procedure for health projects as part of the Decade of Roma Inclusion", which was published by the Ministry of Health, in cooperation with the PRS Implementation Focus Point (July 2008) and which is available to all interested participants for the realization of their projects. The projects are realized at the local level by health care institution in collaboration with the non-governmental sector.

Box 1.

Health projects implemented in 2006 and 2007, as part of the Decade of Roma Inclusion

The projects that are realized based on the goals laid down in the Action Plan for Roma Health, adopted by the Government of the Republic of Serbia as part of the Decade of Roma Inclusion, are supposed to contribute to the achievement of two goals:

- First, the improvement of healthcare for the entire Roma population presented in the action plan for healthcare, and
- Second, the improvement of living environment of the Roma community.

In 2006 a total of 64 projects were realized through partnerships between healthcare centers and NGOs. Funds totaling RSD 36,312,669.00 were spent on the realization of these projects in 2006, of which RSD 35,071,179.00 was provided from the national Budget, and around RSD 1,241,490.00 from funds obtained through local NGOs and sponsorships.

39 projects were realized in 2007 through partnerships between healthcare centers and NGOs, for which funds totaling RSD 27,891,097.66 were spend, of which RSD 26,462,359.00 was from the national budget and around RSD 1,428,738.00 was from funds obtained through local NGOs and sponsorships. The projects were mainly aimed at improving health and living conditions in Roma settlements, introducing Roma health mediators into the healthcare system, supporting the National Council of the Roma ethnic minority for collecting data for the issuing healthcare documents for Roma, collaboration with the civil sector. Most often the target groups are women, children and Roma families living in unhygienic settlements. The Ministry of Health of the Republic of Serbia, in cooperation with the PRS Implementation Focus Point, has started establishing a system for monitoring and evaluating projects realized as part of the Decade of Roma Inclusion.

Source: The Ministry of Health of the Republic of Serbia, Belgrade, 2008. website: www.zdravlje.sr.gov.yu; Decade of Roma Inclusion, Guide for competition procedure for health projects as part of the Decade of Roma Inclusion, Ministry of Health of the Republic of Serbia, July 2008

The funds for covering the healthcare expenses of poor Roma and Roma that do not have permanent residence in Serbia are allocated from the Budget of the Republic of Serbia.

The Budget of the Republic of Serbia includes a special budget line for allocating funds for the implementation of the Action Plan for Health within the Decade of Roma Inclusion.

Box 2.

Program budgeting introduced for promoting Roma health

The Ministry of Health (MH) is the only ministry that has had clearly allocated funds for the implementation of the NAP for the improvement of the position of Roma, in 2006, 2007 and 2008.

Source: *Annual report on the implementation of the action plans of the Decade of Roma Inclusion for 2007, DECADE OF ROMA, Bulletin by the Center for Minority Rights, January 2008*

It is worth mentioning that 15 Roma healthcare mediators, who have the role of being intermediaries between the Roma community and the healthcare system, have been employed through of the Ministry of Health of the Republic of Serbia. The aim of introducing the institution of Roma mediators is to overcome barriers in the realization of Roma healthcare. However, it is necessary to provide evaluation of the projects that are being realized, and analyzing the compliance of the Action Plan and realized projects. We will present several examples of successfully realized projects (boxes 4 and 5).

Box 3.

Project Improving Health of Young Roma, Voždovac Healthcare Center and Roma NGO Oasis

The project **Improving Health of Young Roma** was also realized as part of the projects chosen the competition and approved by the Ministry of Health, aimed at the implementation of the Roma Action Plan. This project was carried out in partnership with the Healthcare Center in the Voždovac municipality in Belgrade, and the Roma NGO Oasis, between October 2006 and September 2007, and the project activities included health workers, Roma coordinators, project coordinators from the Healthcare Center and representatives of the Youth Counseling Center. The target group for the activities of this project was children and youths age 10 to 18. The aim of the project was for young Roma, mainly residents of insanitary settlements in the Voždovac municipality to learn about the importance of health through workshops and educational seminars, as well as to eliminate the barrier that exists between medical staff and the Roma population. 220 young Roma applied for participation in project activities, but as the project moved forward full inclusion of the children that had applied was not achieved. The score of this project is the visitation of 37 families in settlements with 151 children, and 12 visits to settlements. During visits to the children it was determined that all the children have healthcare documents, with the exception of one girl who was in the process of registering with the unemployment agency, and that they were properly vaccinated. The workshops for youth were organized in two locations, in schools for children attending school, and at the Youth Counseling Center for those that did not attend. The topics addressed in the workshops were personal and generally hygiene, nutrition, personal and general health, reproductive health, family planning, addiction and violence. In order to achieve greater effects, i.e. to attract a larger number of participants, one mixed workshop was organized in even elementary school in the Voždovac municipality.

Source: Ministry of Health, *Reports on Project for Improving Roma Health in 2007: Decade of Roma Inclusion 2005-2015*. Report by the Voždovac Healthcare Center and the Oasis NGO, October 2007.

The successful implementation of a healthcare policy aimed at improving Roma health, in the section on the realization of studies related to the identification of the state of Roma health and introduction of an integrated information system, has allowed for a more efficient overview of Roma health needs. The study of indicators of the health of Roma children and women (MICS)³⁰ indicates that the mortality rate among Roma women in the reproduction period is significantly higher than that of the average female population. Also noted was a great deviation in the percentage of deliveries with professional help among Roma women (66.6% in 2005) compared to deliveries among women in the general population (99%).

Box 4.

Project For the Healthy Roma Woman, Loznica Healthcare Center and Roma Happiness

Among the projects aimed at improving the health of Roma in Serbia, which were included in the competition of the Ministry of Health in 2007, we would like to point out the project **For the Healthy Roma Woman**, which was realized by the Healthcare Center in Loznica and the Roma Happiness Roma association, from Joševa. This is a six-month project that was realized in the first half of 2008. The activities of this project were very concrete and aimed at increasing the inclusion of Roma women in gynecological exams, carrying out necessary laboratory analyses and prescribing hospital treatment and undergoing surgery in cases where it is necessary, creating a social chart for Roma women that took part in the project, carrying out individual healthcare education work with Roma women and organizing workshops for group healthcare education work while handing out education material and media promotion of the health of Roma women, as well as prescribing therapy for women that have been examined. The inclusion of Roma women in this project exceeded the plan by 13%. Namely, instead of 100 women age 15 to 76, the examinations included 113 women, and the health services implied examining women for the early diagnosing of uterine and breast cancer, and family planning. A social chart and database were created for these women including education elements, age structure, family status and living conditions, and on such a self-styled sample it was determined that 24.8% of the women do not have healthcare documents, while the reasons for not having healthcare documents were not determined. As part of the education activities, 14 workshops were held during the duration of the project, where women were given information about risk factors for the development of malignancies, especially those of reproduction organs, on how preventive measures can thwart the development of uterine and breast cancer, and how to recognize the symptoms of these illnesses, as well as about the importance of contraceptive measures.

Source: Ministry of Health, *Reports on Project for Improving Roma Health in 2007: Decade of Roma Inclusion 2005-2015*. Report by the Loznica Healthcare Center and the "Roma Happiness" Roma Association, June 2008.

Health legislation provides healthcare for socially vulnerable persons with low income. According to data from the Living Standards Measurement Survey, in 2007 around half of the Roma population (49.2%) had earnings below the national poverty line, calculated in the equivalent unit.³¹ The living conditions of Roma living in unhygienic settlements in cities in Serbia are extremely poor.

³⁰ UNICEF (2007), *Multiple Indicator Cluster Survey MICS 2005*.

³¹ Living Standards Measurement Survey, 2007, Statistical Office of the Republic of Serbia.

Box 5.

How to ascertain the status of insured person for an individual of Roma ethnicity, according to Article 22, para. 1, item 11, of the Law on Health Insurance of the Republic of Serbia – Instructions by the Ministry of Health to the branches of the health insurance system

In Article 22, paragraph 1, item 11), *persons of Roma ethnicity who due to a traditional way of living do not have a permanent or temporary residence in the Republic*, of the Law on Health Insurance stipulates that, in sense of this law, persons of Roma ethnicity that do not have permanent or temporary residence are considered insured persons in the Republic due to a traditional way of life, if they do not meet the requirements for gaining the status of insured person from Article 17 of the Law, or if they are not exercising the rights from the compulsory health insurance as family members of an insured person.

Citizens of the Republic of Serbia, who are also nationals of the Republic of Serbia, are considered to be the persons referred to in item 11). Namely, based on Article 22, para. 1, item 11) of the Law, foreign nationals passing through the territory of the Republic of Serbia as Roma, or staying in the Republic of Serbia, cannot exercise the rights from the compulsory health insurance in accordance with the Law on Health Insurance, i.e. cannot exercise the right to healthcare in accordance with Article 11, para. 1, item 11) of the Law on Health Insurance.

Persons of Roma ethnicity who are also foreign nationals, realize healthcare in accordance with Articles 238-242 of the Law on Health Insurance.

Persons of Roma ethnicity who are citizens of the Republic of Serbia, i.e. nationals of the Republic of Serbia, must submit proof for ascertaining the status of insured persons, i.e. for exercising the right to healthcare. The person's personal documents (identification card, birth certificate, proof of citizenship, etc) can be submitted as proof. Other proof can include taking a statement from the person that he/she is of Roma ethnicity, along with other records (including those obtained officially by the appropriate branch office) handled by the competent authorities regarding the status of the citizens of the Republic of Serbia.

These persons apply on their own with the appropriate branch office for the exercising of the right to compulsory health insurance (the branch office in whose jurisdiction they have temporary or permanent residence). If such persons do not previously cancel their registration with a health insurance branch office, and apply for health insurance (i.e. request the issuing of healthcare documents) in another branch office, the health insurance branch office that the person has addressed, may submit a cancellation of registration with the previous branch office, using official channels, in direct contact with the said branch office.

Since Article 22 of the Law on Health Insurance has been in effect since January 1, 2007, during 2006 the right to healthcare could be exercised in accordance with Article 11, para. 1, item 11 of the Law on Healthcare.

Source: *Center for Minority Rights, Decade of Roma Inclusion: Bulletin by the Center for Minority Rights, No. 4, pp. 13, April 2006*

The Ministry of Health of the Republic of Serbia is carrying out two national programs with the support of the Global Fund for Fighting AIDS, Tuberculosis and Malaria, of which one addresses controlling tuberculosis, and the other addresses HIV/AIDS protection. The programs include high-risk population groups, including the Roma population.

Box 6.

Controlling tuberculosis in Serbia

The Ministry of Health of the Republic of Serbia, with financial support from the *Global Fund for Fighting AIDS, Tuberculosis and Malaria*, is realizing the national project **Controlling tuberculosis in Serbia through the implementation of the strategy for direct observation of therapy and including high-risk populations**. The project is being realized over a five-year period, from December 2004 to November 2009, with the support of a grant of US\$ 4,087,979. The aim of the project is three-fold: strengthening the system of healthcare for controlling tuberculosis, 100-percent implementation of the directly observed therapy (DOTS) throughout Serbia, improving tuberculosis control in high-risk population groups and prevention in the event that cases resistant to drugs emerge. This project is also expected to contribute to the reduction of tuberculosis incidents in Serbia from 36.8 to 25 new cases per 100,000 capita, annually.

The risk groups that were included in the program of tuberculosis control, in addition to refugees and internally displaced persons housed in refugee camps, as well as persons housed in institutions for the mentally ill, includes the Roma population living in isolated slums. The program for controlling tuberculosis included 181 Roma settlements. The Ministry of Health has entrusted to the Red Cross of Serbia the activities of assessing tuberculosis protection for high-risk groups, including the Roma population (13,644 slum residents were examined), determining the number of sick persons (only one sick person) in the observed slums aimed at prescribing further monitoring (338), as well as organizing educational seminars for the Roma population on the preventive healthcare for tuberculosis protection (7,031 plus 12,843). Since 2008 regular activities of the Red Cross of Serbia have included educational seminars and sending symptomatic cases to the clinic for further testing.

Roma children up to the age of 14, living in Roma settlements, were considered a special target group for testing tuberculosis sensitivity. After carrying out tests on a sample of 7,999 Roma children it was determined that around 4% are susceptible to tuberculosis infection, which is the same as in the total population of children of this age. This confirms the rather good inclusion of Roma children living in Roma settlements in the immunization, which is the result of the vaccination of Roma children born in hospital, but also the result of efforts by mobile medical teams that visit certain Roma settlements

Source: *Ministry of Health, Project: Controlling tuberculosis in Serbia through the implementation of the strategy for direct observation of therapy and including high-risk populations*: www.tbc.zdravlje.sr.gov.yu. Annual report for 2006 and 2007.

Having adopted the National Strategy for Fighting HIV/AIDS, the Ministry of Health of the Republic of Serbia began a study about HIV/AIDS among young Roma in order to identify the realistic situation in this area, aimed at taking infection prevention measures. The study was carried out by interviews with young Roma in Belgrade and Vranje.³²

³² Ministry of Health and the Serbian Institute for Public Health (2008), *Study of populations with higher HIV risk and persons living with HIV*.

Attempts are being made to resolve Roma health issues in the most suitable way through the realization of partner relations between city, i.e. local authorities, and the non-governmental sector.

Box 7.

Project *Joint Community Development*, Red Cross of Serbia

Through the realization of the *Joint Community Development* project, the Red Cross of Serbia provides assistance to vulnerable population groups, including Roma, through their active inclusion, regardless of whether it is in the training phase, decision-making phase or implementation phase of the given activity. As stated in the report on the implementation, "the basic goal is for the vulnerable population, together with the main factors of their local communities, to define and establish mechanisms for sustainable development and improvement of living conditions, through the application of the participative approach." The Red Cross of Serbia has been realizing this project with 12 of its organizations since April 2002, and after the intended trainings, where teams were formed for assessing the vulnerability of the local community populations, the Red Cross organizations guided these teams and realized the program, which 2,330 Roma took part in.

Source: Red Cross of Serbia (2008b), Report on the realization of the Joint Community Development project.

When looking at the indicators of the health condition of the Roma population, especially those living in Roma settlements, unacceptable differences are observed, which demand targeted focused activities, parallel to general reforms.³³

Box 8.

**Health promotion for Roma residents of the Jabučki Rit unhygienic settlement
"Let's preserve the health of the population of the left bank of the Danube in Palilula"**

The Center for Preventive Health Services with the Palilula Healthcare Center, with the help of the Mobile Prevention Unit organized a promotion of health for Roma living in the Jabučki Rit unhygienic settlement. The activity carried out by this center was carried out under the slogan "Let's preserve the health of the population of the left Danube riverbank in Palilula", and it targets the population of this settlement, which consists of around 120 Roma. The campaign was supported by the Red Cross of the Palilula municipality, the advisor for ethnic minorities and the municipality's Center for Social Work. This activity certainly merited attention and was rightly included in the Bulletin of the Center for Minority Rights on the Implementation of the Goals of the Decade of Roma Inclusion, and we especially emphasize the purpose that these activities aimed to achieve "vaccination, improving the health of COLD patients, information about the method of exercising rights to social assistance and healthcare, improving oral hygiene among children, improving the health of adult residents, registration and precise recording of healthcare problems of the Roma" living in this municipality.

Source: Center for Minority Rights, Decade of Roma Inclusion: Bulletin by the Center for Minority Rights, No. 5, pp. 23, August 2006.

³³ Government of the Republic of Serbia, *Second Report on the Implementation of the Poverty Reduction Strategy in Serbia*, August 2007, pg. 101.

Based on what has been presented so far, as well as numerous research studies and official documents that were consulted, it could be asserted that the Ministry of Health of the Republic of Serbia, in collaboration with all the competent local health institutions, Roma non-governmental organizations and non-governmental organizations involved in Roma health, have carried out a series of activities for the purpose of effective implementation of the adopted health policies and legislation, aimed at increasing the accessibility of healthcare institutions to Roma in Serbia, with the goal of improving their health condition. However, lacking is a registration system that would provide databases for the continual monitoring of the realization of the adopted health policies and evaluation of the set goals and priorities for the realization of the conditions aimed at providing greater health institution accessibility to Roma, and which would be available to all interested institutions, researchers and general public. Therefore it is necessary to provide a link between the existing information systems in health institutions with the Statistical Office of the Republic of Serbia, as well as allow for the development of information systems in health institutions where they already exist, and which would also be linked to the Statistical Office.

5. IMPACT OF IMPLEMENTED POLICIES ON ACCESS OF ROMA TO HEALTH CARE

The impact analysis of policies – goals, measures and activities³⁴ – aimed at improving Roma access to healthcare, is the result of effort to overview all the policies and establish the achievements of their operation between 2003 and 2007. During this period the adopted and implemented policies could produce effects through improving healthcare and improving Roma health. The assessment of the impact of the health policies also included analyses of the changes in quantitative parameters, i.e. condition indicators, as well as a *cost-benefit* analysis of the investment in the programs that primarily target children and young Roma. The entire analysis of the impact of the policies on Roma access to healthcare was also backed by qualitative evaluations, i.e. views of the participants in the process of implementing these policies, as well as views of independent experts and representatives of Roma associations and organization that were the beneficiaries of these policies. The list of questions that we used in interviews as well as the list of 23 participants in the interviews, is included in the study annex (Annexes 3 and 4). The legislative frame that represents the basis for the exercising of Roma rights to health care, the effects of which were also analyzed, is provided in Annex 1.

5.1 Impact of implemented policies

Prior to assessing the impact of the implemented policies on the access of the Roma population to health care, it should be pointed out that certain quantitative indicators for measuring policy impact are the reflection of subjective views and perceptions of members of the Roma ethnic minority who took part in the representative studies, and based on which data of national significance was collected (RSO, 2008; UNICEF, 2007). The explanation of the policy impact on Roma health care access will be given through the direction that the impact of a given policy has – positive or negative change – without interpreting the range and scope of the determined changes. Additionally, when interpreting the impact of health policies one should bear in mind that the expected outcomes of the application of all policies range from improving the general health of the Roma population to the reduction in inequality in Roma health care access compared to the general population.

One should also point out that at the national level there is no significant set of data regarding the Roma population in Serbia, primarily because the size of this subpopulation is underrated and because a certain number of Roma do not have the formal status of citizens of the Republic of Serbia (Antić, 2005, 2006). Data from the 2002 Census showed that there are 108,193 Roma living in Serbia. However, estimates indicate that this number is far greater, and that it is between 400,000 and 500,000 (Antić, 2006). The basic data sources for the assessment of the impact of health policies on the health of the Roma population will be the Living Standards Measurement Survey (RSO, 2008), a series of health indicators on children and women from the 2005 MICS (UNICEF, 2007), the results of the study on the social vulnerability of Roma, refugees and internally displaced persons, carried out by UNDP (UNDP, 2007) and data from the Ministry of Health on program and projects realized as part of the Decade of Roma Inclusion.

³⁴ Deputy Prime Minister's Poverty Reduction Strategy Implementation Focal Point and CLDS (2008), Base of adopted policies and measures of the Government of the Republic of Serbia 2003-2007: http://www.prsp.sr.gov.yu/baza_usv_mera.jsp

The number of participants included in various projects that are part of the Decade of Roma Inclusion has almost doubled between 2006 and 2007, where one should bear in mind that a person could be included in several activities (Table 3) at the same time. However, without comparative data on the health condition of the most vulnerable parts of the population, it is very difficult to assess and predict the effects of the implemented measures that have been converted into the realization of project activities at the local level. The last MICS results are from 2005³⁵, and this is a year that represents a central point in the observation of the impact of health policies, so it is difficult to assess and predict how the values of the indicators have changed (this especially applies to child mortality, immunization, women's health of reproductive age, etc.), before the following study and collection of relevant statistical indicators on the total Roma population, as well as socially vulnerable Roma living in informal Roma settlements under very poor sanitary and hygienic conditions.

When exercising the right to healthcare, Roma most often encounter the problem of not having identification papers and not knowing on which grounds they are exercising the right to health care. The experiences of the interviewed health workers testify to this, as do the expert assessments and views of the representatives of the Roma population in Serbia. A large number of Roma, especially those displaced from Kosovo and Metohija, are not included in the birth registers of citizens of the Republic of Serbia, which creates problems when issuing personal documents.³⁶ Furthermore, their problems are also created due to the inability to communicate on account of language barriers, which can often cause barriers in access to health care and various other forms of discrimination. Therefore, activities such as employing 15 Roma mediators in health care institutions and Roma community, understanding the role of Roma associations as mediators in healthcare and informing the Roma community, conducting the "my doctor" campaign, child immunization and visits by healthcare services to Roma settlements, additional Roma healthcare through the implementation of Decade of Roma Inclusion projects carried out by the Ministry of Health, still indicate that all the measures that are being taken to include Roma in the healthcare system should contribute not only to the improvement of the health image of this population group and elimination of stigmatization and changing of perceptions of the members of the Roma ethnic minority in the local community, but also to educating the Roma population on accepting certain norms that formal membership in a given social environment carries.

The most common forms of violation of Roma rights to health care, as indicated by case studies in Belgrade and Novi Sad, are non-responses by doctors to help sought by Roma women in labor and emergency services not responding to calls, encountering discrimination when visiting health care centers, stigmatization, human rights violations and insults on grounds of ethnicity, charging fees to Roma women that didn't have health card for deliveries, not stamping medical letters of reference for internally displaced persons from Kosovo and Metohija who didn't have health cards or certificates stating their right to healthcare for internally displaced persons, etc. (Antić 2005; Jovanović, 2005). It was the opinion of the interviewed representatives of Roma associations, health workers and creators of health policies that the violations of Roma rights occur most often due to discrimination based on ethnicity and social status. Such examples in practice are the result of ignorance and negligence of the Roma population regarding the necessity to hold health cards for the purpose

³⁵ Base of statistical data DevInfo of the Statistical Office of the Republic of Serbia, in the second on vital statistics of the Roma population, also updated in 2005.

³⁶ Pointing out the problems of socially vulnerable Roma, Antić (2006) classifies this Roma population in four subgroups: internally displaced persons from Kosovo and Metohija, persons living in illegal settlements, persons born in the former Yugoslav Republic, and returnees in the readmission process.

of exercising their right to healthcare in public health institutions, on one hand, and the rigidity of certain representatives of health services when ethnic Roma patients are concerned. A good approach to overcoming such problems is provided in the Ministry of Health working on educating the Roma population and promoting health, through establishing partnerships between health institutions and Roma nongovernmental organizations, as well as by eliminating barriers between beneficiaries of health services and medical staff, and eliminating discrimination. Another source of these problems could be resolved through the legal grounds for registering residence.

The efficiency of health care policies, aimed at improving the availability of healthcare to Roma is given an average rating, according to most people interviewed. Namely, the highest legal act of the Republic of Serbia and laws in the domain of individual healthcare stipulate that the right to health care is provided to all, regardless of their religious affiliation or ethnicity. In order to exercise the right to health care by public health services, the beneficiary must have health card as proof of health insurance. If the right to health insurance cannot be exercised on any grounds, and due to the fact that the Roma are recognized as a vulnerable group, whose members often have greater problems regarding permanent and temporary residence registration in the territory of the Republic of Serbia, they have been provided the possibility to declare themselves as ethnic Roma or to provide proof of residence with the help of witnesses or submit appropriate documents, so that they might exercise their right to health insurance, in accordance with the Law on Health Insurance. Therefore, in accordance with the Law on Health Insurance, as part of Article 22, paragraph 1, item 11, provides that socially vulnerable persons of Roma ethnicity who cannot exercise the right to health insurance on any other grounds, can exercise this right by making a statement of Roma ethnicity. This legal solution provides better targeting by health care measures for all Roma that do not have permanent residence, i.e. temporary residence in the Republic of Serbia.

Roma non-governmental organizations and civil associations that have taken part in the realization of the Decade of Roma Inclusion projects have very positive experiences, especially if they were included in several consecutive projects. Namely, due to the longer period of project realization led to the habit of regular health checkups among most groups targeted by these projects. Such experiences are shared by project coordinators at the health institutions implementing health policies at the local level, adding to the role and importance of the decentralization of the health care system and benefits of decentralization for the local population. However, there are experts that believe that in the case of the poorest segment of the Roma population, the programs and projects that are being realized with the aim of improving Roma health care have a very weak impact due to the low inclusion of the Roma population, and there is also a gap emerging between the legal norms and their implementation in practices, as already been elaborated in the study.

According to data from the Ministry of Health, based on records of the Republic Institute for Health Insurance, in June 2008, there were 2,174 ethnic Roma insurance holders registered in accordance with Article 22 of the Law on Health Insurance. The total number of insurance holders with the Republic Institute for Health Insurance that have gained the right to health insurance based on Article 22 and for which funds will be provided in the Republic budget for the following year is 1,167,601 persons. Bearing in mind the fact that the implementation of this stipulation of the Law on Health Insurance has been in effect since January 1, 2007, the dynamics of exercising the right to health insurance, as well as the percentage of the Roma population in Serbia that do not have health card (17% LSMS 2008), we can conclude that it

will take several years for all the Roma that wish to exercise the right to healthcare to actually do so.

Despite this, based in interviews with participants, the general conclusion can be made that the impact of health policies on the health of the general population in Serbia is positive.

Table 5 Changes in impact of implemented policies on access of Roma to health care in Serbia

POTENTIAL IMPACT OF HEALTH CARE POLICY ON	Change (+/-)*
I HEALTH STATUS OF ROMA POPULATION	
Self-assessment of health status	+
Understanding on transferability of HIV from mother to child	+
Percentage of patients with chronic diseases	-
Infant mortality rate	+
Mortality rate of children up to the age of 5	+
Percentage of children suffering from pneumonia	n/a
Percentage of pregnant women under medical supervision	n/a
Percentage of young Roma women marrying before the age of 15	n/a
II ACCESS TO HEALTH CARE	+
Capture of persons with health insurance	+
Capture of children with immunization – all prescribed vaccines	+
BCG inoculation of children	+
Percentage of health care services beneficiaries	+
Regular recipients of therapy for chronic illnesses	+
Percentage of beneficiaries of out-of-hospital services	-
Percentage of beneficiaries of hospital services	-
Percentage of beneficiaries of dental services	
Percentage of persons who treated themselves or resorted to alternative medicine	
IMPACT OF ECONOMIC FACTORS	
Poverty rate	+
Percentage of expenditures for health care services in total household consumption	+
Share of public expenditures for health in GDP	Constant

The general conclusion, which could be made based on the monitoring of indicator changes shown in the table above, is that the impact of health policy measures on the accessibility of healthcare to the Roma population in Serbia is positive. The direction of the impact of the pursued policies on Roma health can be assessed by monitoring of the changes in indicators that reflect the health condition of the Roma population, presented through the data analysis in the third part of this study. The health condition of the Roma, especially the most vulnerable parts of this population, are slightly improving, which represents a step towards achieving the Millennium Development Goals. An exception is the increase in the number of people suffering from chronic conditions, which is also the trend in the general population in Serbia.

Access to healthcare is improving, hence the strategic goal, aimed at achieving a reduction in inequality in access to primarily healthcare for the socially most vulnerable portions of the

population, is being realized with moderate dynamics. The increase in the number of chronic conditions implies a greater frequency of visits to health services and hospitals, not only among the general population but also among the Roma population. However, the dental health of children and adults, is given less attention in the Roma population, thus the number of visits to the dentist's is in negative correlation with the price of dental services. Health policies or economic conditions can have an indirect effect on the increase of the number of users of alternative medicine or and those that rely on "home remedies". There is not a single cause for such occurrences, but one of the possible explanations certainly lies in the inequality of accessibility of health services. In any case, health policy measures should be aimed at suppressing such occurrences, since it is characteristic of the Roma population, as well as the general population.

We would also like to point out certain problems that are caused by cultural and demographic differences. Representatives of Roma associations and the implementers of local health policies believe that the achievements of health policies in certain cases can be decreased due to differences that exist and which are deeply rooted in Roma tradition. The idea was to point out the differences that have been confirmed by gender sensitive analyses³⁷, and which indicate the inequality of the genders – in the sense of the disbalance of power between men and women – is especially prominent in the Roma population, influencing the lives, health and welfare of the people. At the same time Roma women are especially vulnerable because they suffer the burden of dual discrimination – racial- and gender-based – and therefore healthcare is less accessible to them. Roma women very often don't have no say, since men decide on their lives, number of children, abortions, visits to the doctor, contraception, education, etc.

The potential impact of economic factors on the health of the population is very high, especially among the poor. Roma households have below-average allocations for health services, and even more so taking into account that the average Roma household has twice as many members as the average household in Serbia. Finally, it should be pointed out that the healthcare accessibility to the poorest populations depends on the proportion of public spending on healthcare according to the gross domestic product. This spending has not changed in relative terms for a long time and it is around 7% of the gross domestic product.

The impact that the national program for the controlling tuberculosis and HIV/AIDS have on the health of the Roma population can be perceived through the annual reports on their realization. It should be pointed out that in the first years of the implementation of the HIV/AIDS protection program there were no reports that would provide an overview of the implemented activities and realized effects regarding the target goals. The first comprehensive report on the implementation of this program is available only as of this year³⁸. In addition to the information on the campaigns on HIV/AIDS protection, general education, establishing partnerships with key organizations in the struggle against HIV/AIDS, realized among the target groups, it also contains part of the studies on young Roma, who were especially targeted through the study carried out in Belgrade and Vranje, being one of seven vulnerable groups, and which showed that 3.9% of the people in Belgrade and 11.6% of the young Roma in Vranje suffered from sexually transmitted diseases, including HIV/AIDS.³⁹ The UNICEF study, which also represents the first and only economic

³⁷ The Association for Women's Initiative (2006) *Gender Barometre: social status and quality of life of women and men in Serbia*, Study digest, <http://www.awin.org.yu/images/pdf/RodniBarometar.pdf>.

³⁸ Ministry of Health of the Republic of Serbia (2008), *Annual Report: Scaling up the National HIV/AIDS Response by Decentralizing the Delivery of Key Services*, September 2008.

³⁹ Ministry of Health and the Serbian Institute for Public Health (2008), *Study of populations with higher HIV risk and persons living with HIV*, pg. 143.

evaluation of the effects of the implementation of preventive measures against the transmitting of HIV/AIDS from mother to child, confirmed the economic gain of the implementation of the targeted health policy. The results of the economic analysis confirmed that the diagnosing of one HIV positive pregnant woman saves the state between EUR 34,977 and EUR 39,881, based on child support, depending on whether the minimal or maximal number of pregnant woman is taken into account, while also gaining 25.3 years of child life.⁴⁰

Already in the first years of the realization of the project activities, the effects of the implementation of the tuberculosis protection program showed a reduction of the number of new tuberculosis cases. Based on data on the number of new patients in the total population, per 100,000 capital, it is apparent that the number of new cases has dropped faster between 2004 and 2006 (from 35 to 29 new cases annually, per 100,000 capita), than between 2002 and 2004 (from 38 to 35 new cases per 100,000 capita).⁴¹ Unfortunately, there is no data on the sick among the Roma population, so we cannot conclude with certainty whether there has been a decrease in the number of new cases, and to what extent, i.e. whether the project activities (education of the Roma population and diagnosing of tuberculosis cases in Roma settlements and their treatment) have led to a decrease in the number of new tuberculosis cases in the Roma population. It should certainly be emphasized that the inclusion of Roma in testing for this disease has increased from the planned 11,500 to 13,644.

However, regarding the participation of representatives of the Roma population in the implementation of the programs that particularly target this group, it is necessary to provide better coordination between the authorities and Roma associations. We can support such views with conclusions from the report on the activities of the Global Fund for Fighting AIDS, Tuberculosis and Malaria in the countries that are members of the Decade of Roma Inclusion. Namely, the report states that the civil sector and Roma nongovernmental organizations remain poorly represented in the realization of the activities of these programs in Serbia.⁴²

5.2 Evaluation of the impact of investing in programs for improving the health of Roma children and youths

Cost-benefit analysis is a very suitable method for measuring the impact of health policies and legislation on improving Roma health. However, the application of cost-benefit analyses in Serbia in this area is very difficult today due to the lack of necessary data. First of all, health policies directed towards improving Roma health, as we have pointed out before, are defined in several plan documents. However, the planned activities associated with the implementation of these strategic document are not budgeted, which impedes the monitoring of their implementation from the aspect of invested funds and realized effects. Furthermore, the state budgets (national and local) are not transparent to the necessary degree, because the budget lines for individual programs are invisible, i.e. the Budget Bill defines synthetic budget lines which contain funds for a number of purposes. This prevents the identification of budget investments on various grounds in the improvement of Roma health (the same applies to the general population). An exception are the special budget lines "Implementation of the Plan on

⁴⁰ UNICEF (2004), *Estimated Effectiveness of the Program for Prevention of Mother-to-Child HIV Transmission*, pg. 16.

⁴¹ Ministry of Health. *Project: Controlling Tuberculosis in Serbia Thorough Implementation of the Strategy of Directly Observed Therapy and Inclusion of High-Risk Populations*, Annual Report for 2007, March 2008.

⁴² Open Society Institute (2007), *How the Global Fund Can Improve Roma Health: An assessment of HIV and TBC programs in Bulgaria, Macedonia, Romania and Serbia*, str. 25.

Roma Healthcare”, which is a great improvement in budgeting state funds. However, there is no data on the total investments in improving Roma health through nongovernmental organization which support and are involved in the implementation of certain health programs with the **National Health Care Action Plan for Roma until 2015**, from the Decade of Roma Inclusion.

The Ministry of Health of the Republic of Serbia has made efforts to identify, to a high degree, investments in the realization of projects related to the implementation of the National Health Care Action Plan within the Decade of Roma Inclusion for 2006 and 2007.⁴³ Namely, the total budget funds spent have been identified, while data on investments through nongovernmental organization is incomplete, i.e. the Ministry of Health states that the identified sums are the smallest, therefore the impression is that these are funds that NGOs received as donations from the national and local budgets, and that funds that were provided by other donors most likely are not included in these sums.

Table 6: Implementation costs for the Health Care Action Plan for Roma, as part of the Decade of Roma Inclusion

Funding Source/Year	2006	2007	2008 (Plan)
Total funds	36,312,669	27,891,098	21,646,968
Funds from the budget of the Republic of Serbia – budget line “Implementation of the Plan on Roma Healthcare”	35,071,179	26,462,360	20,000,000
Local NGOs – on all grounds (estimate)	1,241,490	1,428,738	1,646,968
% of funds provided through NGOs from the funds in the budget line “Implementation of the Plan on Roma Healthcare”	3.54	5.40	8.23

In 2007 there was a drop in the funds from the Budget of the Republic of Serbia, compared to the previous year, which were spent on financing activities in the process of implementing the Health Care Action Plan for Roma within the Decade of Roma Inclusion. Based on the conducted interviews we have learned that the reduction of budget funding was the consequence of the fact that the approved funds (which were significantly greater than the funds spent) in the first year of the implementation of the Action Plan were not spent and that fewer funds were planned in the Republic Budget for the following year. This is likely the reason why even fewer funds are planned in the Republic Budget for 2008, compared to the previous year. This indicates the need to increase the efficiency of the process of implementing the **Health Care Action Plan for Roma until 2015** as part of the Decade of Roma Inclusion. The unsatisfactory quality of the project proposals contributed to this. This is why the Ministry of Health organized workshops on writing projects. In mid-2008 the Ministry of Health, in cooperation with the PRS Implementation Focal Point, published a handbook explaining the procedures that accompany the competition for support for health projects that are part of the Decade of Roma Inclusion.

⁴³ Decade of Roma Inclusion, Guide to the Procedures for Health Projects Included in the Decade of Roma Inclusion, Ministry of Health of the Republic of Serbia, July 2008, pg. 9.

The structure of the realized project, according to fields which are essentially linked to the set strategic goals, in the Health Care AP as part of the Decade of Roma Inclusions, as well as in the Poverty Reduction Strategy and other health-related strategies, indicates that it is very good to perform cost-benefit analyses for all programs, for the period up to 2015, which this Action Plan applies to. However, this would require significantly more time and effort in preparing data, especially assessing the benefits of each individual program.

Based on what has been said above, we have decided to perform a cost-benefit analysis for the Child and Youth Health program which being implemented as part of the **Health Care Action Plan for Roma until 2015**. The reason is the fact that the life expectancy of Roma in Serbia is significantly shorter than that of the general population and more than half the Roma in Serbia are younger than 25 years of age. It is our opinion that despite the fact that children and youths are included in other specific programs, the accent in investments should be the inclusion of a greater number of children and youths in the health program of the Decade of Roma Inclusion, because we believe that this would contribute to the significant improvement of the health of Roma children and youths, and which would lead to the increase in life expectancy in the future for the entire Roma population living in Serbia.

5.2.1 Evaluation of investments (costs)

One of the priorities of the Health Care AP for Roma are children and youths. This is why we decided to assess the investment in the Child and Youth Health program for 2006 and 2007. We carried out the assessment based on data from the Ministry of Health on (1) the total investment (presented in the previous table) and on (2) the inclusion of children and youth in this program, in the given years. The extent of the invested funds in this program was estimated based on the estimate of the portion of children and youths included in this program in the total included population in all the implemented health programs in the Decade of Roma Inclusion. In 2006 the population included in the analyzed program was 1,823 participants (22.7% of the total number of all analyzed programs in the Health Care AP in the Decade of Roma Inclusion), and in 2007 it was 1,777 participants (11.7%). We estimated that in 2008 this program included around 1,800 participants (the average number of users for 2006 and 2007), i.e. 18.1%.

By applying calculated percentages of participants to the total invested funds in each observed year we calculated that the investment in the analyzed program was:

- RSD 8,226,419 in 2006;
- RSD 3,267,569 in 2007;
- RSD 3,929,468 in 2008.

The estimation of the nominal investments 2009 – 2015 by year was carried out based on data on:

- the projected real growth of the gross domestic product in the observed period. We used official data from the Memorandum on Budget and Economic and Fiscal Policy for 2009, with Projections for 2010 and 2011⁴⁴, as well as projections from the developed national strategies that have been adopted by the government. The a projected average annual growth of the gross domestic product for the period 2009-2015 is around 6.1%;

⁴⁴ Ministry of Finance of the Republic of Serbia, Belgrade, May 2008.

- the projected inflation rate, also from the Memorandum on Budget and Economic and Fiscal Policy for 2009, with Projections for 2010 and 2011. The projected average annual inflation rate for the period from 2009 to 2015 is around 4.8%;
- the projected number of users of the analyzed program. The projections were carried out based on the assessed needs for including Roma children and youth in the health program for children and youths from the Decade of Roma Inclusion, which in turn is based on the assessment of the influence that this program on significantly improving the health of Roma children and youths which would allow for the continuous extension of the life span of the Roma population living in Serbia. Considering the greatly impeded health condition of the Roma and general population, we assessed that the inclusion of Roma children and youths in this health program should be very dynamic, i.e. that it should have a growth rate of 20% per year, with the rate being slower in the first four year, and significantly faster in the remaining three. According to the planned dynamics, slightly more than 30,000 Roma children and youths would be included in the analyzed program, i.e. they would pass through his program, during the entire period. Bearing in mind that according to the latest data from the official statistics (the 2002 census) there are 108,000 Roma living, and that 62% are younger than 25 years of age, we conclude that including a greater number of Roma children and youths in the analyzed health program, with the realization of a peer health education program, could yield significant effects in extending their life span only in the decades to come.

In order to assess the total necessary investment in this program during the entire implementation period of the Health Care Action Plan from the Decade of Roma Inclusion, i.e. between 2006 and 2015, we discounted the projected nominal investments. Bearing in mind local experience⁴⁵ which is based on international experiences, we assessed that the discount rate in this case should be slightly lower than the rate of inflation. We thus estimated that the discount rate of 3% annually on average, during the observed period, would be realistic for Serbia.

The key result i.e. the effect of investments into the above program would be the extension of life expectancy of Roma. This would result in a better demographic distribution of Roma population. The indirect effects would be: enhanced inclusion into the society, extension of labour active years of employed Roma, increase of productivity and wellbeing, etc.

Serbia has no database that would serve as basis for quantitative assessment of different effects of investments into health care programs targeting Roma. That is why we opted for quantifying the effects of investment into the program "Health of Children and Young People" within the framework of Roma Decade, i.e. for impact assessment of projected investments into extension of life expectancy of Roma. We need to note that we faced enormous limitations resulting from the lack of data. Therefore, we had to assess the required data for calculation of effects of investment into extension of life expectancy of Roma. The key assumptions are:

⁴⁵ Miroslav Dinkić (1990), *Cost-Benefit Analysis*, Economics Institute; UNICEF (2004), *Estimated Effectiveness of the Program for Prevention of Mother-to-Child HIV Transmission*; Center for Independent Living of Persons with Disabilities (2005), *Analysis of Justification of Investments in Organizing Personal Assistance Services for Persons with Disabilities in Serbia*. Health Challenge Wales (2005), *Health ASERT Programme Wales: Enhancing the Health Promotion evidence base on Minority Ethnic Groups Refugees/Asylum seekers, and Gypsy Travellers*. Morag M. Macneil, Robert N. Stradling, Alison Clark, Sarah R. Minty (2005), *Promoting the Health and Wellbeing of Gypsy/Travellers in Highland, An Evaluation of the initiative*. European Policy, *Health Impact – A Guide*, ISBN 1 874038 75 9 (May 2004). Patrice Van Cleemput (2007), *Health Impact of Gypsy Sites Policy in the UK*, Cambridge University Press. Teresa Janevic, *Disparities in Health in Serbia: A Focus on Malnutrition in Roma Children*, Mailman School of Public Health, Columbia University.

- inclusion into calculation of probability to reach the age of expected life calculated for the entire population in Serbia ⁴⁶
- for Roma in neighbouring countries to have a similar life expectancy shorter from the total population for 15 years⁴⁷
- life expectancy at birth for total population in Serbia is 73. We have assessed that life expectancy with Roma in Serbia is 58
- that the evaluated program would include in, in the period 2006-2015 (Table 7) an average of 2,918 Roma beneficiaries under the age of 24 a year.

Table 7: Assessment of investments and effects of the Decade of Roma Inclusion child and youth program

Year	Program participants (number)	Nominal value of investments (RSD)	Current investment value (RSD)	Discount factor	Effects
2006	1,823	8,226,419	7,754,189	94.26	1. Increasing life expectancy/beneficiary/annum is 0.18 years
2007	1,777	3,267,569	3,172,397	97.09	
2008	1,800	3,929,468	3,929,468	100.00	
2009	1,980	4,858,125	4,716,626	103.00	2. Total no. of obtained years of life during program implementation is 518
2010	2,178	5,458,467	5,145,129	106.09	
2011	2,505	6,410,629	5,866,633	109.27	
2012	2,880	7,101,054	5,765,806	112.55	
2013	3,456	8,207,830	7,080,146	115.93	
2014	4,493	9,709,863	8,131,857	119.41	
2015	6,291	11,418,799	9,284,528	122.99	
Total	29,184	68,588,221	60,846,780		

In assessing the effect related to extension of life expectancy of Roma, we took into consideration the population that was, according to the data available from the Ministry of Health, involved in this rather wide program (capturing services of primary health care, dentist' check-ups and services, laboratory analyses, immunization) aged 0-24. The implementation of this program over a 10-year period presupposes extension of life expectancy of the above mentioned age group from 58 to 63. The difference between the implementation and failure to implement the program represents a net effect reflected in extension of life expectancy of the program beneficiaries (Table 7).

Starting from the initial investment in this program, it is estimated that the total investment in the entire observed period is acceptable. With the assessed investments significant effects would be achieved related to Roma inclusion in social life and in the healthcare system, improving health and quality of life for them and their families.

⁴⁶ Tables indicating mortality 2001-2003, RSO

⁴⁷ Data of the European Commission for Hungary, 2002

5.3 Conclusions

It cannot be expected that the more significant effects of the realization of activities through the implementation of the projects intended for improving access to healthcare as part of the Decade of Roma Inclusion will be immediately visible, but this would be helped by monitoring them through the creation of a system of monitoring and evaluation of the impact of the measures. Therefore, it is certain that these activities, in addition to other health policy measures will contribute to improving the indicators of Roma health, such as reducing child mortality and extending the life span, improving the reproductive health of women, increasing child inclusion in immunization, reducing the number of persons suffering from chronic conditions, etc. The concern for the health of Roma families living in unhygienic settlements is becoming obvious, since a growing number of local self-governments is recognizing the assessment of the hygienic and epidemiological conditions in settlements inhabited by Roma as an important and priority factor in protecting the health of their citizens. Furthermore, legislative solutions that will lead to the formal resolution of the status of ethnic Roma citizens in the Republic of Serbia, in addition to eliminating administrative barriers for their faster implementation, are certainly another measure that should lead to the reduction of the inequalities in the access to healthcare for ethnic Roma. The calculated effects of implementation of "Health of Children and Young People" over a 10-year period amount to 518 obtained years on the basis of extension of life expectancy of the program beneficiaries.

6. ACCESS TO HEALTH CARE SERVICES FOR THE ROMA PEOPLE – EXAMPLES OF EU BEST PRACTICES

There are estimated to be some 8-10 million Roma people in Europe and at least 5 million in the new EU member states, although Roma and Traveller are found in almost all Council of Europe member states. The EC Report "The Situation of Roma in an Enlarged EU" described the treatment of Roma people as "one of the most pressing political, social and human rights issues facing Europe". This is placed within the context of the Council of Europe's three top priorities, since 1993, or protection of minorities, fighting racism and eliminating social exclusion. In 1995 a Specialist Group on Roma, Gypsies and Travellers issues was established. The main objective of the group was to encourage member states to adopt a comprehensive approach to Roma and Traveller issues. Within the EC an inter-sectoral group bringing together 14 different departments and chaired by the Employment, Social Affairs and Equal Opportunities Department co-ordinating the different policies and programmes affecting Roma issues.

With specific reference to health, the "Recommendation of the Committee of Ministers of the Council of Europe on Better Access to Health Care for Roma and Travellers in Europe" (2006) was issued. This set out a model for member states to help them develop appropriate health policies for Roma and Traveller population in accordance with their constitutional structures and legalature including effective access to services (non-discrimination, physical and information accessibility); planning; health education; sexual and reproductive health; participation (particularly in respect of Roma women) and staff training.

2005 saw the launch of the Decade of Roma Inclusion primarily involving Central European countries with Spain becoming the first Western European country expressing the wish to join the Decade. The health condition of Roma was top of the agenda with the following aims:

- Ensure access to health care
- Increase the information base on Roma health
- Increase inclusiveness of health systems
- Improve health in vulnerable sub-communities particularly women and children

'Decade Watch' – a group of Roma activists – is assessing progress on the Roma Decade and has concluded thus far that although there are good examples of systemic policy approaches in most countries, as yet there are limited tangible outcomes.

In the light of this the rest of this paper will take a wider focus on the issue of access to health care including policy approaches; assessment of health needs and access; projects to improve access to services and to health promotion, education and information. These are examples and not intended to provide a comprehensive or general appraisal of policy.

6.1 General Policy Approaches

As stated above, and in the context of the EU statements on social inclusion, many EU countries have developed strategic policy documents in respect of Roma people and their access to a range of services including health care. Following the launch of the Decade of the Roma the Czech Republic launched its "Governmental Department for Social Inclusion of Excluded Roma Communities" promoting high level partnerships and innovative and complex social inclusion policies in marginalised Roma localities. Hungary is in the first phase of a National Development Plan that has provided some funding for health care mediators.

The Scottish Government has undertaken a multi-faceted strategic approach including launching research on health and health needs; training of healthcare staff; developing new services in consultation with Gypsy Travellers. A national Gypsy Traveller Network has set up an action plan focusing on four key areas:

1. Extension of best practice models nationally, e.g. manual medical records
2. Community led national health needs assessment
3. Production of health promotion materials in accessible formats e.g. video/TV
4. Employment of community researchers to develop action based research

In the Republic of Ireland the government's Traveller Health Strategy 2003-2005 was developed following a report of the Task Force on the Travelling Community. This focused on the importance of inter-sectoral co-ordination to tackle the multi-causal factors affecting travellers health status. The Welsh Assembly Government also takes an inter-agency approach and is developing a policy framework for the provision of services for Gypsy Travellers. The objectives of the policy is to ensure the needs of Gypsy Travellers are assessed, planned and implemented in more strategic ways. Recognising how various factors impact on health the focus has been on the provision of accommodation and therefore £1.5m has been earmarked for new construction. There is, as yet, however little information on the impact of these policy developments.

6.2 Assessing the Health Status and Health Needs of Roma People

Undertaking needs assessment of Roma Traveller people has been a key action for a number of EU governments and researchers within those communities including Hungary, Slovakia, Ireland, Wales and England. The review of Irish Travellers Health by the well known *Pavee Point Project* in Dublin found health in travellers to be significantly poorer than other lower socio-economic population groups. This manifested itself in higher levels of miscarriages, still births, infant deaths and childhood accidents. In later life higher rates of long term illness, ill health and disability were exhibited. Most significantly there were higher rates of illness in respiratory disease, heart disease, chronic pain and sensory difficulties. Levels of anxiety and depression were also higher. The study concluded that complex socio-economic determinants contributed to this as did cultural factors.

The Department of Health in England commissioned Sheffield University to undertake a review of the Health Status of Gypsy Travellers in England and this reported in 2004. The study demonstrated significantly poorer health status and significantly more self-reported symptoms of ill health than other UK resident English speaking minorities and economically

disadvantaged white UK residents. Using standardised measures as indicators of health, Gypsy Travellers have poorer health than that of their age sex matched comparators. Those who rarely travelled had poorer health as did Gypsy Traveller women. The most marked inequalities, mirroring the Irish study, were in self reported anxiety, respiratory problems including asthma and bronchitis and chest pain. Excess prevalence of miscarriages, stillbirths, infant deaths and premature death of older offspring were also conspicuous.

There was some evidence of an inverse relationship between health needs and use of health and related services with fewer services and therapies used. Ability to register with a General Practitioner (the gatekeeper to English health services) and widespread communication difficulties between health workers and Gypsy Travellers with a defensive expectation of racism and prejudice were reported. Barriers to health care access were experienced including the reluctance of GPs to register travellers or to visit them; practical problems of access whilst travelling and disparity of expectations and stigmatization were also reported although there were also positive experiences particularly with community health workers. Good practice in Cambridge, Newark and Leeds were reported where Gypsy Travellers were working in community development and in close partnership with health workers. Dedicated health visitors for travellers were highly valued and played an important role in facilitating access to other health services.

The 2004 report also explored Gypsy Travellers health beliefs and attitudes which demonstrated a cultural pride in self reliance. Stoicism and tolerance of chronic illnesses were reported with a deep rooted fear of cancer or other diagnoses perceived as terminal and resulted in an avoidance of screening. Some fatalistic and nihilistic attitudes to illness were expressed – illness was seen as inevitable and medical treatment seen as unlikely to make a difference with more trust in the family than in professional care. Accommodation was an overriding factor in the context of health effects resulting in an emphasis on accommodation as part of an approach to tackling ill health.

The Health ASERT programme of the Government of Wales (2003) identified a scarcity of robust evidence in respect of Gypsy Travellers. It also emphasised poor housing and sanitation as contributing to poorer health status. Problems were experienced in accessing health promotion as there was a lack of appropriate cultural awareness in developing services and resources with a level of culturally and linguistically appropriate health information and advice. Good practice in health promotion was reported as well however, including *NHS Direct*, community based projects, health education in schools, public anti-smoking campaigns, road safety and health visitor and midwifery practice. Women were more open to health promotion and wished to engage in its design and delivery.

6.3 Accessing Health Services – Practical Projects

A range of projects focused on improving health status, access to services and health promotion have been undertaken across the EU. These have often emerged at a localised *ad hoc* level, sometimes with NGO support, and with limited evaluation. Most projects have focused on developing community workers (particularly in the development of health mediators in Central Europe) and on collaborative partnership approaches.

Since 1994 the *Pavee Point Project* in Ireland has undertaken a Primary Health Care for Travellers Programme. 16 Traveller women were trained to work as Community Health Workers with their role involving in-service training for health professionals; community based liaison work; on-site health education sessions; co-ordinating visits to a variety of clinics; production of traveller specific health promotion material; research; seminars and conferences. The model has been replicated by numerous traveller organisations and Health Boards across Ireland and *Pavee Point* has undertaken a university accredited Training for Trainers course.

In Romania as part of "Improving the Roma's Health in Romania" (2004-2005) 18 members of local Roma community trained as health and sanitary mediators whose job was to inform the population about TB (identified as a specific priority).

Apart from information campaigns mediators helped doctors and nurses by bringing in large numbers of people and also helped in identifying persons with whom TB patients had had contact and were also engaged in changing perceptions of the disease. In 2007 the Ministry of Health employed more health mediators with the numbers reaching 600. Occupational standards for these roles were developed as an official recognition of health mediator profession combined with professional development of trainers for health mediators training.

As discussed above health mediators have been developed in a number of Central European countries including the Czech and Slovak republics, Hungary, Bulgaria and Romania. EPHA undertook a study in 2006 into the effectiveness of the health mediator model in Bulgaria, Finland and Romania. The study found generally favourable results with regard to the efficiency of Roma Health Mediators (RHMs) in assisting individual Roma clients. At higher levels though the structural inequities hindering improvements in Roma health care were not targeted by RHM activities sufficiently to bring about significant change. More specifically some RHM programmes failed to be supported by legislative changes or to be integrated into the overall public health system and therefore failed to tackle deeper rooted obstacles to improved Roma health which required political support. On an individual level, the RMH programmes effectively addressed several components of Roma health and helped with reducing bureaucratic and community obstacles faced by Roma communities. The study recommended increased individual/community empowerment combined with improved legislative reforms.

The Scottish Government and NHS Highland Health Board funded a project in the Scottish Highlands to promote the health and well being of Gypsy Travellers from 2002-2005. Two outreach workers were established as were two specific projects – a primary care outreach service aiming to adapt primary care services to address Gypsy Travellers needs and a second project to explore how health service provision for Gypsy Travellers can be developed to meet the identified needs in an efficient and cost effective manner. A specialist health visitor and community specialist practitioner was also appointed.

The evaluation of this project found that it had played a major part in enhancing the potential for greater and more effective service provision and access. It had led to beginning of debates between Gypsy Travellers and service providers. The aim of equity of service provision resulting in enhanced health and well being was unlikely to be achieved within the three year timeframe and with such a small team. The project did, however, establish more widespread awareness and it raised expectations and it was concluded that the project should be mainstreamed. However, as identified in the evaluation of the health mediators projects, it was found that there was a need for a senior post at decision making level to embed changes. However, until significant change happened it was necessary to retain specialist outreach

workers although policy to practice efficiency could be enhanced were it possible to link outreach posts to senior posts and cut across service structures. Other similar projects found that mediators were predominantly female and whilst that had specific advantages in terms of maternal and child health there was also a need to train more men to better meet the health needs of Roma men.

Also in Scotland the Angus Health Worker project revealed the continued difficulties of Gypsy Travellers in accessing health services. The project found a lack of knowledge about services; lack of information on how to contact service providers; health information was found to be difficult to understand; it was difficult to keep appointments; GPs were perceived to be far away and difficult to access and there was experience of discrimination.

In terms of access to health promotion and education the NGO Roma Mission in Helsinki, Finland developed health education programmes for adolescent girls providing opportunities to ask questions of Roma or non Roma Finnish women they could not ask their mothers. In Bulgaria the Foundation for Promotion of Roma Youth also organized discussion on prevention of STDs and HIV/AIDS and outreach to Roma drug addicts. In England the Sussex Traveller Health Project established a model of traveller participation in health promotion.

6.4 Conclusions

Improving access to health services and improving the health status of Roma Gypsy Travellers has been identified as a key priority areas within the EU. This has resulted in the development of strategic policy frameworks in many countries although it is still difficult to see the tangible benefits emerging from these policies. Work has been undertaken to assessing health needs, establishing health status and barriers in accessing services although again there is as yet little evidence of how this has been translated into action. There is limited evaluation of the impact either of policy developments or the implementation of these policies. Specific projects have tended to focus on community engagement primarily through the development of Roma Gypsy Traveller community workers or health mediators and these are seen to have realised benefits although they need to be combined with the creation of senior level decision making posts to link practice to policy.

7. BASIC CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusions

1. The Government endorsed a series of strategic documents and changed regulations defining health policy to Roma in Serbia with a view reducing inequalities in access to health care during the period of PRS implementation.
2. Article 22 of the Law on Health Insurance in force since January 2007 provides for exercise of rights to health care of all Roma who cannot exercise these rights on any other basis. However, only a small number of Roma i.e. 2,174 Roma exercised this right over the past 18 months. According to the LSMS data, some 17% of Roma do not have a health card which implies slow inclusion of Roma into the health insurance system having acquired this right. Evidently, Roma are insufficiently informed on the rights available in the health insurance system.
3. The Ministry of Health supports implementation of projects within the framework of Programs for Improvement of Roma Health of the Roma Decade through partnerships of health care institutions and the civil sector. This programme particularly targets the extremely vulnerable groups within Roma population – women, children, inhabitants of unhygienic settlements. 103 projects involving 23,215 beneficiaries were implemented in the course of 2006 and 2007. It must be noted that one person was eligible for several projects. However, due to modest capture of the most vulnerable, the projects and programmes have a weak impact on improvement of health care among Roma.
4. The downward trend of available budget for financing programs and projects of the Roma Decade has been observed over the past three years. The key reason is the poor timing of publication of tenders for participation in projects and thereby, the impossibility to implement projects during the period planned, poor utilisation of the approved funds and the resulting inability to obtain higher budget allocations in the following year.
5. Project implementation monitoring did not result in establishing databases and systematization of data per relevant criteria which should provide for continuity in assessment and evaluation of policies and regulations.
6. Also, the state statistics do not yet provide databases for calculation of key indicators of impact assessment of health policies and accessibility of health care services to Roma population and other vulnerable groups.
7. Inclusion of Roma into health services is on the increase. On the average, 25% of Roma use different health care services on a monthly level, in contrast to 35% of citizens pertaining to total population.
8. The greatest impact on accessibility of health services to Roma are availability of health care service in local communities, extension of the positive list of medications and an overall improvement of the health care system in Serbia.

7.2 Recommendations

1. The existing health policies are good. In order for their impact on health status of the targeted population to be greater, their implementation should be intensified. Contribution of the Ministry of Health and other relevant ministries, as well as local self-governments and the civil sector dealing with the problems of Roma, should be intensified, through implementation of partnership projects and programmes.

2. Programmes for the Roma population should be tailored by the Ministry of Health, Ministry of Education, Ministry of Labour and Social Policy, Ministry of Youth and Sports, local self-governments and non-government sector so as to respond to their specific needs. In this way, Roma will eventually become a part of the system of complete health care of Serbia's population.
3. Changes and amendments to relevant regulations should remove administrative obstacles for faster obtaining of personal identification numbers and health cards by Roma without habitual/temporary residence. In order to achieve this goal, information campaigns should be launched to inform Roma on the procedures and possibilities for obtaining health cards. This will ensure their larger inclusion into the system of health care services.
4. «Door to door» informing of Roma families on their rights from health insurance should be a continuous effort. This particularly refers to the rights of socially vulnerable Roma as defined in Article 22 of the Law on Health Insurance.
5. In cooperation with the non-governmental sector and support of the media, the ministries of health and local self-government should launch an extensive campaign to educate the socially vulnerable Roma on their responsibilities for their own health and that of their families with a view to promoting health life styles, care of health and importance of prevention.
6. The Ministry of Health should publish a tender for participation in projects early on in a calendar year on the basis of the funds earmarked in the Law on Republic Budget, to establish an expert team that will duly evaluate the offers and decide on participation in implementation of programmes and projects to be implemented over that year. The team of the Ministry of Health should develop a reporting format, evaluate results to serve as basis for the following project cycle.
7. On the basis of reports submitted in a given format, the Ministry of Health should provide for establishment of electronic databases in order to ensure proper impact assessment and minimise the risks to effective project implementation/completion.
8. In order to provide to the decision-makers precise impact assessments of measures targeting Roma, the state institution in charge of statistics i.e. the Republic Statistical Office should be tasked with establishing databases for monitoring and analyzing inclusion of Roma into health care system and their utilization of health care service bearing in mind the key criteria of evaluation of health policies endorsed by the Government in the form of relevant strategies and laws.
9. With a view to extending life expectancy of Roma population and reducing infant and child mortality, registration of Roma in unhygienic settlements should be undertaken and immunisation and inoculation of children conducted.
10. Starting from the fact that almost half of the Roma in Serbia live under the poverty line, the cooperation between local non-governmental organisations dealing with problems of Roma and local community institutions (health care institutions, utility companies, sanitary inspectorates, etc.) should be improved. This would result in reducing exposure of Roma (particularly the groups living in unhygienic settlements, collecting scrap materials and living on monotonous diet) to risks of chronic contagious and non-contagious diseases.

ANNEX 1

Poverty among Roma

Following the trend of general reduction of poverty among the population in Serbia, poverty among Roma also decreased slightly in the period 2003-2007. Namely, the number of poor Roma in 2007 decreased to less than one half of the total Roma population – 49.2% (RSO, 2008)⁴⁸. In the same period, the number of poor at the level of total population decreased from 14% to 6.6% (RSO, 2008). However, 6.4% population lives in extreme poverty, although it is deemed that the general poverty rate of Roma population would have been higher had the LSMS covered the population living in unhygienic Roma settlements and slums (RSO, 2008). The level of poverty is similar among women and men (51.8% and 46.6% respectively), but it is much more pronounced among Roma children (poverty rate among children up to 14% is 56.3% and is horizontally decreasing up to population aged over 60 – 40.9%), as well as among rural population (62.1%).

The consumption of an average household in Serbia in 2007 amounted to an average RSD 52,843/month, while the consumption of an average Roma household totalled RSD 39,111⁴⁹. As Roma constitute a socially vulnerable group, so are their consumption habits most often directed to expenditures for food, housing, alcohol and tobacco⁵⁰. According to the 2007 LSMS, the expenditures of these three consumption categories amounted to 76.3% of total expenditures of Roma families, relative to 56.2% spent for the same purposes by all the households in Serbia. The total expenditures for health care (hospital and out-of-hospital) among Roma (3% of total household consumption), are just only lower as compared to the total population (4.1% of total household consumption). Furthermore, almost 25% of Roma population living in Belgrade⁵¹ do not possess a health card⁵², and that they cannot exercise the right to health care; the only alternative being to pay for a certain health service or to give up on visiting a doctor as they cannot afford the treatment⁵³. However, certain progress has been achieved

⁴⁸ According to the LSMS data (UNDP, p.5, 2006), 57% of Roma lived beneath the poverty line in 2003. However, due to the differences in poverty measurement methodology it is impossible to simply compare the number of poor Roma in 2003 and in 2007. More on the poverty measurement methodology on the basis of the 2007 Living Standards Measurement Survey in "Smith-Govoni, R. and Krstic (2008) in Living Standards Measurement Survey, RSO, pp. 167-186

⁴⁹ Only 1/10 Roma are in the middle consumption quintile, while 86.8% Roma are distributed among the most vulnerable two quintiles and the rest is among the two quintiles indicating the richest population (RSO, 2008).

⁵⁰ It is more of a reason for concern than a surprise that Roma households spend 7.9% of their total consumption on alcohol and tobacco as compared to all households that spend 50% of that amount i.e. 3.9% for the same purposes (RSO, 2008). Namely, Roma children start smoking at an early age, and due to difficult socio-economic conditions, Roma population is more often suffering from psychological problems (UNDP, 2006). Among the Roma aged 15-25, 55% and 30.4% in Belgrade and Vranje respectively declared themselves as smokers (Ministry of Health and Serbian Public Health Institute, 2008, p. 139). Also there are 80% smokers among the Roma population (Antic, 2005, p.8)

⁵¹ Centre for Minority Rights (2006), *Roma and Right to Legal Subjectivity in Serbia*, p. 19

⁵² In order to stress the gravity of the problem of absence of personal documents, and in this case of the health card, we shall cite yet another source confirming this problem. Namely, according to the data stated by Djurdjica Zoric from the Roma women association Bibija and published in the Centre for Minority Rights Bulletin no.5, p.22, 2006, 65% Roma (40% women) including those who live in unhygienic settlements and slums do not have a health card. The situation is particularly difficult among refugees, internally displaced persons and returnees on the basis of readmission agreements of whom 85% (70% women) i.e. 95 have not regulated their status nor do they hold a health card.

⁵³ According to the UNDP survey, some 55% of Roma households cannot afford the prescribed medications (UNDP, 2006, p.5).

with respect to capture with health insurance, especially of the younger cohort of Roma population. Despite the assessment made on the basis of the 2007 LSMS, that 17% of Roma do not have health insurance which is more than double relative to the entire population (6%) (Grozdanov, 2008), the survey conducted among the younger Roma aged 15-25 showed that 77.6% of respondents in Belgrade have health insurance. This percentage is significantly higher in Vranje – 97.5%⁵⁴

Education as a significant determinant of exit from poverty in general and poverty reduction among Roma should also be noted. Regretfully, expenditures for education in Serbia are still less important than expenditures for, for instance, alcohol and tobacco, although a decrease of the number of smokers in Serbia has been observed⁵⁵. Thus, for the total population, the share of expenditures for education in the total household budget has been assessed as only 1.4%. This data is unavailable for Roma population. Although preschool education in Serbia has become mandatory in 2006, inclusion of Roma children rarely follows the recommendations of the state policy with respect to integrated access to education.

Box A2.1

Project of the Red Cross of Serbia: «Open kindergarten for Roma children from socially vulnerable families»

This project was launched in 2002 within the programme activities of the Red Cross of Serbia, i.e. before the adoption of the Action Plan on Roma Education. In 2008, the project is implemented in 33 kindergartens through 30 Red Cross branch offices. Its implementation was to ensure higher inclusion of Roma children into the system of preschool education. As of 2002, the project has covered 2,030 Roma children who attended kindergartens and 1,325 parents who contributed to the realisation of different projects in kindergartens. In addition, the share of children who attend kindergartens and who later enrol into regular schooling is increasing but the full effect has not yet been achieved⁵⁶. The general remark that can be made with respect to the implementation of this project is that its implementation resulted in segregation of Roma children into isolated groups who are literally physically divided from kindergartens for other children. This method of work with Roma children is not conducive to removing barriers, the first of which is language and that could result in them enrolling into regular schools⁵⁷

Source: Red Cross of Serbia (2008), Report on implementation of the project «Open kindergarten for Roma children from socially vulnerable families»

⁵⁴ Ministry of health and Public Health Institute (2008), *Surveys of populations exposed to higher risk of HIV and persons living with HIV*, pp. 139

⁵⁵ As compared to 2000, the number of smokers in the total population in 2006 decreased from 41% to 34% (Grozdanov, 2008).

⁵⁶ According to the data of the Red Cross of Serbia, 62.1% of children who attended preparatory preschool programme in kindergartens enrolled primary school 2005/06. In the ensuing 2006/07, 85.7% of Roma children who attended preparatory preschool programme enrolled (Red Cross of Serbia, 2008).

⁵⁷ The PRS Focal Point, *Comments on the Project Implementation in the context of implementing the Action Plan on Education within the framework of the Decade of Roma Inclusion*, internal materials.

ANNEX 2

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ANNEX 3

LEGAL FRAMEWORK

Legislation which allows for efficient implementation of health care policies related to the health of Roma in Serbia is incorporated into two key laws:

- Law on Health Care
- Law on Health Insurance

Basic provisions of the **Law on Health Care**⁵⁸ (hereinafter: the Law) define health care of Serbian citizens as organised and comprehensive activity of the society, aimed at achieving the highest level of health protection of citizens and families. It comprises implementation of measures for protecting and improving the health of citizens, prevention, curbing and early detection of illnesses, injuries and other health disorders, as well as timely and efficient curing and rehabilitation. Each citizen of the Republic of Serbia, as well as other persons with habitual/temporary residence within the Republic of Serbia, has the right to health care, in line with the law, and responsibility to protect and improve their health and health of other citizens, as well as the healthy living and working environment.

The Law further stipulates that participants in providing and implementing the health care of citizens are: citizens, families, employers, educational and other institutions, humanitarian, religious, sport and other organisations, associations, health care service, health insurance organisation, as well as municipalities, towns, autonomous provinces and the Republic. These are the subjects and institutions which provide funds for financing health care services and which carry out the health care of citizens by providing health care services.

Second part of the Law regulates issues related to public care for population's health. Article 11 envisages public care for the health of Serbian citizens under equal conditions, which implies health care of the socially vulnerable population. Concerning the Roma, as a vulnerable group, their health care is guaranteed by implementation of all provisions of the Law which regulate health care of the socially vulnerable population. The main provisions are related to:

- Children up to 15 years of age, school children and students until the end of prescribed period of studies, and not exceeding 26 years of age, in line with the Law;
- Women, in the context of family planning, as well as during pregnancy, delivery and maternity, up to 12 months after the delivery;
- Persons above 65 years of age;
- Disabled persons and mentally challenged persons;
- Persons affected by HIV or other contagious diseases specified in the special law which governs the protection of the population from contagious diseases, persons with malignant diseases, haemophilia, diabetes, psychosis, epilepsy, multiple sclerosis, persons in the terminal phase of chronic kidney insufficiency, cystic fibrosis, illness of the autoimmune system, scarlet fever, addictions, ill or injured persons who need

⁵⁸ National Assembly of the Republic of Serbia.

urgent medical assistance, as well as health care in relation to organ and tissue transplantation.

- Unemployed and other categories of socially vulnerable persons whose monthly earnings are below the level prescribed by the Law regulating health insurance;
- Persons of Roma nationality who, due to their traditional way of life, don't have a permanent or temporary residence in the Republic of Serbia.

In order to enjoy their health care rights, specified in the aforementioned paragraph of the Article 11 of the Law on Health Care and Article 22 of the Law on Health Insurance, the Roma persons are required to: (1) provide a statement of two witnesses on the address of their temporary residence, certified in the municipality in which they reside, and (2) to provide a signed statement that they are persons of Roma nationality, in order to prevent abuse of the rights stipulated by the aforementioned articles, which could be interpreted as a positive discrimination. This is the legal form by means of which persons of Roma nationality in the Republic of Serbia gain the status of persons with compulsory insurance and the right to health care, on the basis of obtained and certified medical insurance cards.

Unless the Law specifies otherwise, funds for financing the health care of above mentioned persons who are not included into the mandatory health insurance, are earmarked from the budget of the Republic of Serbia and transferred to the organisation for mandatory health insurance.

Public care for Roma health is provided and implemented at the local level (province, town and municipality) by local authorities, in cooperation with non-government sector and health-care institutions – health care service providers. Local authorities are required by law to monitor the health status of the population and the work of health care services in their area, as well as to take care of implementation of health care priorities and to create conditions for accessibility and equality in the usage of primary health care in their local areas. Local authorities provide financial resources to health care institutions in line with the Law and the Plan of the Health Care Institutions Network. The purpose of these investments is building, maintenance and equipping of the health-care institutions; equipping and maintaining of the integrated health care information system⁵⁹, as well as other requirements set forth by the Law and ordinance on founding health care institutions in the local area.

Law on Health Care established the concept of continual health care (Article 22). Continual health care is accomplished through entire organisation of the health care system, which must be functionally linked and harmonised at different levels, from the primary, over the secondary, up to the tertiary level and which provides constant health care to the citizens of Serbia, regardless of their age. This legal concept makes possible for the health care of Roma in Serbia, at all levels, from the primary, over the secondary, up to the tertiary level of health care, provided that they possess certified medical insurance cards, obtained within the previously described procedure, on the basis of the Article 22 of the Law on Health Insurance. According to the Ministry of Health, the total number of Roma persons who owned certified medical insurance cards in June 2008, in line with the Article 22 of the Law on Health Insurance, amounted to 2,174 of which 1,170 Roma were insurance holders and 969 were members of their families.

⁵⁹ An integrated health care information system is organized and developed in the Republic of Serbia, with the aim of planning and efficient management of the health care system, as well as collecting and processing the data on the health status of the population and functioning of the health care service, that is collecting and processing health related information. The Government adopts the programme of work, development and organization of the integrated health care information system, in line with the law.

The **Law on Health Insurance**⁶⁰ regulates the financing of mandatory and voluntary health insurance and the rights of citizens resulting from abovementioned forms of health insurance. Mandatory health insurance is directly related to the labour market status of the citizens, i.e. employment, as it is financed from contributions assessed on gross personal incomes of the employees. The system of compulsory health insurance in Serbia is based on the concepts of solidarity and mutuality. This insurance covers the cases of illness or injury not related to work, as well as the cases of work related injuries or professional illnesses. The concept of compulsory insurance implies obligatory payment of health insurance contributions, which guarantees the right to health care of insured persons and their family members. The concept of solidarity and mutuality is accomplished by establishing intergenerational solidarity and mutuality, solidarity and mutuality between genders, between healthy and the ill, as well as between persons of different material statuses, including the individuals from vulnerable population.

On the basis of the foregoing, employed Roma and unemployed Roma who actively seek employment are insured within the system of compulsory health insurance and enjoy all the health related rights like all the other citizens and their families with the same status on the labour market.

Among the insured persons, the new Law also includes socially vulnerable persons. This means that Roma persons who don't have a permanent residence in the Republic of Serbia, due to their traditional way of life, enjoy the status of insured persons and the right to health care services, in line with the Article 22 of the Law.

For the purpose of protecting and improving the health of insured persons, including Roma who gained that status in line with the Article 22, the Law specifies prevention measures, which consist of:

- Health education organised by way of special lectures or advices, given by health workers, on the protection and improvement of health, on gaining healthy lifestyle knowledge and habits and on discovering and curbing the risk factors;
- Systematic and other medical examinations of children, school children, students until the end of the prescribed period of studies, and not exceeding 26 years of age, women in relation to pregnancy and adults in line with the Republic programme for prevention and early detection of illnesses with major social and medical impact and established standards;
- Preventive dental and prophylactic measures for preventing the mouth and teeth illnesses of pregnant women and children up to 18 years of age, as well as of elderly persons with serious mental or physical developmental disorders;
- Health education on the family planning, prevention of pregnancy, contraception and surgical sterilisation, pregnancy testing, testing and curing sexually transmitted diseases and HIV infection;
- Vaccination, immunoprophylaxis and chemoprophylaxis which is compulsory in line with the Republic programme of immunisation of the population against certain contagious diseases;

⁶⁰ National Assembly of the Republic of Serbia.

- Hygienic, epidemiologic and other measures and procedures prescribed by law with the aim of preventing, discovering and curing the HIV infection and other contagious diseases and preventing their spreading.

The Government adopts the Republic programme for prevention and early detection of illnesses with greater social and medical impact, Republic programme of dental health care of children up to 18 years of age and pregnant women, the Republic programme of immunisation of the population against certain contagious diseases, as well as the medical standards for measures and actions proceeding from the programme.

The right to health care of the person with mandatory health insurance is established on the basis of the plan for health care from the mandatory health insurance. The plan is adopted on the basis of the following requirements:

- Health requirements of insured persons;
- Financial assets provided for the implementation of compulsory health insurance;
- Established priorities for the implementation of health care at the primary, secondary and tertiary levels;
- Available capacities of the health care service.

The health care plan for the mandatory health insurance is adopted by the Republic Health Insurance Office for each calendar year, by 31 December of the previous year. Competent minister approves this plan, before its being published in the Official Gazette of the Republic of Serbia. This ensures the transparency of health care, as all citizens of Serbia, especially those insured in line with this law, including the Roma, can access information on the planned health care measures which will be realised through the system of compulsory health insurance and can participate as beneficiaries of certain programmes which are important for improving their health status and health status of their family members, who are also considered as insured persons of the compulsory health insurance, in line with this law.

The state guarantees the carrying out of the responsibilities of the Republic Health Insurance Office in realising the rights from the compulsory health insurance (state guarantee). This applies to urgent medical assistance and health care provided to insured persons within health care institutions, regardless of their status within the system of financing. This is exceedingly important for the Roma and other socially vulnerable groups.

The manner of, procedure and evidence required for gaining the status of insured person, in line with Article 22 of the Law, is prescribed by the general act adopted by the Republic Health Insurance Office. Insured persons listed in the Article 22 of the Law, such as Roma without permanent residence in Serbia due to their traditional way of life, exercise their rights from the compulsory health insurance at the local office in the territory on which those persons have reported their temporary residence, in line with the abovementioned procedure.

It is necessary to emphasise the complementarity of the two aforementioned laws from the standpoint of creation and implementation of the health policy directed towards increased availability of health care services to the Roma in Serbia, for the purpose of improving their health. That is to say, the first law safeguards the right to health care and funds earmarked from the national budget for financing health care services used by Roma as a vulnerable group (provided that they are unemployed and have the status of unemployed persons at the labour market, for whom contribution is paid for mandatory health insurance). These funds are

transferred to the Republic Health Care Fund for the realisation of health care programmes which target this population. The second analysed law provides the insured status to the Roma and their family members, within the system of compulsory health insurance, on the basis of the principle of solidarity and mutuality.

Results of the preceding analysis indicate that Roma are included into the health care policy and system, that is the legislative. Results of the analysis on the influence of health care policy and system on the inclusion of Roma into the health care system of Serbia (Chapter 5 of the text) point out the level of effectiveness of established objectives and legal solutions in practice, within the period of their previous implementation.

Annex 4

INTERVIEW QUESTIONNAIRE⁶¹

FOR DECISION-MAKERS, EXPERTS, PARTICIPANTS IN THE IMPLEMENTATION OF
HEALTH-CARE POLICIES AIMED AT THE HEALTH CARE OF THE ROMA

Name, surname and position:...

Institution/Organisation/Agency:...

Phone number:... E-mail:...

1. Evaluate the influence of health care policies on the entire health care picture and welfare of the population in Serbia and give a commentary to your evaluation:...

/-2 very unfavourable influence; -1 unfavourable influence; 0 no influence whatsoever; 1 positive influence; 2 very positive influence/

...

2. According to your knowledge, which health care policies are being implemented and which official documents have been adopted, in relation to health care of the Roma population in Serbia?

(1)...

(2)...

(3)...

3. On the 1 to 5 scale evaluate the efficiency of health care policies aiming at the protection of health of the Roma and give a commentary to your evaluation:

/1- insufficient, ..., 5- excellent/

...

4. In your opinion, is there a difference in the effects of health policies in relation to gender, age or other demographic characteristics of the Roma and what are your proposals for overcoming the negative influences?

...

5. Write down the determinants which influence Roma health to the most and which are within and/or beyond the health care system of services:

Within: (1)...

Beyond: (1)...

6. Evaluate the influence of the following groups of factors on the health status of the Roma and give reasons for the evaluation:

/-2 very unfavourable influence; -1 unfavourable influence; 0 no influence whatsoever; 1 positive influence; 2 very positive influence/

6.1. Lifestyle:...

6.2. Social and community influences:...

6.3. Living and working conditions:...

6.4. Overall socio-economic and cultural influences and the environment:...

7. Evaluate the influence of health policies to general health status of the Roma in Serbia and give reasons for the evaluation:

⁶¹ By filling this questionnaire you support the realisation of one segment of the survey named "Analysis of the Policy Influence" conducted by the Deputy Prime Minister's Poverty Reduction Strategy Implementation Focal Point.

/-2 very unfavourable influence; -1 unfavourable influence; 0 no influence whatsoever; 1 positive influence; 2 very positive influence /

...

8. Give at least one good practice example on the influence of health care policies to Roma health:

...

9. In your opinion, what are the most frequent problems encountered by the Roma in exercising their right to health care?

...

10. According to your knowledge, what are the most frequent cases of infringing the Roma rights to health care?

...

11. In your opinion, what is the most efficient way of solving the problems encountered by the Roma in exercising their right to health care?

...

12. Which Roma related health policies should be modified, in what way, who is competent for implementing the modifications and when can the effects of those policies be expected?

...

13. List several factors, starting from the most significant, which influence to the most the unequal availability of health care to the Roma population:

...

14. Which measures would you propose for solving the problem of inequality in the availability of health care to the Roma?

...

15. Is it necessary to introduce changes into the legal and institutional framework (if yes, in what way) in order to reduce the unequal availability of health care and increase the efficiency of health care policy measures related to the Roma?

...

16. In the 1-*insufficient* to 5-*excellent* scale evaluate overall efforts in the health promotion and education of the Roma:

16.1 *State*:...

16.2 *Local self-government*:...

16.3 *Non-government sector*:...

16.4 *Other* _____:...

Thank you for participating in the interview!

Annex 5

List of interviewed persons:

I. Roma NGOs that participated in the projects of the Ministry of Health, within the Roma Decade:

1. *Ana Saćipović*, Association of Roma Women "Osvit", Niš
2. *Nelica Atanasković*, Association for Democratization and Education of the Roma, Trstenik
3. *Petar Dumitru*, Roma Association "Mali rit-London", Pančevo
4. *Radmila Gačević*, Association of Citizens, "Romski cvetovi", Belgrade
5. *Vladimir Petrović*, Association "Rom", Braničevo County, Požarevac
6. *Zoran Petrović*, NGO "Ruke prijateljstva", Kraljevo

II. Coordinators of the Ministry of Health projects within health care institutions:

7. *Časlav Nedeljković*, Health Care Centre, Leskovac
8. *Jelena Brcanski*, Institution for Public Health, Kikinda
9. *Milka Burlica*, Institution for Public Health, Sremska Mitrovica
10. *Mirjana Avramović*, Institution for Public Health, Kruševac
11. *Nada Đurić*, Health Care Centre, Loznica
12. *Snežana Matić*, City Institution for Public Health, Belgrade

III. Creators of health care policies, experts and international organisations:

13. *Aleksandar Bojović*, Ministry of Health of the Republic of Serbia
14. *Dubravka Šaranović*, Ministry of Health of the Republic of Serbia, advisor in the Sector for Programmatic Health Care
15. *Gordana Radosavljević Ašić*, president of the Republic Comity for Tuberculosis of the Ministry of Health of the Republic of Serbia
16. *Gordana Tamburkovski*, Ministry of Health of the Republic of Serbia
17. *Farida Bassioni Stamenić*, Ministry of Health of the Republic of Serbia, project "Improving the National Response to HIV/Aids by Decentralisation of Key Health Care Services"
18. *Ivana Mišić*, Ministry of Health of the Republic of Serbia, assistant minister in the Sector for the Organisation of Health Care Service
19. *Jelena Čurčić*, Canadian International Development Agency (CIDA)
20. *Nataša Lazarević*, Ministry of Health of the Republic of Serbia, project "Control of Tuberculosis in the Republic of Serbia"
21. *Petar Antić*, Centre for Minority Rights, Belgrade
22. *Sanja Drežgić-Ostojić*, Red Cross of Serbia
23. *Tanja Knežević*, Institute for Public Health of Serbia "Milan Jovanovic – Batut", Belgrade