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REVIEW AND REORIENTATION OF PROGRAMMES FOR GREATER HEALTH EQUITY WITH EXPLICIT BUT NOT EXCLUSIVE FOCUS ON ROMA POPULATION

Context and problem

According to the last census, 2,66% (or 53.800 people) of the population are Roma (Multi-Annual Operational Programme Human Resources Development, 2007). However, both governmental and non-governmental entities suggest that Roma under-report ethnicity, due to stigma or other reasons (real number to be somewhere between 200.000 and 260.000).

The Vulnerability study produced by the UNDP states that 22% of Roma men and 39% of Roma women don't have or have incomplete education and 65% of Roma men and 83% of Roma women have never been employed; the unemployment rate in Roma is 71% (1). Primary education completion rate among Roma children is 67,1% (among Macedonian children is 7,4%). (2) Fifty two per cent of the Roma population in Macedonia live under the poverty line according to the income-based poverty rate (UNDP, 2005). Large numbers of Roma find themselves unable to take advantage of the health care services

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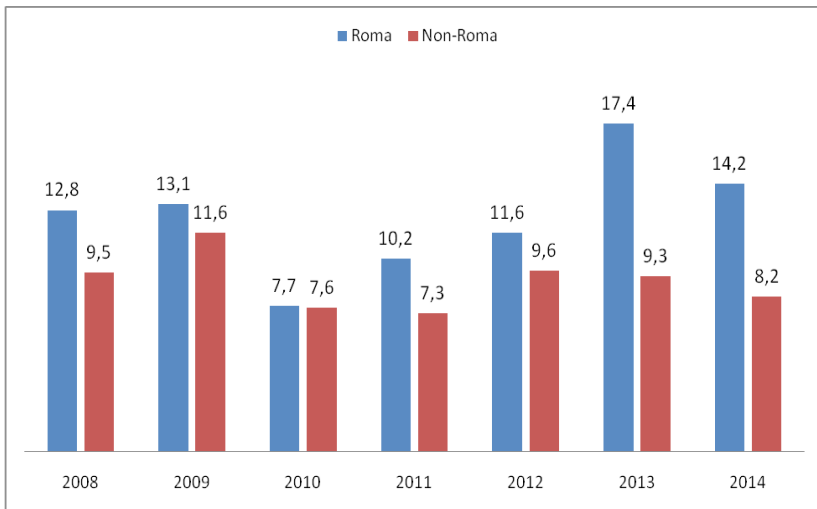
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available to the rest of the population, due to lack of health insurance.

Evidence indicates significant inequity in health status and health system access between Roma and majority populations. There are indications that life expectancy among Roma communities is 10–15 years lower than average. Higher rates of chronic illnesses have been reported among Roma populations than among majority populations, with higher rates of type 2 diabetes, hypertension, coronary artery disease and obesity among adults (3). According to ESE, 45% of Roma men and 64% of Roma women suffer from chronic diseases (in comparison to 23% of non-Roma population). Furthermore, 73% of Roma with chronic diseases cannot afford the necessary medication (4).

Data on IMR (infant mortality rate) continuously show disparities within the indicator, related to educational level of the mother and ethnical background. In 2014, IMR was two times higher among women with low educational level (mothers with or without completed primary education -12,4/1000 per live births) than in mothers with high educational level (6.6/1000 per live births). IMR among Roma was 17,4/1000 per live births while among Macedonian women was 10,7/1000 per live births. Disparities in IMR between Roma and non-Roma are shown in Fig.1 (5).

Fig. 1. Infant mortality per 1000 live births among Roma and non-Roma, 2008-2014



In 2014, 59% of infant deaths occurred during the neonatal period or the first month of life (0–28 days). The main medical cause of neonatal

deaths is preterm birth (73,3%). Data at global level show that preterm birth is highly associated with smoking during pregnancy, unhealthy diet, psychosocial stress, hard physical work, and inappropriate and untimely use of health services during the pregnancy (5,6,7). Factors associated with increased risk of LBW include maternal poverty, low levels of educational attainment and teenage pregnancy, while all these factors tend to accumulate in certain groups like Roma and poor people (8).

Roma women face additional health problems, such as higher teenage pregnancy rate and limited access to services due variety of barriers (lack of ID/citizenship, language and economic barriers, low level of education and information about healthy life style, gender imbalance, cultural factors which influence their health seeking behaviour - irregular visits to gynaecologist during pregnancy etc. (9, 10).

Access to health services is one of the factors that determine the Roma health status, and certainly very important for their social inclusion. Many factors and barriers play important role, like socioeconomic factors (poverty, social exclusion, low educational level, unemployment, inappropriate health-seeking behaviour, inadequate nutrition, smoking), cultural and traditional norms (early marriages, gender issues). Indirect discrimination and communication barriers are one of the main reasons for low level of satisfaction with the health care services, among Roma population. The inability of health systems to provide equity across all functions continues to undermine efforts to improve the health of Roma and other vulnerable populations (11).

Interventions for improving Roma health

Macedonia, through its domestic legislation and a large number of ratified International Treaties, has committed itself to protecting, respecting and fulfilling the obligations emerging from these international acts for all citizens, among which Roma. Macedonia is a signatory of the Decade for Roma Inclusion 2005-2015, and therefore had a political commitment to contribute to the social inclusion of Roma, prioritizing fields of education, healthcare, employment and housing. In this line, in 2005 the Government has adopted the National Strategy for the Roma in Republic of Macedonia and the National Action Plan (NAP).

Existing information on progress in implementation of the NAP is showing slow progress in relation to the health status improvement. There are number of positive examples of interventions in different sectors, such as the introduction of Roma Health Mediators, establishment of Nation-

al Roma Centres, establishment of Centres for Early Child Education in Roma communities etc. Despite some improvements in the health status of the Roma population, such as improvement in vaccination coverage among Roma children (immunization coverage among Roma is 90%, in Macedonian is 95%) (2), much remains to be done.

National Action Plan for Roma Health – Roma Strategy has been revised according to the European policy for health and well-being - Health 2020 Strategy, where several action were prioritized, such as inter-sectorial collaboration and coordination, social participation, sensitization of health providers for working with Roma etc.

In line with the UN Millennium Development Goals 4 and 5 and WHO/EURO Health 2020 Strategy, the Ministry of Health of the former Yugoslav Republic of Macedonia has implemented the Action plan for Improvement of maternal, perinatal and neonatal health 2013-2014, where improvement of health of vulnerable groups of mothers was recognized as one of the priorities.

The role of WHO

The need for commitment to address these root causes of health inequity was emphasized in a 2008 report by the WHO Commission on Social Determinants of Health (CSDH), the related 2009 World Health Assembly Resolution, the Rio Political Declaration on Social Determinants of Health (2011), and the European Review of Social Determinants and the Health Divide (2012). Improving health for all and reducing health inequities are also among the strategic objectives of Health 2020, the European policy framework supporting action across government and society for health and well-being.

Strengthening health systems and addressing underlying determinants of health to protect the right to health of vulnerable groups—especially Roma, migrants, and other populations experiencing poverty and social exclusion, has been priority of the WHO Regional Office for Europe as well of the WHO CO in Skopje.

Guided by the values and principles of Health 2020 Framework, Regional Office was facilitating the interagency coordination initiative “Scaling up actions towards Millennium Development Goals 4 and 5 in the context of the Decade of Roma Inclusion and National Roma Integration Strategies”. Macedonia was one of the leading countries that included the multi-country training in its Biannual Collaborative Agreement for 2012-2013, and implemented the reorientation process of Strategies, Pro-

grammes and Activities (SPAs) to health equity with an explicit but not exclusive focus on Roma which. The whole process was finalized with the publication of a Case Study in 2015 (12).

The Case Study report describes the Macedonian experience in reviewing and reorienting National Mother and Child Health Programme (MCHP) which, according to national data appears that it was not reaching all the population equitably. Consequently, the MCHP integrated a number of public health interventions required for the improvement of mother and child health.

The review and reorientation process aimed to analyse how the SPA is working and for whom, looking to reinforce the most effective interventions and to make them equitable for all. The review process revealed the relationships and mechanisms operating behind the barriers and facilitating factors identified by the review team, related to the socioeconomic position of the priority subpopulation through structural and intermediate social determinants of health. Differences have been explored in the review process, the main causes of inequities have been detected and effective interventions integrated in the programme in order to strengthen equity, social determinants, gender and human rights issues.

Analysis showed that despite the fact that the health sector has an important role in providing equitable health, numerous factors that create inequities come from outside this sector. One of the responsibilities of the health sector is to provide evidence of the health inequities and visibility of certain population groups that need action from other sectors within the SDH approach. One of the benefits of this process of reorientation was awareness rising, in this context and calling for action from other sectors which have an impact on health.

The role of intersectoral action and participation as cross-cutting themes for each key stage of the programme in order to tackle health inequities was considered in the redesign of the SPA. Civil society representatives were part of the review team and participated through the entire review process. Experiences were exchanged; also information and data were enriched from the Roma community side. Feedback from the community was also taken into consideration through research reports, which allowed the use of community-generated evidence. Social participation undoubtedly added value to the redesign process and also initiated a channel of collaboration for improving other health programmes. In this term social groups, particularly the prioritized subpopulation have been empowered, to achieve better programme results.

Some of the results that are linked directly to the programme include identification of the so-called hidden barriers to implementation of the activities. The new SPA is more focused and enriched with interventions that are expected to improve the quality of the programme and its implementation, which will lead to further availability, accessibility and coverage of the services for all women, specifically those from the most vulnerable groups including Roma, and therefore to the improvement of the overall mother and infant health.

The new proposed MCHP was presented after the adoption of the programme by the MoH, to representatives from different stakeholders: the Safe Motherhood Committee, NGOs, Roma community representatives, United Nations agencies, civil society and other partners, in order to obtain greater collaboration and more successful implementation.

Recommendations and conclusions

In taking Health 2020 forward, our country will not only face different contexts and starting points, but will also need to have the capacity to adapt to both anticipated and unanticipated conditions, under which policies must be implemented. In that regard, country needs support to strengthen overall governance capacities to address the social determinants of health and the health divide. Requests for technical assistance from WHO to increase country capacities, to address the social determinants of health and related health inequities, have been increasing continually, specifically this kind of review process have elevated perception for its need. The requests for capacity building have increased further with the introduction of the National Health 2020 Strategy and its Action Plan in the Macedonia.

The review process has been shown as: useful (it supported review team members to redesign their programme to better address equity, social determinants, gender and human rights), applicable (participants are continuously implementing this expertise during designing and implementation of different SPAs in their everyday work) and transferable (participants are now so-called leaders in health equity and can influence others in reviewing and reorienting SPAs).

There is a need to transfer the concept of reorienting and review processes not only to health policy-makers but also other sectors, in order to achieve greater impact on health.

Building capacity among professionals, from public health and other sectors, which have an impact on health, on the concept of equity and the

use and implementation of the WHO methodology facilitated by WHO, can be a great advantage.

Insufficient attention is explicitly paid to the equity impact of the SPA; the process should be expanded by additional use of different models – for example, implementation of the concept of the equity lens in teaching curricula; empowerment of NGO representatives; training health professionals, health managers and policy-makers in sensitivity to diversity (both at individual and organizational level); improvement of intersectoral collaboration; improvement of social participation through greater collaboration primarily with civil society; greater role of civil society in the creation and implementation of national Programmes; the local government should support community nurses and Roma Health Mediators programme; the Ministry of Labour and Social Policy should improve registration policies and ID provision, including additional financing for antenatal care and delivering services for women without ID.

To make all this possible, there is a need for coordination and introduction of the equity review process to government representatives, decision makers of different sectors and local authorities.

The importance of collaboration with different stakeholders and social participation has been recognized by all participants in the review process and will be adopted, as a practice in the future during design and implementation of programmes.

Moreover, establishment of mechanisms for intersectoral action, such as a coordinating body responsible for the development, implementation, and M&E of programmes with representatives from each relevant sector, including representatives from United Nations organizations and NGOs, is fundamental.

The importance of collaboration with different stakeholders and of social participation has been recognized by all participants in the review process and should be adopted as a practice in the future during creation and implementation of the programme.

Executive summary

Despite severe shortage of data on the health status of Roma, numerous studies have documented health disparities between Roma and non-Roma population in Macedonia. Access to health services for Roma is compromised by many factors like poverty, social exclusion, low educational level, unemployment, inappropriate health-seeking behaviour, cultural and traditional norms, indirect discrimination and communication barriers. Among all, the inability of the health system to provide equity across all functions continues to undermine efforts to improve the health of Roma and other marginalized populations.

There are number of positive examples of interventions in different sectors aimed to improve the health of Roma in the country, but existing information is showing slow progress in relation to the health status improvement. Strengthening health systems and addressing underlying determinants of health to protect the right to health of vulnerable groups—especially Roma, has been priority of the WHO Regional Office for Europe as well as the WHO CO in Skopje. Regional Office was facilitating the inter-agency coordination initiative “Scaling up actions towards Millennium Development Goals 4 and 5 in the context of the Decade of Roma Inclusion and in support of National Roma Integration Strategies”. Macedonia was one of the leading countries that included the multi-country training in it’s Biannual Collaborative Agreement for 2012-2013, and implemented the reorientation process of Strategies, Programmes and Activities (SPAs) towards health equity with an explicit but not exclusive focus on Roma, which concluded with the Case Study. During the process of review and re-orientation of the National Mother and Child Health Programme (MCHP), main causes of inequities were detected and effective interventions have been integrated in order to strengthen equity, social determinants, gender and human rights aspects in the programme. The new MCHP was enriched with interventions that are expected to improve the availability, accessibility and coverage of the services for all women, specifically those most vulnerable like Roma.

Strengthening the governance capacities to address equity in existing or planned health programmes, is a necessity.

Health policies need to address vulnerability differences between populations, with an intention of reducing health inequities, by considering Social Determinants of Health (SDH) significances over the health status, in general.

References

1. United Nations Development Program. Avoiding the dependency trap: The Roma Human development Report (2003). www.undp.org
2. Multiple Indicator Cluster Survey, UNICEF, Republic of Macedonia, 2011.
3. Information on health status and health protection of Roma in Republic of Macedonia. Public Health Institute of Macedonia, 2012.
4. Pavlovski B. Health, health care and influences over the health of the Roma in R Macedonia, 2008, available at http://esem.org.mk/pdf/Publikacii/Ostanati/Zdravjeto_zdravstvena_zastita_i_vlijanija_vrz_zdravjeto_kaj_Romite_vo_RM.pdf
5. Information on health stays and health protection of mothers and children in Macedonia in 2014. Institute of Mother and Child Health, Skopje, 2015
6. EURO-PERISTAT Project, with SCPE, EUROCAT, EURONEOSTAT. European Perinatal Health Report 2008.
7. Salmasi G, Grady R, Jones J, et al. Environmental tobacco smoke exposure and perinatal outcomes: a systematic review and meta-analyses. *Acta Obstet Gynecol Scand.* 2010;89(4):423-41.
8. IHE Report. Determinants and Prevention of LBW: A synopsis of evidence. Institute of Health Economics, Alberta, Canada, 2008.
9. Pregnancy and postpartum health care among Roma women in the Municipality of Shuto Orizari-Community Assessment Card, NGO HERA, Skopje, available at: <http://hera.org.mk/?p=2155&lang=en>
10. Report on the focus groups for services in the reproductive period of the National Resource Centre, available at <http://www.nationalromacentrum.org/mk/publikacii/istrazuvanja/izvestaj-od-fokus-grupi/>
11. Roma population in the Republic of Macedonia-Strategy for social inclusion and integration. Donev D, Cicevalieva S, Kosevska E, Kendrovski V. Institute of Social Medicine, Faculty of Medicine "Ss Cyril and Methodius" University, Skopje, Republic of Macedonia, Ministry of Health of the Republic of Macedonia. Institute of Public Health, Skopje, Republic of Macedonia.
12. World Health Organization, 2015. Review and reorientation of the "Programme for active health protection of mothers and children" for greater health equity with an explicit but not exclusive focus on the Roma population" in the FYR Macedonia: Roma health – case study series No.2.