

Sexual and reproductive health needs and access to services for vulnerable groups in Eastern Europe and Central Asia



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List of abbreviations

AIDS	: Acquired immunodeficiency syndrome
ANC	: Ante-natal care
CEDAW	: Convention on the Elimination of All Forms of Discrimination against Women
CRC	: Convention on the Rights of the Child
DHS	: Demographic and Health Survey
EC	: Emergency contraception
EECA	: Eastern Europe and Central Asia
ESCR	: Covenant on Economic, Social and Cultural Rights
FGDs	: Focus group discussions
FP	: Family planning
GP	: General practitioner
HFA	: European Health for All database [online database]
HIV	: Human immunodeficiency virus
IDPs	: Internally displaced people
ICPD	: International Conference on Population and Development
IPPF	: International Planned Parenthood Federation
IUDs	: Intrauterine devices
MCH	: Maternal and child health
MDGs	: Millennium Development Goals
MMR	: Maternal mortality ratio
NGO	: Non-governmental organisations
PNC	: Postnatal care
PRB	: Population Reference Bureau
RH	: Reproductive health
RHM	: Roma health mediator
SRH	: Sexual and reproductive health
STIs	: Sexually transmitted infections
UNICEF	: United Nations Children's Fund
UNFPA	: United Nations Population Fund
WHO	: World Health Organization
WHOSIS	: World Health Organization Statistical Information System [online database]
YFS	: Youth-friendly services

Executive summary

Aim and Purpose

This report aims to understand sexual and reproductive health (SRH) needs and related policies for three selected vulnerable groups - Roma (men and women), internally displaced people (IDPs) and adolescents - in eight Eastern European and Central Asian countries. The purpose of the study is to contribute to a policy dialogue on focusing national programs on the SRH needs of vulnerable groups and will be presented at a stakeholders' meeting in the region in early 2011.

Methods

This report is based on two methods of data collection. First, an extensive review of existing literature (published and 'grey' reports) was undertaken to examine SRH issues with regard to the following population groups:

- Roma (in Albania, Bulgaria and Macedonia);
- Internally displaced people (in Bosnia and Herzegovina, Georgia and Turkey);
- Adolescents (in Kyrgyzstan and Tajikistan).

Grey literature included:

- published and unpublished national, United Nations, and non-governmental organizations (NGO) documentation provided by the United Nations Population Fund (UNFPA) and their partner offices, including the International Planned Parenthood Federation (IPPF), and retrieved from the internet;
- published articles identified through database searches of PubMed and POPLINE.

The second method of data collection involved conducting and analyzing 18 focus group discussions (FGDs) in seven of the study countries in August and September of 2010 (Turkey was originally to be included, but in the end did not participate in the FGDs). The FGDs were conducted by IPPF staff in each country, trained by the London School of Hygiene & Tropical Medicine staff in FGD facilitation and the use of topic guides developed for this study (a template can be found in Annex 1). FGD proceedings were transcribed into written text in Word and then translated into English. The English-language transcriptions were analyzed by the authors using AtlasTi version 6.2.11, and summary tables were generated in Excel. This report incorporates the analysis of the FGDs, with original quotes from each of the study countries in relevant sections of the report.

Findings

Our study revealed a number of barriers to accessing SRH services for each of the vulnerable groups we studied.

For Roma, the barriers deemed most important by participants of the FGDs were high levels of poverty and the lack of appropriate mechanisms of financial protection, exacerbated by requests from health care providers for informal payments. These findings are confirmed by the wider literature, which has shown that prevalence of out-of-pocket payments (both formal and informal) in Eastern Europe has led to a disproportionate exclusion of many Roma from accessing the health care system or health insurance, as many are unemployed or do not have a regular income. The lack of essential documentation (e.g. birth certificates) also makes it difficult for them to access health insurance.

Discrimination against Roma, including explicit racial discrimination, is anecdotally reported in

the literature and confirmed as widespread by the participants in our FGDs, contributing to their unwillingness to seek services. Geographical barriers were identified by participants living outside large urban areas. Poor knowledge of SRH was also a common theme in our FGDs, though there is much less information on this in the literature. Gender inequities can also exacerbate lack of access to information and services, a finding confirmed in the literature.

For IDPs, their absolute poverty levels emerged most strongly from FGDs as a barrier to accessing services, linked to the distance they needed to travel to reach facilities, and these findings were confirmed by the literature. Lack of emergency transport was also highlighted as a problem, given the distance to hospitals. Issues of poverty and distance often interact, for example, while FGD participants acknowledged that IDP clinics were cheaper than other clinics, there was still a problem of no or few clinics and medical supplies, including for family planning (FP), in the IDP camps or settlement areas. FGD participants preferred to access IDP clinics, although they did not report widespread discrimination in other clinics. The lack of health insurance was cited by our FGD participants as a major problem in accessing health services and confirmed in the literature. FGD participants gave an ambiguous picture of what was covered by insurance (or welfare, for those below the poverty line) regarding pregnancy and delivery care, which is supposed to be free.

Poverty also emerged in IDPs' FGDs as an issue in relation to SRH knowledge and prioritization – when people struggled to send their children to school, they did not perceive SRH as important. In Bosnia and Herzegovina it seemed particularly difficult to discuss this issue among the participants. Few sources of information seemed available, though in Georgia NGOs were mentioned. The literature also highlights gender inequities as playing a part in IDPs' poor knowledge of SRH. FGDs, especially in Georgia, confirmed the dominance of men in SRH decision-making and the stigma associated with men seeking SRH services.

For adolescents, the stigma of accessing SRH services, lack of information on SRH and financial barriers were paramount in FGDs, confirming the widespread literature on these topics. Social norms in Kyrgyzstan and Tajikistan place high value on virginity and early sexuality is taboo, making it difficult for young people to talk to adults or access information and services. Many FGD participants described doctors not willing to pay them attention, especially in busy clinics, but even at specialist youth-friendly services (YFS), and treating them rudely if no adult was present. Poor knowledge of SRH and SRH services was reported in both Kyrgyzstan and Tajikistan, with participants in both countries giving the media and internet as primary sources of SRH information. Financial barriers were discussed in both countries as important problems, including the lack of free services (Tajikistan) and widespread informal payments (Kyrgyzstan), with participants explaining how even 'free condoms' were not free. There was some acknowledgement that state services were cheaper, but private facilities were seen as offering better quality. Gender-based violence against young women is documented in the literature, but what came out more strongly in FGDs in both countries was forced early marriage. Rape and bride-kidnapping (in Kyrgyzstan) were also discussed. A general climate of fear, especially for girls, seriously impedes their ability to discuss SRH issues or seek services for fear of assumptions about their lack of virginity.

Conclusions

Our findings suggest that health systems in the region have failed to provide financial protection and equitable SRH services to some of the most vulnerable groups of society. There is an urgent need to improve access to high-quality SRH services, especially access to information about SRH issues and services, contraception and pregnancy-related services and commodities, to vulnerable groups in Eastern Europe and Central Asia. .

The limited scope of health services covered by insurance schemes, the exclusion of many vulnerable

groups from these schemes, and the continued existence of informal payments are among the most pressing financial challenges for improving access to SRH services in this region. There is also a clear need for overcoming racial discrimination against Roma, improving awareness and information among all vulnerable groups, and addressing gender inequities and youth sexuality.

Specific Recommendations

Access

- > Improve financial, geographical and legal access to SRH care of Roma, IDPs and adolescents through:
 - » bringing services to them (improve physical access in remote rural and deprived urban areas), particularly, but not limited to contraception, pregnancy-related services, reproductive health commodities, and a wide range of SRH information and counselling;
 - » ensuring financial protection and, wherever possible, access to free SRH care for all vulnerable groups by:
 - improving health insurance coverage;
 - improving access to health care for uninsured vulnerable populations;
 - ensuring free or partially reimbursed contraceptives for women in all vulnerable groups; and
 - including SRH care, including contraception, in basic benefit packages;
 - » expanding specialised youth services, including anonymous services, well-informed and non-judgmental staff, in- and out-of-school sex education and information campaigns, expanded access to free/low cost family planning, more effective marketing of condoms (linked to emergency contraception for backup), and investments in female education.

Awareness and education

- > Improve awareness of all vulnerable groups (especially women and girls) of their entitlements and rights and of the SRH services available to them, such as through:
 - » health mediators; and
 - » community outreach campaigns.
- > Address cultural barriers to access, including traditional perceptions among vulnerable groups of the role of women.
- > Provide information and services in the languages spoken by vulnerable groups where those differ from the dominant language.
- > Provide telephone hotlines on SRH issues, including on mobile phone networks.

Quality of Care

- > Improve quality of SRH care through:
 - » creating programmes to improve antenatal care and screening of pregnant women in vulnerable groups, particularly for sexually transmitted infections and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS); and
 - » improving immunisation coverage;

Legislation and Policy

- > Improve the legislative framework, service provision and national policies related to the SRH of vulnerable groups through:
 - » making specific provision and targets for meeting SRH needs of vulnerable groups;
 - » developing national SRH policies and strategies including family planning, where these do not exist;
 - » better integrating SRH strategies and implementing mechanisms into existing legislation for

- » vulnerable groups; and
- » involving vulnerable groups in the development, implementation, and evaluation of SRH policies and programmes.
- > Reduce discriminatory practices towards vulnerable groups through:
 - » better training of staff in mainstream services to reduce stigma and prejudices against vulnerable groups;
 - » public education campaigns; and
 - » improved legislative and institutional framework to address discrimination against these groups.
- > Improve monitoring and reporting of SRH for both the general population and particularly vulnerable groups, as there is currently too little data in most countries to adequately monitor the current situation or progress.

1. Background

The Eastern Europe and Central Asia (EECA) region has achieved positive results in recent years in improving access to maternal and reproductive health (RH). However there remain great disparities among countries in achieving universal access to sexual and reproductive health (SRH) and reducing maternal mortality. For example, use of modern contraception is relatively low in the region, but varies from 10 per cent in Macedonia to 59 per cent in Uzbekistan[1-2]. Abortion has dropped significantly in the region, from 566 per 1000 live births in 1999 to 388 in 2006. Nevertheless, reliance on abortion as a means of fertility control remains high, especially in countries of the Commonwealth of Independent States, where the abortion ratio was registered at 557 per 1000 live births in 2006.

While maternal deaths have decreased in many countries over the past ten years, some countries have experienced declines that were insignificant, while others even witnessed a rise in maternal mortality. For example, in Albania officially recorded maternal mortality has risen from 13.81 per 100,000 live births in 1999 to 19.31 in 2008, and in Kyrgyzstan from 46.12 per 100,000 live births in 1999 to 58.90 in 2008 [3]. The Central Asian Republics still have the highest maternal mortality ratio (MMR) in the region[4]. The officially recorded MMR in the WHO European region was 14.29 per 100,000 live births in 2005, compared to 36.73 in the Central Asian Republics[3]. However, real maternal mortality ratios in Central Asia are believed to be many times higher.

There are also disparities in maternal mortality ratios within countries. Rural populations tend to have higher maternal mortality than their urban counterparts. Ratios and risk vary widely by ethnicity, education and wealth status, and remote areas bear a disproportionate burden of deaths. For example, according to Demographic and Health Survey (DHS) data from 2000, in Azerbaijan, 18 per cent of women with incomplete secondary education were not assisted by a skilled birth attendant during childbirth, as opposed to only 1 per cent of women with post-secondary education[5].

Within urban areas, the risk of maternal mortality and morbidity also differs significantly between women living in wealthy areas and poor settlements. A recent study in Commonwealth of Independent States (CIS) countries showed that 61 per cent of people in the lowest income quintile do not seek care when needed, in contrast to 33 per cent in the highest income quintile [6]. Access to modern contraception has been unequal as well, with on average only 29 per cent of poor women using modern contraceptives, compared to 40 per cent of wealthy women [1].

Throughout the region, Roma, other ethnic minorities, people living in poverty, migrants, and internally displaced people (IDPs) appear to be systematically disadvantaged in accessing maternal and reproductive health care. Inequities in service provision and access to reproductive health and maternal health care exist in most countries in the region. Key factors contributing to these disparities include inadequate RH policy and legislation; weak health infrastructure in remote and rural areas; poor organization of health service delivery that often emphasizes inpatient care; inadequate distribution of health care personnel; poor quality of care; an incomplete essential package for reproductive and maternal health; unaffordable cost of services; inadequate and unsustainable budgets allocated for maternal health; and lack of collaboration between maternal care and other

health services. In addition, there is a lack of disaggregated data on the reproductive and maternal health of disadvantaged populations that would be needed to make evidence-based decisions on service delivery.

Factors outside the health system that adversely influence the maternal and reproductive health of women include poverty, inadequate transportation, and poor educational levels. Finally, there are problems within households and communities. These include a lack of self-care at home and women who are not empowered to make decisions, which may lead to delays in seeking care. In many cases, women and their families do not have adequate information about health services in the community.

2. Scope and objectives

The Eastern Europe and Central Asia Regional Office of the United Nations Population Fund (UNFPA) is developing regional SRH strategies and operational mechanisms to follow up on the calls to action constituted by the fifth of the Millennium Development Goals, to improve maternal health, and the International Conference on Population and Development (ICPD) 15-year review. The key focus of these strategic documents is on vulnerable groups in the region. These populations include, but are not limited to, Roma, internally displaced people, migrants, poor people, rural residents, and disadvantaged youth.

This report aims to understand SRH needs and related policies for three selected vulnerable groups - Roma (men and women), IDPs and adolescents - in eight Eastern European and Central Asian countries. This study will contribute to a policy dialogue on focusing national programs on the SRH needs of vulnerable groups and will be presented at the stakeholders' meeting and the sixteenth ICPD conference this year.

After describing the methods we used to collect data on the topic under investigation, this report provides an overview of the SRH status of the selected vulnerable groups. This is followed by a description of the policy environment and the barriers vulnerable populations face when accessing SRH services. The report then provides conclusions and recommendations. Appendices provide more details on the selected countries' existing policies and barriers to access.

3. Methods

This report is based on two main methods of data collection. First, an extensive review of existing literature (published and 'grey' reports) was undertaken to examine SRH issues with regard to the following population groups:

- > Roma (in Albania, Bulgaria and Macedonia);
- > IDPs (in Bosnia and Herzegovina, Georgia and Turkey);
- > Adolescents (in Kyrgyzstan and Tajikistan).

For each of these selected population groups and countries, the report provides:

- > an overview of SRH needs and the extent to which they are currently being met;
- > an analysis of existing policies.

Documentation reviewed included:

- > published and unpublished national, United Nations, and non-governmental organisations (NGO) documentation provided by the UNFPA and their partner offices, including the International Planned Parenthood Federation (IPPF), and retrieved from the internet;
- > published articles identified through database searches of PubMed and POPLINE.

While every effort has been made to identify available documentation, our review revealed a scarcity of published articles on SRH of the identified vulnerable groups in the selected countries. In particular, the literature on IDPs was far more limited and much of the adolescent literature was very generic.

The second method of data collection involved conducting and analyzing 18 focus group discussions (FGDs) in seven of the eight study countries in August and September of 2010 (Turkey was originally to be included, but in the end did not participate in the FGDs). The FGDs were conducted by IPPF staff in each country, trained by London School of Hygiene & Tropical Medicine staff in FGD facilitation and the use of topic guides developed for this study (a template can be found in Annex 1). FGDs proceedings were transcribed into written text in Word and then translated into English. The English-language transcriptions were analyzed by the authors using AtlasTi version 6.2.11, and summary tables were generated in Excel. This report incorporates the analysis of the FGDs, with original quotes from each of the study countries (except Turkey) in relevant sections of the report. The table below gives details of the FGDs conducted by country, type of group, number and characteristics of respondents.

Table 1: Focus group discussions conducted, by country and participant information

FGD country and location	Vulnerable group	Gender of respondents	Number of and characteristics of participants
1 Macedonia, Skopje (SutoOrizari)	Roma	Female	10 women aged between 24 and 44 years, service non-users
2 Macedonia, Skopje (SutoOrizari)	Roma	Female	10 women aged between 24 and 44 years, service users
3 Albania, , Tirana	Roma	Male	8 men aged between 15 and 35 years
4 Albania, Tirana	Roma	Mixed gender	6 males and females aged between 18 and 25 years, attending University
5 Bulgaria, Medkovets	Roma	Female	8 women aged between 24 and 47 years,all but one had children
6 Bulgaria, Peshtera	Roma	Female	8 women aged between 17 and 25, uneducated, all but one had children
7 Bulgaria, Peshtera	Roma	Male	8 men aged between 17 and 28 years

8 Georgia, Kutaisi	IDPs	Female	Women aged between 33 and 49 years, married, all with children
9 Georgia, Gori	IDPs	Female	Women aged between 17 and 29 years, married
10 Georgia, Tbilisi	IDPs	Female	Women aged between 18 and 30 years, married
11 Bosnia, Jezevac camp (near Tuzla)	IDPs	Female	8 women aged between 31 and 56 years
12 Bosnia, Karaula camp (near Tuzla)	IDPs	Female	12 females aged between 13 and 21 years
13 Kyrgyzstan, Jalal-Abad (Central-Western region)	Youth	Mixed gender	10 teens aged between 16 and 19 years, unmarried
14 Kyrgyzstan, Chui Oblast	Youth	Mixed gender	3 males and 16 females aged between 15 and 22 years, unmarried
15 Kyrgyzstan, IssykKul	Youth	Mixed gender	4 males and 6 females aged between 14 and 19, unmarried
16 Tajikistan, Dushanbe	Youth	Mixed gender	10 youth aged between 17 and 22 years, urban
17 Tajikistan, Vahdat	Youth	Female	10 females aged between 16 and 22 years, rural
18 Tajikistan, Yavan	Youth	Male	10 males aged between 15 and 22, rural

In addition to the FGDs, interviews were conducted in Bulgaria and Georgia with policy-makers and in Bulgaria with Roma mediators. The findings are reported at relevant points in the report; the mediator interviews specifically inform the Box on Roma mediators on pages 36-37.

4. Overview of the sexual and reproductive health situation in the Eastern Europe and Central Asia region

Although the Eastern Europe and Central Asia (EECA) region is diverse, some general trends are evident for SRH, which are exacerbated for poor, vulnerable groups. Key indicators on SRH for the eight study countries are shown in Table 2.

Table 2 Key sexual and reproductive health indicators in the general population

SRH Indicator	Albania	Bosnia and Herzegovina	Macedonia	Bulgaria	Georgia	Turkey	Kyrgyzstan	Tajikistan
Maternal mortality ratio per 100 000 live births [3]	19 (2008)	22 (1991)	0 (2008)	7 (2006)	14 (2008)	19 (2008)	59 (2008)	43 (2006)
WHO/ UNICEF/ UNFPA Estimated maternal mortality ratio [7]	92	3	10	11	66	44	150	170
Lifetime chance of dying from maternal causes 1 in: [8]	490	29 000	6500	7400	1100	880	240	160
Total fertility rate [1]	1.6	1.2	1.5	1.4	1.4	2.2	2.8	3.3
Contraceptive use: % currently married women aged 15-49 using any method [3]	75 (2002)	36 (2006)	14 (2006)	42 (1997)	47 (2005)	71 (2003)	48 (2006)	38 (2005)
Contraceptive use: % currently married women aged 15-49 using modern methods [1]	8	16	10	26	27	43	49	43
% women receiving a minimum of 4 antenatal care visits	-	-	-	-	75 WHOSIS 2005	54 WHOSIS 2003	81 WHOSIS 1997	-
% births attended by skilled providers	100	-	98 WHOSIS 2005	99	92	83 WHOSIS 2003	98	83
Abortion per 1000 live births [3]	223 (2008)	981 (1991)	257 (2008)	471 (2008)	390 (2008)	104 (2008)	54 (2006)	54 (2006)

Across the region, use of modern contraceptives is low, especially in some countries in South Eastern Europe, such as Albania, Macedonia, and Bosnia and Herzegovina. In these countries, contraceptive use levels are on a par with the poorest countries in West Africa, although it should be noted that much of the information on family planning (FP) methods is outdated. As far as the available evidence allows conclusions, in South Eastern Europe there still seems to be a heavy reliance on ineffective non-modern contraceptives (e.g. withdrawal) or on abortion to keep fertility to the very low levels seen. There also seems to be a high unmet need for modern contraception in this region (as indicated by high rates of abortion in several countries, such as Bulgaria or Georgia). Social surveys, however, have also indicated suspicion of modern contraceptive methods among the public, possibly related to a lack of information about modern methods, how they work and their possible side-effects [9]. Furthermore, some countries of South Eastern Europe have a history of poor contraceptive method mix (i.e. a lack of choice of different contraceptive methods), which discourages developing FP strategies; rather, a lack of options is conducive to stopping FP altogether.

Reliable contraception is important for attaining the reduced maternal mortality target of the fifth of the Millennium Development Goals, to improve maternal health, because the high abortion rates in some countries contribute to high maternal mortality, in particular where abortions are of poor quality and where post-abortion counseling and contraception are lacking. Several countries with reliable data on abortions, contraceptive use and fertility (Romania, Hungary) show clear evidence of the links between non-modern methods of contraception, high abortion rates and high maternal death rates where abortion is unsafe, and, conversely, links between increasing use of modern methods and decreasing abortion rates. Legalization of abortion is known to play a major role in decreasing mortality rates, but quality of, and access to, services is also important, particularly for the most vulnerable groups who cannot afford to pay for maternal care.

Access to reliable methods of contraception is a reproductive (human) right for women – one that many countries in the region recognize in law. Lack of access to modern contraception is also linked to poverty, which becomes a broader equity and rights issue. Strangely, perhaps, the countries of Central Asia and Turkey have some of the highest modern contraceptive prevalence rates in the region, but also high levels of population growth and high levels of poverty. The relatively high modern contraceptive prevalence is probably explained by the greater presence of donor aid by UNFPA and other development agencies in those countries for the provision of FP and RH commodities. The high fertility levels can be explained by the much younger populations in those countries. The significantly higher chances of dying from maternal causes in these countries are due to the poor quality of and access to obstetric care.

Poverty-fertility differences exist at a sub-national level in all of the selected countries. The poorest sections of society – Roma and displaced populations in Eastern Europe, and young and migrant populations in Central Asia and Turkey – have the highest levels of fertility. This indicates inequities, since unwanted fertility (and consequently potentially unsafe abortion) is disproportionately present in disadvantaged populations in the lowest wealth quintiles [10].

Throughout the region, there seems to be a need to create demand for modern contraception, as

1- The countries of South Eastern Europe comprise Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, Romania, Serbia and Slovenia.

abortion rates are still high, although they have fallen substantially in many countries of South Eastern Europe and the former Soviet Union over the last two decades [3]. In Bulgaria, for example, the rate of abortions per 1000 live births fell from 1375 in 1990 to 471 in 2008, while in the Commonwealth of Independent States, the rate declined from 1259 in 1990 to 492 in 2008, with rates being particularly low in some of the Central Asian countries, registering 54 abortions per 1000 live births in Tajikistan in 2008 and 104 in Kyrgyzstan in the same year. This compared to a European Union average of 236 in 2008 (declining from 429 in 1990). While many countries have embraced national policies and programmes on improving maternal health care, family planning is often not included or given low priority. These issues are discussed in more detail in Section 6 on the policy environment.

5. Why are they vulnerable? The reproductive health status of vulnerable populations

This section summarises the factors that influence vulnerability according to information available from the published and grey literature. An overview of the literature by theme and country is given in Appendix 2. Section 8 provides more detailed discussion of specific barriers, drawing on both the literature and the FGDs, and highlights some additional issues not evident in the existing literature.

5.1 The sexual and reproductive health vulnerability of Roma in South Eastern Europe

Throughout Eastern Europe, Roma communities are subject to widespread health problems, pervasive poverty, limited access to educational opportunities, and racial discrimination [11-13]. Roma are among the most vulnerable groups, and it has been documented that Roma women in countries such as Bosnia and Herzegovina and Macedonia have lower access to SRH services than the majority populations. There is, however, overall very little information about the SRH needs and services for Roma communities, particularly Roma women [14]. In general, Roma women seem to have lower access to family planning supplies and maternal health services. This is due to a number of reasons, including barriers to education, health and social services. For instance, in Macedonia, the percentage of women assisted by a doctor during antenatal care (ANC) is lower among Roma women than among the general population (79 per cent versus 98 per cent) [15].

Maternal health is a serious concern among Roma women. Due to inadequate access (geographical, financial, social, and structural) to care, poor living conditions, inadequate nutrition, low levels of education, unhealthy lifestyles, high birth and abortion rates, and a high number of teenage pregnancies, Roma women are at a higher risk of complications during pregnancy than the general population [16]. A survey in 2002 indicated that rural poor women in Eastern Europe were less likely to have received antenatal care. Considering that Roma women are overrepresented among the poor and primarily located in rural and poor urban areas, they can be assumed to have less access to ANC [17]. Studies conducted in the Czech Republic, Hungary and Slovakia found that Roma women were at least twice as likely to have complications during pregnancy, as well as premature births and low-birthweight babies, than non-Roma women, which has been attributed to their social disadvantage

and low level of education [18-20].

Roma women are also affected by the unmet need for modern contraception that can be found across Eastern Europe [21]. The higher fertility among Roma families is partly related to the fact that few women use contraception. For example, a study on the health status of Roma women in Bulgaria showed that contraceptive use is still not widely used among Roma: 59 per cent of interviewed Roma women did not use any contraceptive method, with coitus interruptus (37 per cent) and intrauterine devices (IUDs) (35 per cent) being the most practiced methods. High fertility leads to a greater number of abortions. Cultural factors, such as low reproductive decision-making autonomy for women, low education levels and high poverty seem to impact family planning among Roma women. In many countries of the region, among both Roma and non-Roma, contraceptive protection is not seen as a man's responsibility, with women left to shoulder this burden. In Bulgaria, only 35 per cent of richer and more educated Roma women stated they did not use any family planning method, compared to the above-mentioned share of 59 per cent among all interviewed Roma women [22]. Similar data are also reported in a study on Roma women in Macedonia [23].

Lack of access to and use of contraception often results in teenage and unwanted pregnancies. The high number of unwanted pregnancies result in a high number of abortions[24], with illegal or unsafe abortions common among the Roma, as well as high rates of sexually transmitted infections (STIs). As among women in Eastern Europe in general, abortion is still a widespread method of family planning among Roma women. For instance, in Bulgaria, 52 per cent of Roma women stated they had an abortion, with the highest percentage among 18- to 23-year-olds. Around 25 per cent of the women who had abortions had more than 3 [22].

5.2 The sexual and reproductive health vulnerability of internally displaced people in Bosnia and Herzegovina, Georgia and Turkey

IDPs may face unique health challenges, due to difficulties in accessing health care and their lower socio-economic status. A study from 2004 suggested that the overall health status of IDPs in Georgia was worse than that of the general population, particularly for those displaced people living in collective centers, which are temporary accommodation. The IDP morbidity rates exceeded the average indicators for the general population 2-2.5 times [25].

Although women represent a high proportion of internally displaced people, their reproductive health needs tend to be overlooked. However, the need for SRH services among IDPs remains great. Internally displaced women tend to face unwanted and poorly spaced pregnancies, due to limited access to contraceptive services and busy providers with little time to educate or counsel clients, as well as sexual and domestic violence [26]. Anecdotal evidence also seems to indicate higher rates of STIs for internally displaced women, which coincide with lower awareness levels about sexual health, substantial unmet need for modern contraceptives, and high reliance on abortion, especially in Bosnia and Herzegovina and Georgia. These findings in the literature were also supported by FGD findings. This evidence is not, however, generalisable: for example, a study of the 1999 RH Survey in Georgia showed that internally displaced women were less likely (7.2 per cent) than non-IDPs (10 per

cent) to have been diagnosed with an STI [27].

Maternal mortality and morbidity is a major issue for displaced women, as they are more likely to receive poorer quality of care, due to a breakdown of infrastructure and the shortage of qualified personnel. Moreover, they may not be able to afford the costs of transportation to the nearest hospital, even where financial coverage and maternal health programmes for IDPs exist. In Turkey, for instance, 52 per cent of all births by displaced women were not attended by health professionals, resulting in a much higher risk of infant and maternal death [28]. In contrast, 31.1 per cent of births of all women living in rural areas in Turkey were not attended by health professionals [29].

5.3 The sexual and reproductive health vulnerability of adolescents in Central Asia

Young people under 25 years of age constitute over half of the population in both Kyrgyzstan and Tajikistan [30-32]. They are particularly vulnerable to poor reproductive health, due to several factors. First, early marriages and early pregnancies are quite prevalent in Central Asia, putting young women at risk of maternal mortality and morbidity. For instance, in Tajikistan, 15 per cent of young people are married by the age of 18, especially when they are poorer or less educated [33].

Second, although there are negative traditional attitudes towards sexual relations before marriage, adolescents still reported to have sexual intercourse while unmarried. For instance, the average age of first sexual intercourse among boys attending vocational schools in Kyrgyzstan was 13 years [34]. Most (70 per cent) first sexual contacts and experiences in Tajikistan are reported to take place between 17 and 20 years of age [35]. In a 2006 survey of Tajik schoolchildren in grades 7-9, 3 per cent stated having had their first sexual intercourse before the age of 13 [36].

Third, condom use is low among young people, despite increased awareness in recent years. For instance, in Tajikistan, 32.8 per cent of interviewed adolescents stated they did not use a condom in their most recent sexual relation with a casual partner [36]. Moreover, in Tajikistan, sexually active adolescents are far less likely to use modern contraception than older women. Only about 9 per cent of young married or in-union girls aged 15-19 currently use any form of modern contraception, compared to 50 per cent of women aged 35-49 [37].

Fourth, high abortion rates among teenage girls are a rising problem in Central Asia [38-39], which is closely related to the low use of family planning methods among young people. In Tajikistan, abortions among adolescents increased from 4 per cent in 1998 to 20 per cent in 2002 [40]. However, lack of access to safe abortion services - one of the main causes of maternal death in Tajikistan [37] - is a major problem for young girls, especially in rural areas, due to financial barriers and the stigma attached to sexual intercourse before marriage.

Fifth, although HIV/AIDS rates are still low in Central Asia, they have risen rapidly in recent years and young people are particularly at risk of acquiring the disease. In Tajikistan, only 30 per cent of adolescent girls aged 15-19 had heard of HIV in 2005, and the percentage of young people who have knowledge of how to protect themselves from contracting HIV is still very low [41].

Sixth, the volatile political environment also increases SRH vulnerability of adolescents in Central Asia. In June 2010, ethnic violence erupted in southern Kyrgyzstan, resulting in the displacement of more than 400,000 people, 100,000 of whom were reported to have fled to neighbouring Uzbekistan. Reproductive health (including access to family planning methods and exposure to the risk of sexual violence and exploitation) has been identified by the World Health Organization as one of the priority health concerns [42]. The situation was exacerbated by the fact that health systems in Kyrgyzstan and Uzbekistan found it hard to cope with the needs of large numbers of refugee women. By July 2010, all refugees and the majority of IDPs had returned home [43]. The conflict led to an increase in home deliveries, deliveries in rural hospitals, pre-term deliveries, late admissions to hospitals, and an interrupted supply of drugs to patients with chronic diseases, although there was only limited damage to health facilities [44].

Finally, poverty, child labour, and trafficking are other issues of concern[45]. There are about 2,000 children living and working on the streets of Kyrgyzstan's capital Bishkek, and 1,000 in Osh, the second biggest city[46]. Children are also reported to drop out of school, and lower levels of education increase their SRH vulnerability. According to the 2006 Programme for International Student Assessment survey, Kyrgyzstan ranked lowest among the 57 countries covered, with 88 per cent of 15-year-olds not reaching the minimal level of reading literacy [47].

6. Policy environment for sexual and reproductive health and vulnerable groups

This section provides an overview of policy approaches to SRH, the legal situation, and policies and programmes on vulnerable groups in the EECA region. Specific country details are given in Appendix 1.

Most countries of the region have acceded to a range of international treaties, in particular the Convention on the Rights of the Child (CRC), which protects adolescent rights, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) which protects against discrimination of women, including in access to health services, and the Covenant on Economic, Social and Cultural Rights (ESCR) which protects the right to the highest attainable standard of health. Some countries also have protection of the right to health enshrined in their constitutions (Albania, Bosnia and Herzegovina, and Macedonia). Accession to these treaties provides an important legal obligation to transfer them into national law; once this is achieved, governments can be held accountable. In countries with weak policies on SRH or underdeveloped protection of vulnerable groups, these treaties may provide important leverage to achieve the development or strengthening of national policies.

In terms of SRH-specific policies, there is still much to do in developing coherent policy and linked strategy documents. Both Tajikistan and Kyrgyzstan have a Reproductive Health Law and strategies on reproductive health and rights. Bosnia and Herzegovina, Bulgaria and Turkey do not have specific RH laws, but have included RH targets in their national health strategies. Albania is currently

developing a RH strategy and Macedonia has a strategy and programmes in place.

The health systems vary in the region. Many were (and some still are) highly centralised and hierarchical, based on the former Soviet system, but most have undergone health sector reforms involving some form of decentralisation or devolution of some powers. Almost all systems remain highly medicalised and deprioritise preventative strategies. This trend may pose a particular barrier to pregnancy-related services as well contraceptive service provision, since FP is a preventative service and seems to have little place in many EECA countries' RH strategies, as in, for example, Bulgaria. Globally, however, contraception is considered the lynchpin for RH.

The decentralisation of health systems in a number of countries (Bosnia and Herzegovina, Bulgaria, and Macedonia) has resulted in the fragmentation of services and a lack of clear lines of responsibility for SRH. Another consequence of reforms has been the privatisation of services, particularly in Bosnia and Herzegovina and Georgia, making quality difficult to regulate and posing potential barriers to access to quality care. One of the most popular reforms has been the introduction of insurance schemes in all selected countries except Tajikistan. Most schemes are mandatory and the level of support to both the insured and uninsured varies widely. Most cover delivery care and some degree of antenatal care (though the amount of free care may be limited, as, for example, in Bulgaria). Family planning is rarely, if ever, included. For the uninsured – which includes many members of the vulnerable groups covered in this report – support varies even more widely, from (formally) free delivery care in Bulgaria, to subsidized delivery care in Macedonia, to user fees in Bosnia and Herzegovina, where insurance registration is at canton level and, even for the insured, the scheme may not be transferable between cantons. In addition, for both the insured and uninsured, informal payments are common in all countries and out-of-pocket payments for SRH services are high.

Specific policies and strategies for vulnerable groups are even more sparse than those on reproductive health. Albania, Bosnia and Herzegovina, Macedonia and Bulgaria have all signed up to the Decade on Roma Inclusion (2005-2015) and have developed a range of policies. Albania and Bulgaria have the most detailed policies that encompass explicit SRH targets and strategies for Roma. The National Action Plan for Albania envisages the implementation of educational and awareness programmes in Roma communities on reproductive health, including family planning, antenatal and postnatal care, and maternal health. The National Action Plan for Bulgaria envisages improvements in antenatal care, reductions in teenage pregnancies, and better coverage of Roma with screening programmes, such as for cervical cancer. Nevertheless, the integration of Roma-specific issues into national policy and practice in general appears weak in all countries with large Roma minorities.

Georgia and Turkey, which both have IDP populations, have legislation in place to protect the health care of IDPs through guaranteed health funding. However, the quality of health services for IDPs is sometimes problematic, in particular where IDPs live in remote settlements or centres, so that many IDPs in fact lack access to services. Apart from some formal health financing safeguards, neither country appears to have much in the way of explicit policies safeguarding the reproductive rights and health of IDPs, but there is little policy information available.

Tajikistan and Kyrgyzstan, which both have large youthful populations with multiple SRH needs, do not seem to focusspecific health policies on adolescents (beyond some general protection of child health) or SRH.

A summary of policies is given in Table 3 and a more detailed overview of SRH and vulnerable group policies by country is given in Appendix 3.

Country and vulnerable population focus	National sexual and reproductive health policy	National sexual and reproductive health strategy/ programme	National family planning strategy/ programme	Health insurance coverage	Specific policies to protect vulnerable groups	Signing and ratification of international treaties
Albania, Roma	No	Yes	No	Unknown	Roma health, Roma sexual and reproductive health, Roma living standards	CRC, CEDAW, ESCR
Bosnia and Herzegovina, IDPs	YES (In Federation) (draft for Republika Srpska)	No	No	Unknown	Roma health	CEDAW + 20 others
Macedonia, Roma	No	Yes	Not since 2006	Compulsory	Roma health	CEDAW, CRC, ESCR, European Social Charter
Bulgaria, Roma	No	No, but targets in National Health Strategy	Separate from reproductive health	Delivery and some antenatal care	Ethnic minority health, Roma sexual and reproductive health, Roma culture and 'integration'	CRC, CEDAW, ESCR
Georgia, IDPs	Yes	Yes	No, but provided by UNFPA	Most sexual and reproductive health funding is private	Displaced People law protects finance for health; medical Insurance for those under poverty line	CEDAW, ESCR
Turkey, IDPs	No	No	Yes	Unknown	Provision of health financing to IDPs	CRC, CEDAW, ESCR
Tajikistan, Youth	Yes	Yes	Unknown	Not available	Unknown	CEDAW, ESCR
Kyrgyzstan, Youth	Yes	Yes	Unknown	Compulsory	Unknown	CRC, CEDAW, ESCR

7. Experiences of and access to sexual and reproductive health services for vulnerable groups

This section is divided into three sub-sections, each devoted to one of the vulnerable groups addressed in this report. Each sub-section provides a detailed discussion of people's experiences of using SRH services and barriers to access, as well as some information on perceived SRH needs. This discussion draws upon two data sets: one, qualitative data from a series of FGDs undertaken during August and September of 2010 with members of each of the studygroups (see section four, Methods, for details); and two, findings from an extensive literature review of issues affecting use of SRH services by vulnerable groups in this region.

The literature revealed several barriers to SRH services for vulnerable group:

- geographical factors and physical access;
- administrative, legal and financial barriers;
- barriers related to the health system;
- lack of information and awareness;
- discrimination;
- gender inequalities.

In the sections below we review the barriers to accessing services for each of the selected vulnerable groups, using the categories determined by the literature and evidence from the FGDs. It should be noted that the lack of reliable published data on many aspects of SRH, in particular for the vulnerable groups considered here, has been a major challenge in compiling this report and will need to be rectified in the future. FGD participantss tended to confirm the findings of the literature, but also highlighted additional issues that should be further explored. A summary overview of barriers to SRH care, by country, is provided in Appendix 4.

7.1 Health care and sexual and reproductive health services for Roma

Several studies indicate that Roma families have more difficulties accessing and receiving adequate health care than the general population [12, 23, 48-49]. In Albania, only 76 per cent of Roma, compared to 93 per cent of non-Roma, have been immunized against polio, diphtheria, tetanus and whooping cough [50]. There are also reports that Roma are sometimes forced to pay informal payments to access proper medical treatment [23]. For instance, a study in Bulgaria showed that Roma women had to bring their own consumables if they wanted to receive delivery care [51]. Although it should be noted that informal payments for health care are pervasive throughout the region, also affecting the general population, they have particularly severe consequences for Roma, as they tend to occupy the lowest socio-economic strata of society.

Geographical factors and physical access

There are two main geographical barriers to access: the poorer health infrastructure in rural areas and the lack of health care providers in Roma ghettos in the large cities [49]. When living in remote

settlements, health facilities are often not available and transportation to health services outside the settlements is either too expensive for many Roma people or unavailable [23, 51].

FGDs conducted in Albania and Macedonia with Roma women and men suggested that people living in suburban settlements have more difficulties accessing SRH services because of the distance.

There are Roma who live in distant areas from Tirana. They surely have difficulty in accessing such services. (FGD P5, Albania)

The Roma community in Tirana is settled...we don't move from one city to another, or from one place to another...there are health centres in each district...it might take time to go to X health centre for those who live in suburban areas... (FGD P12, Macedonia)

Geographical inequities of access to health care are common barriers for Roma. This is partly due to reforms in primary health care, which have seen the dissolution of polyclinics in urban Roma neighbourhoods and left some areas without a gynaecologist (see the section on health system-related barriers below). While these neighbourhoods were already underserved in communist times, newly-established general practitioners are generally unwilling to set up practices in or close to Roma settlements. Furthermore, the poor condition of roads and lighting in many urban Roma neighbourhoods have contributed to the refusal of emergency services to serve these areas, a practice that has been made worse by prejudice and discrimination [23, 49, 51].

Legal and financial factors

In many countries in the region, access to social benefits for the poor is a condition for obtaining state-provided health insurance. Many eligibility requirements have a disproportionate and discriminatory impact on Roma [23, 51], which is one reason for low insurance coverage rates documented among Roma in several countries of the region. For instance, one survey conducted in Bulgaria in 2004 indicated that 46 per cent of Roma were not insured, contrasting to a much higher coverage rate among the general population [52-54]. Another nationally representative survey in Bulgaria in 2007 found that almost one third of Roma women did not have health insurance [22]. In April 2009, the European Committee of Social Rights found Bulgaria in violation of the European Social Charter for failing to provide adequate access to health care for vulnerable groups such as the Roma. One violation noted was government policies restricting medical insurance and social assistance [55].

Lack of access to health insurance was also a consistent theme across our FGDs in Albania, Bulgaria and Macedonia. One participant in Bulgaria mentioned, “We haven’t health insurance because they [the medical staff] do not pay attention to us” (FGD P15, Bulgaria). Participants in Albania and Macedonia described how the lack of health insurance made accessing health services more expensive. One woman in Macedonia noted: “You can’t do anything without health insurance. You have to pay for everything” (FGD P2, Macedonia).

Problems in obtaining health insurance coverage were described in one of the Macedonian FGDs,

with some Roma running up huge debts to the Insurance Fund:

There were some problems with private health insurance in the Health Insurance Fund. The women paid for one month and they thought, 'that's it.' Nobody from the Fund told the women that if they want to cancel the insurance, they had to do that in person; otherwise, payments and interest add up. It is strange that after the women did not appear for a long time, the insurer did not contact them in any way -- no notifications and no warnings. After two years, the insurer told the women that they owe 2000 Euros because they were insured for the whole time. (FGD P1, Macedonia)

The introduction of health insurance systems and the reliance on out-of-pocket payments (both formal and informal) in Eastern Europe have led to a disproportionate exclusion of many Roma from the health care system, as many are unemployed or do not have a regular income [23, 56]. For example, data from 2002 indicate that 62 per cent of Roma in Bulgaria could not pay for needed health care and medications [54]. The lack of financial coverage for basic health services is likely to limit access to reproductive health care and so contribute to the higher maternal mortality ratios among Roma women, especially when family planning and antenatal care services are not covered. Reports from Macedonia show that Roma mothers often lack health insurance and cannot afford the co-payment and informal costs linked to regular ANC, delivery and postnatal care (PNC), even for the health services that are formally free and subsidised by vertical prevention programmes [57-58]. A new policy has since been introduced that aims to improve health insurance coverage of Roma [59]. In the Western Balkans, family planning services are not always covered by the state health insurance schemes, which may explain the low contraceptive prevalence rate among Roma women in the region [60]. Many poor Roma also cannot afford to pay required user fees or medication costs for the many drugs not covered by the basic health insurance. The lack of health insurance and the costs of health visits and pharmaceuticals have been associated with lower utilisation of health care among poor Roma in Bulgaria [23, 49]. A report on the health of uninsured individuals in Bulgaria showed that 80 per cent were from Roma communities, and that despite a new decree to cover obstetric care for uninsured women, hospital medical benefits were granted to only 39.1 per cent in 2008 [61].

Our FGD findings from Bulgaria corroborate the above-cited findings that medical personnel continue to charge for services that are supposed to be free. For example, participants described how health care providers asked for informal payments for examinations of children, which should be provided for free:

I: Children up to 18 years of age use health services for free. [...] Why do they (the doctors) ask for money for treatment?

A: Recently, I was at the doctor with my child and I paid 50 Bulgarian lev [equivalent to 34 US dollars] for him [the doctor] to see us...

I: And what if you refuse to pay? He'll refuse to see you?

A: Yes, he'll refuse to see me.

I: So, what is needed is to respect the rules. If the state says [health services for] children are free, it should be respected.

A: We know this, but we still pay. They ask for 20 Bulgarian lev just for one check-up. (FGD P15, Bulgaria)

Another participant described the refusal of health workers to provide delivery care until an informal payment was made:

My wife was about to deliver. It was three in the morning. I took the car and we went to the hospital in Pazardhik, but the doctor refused to take care of my wife. He said I had to bring Cleanex. He said we had to wait until the pharmacy was open. Finally, I gave him 50 Bulgarian lev and we were accepted into the hospital. [The speaker demonstrated how the recipient put the money into the pocket of his pants.]

Another FGD participant stated, You know, they [health workers] wait for money. (FGD P19, Bulgaria)

Another participant described a similar experience:

I was transported by ambulance to the hospital in Plovdiv. No one took care of me. I waited for a very long time. Later, I went to the hospital for additional treatment and the nurse gave me an empty box of ten cigarette packs. Do you know why? That was for me to see the brand of cigarettes the doctor smokes and to buy the same, to fill the empty box. (FGD P19, Bulgaria)

Focus group participants revealed that the charging of informal payments for exempted services was also experienced in Macedonia. One participant gave a rare example of insisting on her entitlement to free pregnancy care:

I started to go for regular check-ups with a [gynaecologist] who at first sought money from me, but, after telling him that I know that if a woman is pregnant, she shouldn't pay for the check-ups and that I could sue, I didn't pay for anything [...] I didn't pay the 200 Macedonian denar [equivalent to 4 US dollars] because I knew I don't have to... (FGD P1, Macedonia)

Poverty and the general lack of financial resources also surfaced strongly in both the literature [62] and FGDs in all countries, as a reason for low service use and inadequate access to care:

The financial issue is the most important. [...] In general we are poor and [...] don't have money to pay for health care. (FGD P12, Albania)

We haven't got money. How are we to go to the doctor? (FGD P15, Bulgaria)

Poverty often means people cannot afford health insurance, despite the fact that this often results in withholding of services:

They asked me to pay 11,000 Macedonian denar [equivalent to 252 US dollars]. I didn't have that kind of money, but they weren't interested. So I had to give birth to my child at home [...] The childbirth lasted two days and I fell unconscious several times. [...] And what if I had died? This country does not care about us [Roma] at all. (FGD P1, Macedonia)

Once, I had a Pap smear but they wouldn't give me the results because I don't have health

insurance or a health card. They sent me to the state clinic to take the test and to pay for it. They also gave me an HIV test. But I didn't like how they treated me ... I didn't like the way the gynaecologist treated me or the way he took the smear, it was very painful and careless... (FGD P1, Macedonia)

Furthermore, the challenge of informal payments, described above, often overrides concerns over health insurance coverage, since payments must be paid even if patients hold health insurance:

I: But if you are insured, all of these check-ups will be for free.

A: (Group answer): Ah, no! They ask for money for everything!

(Another woman): They even want the sheets to be brought to the hospital. (FGD P15, Bulgaria)

Every month, I visit a gynaecologist for an ultrasound [the participant is pregnant]. I have health insurance but I also pay 200 Macedonian denar. [...] I don't like the way he treats me... the ultrasound lasts less than a minute [...] he takes the money and that's it. (FGD P1, Macedonia)

The lack of documentation such as birth certificates, personal identity cards, work permits, citizenship documents, and papers certifying eligibility for health insurance and social benefits, is a legal barrier to health care for Roma [23]. 8 per cent of whom reported that they had been denied medical service because of lack of proper documents [62]. In countries like Bosnia and Herzegovina and Macedonia, no citizen is entitled to health insurance without an identity card. This seems to be even more of a barrier for Roma women. For instance, a study on the level of inclusion of Macedonian Roma women in health care and the risk factors they are exposed to showed that 11.7 per cent of interviewed Roma women did not have health insurance because of their lack of any personal documentation [63]. The exclusion of Roma women from health insurance coverage has a detrimental effect on their SRH, as many uninsured women cannot access free ANC and PNC services.

Significant ongoing internal migration among Roma groups, especially in Bosnia and Herzegovina, made health insurance coverage, particularly for their children, more difficult [64].

Health system-related factors

As described above, the introduction of health insurance schemes in Eastern Europe has sometimes exacerbated problems of access. Although some countries of the region have achieved nearly universal coverage, in others, such as Bulgaria or Romania, many Roma have been excluded from health insurance coverage [51, 56, 65-66].

The unequal regional distribution of health services, characterised by the concentration of facilities and health workers in urban areas and shortages in rural areas, is another challenge throughout Eastern Europe and Central Asia [56]. The region is also characterised by a general lack of investment in health facilities, particularly for primary health facilities in rural areas. These regional disparities of both human and financial resources affect Roma women in particular, as many live in rural

areas. For instance, in Albania, health posts in remote rural areas offer very limited contraceptive methods, basic ante- and post-natal care and no basic emergency obstetric care services, which are provided only at secondary level facilities in urban areas [17]. Because many Roma women live in the poorest urban areas and remote rural areas, they are more likely to be affected by the poorer quality of maternal health care in both settings [51]. This is a common problem in Eastern Europe. Despite many efforts to strengthen primary health care, in some countries health reforms have given rise to unintended consequences, such as a fall in preventive services for women of reproductive age, as was documented in Croatia [51, 65, 67-68]. Health care providers still tend to be concentrated at secondary care facilities in urban areas, resulting in few health care professionals in the proximity of Roma settlements. The lower levels of health care provider training and limited availability of drugs at primary health facilities results in a poorer quality of care provided [17, 51].

The lack of local gynaecologists was an issue raised by several Roma women who participated in a qualitative study on barriers to SRH services in Macedonia and Bulgaria:

This is a big municipality, and it is a shame not to have a gynaecological ordination here. How can they open a number of shops, and not provide gynaecological ordination? We are women; we have to go to check-ups....(FGD P2, Macedonia)

In Bulgaria, following the health reforms, polyclinics have been restructured. Many health specialists left these facilities and thus reduced local people's access to primary and specialised care, particularly among poor Roma who cannot afford to pay the transportation costs to health facilities [23]. After the first year of implementing the reformed health insurance system in Romania, only 34 per cent of the Roma were registered with a family doctor, in contrast to 75 per cent of the population at large [23].

The costs of transport to health facilities – because of the lack of local gynaecologists - were mentioned as a major barrier to accessing health services in both Macedonian and Bulgarian FGDs. As one participant in Macedonia described, “I just spend money for taxi fare, check ups, and bus fare. It would be much easier if we had a doctor here, so that we would not have to roam the road”(FGD P2, Macedonia).

Another issue that emerged from FDGs in Macedonia is the lack of registration with a health facility, which subsequently prevents Roma women who are not registered or did not book an appointment from accessing the services:

I was bleeding for two months, so I went to Bit-Pazar (polyclinic in Skopje) for some check-ups. They didn't see me because everything was full, there wasn't a place for me. Afterwards, I went to Cair, but it was the same situation. I am not registered anywhere. (FGD P2, Macedonia)

Lack of information and awareness about access to sexual and reproductive health care

In general, regional data show low awareness among mothers of the need to use health services, especially in rural and poor urban communities, which may also include Roma women. In these communities, poor environmental conditions, low education levels, and conservative cultural norms can contribute to low access to ANC services [64]. Because of low levels of health education and high levels of poverty among many communities [69], Roma women also tend to face health challenges that are common in this population, including inadequate nutrition (anemia in pregnancy) and high levels of smoking during pregnancy [70]. Moreover, considering the limited knowledge among the general population in the region about contraception, disease prevention, and their rights to access health services and health insurance entitlements, it can be assumed that Roma women are even less likely to be aware of these issues [51]. In a qualitative study of access of Roma children to health services in Bulgaria, one interviewee noted that “Of course, the Roma remain the most isolated, because they are the least informed. They get the least assistance to be informed” [49].

Limited SRH awareness and knowledge was a common theme across all FGDs with Roma people in Albania, Bulgaria and Macedonia. A woman in Macedonia said, “I didn’t know that I was 3 months pregnant until the doctor gave me an ultrasound. That’s why we need counseling to advise us...” (FGD P2, Macedonia).

People in Eastern Europe possess highly medicalised expectations for SRH care. Though participants in FGDs across the countries generally had a poor overall understanding of sexual and reproductive health, the aspects of it that they prioritized and for which they wanted more information and services were screening for reproductive cancers, ultrasounds in pregnancy, infertility treatment, STI/AIDS treatment, and greater access to specialist gynaecologists. The importance of delivering in hospital was generally recognized, but the central importance of basic family planning services to prevent high-risk pregnancies, unwanted pregnancies and subsequent abortion, as well as condoms for STI/AIDS prevention (internationally considered the mainstay of SRH programmes) was not recognised.

Initiatives are underway in several countries of the region to increase health literacy and awareness of health services among Roma, but much more remains to be done. The importance of family planning needs to be taken up much more strongly at a political level in all countries of the region. In Macedonia, community outreach campaigns have been implemented to educate the most vulnerable groups on mother and child health issues and also address issues of masculinity. In Bulgaria, Roma health mediator programmes have been established. These programmes aim to improve community health through mediating between Roma patients and physicians during medical consultations, communicating with Roma communities on behalf of the public health system, providing basic health education, and assisting Roma in obtaining health insurance or identity documents necessary to access health services [71].

Available evidence from some countries suggests that the institution of Roma mediators may have a significant impact on promoting the integration of Roma people with available health and social

services [23, 72-73]. In general, Roma mediators are in a very good position to provide valuable knowledge on the reality lived by Roma communities. As part of our qualitative study we were able to interview three mediators in Bulgaria. Our findings (see Box 1, below) seemed to confirm that Roma health mediators provide a valuable role

Box 1 Roma health mediators in Bulgaria

In Bulgaria, the Roma mediator initiative started in 2001 with the support of a consortium of organisations, including Open Society Institute (OSI), Bulgarian Family Planning Association (BFPA) and Ethnic Minorities Health Problems Foundation. As part of a Phare project, around 30 Roma health mediators (RHM) were trained in 2001. The Roma health mediator facilitates the access of Roma to healthcare and social services. Mediators have completed a special training programme, approved by the Ministry of Health (EU15 Profile, health mediator programme in Bulgaria). The main roles of the mediators are to:

- provide health information,
 - organise and conduct health awareness-raising discussions;
 - provide information related to resolving social problems;
 - collect and submit information connected with the needs of the community to health and social workers;
 - assist general practitioners, nurses and social workers on the spot;
 - accompany disadvantaged persons to healthcare and social institutions;
 - provide assistance in completing required documentation;
 - provide psychological support;
 - participate in preventive programmes – immunisations, cervix and breast cancer, tuberculosis, hepatitis, etc.; and
 - help families with chronically ill or disabled family members.
- (EU15 Profile, health mediator programme in Bulgaria)

In 2004, RHMs started to work on maternal and child health care.

In 2007, the National Network of Health Mediators was established, comprising more than 90 trained mediators.

The information provided below has been collected through interviews with three Roma health mediators in Bulgaria: two working in Septemvri (in the south of Bulgaria) with over 40,000 Roma, and one working in Cambri.

RHM are employed by the local municipalities and have to work closely with family doctors. They also have to be welcomed by the Roma community, as otherwise they will not be able to reach them:

Considering the Roma's closed way of living, it is very difficult for external people to be accepted. The RHM [Roma health mediator] must also have a very good reputation ("clean and decent name") to work with Roma to be accepted by them. Another important thing is to know the language and to respect the cultural traditions of the community with whom you are working. Can you imagine someone going to a Roma house for the first time and start talking openly about condoms to prevent pregnancy? (RHM 1)

The RHM have to be on good terms with both GPs and Roma people and act as a "buffer" between the two:

RHM are buffers, and work slowly to change the prejudices, attitudes and behaviours in Roma communities, and also work to change attitudes towards Roma of the GPs. RHM have to be aware of

and up-to-date RHM deal with several issues,,including immunisations of children, care for abandoned newborns, helping women and girls access Pap smears and other gynaecological services, and organising awareness sessions on SRH. However, RHM noted that it was difficult to convince women to access SRH services:

It's very hard to speak openly and directly about such issues. In our municipalities we were [working on]Pap smear screening for gynaecological reasons. It was very hard and difficult to persuade women to go.(RHM 2)

Every second woman has a gynaecological problem, but they do not know. Usually women go to an obstetrician/gynaecologist only if they are pregnant. In my awareness session they say, "I am not pregnant, so why should I go?" (RHM 2)

The mediators interviewed agreed that many Roma women and girls did not know about SRH and were too shy to talk about these issues in a group. For these reasons, women started to approach them individually to discuss condoms and other SRH issues.

When I started to talk about condom distribution, women did not take condoms in the big group. But then, each of them wanted to talk to me privately and each of them asked for condoms. So I realised that if I wanted to achieve something I should go to them individually. If they are shy, they come in pairs.(RHM 2)

A Roma mediator said there is a lot of misinformation and ignorance about family planning methods among Roma women. For example, she said,“There are also myths about IUDs [intrauterine devices] , as they think that the IUD can walk through to their heart. They do not know about their anatomy.” (RHM – WHICH RHM SAID THIS?)

RHM mentioned that the use of family planning was influenced by traditional gender roles,as “women are so subordinate to men” (RHM 1). Moreover, one mentioned the importance of informing young girls about SRH issues, as she noted a trend in the village where she was working of older men marrying younger women, “I in my community older men marry younger women (10 years age difference), because they can manipulate/influence them more easily. It is very important to teach the young women” (RHM1).

Besides their ability to reach Roma women and girls and link them to local general practitioners, good knowledge of the legislation on the part of RHMs is another advantage in helping Roma people access health services, especially when they are not insured and hospitals refuse to treat them. The story below is an example:

Once in my area I got a call by my neighbour who was very sick. I told her, look I am working at the other end of the community now, but I will give you this number and explain what to do. [...] Then I told her to complete all the documents for social services to have the X-rays and other exams paid by the Social Commission; she had TB [tuberculosis], but TB is covered by the state even without health insurance. (RHM 1)

Roma mediators mentioned they faced several challenges, both internally, trying to reach Roma women, as well as externally, having doctors or hospitals willing to treat Roma patients. They seemed very motivated,but frustrated as they could not help all the people.

We face many problems and cases and we feel sorry when we cannot deal with some of the cases. (RHM)

Racial discrimination

There is rich anecdotal evidence in the literature about the existence of racial discrimination perpetrated against Roma when receiving health care. This was confirmed in FGDs, particularly those in Bulgaria and Macedonia, which generated rich data on individual experiences. The literature shows that practices of discrimination are characterised also by the lack of culturally sensitive health care, the lack of interpreters for those Roma who do not speak the majority language, and the almost complete absence of Roma health workers and physicians [49]. Stigma attached to being a Rom [the singular of Roma] often manifests itself in denial of health care, exclusion from access to services, segregation of Roma within medical facilities, and verbal abuse and degrading treatment by health professionals [23, 51]. Some general practitioners (GP) refuse care to women on the basis of their ethnicity. At the time of pregnancy and childbirth, Roma women are even more susceptible to abuse and discrimination by health professionals. Anecdotal evidence from Macedonia and Bulgaria suggests that Roma women in hospitals were often left unattended by health professionals during labour or after delivery, resulting in maternal or perinatal mortalities [23].

In several countries, such as Bulgaria and Hungary, “Gypsy rooms” are still a common practice in maternity wards, where Roma women are located during delivery and PNC and subject to inferior material and sanitary conditions than rooms reserved for non-Roma patients [51]. A maternity hospital in Bulgaria had 3 “Gypsy rooms” out of a total of 13 [23].

Another well-documented violation of Roma women’s reproductive rights is the forced sterilisations that happened, without consent, during the communist period and even in the years thereafter in the Czech Republic [74], Slovakia [75] and Hungary [76].

A wide range of discriminatory practices was evident in FGDs in Bulgaria and Macedonia. In both countries, reported discrimination included refusal of services to Roma because the provider considered them not necessary or had no time, or if the Roma had no health insurance:

There was a case when I went to the [obstetrician/gynaecologist] and requested a Pap smear, but he refused to perform one, saying that I was OK and there was no need for a smear. (FGD P14, Bulgaria)

There are cases in which doctors do not want to examine us... Maybe because we are “black,” “dark.” (FGD P14, Bulgaria)

Sometimes they reject us because of the [lack of health] insurance. (FGD P15, Bulgaria)

No matter if we are first in line, we are always examined last. The Macedonians and the Albanians, they always have priority. And when, at last, it’s our turn, the doctors are always in a hurry, they are not interested and always tell us that everything is fine, even when it isn’t... All that just because we are Roma, although I pay, just like everyone else. (FGD P1, Macedonia)

Doctors treat the Roma in a different way... they don’t have enough time for us, and they always tell us that we are fine, that we don’t have diseases. (FGD P1, Macedonia)

There were other reports of explicit racial discrimination:

I have a case to share. When I gave birth to my sixth child, the midwife told me: “Gypsy job! Only Gypsies have so many children!” It was offensive, I was not happy with this. (FGD P14, Bulgaria)

With my second childbirth, everyone was yelling at me, although the nurse was Roma. (FGD P 2, Macedonia)

Yes, and they call us “Gypsy.” (FGD P1, Macedonia)

This lack of time or care over consultations provided to the participants because they were Roma apparently led in several cases to problems not being diagnosed by the first-line doctor:

The doctor always tells me that everything is fine [...] And just four days ago I had pain and went to the hospital; they told me that I have some infection and vaginal excretion...they gave me treatment, but they didn't tell me anything ...and I didn't pay for that [the participant had health insurance]. Now I have no pain or vaginal excretion ... (FGD P1, Macedonia)

The quote above also hints at another issue, namely, that doctors rarely explained anything about procedures or problems to Roma patients, leaving them feeling disempowered.

Gender inequalities

Gender inequality is a challenge across the region, but Roma women seem to be at a particular disadvantage. The more rigid and closed cultures of many Roma communities tend to disadvantage women and exacerbate gender inequalities in accessing care [14]. Many Roma women are not covered by health insurance, as they are unemployed, working in the informal sector, or married in traditional unions and not civil ones [51]. The health insurance fund in Macedonia, for example, does not cover cohabitating couples, but only those that are legally married. Many younger Roma women are more likely to live in traditional unions and are then not covered.

Moreover, Roma women tend to be less educated than Roma men, which limits their knowledge of entitlements to health care, including family planning services [14, 16, 51, 77-78]. Roma women's autonomy on reproductive health issues seems to be also limited by gender inequalities and identities. For instance, one study in Albania found that only 19 per cent of women decided on their health autonomously, while 66 per cent decided jointly with their partners, and 13 per cent left the decisions to their husbands [79]. A study on the health status of Roma women in Bulgaria also showed how women's fertility choices were not autonomous: 81.2 per cent of Roma women interviewed stated that they made the decision to abort on their own or together with their husband [22].

Limited decision-making power in SRH issues regarding, for example, use of contraception and access to abortion, was also mentioned by several Roma women in the FGDs conducted in Albania, Bulgaria and Macedonia. For example, a Macedonian woman said, “I didn't want to have an abortion, but he made me...I even went to stay at my mother's house for a week, but in the end I had to do that

because he has the final [word]...” (FGD P2, Macedonia).

Roma women may not be able to choose a contraceptive method of their choice or negotiate for condom use with their partner, as they may be accused of infidelity or not wanting to bear children [14]. In addition, purity views and the importance of virginity when getting married lead Roma women and girls to avoid discussions of family planning methods and sexual health issues with health care providers, or to seek any family planning information [14]. The conservative mentality related to premarital sex and virginity among Roma people was also supported by information collected during the seven FGDs conducted in Albania, Bulgaria and Macedonia Roma. For instance, an Albanian man stated: “When I buy a watermelon, first I taste it. If the watermelon is red I take it, if it is white I leave it. The same happens with women...” (FGD P12, Albania).

The emphasis on virginity is one of the reasons for early marriages. A United Nations Development Programme/International Labour Organization survey conducted among Roma in Bulgaria, the Czech Republic, Hungary, Romania and Slovakia found that 35 per cent of Roma women were married when they were 16 years old, 17 per cent when they were 17 or 18 years old, and 26 per cent between 19 and 22 years old[80].

Gender inequalities and strong male dominance among Roma families and communities also increase Roma women’s risks for domestic violence [14]. Roma women participating in FGDs in Macedonia discussed the existence and acceptance of intimate partner violence among Roma communities, particularly forced sex:

...it doesn’t matter what we want, but what the man wants...He could accuse you of sleeping with some other man... (FGD P2, Macedonia)

The FGDs in Macedonia also revealed that young married women seem to be even more at risk of forced sex by their husbands as they cannot refuse to have sexual intercourse due to the cultural or religious traditions.

Well, when I was younger, at the age of 20-25, if I didn’t want to have sex, he would get angry. But now, it’s different.. Now we are having sex if we both want to ... It’s easier. I am older now, but back then I couldn’t say no, he would get angry, and then what? Where should I complain? I would have broken the marriage. The young women today are in the same situation...(FGD P2, Macedonia)

Summary of findings for Roma

For Roma, the barriers deemed most important by participants of the FGDs were high levels of poverty and the lack of appropriate mechanisms of financial protection, exacerbated by requests from health care providers for informal payments. These findings are confirmed by the wider literature, which has also shown that reliance on out-of-pocket payments (both formal and informal) in Eastern Europe has led to a disproportionate exclusion of many Roma from accessing the health care system, as many are unemployed or do not have a regular income. The lack of essential documentation (e.g., birth certificates) also makes it difficult to access health insurance, though it is

the prevalence of informal payments, confirmed by our FGDs, that is particularly disturbing since it deters Roma from attempting to obtain health insurance.

Discrimination against Roma, including explicit racial discrimination, is anecdotally reported in the literature and confirmed as widespread by the participants in FGDs, contributing to their unwillingness to seek services. Geographical barriers were also mentioned by FGD participants for those living outside large urban areas. Poor knowledge of SRH was another common theme in FGDs, though there is much less information on this in the literature, and FGDs and the literature state that gender inequities can exacerbate lack of access to information and services.

7.2 Health care and sexual and reproductive health services for internally displaced people

Providing adequate health care for IDPs has been particularly challenging in Georgia, Bosnia and Herzegovina and Turkey [28, 81-82]. In Georgia, although IDPs legally have access to free medical care and are covered by state insurance programs, this care is limited to consultations with doctors and does not cover advanced laboratory tests or treatment [25]. Also in Georgia, IDPs can choose between IDP clinics and local facilities, but because of geographical, financial and legal barriers, good quality medical services are not easily accessible and their reproductive health is at risk [81]. In Turkey, although 91.2 per cent of IDPs were reported to have free access to basic health services, its quality is rather questionable [28].

Geographical factors and physical access

The uneven availability of health care services, particularly between urban and rural areas, impacts the ability of IDPs to access good quality services [83]. Moreover, the remoteness of the settlements and centres of some IDPs is a barrier to accessing any health care, including SRH. For instance, in Bosnia and Herzegovina, only 35 per cent of displaced households reported having access to a general practitioner, due to their remoteness [82]. In Turkey, the majority of IDPs are presently located in peripheral areas of urban cities, generally with limited access to basic services, including SRH facilities [28]. A 2009 study on maternal mortality in Turkey reported that maternal mortality is highest in regions with a poorer network of good roads, harsher winter conditions and longer distances to secondary level health facilities providing comprehensive obstetric emergency care services [84]. In Georgia, findings from FGDs with young women found that IDPs live in camp settlements far away from the cities where health care services tend to be located and, therefore, it is costly to access them. A participant said, “They live in uncomfortable and disorganised territory without any medical institution. Their camp is far away from town. In order to use services they have to go to Gori, but the transport is costly, as well as the services” (FGD P3, Georgia). Similar challenges were identified in one of the FGDs in Bosnia and Herzegovina, where one participant noted that “we now must go to Banovice, but this is not near and it is also expensive” (FGD P6, Bosnia). In the Bosnian FGDs the need for an ambulance featured highly (including for childbirth), because the distance and expense to get to a hospital meant that emergency care was often obtained late. Distance and travel costs not only impede access to health services, but also to education. In one of the FGDs in Bosnia and Herzegovina, participants noted that the costs of transport prevent children from

going to school. One participant noted, “My children sometimes can’t go to school because of the ticket price [for transportation] and that is a huge problem.” Another stated, “My children don’t go to school, I have three children and only one of them can go to school” (FGD P6, Bosnia).

Legal and financial factors

As noted above, access to SRH services is also hindered by poverty, as many IDPs cannot pay the transportation to reach the nearest hospital [81] or are not insured. For instance, in Bosnia and Herzegovina, 40 per cent of IDPs are not insured, which is partly due to the decentralisation and fragmentation of care in this country (a direct result of the 1995 Dayton Agreement that ended the Bosnian war). Even when insured, however, IDPs cannot afford to pay for their prescribed medications [82]. Out-of-pocket payments for medicines and special treatments, as well as for complications from abortions, are not covered by the state health insurance, forcing many to let illnesses go untreated [81]. In Turkey, some displaced persons have been denied green-cards, which would entitle them to get free health consultation and hospital accommodation, though the costs of medication are not covered [28]. The FGDs in Georgia and Bosnia and Herzegovina confirmed that financial barriers are a major concern for accessing SRH services:

The main financial barrier is that most of them do not work and have no income from permanent jobs. Men are mainly employed on building sites, at the market, etc., and do not have fixed daily payment. Women are staying at home taking care of their children, or most of them are supporting their husbands at the markets. (FGD P3, Georgia)

I: OK, money can be problem, what else?

A: Only money... (FGD P6, Bosnia)

More specifically, with regard to SRH services, one of the facilitators of the FGDs in Georgia noted:

The visit to the gynaecologist is not free of charge and it costs 7 Georgia lari [equivalent to 3.9 US dollars] for IDPs. In non-IDP clinics it costs between 20 [11 US dollars] and 40 Georgia lari [22 US dollars]. A 30-year-old participant mentioned she had visited non-IDP clinics and there was no discrimination or negative attitude towards her, but it was totally impossible to pay 20 Georgia lari per visit only for a consultation, not to speak about diagnostics and treatment. That made her feel very depressed. (FGD P4, Georgia)

In Georgia, maternal health care is offered primarily through private centres, which becomes an issue for poor people and IDPs. In fact, despite ANC and deliveries being (formally) free of charge (policy provides four ANC visits and a voucher for delivery), the remaining reproductive health services are not free [17, 85]. Pregnant women displaced in the military conflict with Russia in August 2008 were particularly vulnerable, as poverty, the destruction of infrastructure, and lack of access to reproductive health services led to an increased risk of complications during pregnancy and delivery [86]. Lack of health insurance coverage or the limited scope of services covered by the insurance scheme was identified as an important barrier in the FGDs in Georgia and Bosnia and Herzegovina. One participant in Georgia noted:

The IDPs do not have any insurance. Only IDPs who fall below the poverty line are covered by health insurance, but it does not include any SRH service, except four antenatal visits for pregnant women. (FGD P4, Georgia)

Health system-related issues

The lack of medical equipment, limited access to qualified staff and high expected payments (formal or informal) for medical care contribute to the reluctance of IDPs to seek medical attention. When internally displaced women receive assistance, it tends to be of low quality [25]. Moreover, because of health reforms and changes to the public health infrastructure, the internally displaced are at a particular disadvantage. For instance, Georgia's public health infrastructure has become widely dilapidated, leading to inadequate service provision and payment structures [87]. Service provision is now almost entirely private, while out-of-pocket payments are the main source of health financing [88]. The shortage of doctors and nurses is another major challenge in many areas in which IDPs are living. Findings from FGDs conducted with IDPs in Georgia and Bosnia also show a lack of medical centres in the camps where they live. In Turkey, many health professionals serving IDPs do not speak their native language and interpreters are lacking. This may contribute to the low ANC coverage among IDPs in Turkey.

Women FGD participants noted they had a limited choice of contraceptives available in the camps and a lack of supplies, particularly family planning methods such as condoms. One woman said that they relied primarily on sporadic campaigns offering free condoms but they did not have permanent availability of any family planning methods:

They have great desire for the campaigns not to be on-and-off, but to have permanent accessibility to FP methods where they live, and not to have to go far, to another town, for pharmacies or services. (FGD P3, Georgia)

Lack of information and awareness about access to sexual and reproductive health care

Because social and information networks tend to weaken and be disrupted during displacement, IDPs may have limited awareness about the availability of health services [89] and information about their entitlements. For instance, in one study on collective resettlement in Georgia, 65 per cent of families reported health-related problems, but did not seek any medical treatment, a rate 15 per cent higher than in the general population [90]. Even in Bosnia and Herzegovina, although health insurance schemes are legally available for IDPs, there is a lack of information on welfare support provisions, particularly for the uninsured (who can access services through user fees) [17, 82].

In Georgia, the FGD participants clearly did not consider SRH as a priority in the face of quite serious economic constraints they faced. This was exacerbated by the low level of SRH knowledge and information, combined with the limited choice of FP methods and the limited access to SRH services. Some participants said that the lack of SRH knowledge among displaced girls resulted in unwanted pregnancies and consequently in abortions.

In the Georgian FGDs, non-governmental organisations (NGOs) were reported as sources of information and awareness-raising initiatives for SRH, but the participants still identified the need for broad information campaigns on SRH issues, using video clips and involving young people:

It is a good idea to organise social campaigns and create video clips based on real stories of everyday life of IDPs, including the quality of their life, domestic conditions, discrimination etc. (FGD P4, Georgia)

It is also good to attract and involve young people. Peer education is the best way to provide and ensure a healthy future for youngsters. (FGD P4, Georgia)

In the FGDs in Bosnia, knowledge about SRH seemed poor and SRH seemed rather taboo as a topic, particularly in the FGD with young people, where there was also some fear expressed of examinations. Regarding family planning, one participant commented “nobody uses this, we don’t need that stuff” (FGD P7, Bosnia).

Stigma and discrimination

Stigmatising IDP status and ethnicity seems to be a practice among some medical personnel. In Georgia and Bosnia and Herzegovina, IDPs prefer to go to special IDP clinics where only displaced people are treated [81-82]. In Bosnia and Herzegovina, IDPs reported not feeling at ease with health staff of local clinics who did not belong to the same ethnic group [82].

The extent of stigma and discrimination, however, was hard to gauge from FGDs. They tended to confirm that IDPs prefer to access IDP clinics, and there was no real discrimination reported at the IDP clinics in either Georgia or Bosnia. In Bosnia, where some IDP participants had used other services, some reported that doctors were rude and kept them waiting “because we are not from here” (FGD P6, Bosnia), but such experiences did not seem widespread.

Gender inequalities

Another issue that emerged from the FGDs is the perception of low confidentiality in the camps, which could impact negatively on IDPs’ use of SRH services, particularly among young girls. Researchers have stated that the overall health of internally displaced women is worse than that of non-displaced women [25]. In societies with strict traditional gender roles, such as Georgia and Turkey, women without family support and close social networks are even more susceptible to have poorer SRH outcomes [91] and to face gender-based violence. Although reliable data on gender-based violence among displaced people are seriously lacking, NGO reports and assessments from Bosnia and Herzegovina and Georgia indicate that this is one of the SRH concerns of displaced women [82, 92]. In Georgia, locally conducted studies estimate that 5-31 per cent of IDP families are affected by sexual and gender-based violence, but this is thought to represent only a fraction of the true figure, since disclosure is very poor due to the stigma attached [93].

Traditional gender roles often prevent women from accessing family planning methods. This could

also be said for displaced women. In fact, FGDs in Georgia found that men are the main decision-makers in relation to SRH issues and they do not want to use condoms.

Most of the women mentioned that their partners refuse to use condoms. In that community a woman has to obey to the man. (FGD P2, Georgia)

In the Georgia focus group discussions with displaced women, traditional Caucasus mentality was said to be a main barrier for men's access to SRH services, particularly for STI treatment. Discussing SRH issues and accessing related services by men was seen as a social taboo, placing displaced men and their partners at risk of SRH consequences.

Men do not like to visit doctors. Generally, women visit them and men use the same prescriptions [as their wives]. When a wife has an STI and needs medical treatment, her husband would also take the same medicine. Men are offered the services of venerologists and urologists, but they do not like to visit them for cultural and financial reasons.... For the Caucasus culture, it is not acceptable to discuss problems connected with men's sexuality and SRH. It is not even desirable for men to discuss these issues with doctors unless there is an express need. (FGD P4, Georgia)

Summary of findings for internally displaced people

For IDPs their absolute poverty levels emerged most strongly as a barrier to accessing services, linked to the distance they needed to travel to reach facilities. These findings were confirmed by both the literature and the study FGDs. Lack of emergency transport was also highlighted as a problem, given the distance to hospitals. Issues of poverty and distance often interact, for example, while our FGD participants acknowledged that IDP clinics were cheaper than other clinics, there was still a problem of no or few clinics or medical supplies, including for FP, in the IDP camps or settlement areas. FGD participants preferred to access IDP clinics, although they did not report widespread discrimination in other clinics. The lack of health insurance was cited by FGD participants and the literature as a major barrier to accessing health services. FGD participants, however, gave an ambiguous picture of what was covered by insurance (or welfare for those below the poverty line) in relation to pregnancy and delivery care, which are supposed to be free.

Poverty also emerged in FGDs as an issue in relation to SRH knowledge and prioritization, because when people struggled to send their children to school they did not see SRH as important. In Bosnia SRH knowledge and prioritization seemed particularly taboo among the participants. Few sources of information seemed available, although in Georgia NGOs were mentioned. The literature also highlights gender inequities as playing a part in poor knowledge of SRH and utilization of related services and FGDs, especially in Georgia, confirmed the dominance of men in SRH decision-making as well as the taboo nature of SRH service-seeking among men.

7.3 Health care and sexual and reproductive health services for adolescents

Adolescents in Central Asia have limited access to SRH services due to several factors, including the scarcity of specialised youth-friendly services, the perceived low levels of confidentiality and

acceptability among health care providers, and the need for parental consent for accessing services when less than 18 years of age or unmarried [39].

Geographical factors and physical access

Physical access to SRH care is a major barrier for people living in remote rural areas. For instance, 25 per cent of the population in rural areas in Kyrgyzstan does not have easy access to health services beyond the primary care level, due to the mountainous terrain, inadequate roads or lack of transport [94]. This also impacts adolescents' access to SRH services and information about SRH issues as, because of the remoteness of some rural areas in Tajikistan and Kyrgyzstan, youth groups and information activities are often inaccessible for adolescents [38]. Poor access to SRH services and information in rural areas was also confirmed in the FGDs conducted with young people in Tajikistan and Kyrgyzstan:

There are services that are available only in cities for young people, but for young people living in rural areas information is not available and there is lack of specialists, lack of gynaecologists, and very often lack of information,; therefore, sick children are born... In rural areas, there is no information on how to prevent STIs... (P6, Kyrgyzstan participant)

Family planning is not widely available in rural areas in Tajikistan or Kyrgyzstan, and young girls and women are forced to resort to abortion or have more children than desired [95].

In Tajikistan in 2008, 40.2 per cent of all births took place at home, reaching 80 per cent in some of the country's regions. Out of all home deliveries, more than 60 per cent are carried out without medical assistance, resulting in significant health risks [96]. Home births and the lack of qualified birth attendants are also a major challenge in Kyrgyzstan.

Legal and financial issues

Parental consent requirements seem to be major obstacles preventing adolescents in Kyrgyzstan and Tajikistan from accessing SRH services. Throughout Central and Eastern Europe, the legal right of adolescents to access services on their own varies. Parental consent is required for all services for adolescents under a specified age (often 18), but perhaps especially for SRH. This presents a major obstacle to improving SRH services for adolescents.

The lack of money and financial resources was raised in FGDs in both Kyrgyzstan and Tajikistan as perhaps the factor that most determines access to health services. In Kyrgyzstan, one participant noted, "At this moment, money decides everything" (FGD P5, Kyrgyzstan). The cost of accessing services can be a barrier even where services are technically provided free of charge, such as in Kyrgyzstan, especially for adolescents [17, 96]. In Tajikistan, while young people said they can formally access contraceptive methods, they often lacked the income to purchase them [35].

The general consensus in FGDs in both countries seemed to be that condoms are sometimes available for free, but that contraceptive pills have to be paid for. The FGDs suggest that services are generally not available for free:

Gynaecologist and urologist services are expensive. I think there are no free services. Not everybody can get services, they are expensive; few [young people] have this kind of money, especially students. (FGD P7, Kyrgyzstan)

The issue of informal payments was raised in all three FGDs in Kyrgyzstan, with descriptions of the lack of transparency regarding the costs of health services and of how patients are asked to pay for services that should be free, but have little choice other than to accept the demands of health care providers. Examples given include:

There are no free services, even in the maternity hospitals. Pregnant women pay for their medical check-ups, although they should be free. (FGD P5, Kyrgyzstan)

My mother went to a hospital. The services should be free, but the doctor asked for 50 [Kyrgyzstan] soms. When other people came, he took 250 soms from them. It would be good if there was a fixed price list. (FGD P6, Kyrgyzstan)

The first of September is World HIV Day. The Red Crescent Society always organises activities that include the distribution of condoms. There was one case when one man asked for the cost of “free” condoms. People already know that free condoms are on sale, they got used to buying them. The “free” condoms are on sale in the drug stores at the price of 15 [Kyrgyzstan] soms each. (FGD P7, Kyrgyzstan)

The emergence of private providers was acknowledged in the Kyrgyzstan FGDs. They were perceived to provide better quality services, with shorter waiting times. However, costs were an issue:

Everyone has the choice to visit either a Center for Family Practice or a private clinic. It is a question of finance. (FGD P6, Kyrgyzstan)

In order to get the services of the private doctors you should have a [lot of money]. In state hospitals you get the information cheaper [but] doctors have lots of work and they will treat you very quickly, “just talk and hurry up,” since there are many people in the queue. (FGD P5, Kyrgyzstan)

All doctors need good money, and good doctors went to the private clinics. In state clinics there are no specialists. To get services in private clinics is quite expensive. (FGD P7, Kyrgyzstan)

Finally, the costs of travelling to urban areas for SRH services were mentioned in one of the FGDs in Kyrgyzstan:

When young people in rural areas seek health services, they do not go to qualified staff, but [to auxiliary health workers], who refer people in difficult cases to Bishkek, where there are... specialists. This creates another problem with transportation costs and finance. (FGD P6, Kyrgyzstan)

Health system-related factors

Some FGD participants stated that young people may not access SRH services because they perceived them as not being very confidential. A male participant from Tajikistan noted “shame, fear of being recognized by other clients, scared that medical personnel may not be confidential” (P16) among the barriers that prevented youth from accessing SRH services. In Tajikistan, all three FGDs underlined the importance of confidentiality, and two argued for free services. In Kyrgyzstan, the need for information on patient rights and entitlements was pointed out.

FGDs in both countries suggested that more clinics for SRH services should be opened. Separate clinics for youth were suggested in both countries, but the lack of resources was acknowledged and separate entrances or schedules to serve different population groups at different times were suggested as alternatives. In Tajikistan, FGD participants suggested that health care providers of SRH services to youth should be young and of the same sex as the client, noted the need for sufficiently qualified personnel and specialists, and recommended the provision of free services and contraceptives and the establishment of mobile teams to serve rural areas.

Another issue that emerged from the FGDs in Tajikistan was about time, specifically, both the lack of convenient opening times for SRH services for youth and the limited time of doctors to serve young people. One participant noted, “[the] lack of a regular schedule for youth services [and] medical personnel do not always have time to provide services” (FGD P16, Tajikistan).

However, health services responsive to youth needs exist within the region. A mapping study of youth-friendly services (YFS) in Eastern Europe and Central Asia found five different types of YFS being implemented: 1) integrated into primary health care facilities; 2) integrated into student health facilities; 3) integrated into educational systems; 4) integrated into and/or linked with Youth Centres; and 5) outreach services for particularly vulnerable young people. Information on the Central Asian states was not available, but in Turkey two pilot counselling services were introduced into primary health centres and youth reproductive health units were established in eight university medical units [97]. In Tajikistan national legislation supports the establishment of youth-friendly services within existing health sector services, but there are no data on the status of these [98].

Lack of information and awareness about access to sexual and reproductive health care

Adolescents’ low use of SRH services, particularly family planning services, in Central Asia is influenced by the general low level of information and awareness about SRH issues. For instance, data from a 2007 survey on HIV risk behaviours showed that awareness of HIV prevention and sexual health issues is relatively poor among adolescents in Tajikistan, with substantial variations between rural and urban areas [35]. The Tajik Multiple Indicator Cluster Survey shows that 1 in 3 young women aged 15-19 years old do not know of any method for preventing a pregnancy [37]. The need to increase awareness of SRH issues was identified in all FGDs. A young girl in Kyrgyzstan stated, “Young people have minimum access to services. Adults know where and why to seek care, they can negotiate. I do not know from whom I should seek care or where [...] There are fewer services for

young people than for adults. Young people do not know where to visit doctors or how to find the right person who could treat them properly” (FGD P7, Kyrgyzstan). One of the FGD participants in Kyrgyzstan pointed to the lack of awareness of patient rights and entitlements, “Nobody taught us about the right to receive contraceptives. Many people do not know what rights youth have for receiving these services. And we ourselves do not know about our rights. Doctors do not inform us” (FGD P5, Kyrgyzstan).

The lack of communication on SRH issues with adults, such as parents, teachers or providers, was also perceived as a limiting factor to accessing SRH information or services:

The majority of my friends cannot talk to their mothers about sex. (FGD P6, Kyrgyzstan)

Youth are without information and learn about their reproductive health on the day of their marriage. Until this day their parents don't talk about it; on the day of their marriage parents inform their children about SRH, but not fully. But it may be that the future spouse is infected. It would be good if the mother could inform her daughter about reproductive health issues earlier, so that the future children will be healthy. (FGD P5, Kyrgyzstan)

SRH awareness among adolescents also depends on their level of education. For instance, in Tajikistan, levels of awareness of HIV among young people increase according to educational levels attained: 60 per cent of those with no education report awareness, 65 per cent of those with primary education report awareness, 85.3 per cent of those with secondary education report awareness, and 93.2 per cent of those with tertiary education report awareness [35]. Opinions differed, however, about the suitability of teachers as transmitters of SRH information, although several participants suggested that these issues should be taught in school. There were also different opinions on the role of parents, with some participants blaming them for not educating their children and others saying that parents are not to blame, as they are not educated in those matters. Telephone hotlines were suggested as alternative in both countries. In Kyrgyzstan, however, one FGD pointed to the lack of access to landlines in rural areas and the lack of confidentiality when using those and suggested instead the provision of a free hotline on the mobile phone network.

A study in the Balkans showed TV, radio and friends were the most commonly mentioned sources of information about contraceptives [99]. The FGDs conducted in Tajikistan and Kyrgyzstan reflect limited awareness of SRH issues and services among youth, in both rural and urban areas, where people stated they access information primarily through friends or the internet. Several participants pointed to the need for high quality information materials that convey messages in a clear and age-appropriate way. A variety of channels for information transmission was suggested, including videos and the mass media. Additionally, in both Kyrgyzstan and Tajikistan, FGD participants pointed to the need for information materials in the national language rather than only in Russian, “In rural areas, some people understand Russian, but some people do not” (FGD P7, Kyrgyzstan).

Stigma and discrimination

Health care providers' negative attitudes towards adolescents asking for contraception have been

widely reported. Sexual health education and services for adolescents are still taboo in Central Asia, where providers are not trained to work with adolescents. In Tajikistan, young people reported being discouraged from buying condoms or asking for FP information by the negative stereotypes associated with their use and premarital sexual intercourse [35].

The negative attitudes of SRH health providers towards young people, especially young women, surfaced strongly also in our FGDs. Doctors were described as rude, unfriendly, judgmental and often refusing to offer services to youth. There were reports of doctors in the public sector, and even (in Tajikistan) in youth-friendly services, not having time for young people:

I know of a doctor who refused services to my friend because he had many clients. We have referred people to the youth-friendly clinic and the medical personnel there refused, said they have no time, and told us to come another day. (FGD P16, Tajikistan)

Moreover, some young peer educator volunteers were perceived by doctors as instigators of sexual acts:

The doctor said that youth volunteers who distribute information about SRH, including free condoms and brochures, prompt other youth to start an early sexual life. If a young person wants to receive information and goes to the doctor for SRH services, the doctor thinks “if this person comes to see me, then he has already started sexual life.” (FGD P5, Kyrgyzstan)

In Kyrgyzstan there were reports that doctors would treat young people better if they went with their parents:

If you go together with your mother, doctors treat you better because they know you are with an adult. And if you go just by yourself the attitude is different - rude and cruel. I have experienced it myself and prefer to go with my mother. (FGD P6, Kyrgyzstan)

Given that most young people do not feel comfortable talking to their parents about SRH issues (discussed in the section on lack of information and awareness, above), however, this is problematic. As one participant in Kyrgyzstan noted, “Our mentality and the way children are brought up lead to shyness” (FGD P7, Kyrgyzstan).

Gender inequalities

Traditional gender roles affect young girls’ ability to access SRH services and information, especially in rural areas. Gender roles and stereotypes also seem to impact on the possibility of obtaining family planning methods. For instance, in Tajikistan, young boys reported having greater access to condoms (80.6 per cent) than young girls (48.1 per cent) [35]. Tajik girls tend to leave school at an early age because they have to help their mothers with housework or marry early [100]. Forced early marriages were discussed in the FGDs in both Kyrgyzstan and Tajikistan as being part of local traditions, especially in villages and among less educated people, where the loss of virginity prior the wedding is a social taboo.

There are some places where Uzbek women allow their daughters to marry early, although the daughters are not mature, and they do not know what they are supposed to do. There are more educated parents, who understand; if their child is still young, they do not promote marriage. In other places [...there] are traditions that allow people to gossip; if a girl is not married by a certain age, that it means no one wants to marry her and that she is not a virgin anymore (FGD P5, Kyrgyzstan)

Socio-cultural issues around early sexuality and the importance of virginity, especially for girls, seem to impact both providers' and parents' attitudes, contributing to young people's fear of recognition and stigma when accessing SRH services, even when they are free:

Although there are informational activities at schools, they do not reach everyone. When young people use services, parents could have wrong perceptions about why their child went to see a gynaecologist or urologist.(FGD P16, Tajikistan)

Polygamous, forced or unregistered traditional marriages increase the risk of domestic violence [101] and other forms of gender-based violence. For instance, in some regions of Kyrgyzstan, 80 per cent of young women (between 16 and 25 years of age) have been bride-kidnapped without their consent [38, 102]. Rape and bride-kidnapping were also discussed in our FGDs and defined as forms of violence against women. A participant from Kyrgyzstan said, "Sexual violence takes place in the kidnapping of brides. The girl may oppose, but even if there was no sexual intercourse, when she spends the night in a boy's house, it will be announced that the girl has lost her virginity. This is violence" (FGD P7, Kyrgyzstan). In Tajikistan, one third to one half of women may at some time experience physical, psychological or sexual violence at the hands of husbands or other family members [101].

Summary of findings for adolescents

For adolescents, stigma of accessing SRH services, lack of information on SRH and financial barriers were all paramount in FGDs, confirming the widespread literature on these topics. Social norms in Kyrgyzstan and Tajikistan place high value on virginity and early sexuality is taboo, making it difficult for young people to talk to adults or access information and services. Many of our FGD participants described doctors not being willing to give them time, especially in busy clinics, but even at specialist YFS, and treating them rudely if an adult was not present. Poor knowledge of SRH and services was reported in both Kyrgyzstan and Tajikistan with participants in both countries giving the media and internet as primary sources of SRH information. Financial barriers were discussed in both countries as important problems and the lack of free services (Tajikistan) and widespread informal payments (Kyrgyzstan) were raised, with participants explaining how even "free condoms" were not free. There was some acknowledgement that state services were cheaper, but private facilities were seen as better quality.

Gender-based violence against young women is documented in the literature, though what came out more strongly in our FGDs was forced early marriage, in both countries. Rape and bride-kidnapping (in Kyrgyzstan) were also discussed together with the general climate of fear, especially for girls, that seriously impedes their ability to discuss SRH issues or seek services for fear of recognition and consequent assumptions about their lack of virginity.

8. Study Limitations

While the study aimed to provide a comprehensive review of SRH needs and access to services for vulnerable groups in Eastern Europe and Central Asia, it is important to highlight several limitations. First, analysis focussed on selected countries of the region. While many of the issues discussed in this report may also exist in other countries of Eastern Europe and Central Asia, further investigations are required to verify this assumption.

A second limitation is that the research component relied on a literature review and a qualitative research approach, with only a small number of FGDs. Qualitative research is typically not intended to be representative, but instead provides richness of detail. While many of the key themes of the FGDs corroborated findings of the literature review, large-scale representative quantitative surveys would ideally complement a more small-scale qualitative research approach.

Finally, not all FGDs and transcripts were of the same quality. The Macedonian, Bulgarian and Kyrgyz ones were particularly rich and detailed, while others, notably those from Georgia, Albania and Bosnia, were not as useful. This was partly due to the fact that some of the latter FGDs were not recorded verbatim, because women did not give their permission for this. Translation of the FGD transcripts from other languages into English may also have resulted in a loss of information. These issues underline the need for more research and local capacity building.

9. Conclusions

Our findings suggest that there is an urgent need to improve access to high-quality SRH services to vulnerable groups in Eastern Europe and Central Asia. This includes a variety of services, of which the most important are access to FP and pregnancy-related services and commodities.

Access to SRH information and services must be ensured for the poor and vulnerable. This includes eliminating administrative, financial and legal barriers, as well as “unofficial” charges. For the many countries that have no national family planning programme or clinic network, this needs to be rectified.

With regard to FP, while there is not much evidence that free FP increases coverage in general, it does so for the very poorest, including the vulnerable groups discussed in this report. In-service training of providers at all levels of the health care system is needed to promote a wide contraceptive method-mix (including emergency contraception if there are periods of traditional method use) and enhance uptake and continuation of FP use.

Increased promotion of post-partum/abortion contraception is an easy-win intervention since a high proportion of births and abortions in the region are attended at medical facilities.

Another relatively easy win is to ensure that FP, post-abortion care and maternity services are included in the financing and financial protection schemes of countries in the region. If it is politically difficult to include abortion services in standard insurance packages then contraception

(to prevent abortion) should be a priority, together with improving and maintaining the quality of abortion services (including continuity of care) in both public and private sectors.

Finally, reliable data on many aspects of RH in the region are missing, particularly with regard to the vulnerable groups discussed here. Ways of addressing this include better routine data collection and large-scale surveys.

10. Recommendations

10.1 Access

- > Improve financial, geographical and legal access to SRH care of Roma, IDPs and adolescents through:
 - » bringing services to them (improve physical access in remote rural and deprived urban areas) including, but not limited to, contraception, pregnancy-related services, reproductive health commodities, and a wide range of SRH information and counselling;
 - » ensuring financial protection and access to free SRH care for all vulnerable groups by:
 - improving health insurance coverage;
 - improving access to health care for uninsured vulnerable populations;
 - ensuring free or partially reimbursed contraceptives for women in all vulnerable groups;
 - including SRH care, including contraception, in basic benefit packages;
 - » for youth:
 - expand specialist youth services;
 - provide anonymous services;
 - provide well-informed and non-judgmental staff;
 - implement in and out-of-school sex-education and information campaigns;
 - expand access to free/low costs FP;
 - market condoms effectively and link to EC for backup;
 - invest in female education.

10.2 Awareness and education

- > Improve awareness of all vulnerable groups (especially women and girls) of their entitlements and rights and of the SRH services available to them, such as through:
 - » health mediators;
 - » community outreach campaigns.
- > Address cultural barriers to access, including traditional perceptions among vulnerable groups of the role of women.
- > Provide information and services in the languages spoken by vulnerable groups where those differ from the dominant language.
- > Provide telephone hotlines on SRH issues, including on mobile phone networks.

10.3 Quality of care

- > Improve the quality of SRH care through:
 - » creating programmes to improve ANC screening of pregnant women in vulnerable groups, particularly for STIs and HIV/AIDS;
 - » enhancing immunisation coverage.

10.4 Legislation and policy

- > Improve the legislative framework, service provision and national policies related to the SRH of vulnerable groups through:
 - » making specific provision and targets for meeting SRH needs of vulnerable groups;
 - » developing national SRH policies and strategies, including family planning, where these do not exist;
 - » better integrating SRH strategies and implementing mechanisms into existing legislation on vulnerable groups;
 - » involving vulnerable groups in the development, implementation and evaluation of SRH policies and programmes.
- > Reduce discriminatory practices towards vulnerable groups through:
 - » better training of staff in mainstream services to reduce stigma and prejudices against vulnerable groups;
 - » public education campaigns;
 - » improving legislative and institutional frameworks to address discrimination against these groups.
- > Improve monitoring and reporting of SRH for both the general population and particularly vulnerable groups (there is currently too little data in most countries to adequately monitor current situations or progress).

11. Appendices

Appendix 1 Generic discussion guide for focus group discussions

Each topic guide was adapted for the vulnerable group (Roma, internally displaced people (IDPs) and adolescents) and for each country. While broad topic areas remained the same, there were specific questions or probes that were country-specific.

Focus Group Discussion (FGD): Generic Discussion Guide

Introduction:

1. Introduce facilitators.
2. Introduce participants.
3. Explain why we are here (aims of the FGD, how long it will take).
4. Explain that all answers will be treated confidentially (no names revealed, what will happen to the data and assurance of confidentiality).

5. Ask whether participants are willing to participate in the group discussion (participation is voluntary and no need to answer questions they do not want to answer).

[Note to facilitators: At this point, if there are participants who are not willing to participate, thank those participants now and politely ask them to leave – you should reassure all participants who DO agree, that if there are any questions that they do not wish to answer, they have the right to refuse and they may also leave the FGD at any time without giving a reason.]

6. Do an ice-breaker to make participants feel comfortable with each other.

Discussion guide

1. Sexual and reproductive health (SRH) needs and unmet needs

- What do you think are common SRH needs of people of your age?

2. Experience of and barriers in accessing SRH services

- Do you think that [Roma/IDPs/adolescents] use SRH services less than other people? Why?
- What is your, or your friends', experience of using sexual and reproductive health services?
- Have you or your friends ever faced any barriers when accessing sexual and reproductive health services?
- What other barriers do you think [Roma/IDPs/adolescents] may face when accessing SRH services?

[Note to facilitators: Probe throughout this section for experience of different kinds of specific SRH services: family planning (FP), sexually transmitted infections, human immunodeficiency virus, maternal health, any other related services.]

2.1. Geographical barriers

- What do you think about [Roma/IDPs/adolescents] living in rural areas and their access to family planning methods and information?

2.2. Health-systems barriers and discrimination

- Do you feel health providers can offer you the services you need?
- How do you think health providers in SRH services treat [Roma/IDPs/adolescents]?
- Have you or your friends ever had any bad or good experiences you want to share?
- Have you ever heard of [Roma/IDPs/adolescents] not being offered SRH services by a doctor or a nurse because of being [Roma/IDPs/adolescents]? What happened? Has this ever happened to you or your friends?

2.3. Financial and legal barriers

- Where can you get FP methods like condoms? How much do you have to pay to buy them?
- What about other SRH services, do you have to pay for these?
- Are you aware of any health insurance schemes available to [Roma/IDPs/adolescents]? What do you know about it? Do you or your friends have health insurance? Have you ever had to use it? How did it work? What were your experiences?

2.4. Lack of information and awareness about SRH services

- If you or your friends have an SRH problem, where do you go to seek help?
- Are you aware of any specialist SRH services available for [Roma/IDPs/adolescents] like you?
- Are you aware of any rights or benefits that are available for [Roma/IDPs/adolescents]?

2.5. Gender inequalities

- Do you think health providers treat [women and men/boys and girls] differently? In what way? Does this affect [men's or women's/boy's or girl's] access to services in any way?
- Do you think [Roma women/IDP women/girls and young women] can decide alone about accessing SRH services such as FP or abortion?

3. Recommendations

- How do you think SRH services and access to them can be improved for [Roma/IDPs/adolescents]?

Closing

1. Summing up: finish by summarising key points raised in the discussion. Ask participants if they want to add anything.
2. Thank them for attending and express how helpful their answers have been.
3. Explain next steps (results to be written up anonymously and presented at a regional meeting on SRH needs in the region). Indicate that although we hope our report will influence policy makers to improve services, there are no guarantees that this will happen, but it is important that they have helped us provide evidence that can be used to inform policy.

Appendix 2 Overview of literature on sexual and reproductive health and vulnerable groups, by theme and country

	Albania	Bosnia and Herzegovina	Macedonia	Bulgaria	Georgia	Turkey	Kyrgyzstan	Tajikistan
Vulnerable groups	Roma women, especially nomadic communities around Shkodra, the Bread Factory in Tirana, and the village of Sharra[103]. National and international non-governmental organisations estimate that 95,000 to 150,000 Roma live in Albania; the World Bank's estimate of 95,000 (2% of the total population) is considered the most accurate[104]. Largest groups are found in central and southeast Albania in regions like Tirana.	Roma (between 30,000 to 60,000 - 135,000)[63] and internally displaced people (114,000 - 3% of total population)[82]	Roma women, though very little information is available. 10.9% of the population is Roma [105].	Roma (8.8% of population)[102], who are among the most vulnerable groups and among the poorest and lower educated. 46% of Roma are not insured and 55% stated they had difficulties in accessing care due to the remoteness of medical care[54].	Internally displaced people(at least 230,000 or 5.3% of total population). 2004 studies suggested that compared to the general population, the overall health status of internally displaced people was worse, particularly for those in collective centres[25].	Internally displaced people(953,680 - 1,201,200 people displaced between 1986-2005)[28]. 80% of internal displacement between 1986-2005 is rural originated and 20% is urban originated[28]. The majority of IDPs are presently located in urban area in southeastern or northwestern Turkey. Internally displaced people located in peripheral areas of urban cities generally with limited access to basic services[25]. Roma: social marginalization, limited access to health; dislocation in various parts of Turkey, especially in the context of urban renovation projects (particularly in the historic area of Sultankule, Istanbul) [106].	Women in poor households and/or living in remote areas.	Women in poor households and/or living in remote areas. more than 72% of women live in rural areas[107]. Wives of migrants to Russian Federation primarily for seasonal jobs are vulnerable to sexually transmitted infections and human immunodeficiency virus[33].
Family planning (FP) overall	Unmet need for modern contraception (75% in 2002, decreased to 71%) [79]. Modern FP methods use increased to 11% [79].	Low contraceptive prevalence rate. High abortion rates among adolescents[17]	Low contraceptive prevalence rate among Roma women [63]. Contraceptive prevalence rate among married women is very low: 14% all methods and 10% for modern methods. Abortion is the most used form of FP. Low access to FP supplies and maternal health services among	Low use of FP (41% all methods and 26% modern ones). FP not covered under health insurance scheme and costs appear unaffordable, unlike abortions, which are offered free-of-charge[17]. A study on health status of Roma women shows that contraceptive use is	Low contraceptive prevalence rate (47%) and lower for modern methods (27%). Low fertility rate (1.4) [17]. United Nations Population Fund remains one of the main providers of free-of-charge contraceptives to the country. Highest rate of abortion in the region (3.1 abortions per	High contraceptive prevalence rate: 71% (43% modern methods) [17]. Abortion rate is relatively high (24%) [17].	Contraceptive prevalence rate: 60% (49% modern methods) [17].	Low contraceptive prevalence rate: 38% of married women use FP (33% modern methods) [107]. Limited knowledge and use of FP. Relatively low abortion rate (54.39) in comparison to neighboring countries.

woman).

Roma women also due to privatisation of primary health care, with FP moved to private family doctors [57].

still not widespread by Roma people: 59.2% of interviewed women do not use any FP. Among richer and more educated Roma, only 35% stated they did not use FP; coitus interruptus (37%) and intrauterine devices (35%) are the most practiced methods. Contraceptive protection is not seen as a man's responsibility. Abortion still widespread: 52% of the sampled women stated they had an abortion, with the highest % among 18-23-year-olds. Around 25% of the women who had abortions had more than 3 abortions. 81.2% stated they took the decision on their own or together with their husband (which could hide forced abortions)[22]. High teenage pregnancies and abortion rates could be linked to Roma high rates of early marriage.

Maternal
and child
health
(MCH) care
(overall)

Maternal mortality ratio: 10 (though adjusted is much higher) [108]. 97% of births attended by skilled personnel [79]. 2002 reproductive health survey indicated that rural poor women were less likely to have received antenatal care [17].

Very low maternal mortality ratio: 3 (adjusted by World Health Organization in 2005). High level of rape [82].

Low maternal mortality ratio: 10. 98% attended births, though the % of women assisted by a doctor is lower among Roma women [15]. Poor ante-natal care [105].

Quite high maternal mortality ratio: 25.69[110], varying between 40 to 66, with the majority of deaths among rural women between 19 and 34 years of age). 100% attended births [110-111] and 95% ante-natal care coverage. High abortion rates (417.25/1000 births), with high mortality due to complications.

Relatively low maternal mortality ratio (19.4) [29] though much higher in rural areas (40) [17]. High fertility; 80% ante-natal care coverage. Poor MCH quality and coverage due to urban/rural divide. 83% of attended births, with regional divide (59.7% in the east, 90% urban and 68.9% rural); 54.9% for uneducated women, 98.5% for

High maternal mortality ratio: 150 (adjusted by WHO) [17]. Nearly universal ante-natal care coverage and attended births (both 97%); 60.1% of women in poorest and 96.3% of women in richest quintile groups were assisted by a doctor [112]. Low quality of MCH care, especially at district hospital levels.

High maternal mortality ratio: 170 (adjusted); low ante-natal care coverage (77%) [17]. Antenatal care (ANC) coverage in urban/rural settings: ANC is 10% higher in urban areas. ANC coverage is lower among the older and less educated women as well as women from poor households [37]. Attended births 83%, higher in urban areas

<p>Description of the health system</p>	<p>Maternal health care provided through primary health care network. The state budget provides most financing for the health care system (mandatory taxation insurance scheme). A health insurance scheme for primary and maternity care will be introduced during 2009. Informal payments affect particularly the poorer people [17].</p>	<p>Health care reforms have prioritised primary health care, with the development of family doctors. Public health insurance schemes administered at republic and canton levels [17].</p>	<p>Compulsory health insurance for basic health care package, with out-of-pocket payments. Focus on primary health care since the health sector reform, with compulsory registration with a general practitioner [63].</p>	<p>Health reforms in Bulgaria started at the beginning of 1990s. Compulsory health insurance system is represented by the National Health Insurance Fund and funded primarily from payroll-based contributions, with state and municipal budgets covering low-income and socially disadvantaged sections of the population; restructuring primary care and the introduction of general practitioners as gatekeepers to specialised care [65].</p>	<p>MHC offered primarily through private centres (thus an issue for poor people and internally displaced people). 4 ante-natal care visits and a voucher for delivery free-of-charge, the rest of reproductive health care is not free and provided by private health care institutes [17, 85].</p>	<p>Health care reforms have focussed on the strengthening of primary health care and increasing national coverage (low ante-natal care attendance). Universal health insurance scheme to fund the health care system, together with central government budget [17].</p>	<p>Health care reforms have focussed on the strengthening of primary health care and increasing national coverage (low ante-natal care attendance). Universal health insurance scheme to fund the health care system, together with central government budget [17].</p>	<p>Series of health sector reforms since 1996 aimed at decentralising service provision, strengthening primary health care and creating central pools of funding through the introduction of a mandatory health insurance scheme. A state benefit package and an essential drugs list have been developed in order to ensure access to services following the cessation of free-of-charge services. Out-of-pocket payments estimated to constitute approximately 50% of the total expenditure on health care. A system of official co-payments exists to replace informal fees [17].</p>	<p>(89% than rural ones (81%). High number of home births 60% are attended [37]. 15% women married at less than 18 years of age [17]. Early pregnancies and high maternal mortality in rural areas (over 70% people live in rural areas) [96].</p>
<p>Generic sexual and reproductive health (SRH) policies</p>	<p>There is no specific anti-discrimination legislation. National Reproductive Health Strategy Document and Action Plan being developed (was due for completion in 2009);</p>	<p>No common state-level sexual and reproductive health policy or strategy.</p>	<p>There is no specific law on reproductive health, though a National Strategy for Sexual and Reproductive Health 2009-2015 has been developed with the support of the United</p>	<p>No specific sexual and reproductive health strategy, but goals and targets under National Health Strategy and issues under National Demographic Strategy (NDS) [11,4]. The</p>	<p>New Law on Public Health and the introduction of a system of private service provision and financing in 2007. A public health insurance policy and package will cover.</p>	<p>No specific reproductive health strategy, though the National Strategic Action Plan for the Health Sector 2005-2015 includes sexual and reproductive health issues among its</p>	<p>Law on reproductive rights regulating the protection of reproductive health since 2000 [17]. National Reproductive Health Strategy (2006-2016),</p>	<p>Law on Reproductive Health and Right since 2002, plus several laws and decrees relevant to the protection of maternal and child health. Also a 2008 Bill on Social and Legal</p>	<p>State main public funder and provider of care, though substantial private out-of-pocket payments. Guaranteed Benefit Package and Paid Services programme (approved in 2004) offers free prenatal care and free hospital care at delivery [17]. Growing trend for informal payments including for services in the general service package. Comprehensive national health care reforms toreorient the system towards primary health care, by moving from hospital-based care to family-oriented health services, with a strong emphasis on health promotion and active community involvement in disease prevention.</p>

Nations Population Fund [113]. Sexual and reproductive health is regulated by the laws on health care protection. National Strategy for Protection Against Domestic Violence has been implemented.

NDS, which includes reproductive health commitments, recognises that Roma women have higher maternal mortality ratio due to unequal access to services (because of removal of patronage system) and shortage of specialists in remote areas [52]. Also Maternal Health and National Family Planning Programmes are implemented, though no specific mentions of Roma or vulnerable groups.

1.2 million Georgians living below the poverty line, providing access to basic health services, including reproductive health [85]. Reproductive health strategy plan for Georgia, 2008 [115]. Law on Combating Domestic Violence, Prevention of and Support to Its Victims, May 2006.

priorities (unwanted pregnancies, high maternal mortality ratio, increase of sexually transmitted infections, inequities in access to sexual and reproductive health across regions) [17].

which focuses on MCH. 2nd Health Sector Reform Programme Review, implemented under Sector Wide Approach (SWAP) MCH Programme to eliminate co-payments for distinct vulnerable groups [94].

Protection against Domestic Violence. National Reproductive Health Strategic Plan (2005-2014), approved in 2005, focusing on maternal mortality reduction and FP increase [17].

Appendix 3 Overview of policies for sexual and reproductive health and vulnerable groups, by country

Country	Legal context for sexual and reproductive health (SRH)	Health systems and financing	Legal context for targeted vulnerable groups
Albania	National Reproductive Health Strategy Document and Action Plan (in preparation). Gender equity law, 2008. 1998 Constitution enshrines right to health and rights of women.	Health System Strategy 2007-13 includes health insurance. Health system centralised and hierarchical, despite strengthening of local government.	Albania joined the Decade of Roma Inclusion in 2008; within this framework the government adopted a National Action Plan, which focuses on education, employment and social protection, housing and infrastructure, health, social infrastructure and equal opportunities, and cultural heritage. One objective of the health priority is to raise the awareness of Roma people of health care and public health services, particularly reproductive health (e.g. pregnancy, family planning, maternal and child health) [116]. National Strategy on improving the living conditions of the Roma community, adopted in 2003 by the Albanian Council of Ministers, looks at health care issues, among others. No specific measures to eliminate discrimination against Roma are offered [103].
Bosnia and Herzegovina	No national SRH policy. Draft policy (unapproved) for Republic of Srpska Law on Gender Equity ensures access to health-related resources. Poverty Reduction Strategy Papers include targets for the fifth of the Millennium Development Goals but no monitoring strategy.	Health care reforms emphasize family doctors to improve primary health care access. High level of investment in health care. No state-level health section within Ministry of Civil Affairs. Fragmented health system with 3 sub-national health systems administered by 13 Ministries of Health. Public health insurance scheme and user fees for uninsured administered at both federal and canton level; those registered in one canton may not receive health care in another canton. Geographical inequities regarding access as a result of decentralisation. Privatisation of care increasing.	National Action Plan for Roma Inclusion Decade: Action Plan for addressing Roma in the field of health care.
Macedonia	No specific law on reproductive health. 5 national preventative reproductive health programmes, but no implementation strategy. A National Strategy for Sexual and Reproductive Health 2009-2015 has been developed with the support of United Nations Population Fund[113]. This issue is regulated by the laws on health care protection [58]. National Strategy for Protection Against Domestic Violence has been implemented.	Compulsory health insurance for basic health care package, with out-of-pocket payments. Focus on primary health care since the health sector reform, with compulsory registration with a general practitioner[63]. Ministry of Health is responsible for health systems and policies. Widespread decentralization since 2001. Mandatory health insurance and copayment/user fees in place. Maternal health subsidised for	National Action Plan for Health Care (Decade of Roma Inclusion). Law on Social Protection also regulates health care access for Roma. National Strategy for Roma Population [55-58]. Many Roma remain uninsured and cannot afford the formal or informal payments associated with care.

	<p>Article 39 of Constitution guarantees right to health and aspects of SRH are found in legislations beyond health sector.</p>	<p>uninsured, but informal payments common.</p> <p>Family planning service ended in 2006 with responsibility given to family doctors and gynaecologists</p> <p>Inequities by geography (fewer services in rural areas) and wealth (access to specialist care easier for those who can pay).</p>	
Bulgaria	<p>No specific SRH strategy, but the National Health Strategy includes SRH goals and targets. SRH issues under National Health Strategy and National Demographic Strategy (NDS) [111]. The NDS, which includes reproductive health commitments, recognises that Roma women have higher maternal mortality ratio due to unequal access to services (because of removal of patronage system) and shortage of specialists in remote areas [52]. Also Maternal Health and National Family Planning Programmes are implemented, though no specific mentions to Roma or vulnerable groups.</p> <p>National Programme of SRH due for finalization in 2009.</p>	<p>Health sector reforms in early 1990s included decentralization and development of range of medical practice guidelines.</p> <p>Statutory insurance system guarantees package of services. Deliveries are (formally) free, even for uninsured. Ante-natal care not free and insurance companies may limit amount of free care.</p> <p>Family planning not integral part of reproductive health services.</p>	<p>Health Strategy Concerning People in Disadvantaged Position, belonging to Ethnic Minorities is an integrated part of the National Health Strategy for securing better health for the Bulgarian population.</p> <p>Framework Programme for equal integration of Roma into Bulgarian society and the Action Plan for its implementation do not devote much attention to the health of Roma women, with the exception of a sentence on the importance of overcoming cultural barriers to SRH care [22].</p> <p>National Action Plan of the Decade of Roma Inclusion, which focuses solely on Roma SRH (breast cancer, family planning, prevention of early marriages and care for pregnant women) and not on women's health care in general; very little budget is allocated to its implementation.</p> <p>Health Strategy for People in Vulnerable Position belonging to Ethnic Minorities and its Action Plan 2005-2007, is one of the few documents targeting Roma women, their health and issues related to their equality and gender-based violence.</p>
Georgia	<p>New Law on Public Health and the introduction of a system of private service provision and financing in 2007.</p> <p>Reproductive Health Policy Framework 2007-15, adopted in 2006, includes maternal health as a priority, with specified targets.</p> <p>National Reproductive Health Council operates since 2007 with United Nations Population Fund support.</p> <p>Reproductive health strategy plan for Georgia, 2008 [115].</p> <p>No formal family planning policy.</p> <p>11 reproductive health guidelines/ protocols.</p> <p>Law on Combating Domestic Violence, Prevention of and Support to its Victims, adopted in May 2006</p>	<p>Ministry of Labour, Health and Social Affairs leads government implementation of health care policy.</p> <p>Health care reforms focused on improving primary health care.</p> <p>Most reproductive health services (including ante-natal care and delivery) are not free.</p> <p>Family planning and some other commodities provided free by United Nations Population Fund, operating mobile clinics since 2000.</p> <p>Social insurance scheme exists, but most reproductive health funding is private.</p> <p>All services operate as private – hard for government to intervene; insurance companies can monitor services with which they have an agreement.</p> <p>A (new?) public health insurance policy and package will cover 1.2 million Georgians living under</p>	<p>Law of Georgia on Internally Displaced Persons – the Persecuted states that “cost of medical treatment of vulnerable internally displaced people at the medical institution shall be compensated by the state according to the pre-determined procedure and within state standards and tariffs” [25].</p> <p>Since 2007, there is a State Program of Medical Insurance for Population Living under the Official Poverty Line, which includes internally displaced people. It covers out-patient and in-patient services, and was revised in 2009. There is an ante-natal care and delivery programme, which covers these services, though there is major underfunding and internally displaced people often are not reimbursed [91].</p>

		the poverty line, providing them with access to basic health services, including reproductive health[85].	
Turkey	No specific reproductive health strategy, though the National Strategic Action Plan for the Health Sector 2005-2015 includes SRH issues among its priorities (unwanted pregnancies, high maternal mortality ratio, increase of sexually transmitted infections, inequities in access to SRH across regions) [17].		Law on Compensation of Losses resulting from terrorist acts and measures taken against terrorism (2004) to guarantee access to financial and other forms of support to internally displaced people (including health, though no specific reference to SRH) [114].
Kyrgyzstan	Law on reproductive rights regulating the protection of reproductive health since 2000; lacks implementation mechanisms [17]. National Reproductive Health Strategy (2006-2016).	Series of health sector reforms since 1996 aimed at decentralising service provision and strengthening primary health care whilst creating central pools of funding through the introduction of a mandatory health insurance scheme. A state benefit package and an essential drugs list have been developed in order to ensure access to services following the cessation of free-of-charge services. Out-of-pocket payments estimated to contribute approximately 50% of the total expenditure on health care. A system of official co-payments exists to replace informal fees [17]. Ministry of Health implements health policy and monitors quality. Ante-natal care almost universal (primarily doctors) as is attended delivery (higher attendance by doctors for higher socio-economic status) while women in rural areas rely on midwives and coverage is poorer.	
Tajikistan	Law on Reproductive Health and Rights since 2002. Several laws and decrees relevant to the protection of maternal and child health. 2008 Bill on Social and Legal Protection against Domestic Violence. National Reproductive Health Strategic Plan (2005-2014), approved in 2005, focuses on maternal mortality ratio reduction and family planning increase [17]. Poverty Reduction Strategy Papers and National Development Strategy refer to universal access to reproductive health through strengthening of primary health care.		Guaranteed Benefit Package and Paid Services programme aims at improving access to primary health care services for vulnerable groups. It includes free ante-natal and delivery care at hospital, plus free drugs to vulnerable groups.

Appendix 4 Overview of barriers to sexual and reproductive health care, by country

Barriers to sexual and reproductive (SRH) care	Albania (Roma)	Bosnia and Herzegovina (Roma and internally displaced people)	Bulgaria (Roma)	Georgia (internally displaced people)	Kyrgyzstan (adolescents)	Macedonia (Roma)	Tajikistan (adolescents)	Turkey (IDPs and Roma)
Geographical barriers	Basic health posts in remote rural areas, offering few family planning methods.	Uneven availability of health care services, particularly between urban and rural areas. Remote locations of internally displaced people.	Geographical inequalities among rural and urban areas. High mobility of some Roma makes their access to health care more difficult.	Geographical barriers for rural women who cannot afford to reach health centres. Internally displaced people mainly treated at United Nations Population Fund-supported reproductive health mobile outreach services.	Difficult access to health care beyond primary health care due to lack of transportation, poor roads, mountainous terrain. Family planning and SRH information activities are not available in rural areas.	Geographical inequities for Roma in poor rural areas and poor urban areas.	Geographical barriers include poor roads, limited communications and difficult access in winter.	Low access to SRH in remote areas. Maternal mortality is highest in regions with poorer roads, harsher winter conditions and longer distances to secondary level health facilities, which provide comprehensive obstetric emergency care services.
Legal and financial barriers	Formal and informal payments (despite basic package of service system). Exclusion of Roma from health insurance schemes because employed mainly in the informal market.	Exclusion of internally displaced people from health insurance, due to decentralisation and fragmentation of care and the lack of employment. Even when insured, internally displaced people cannot afford to pay for the medications. Lack of documentation among internally displaced people. Significant migration of both Roma and internally displaced people has contributed to poor registration data, leading to low vaccination coverage of Roma children, refugees and internally displaced people.	Limited insurance coverage among Roma. Family planning and ante-natal care are not universally free of charge and thus can limit access among poor people, like Roma women.	Despite free medical care (consultations, not treatment, with doctors) access is difficult for internally displaced people, as out-of-pocket payments due for medicines and special treatments (e.g., abortions) are not covered by state health insurance. Internally displaced people tend to go to primary health care services but not specialised public services because of their high costs. Many people are still uninsured. Ante-natal care is free of charge, but not the rest of reproductive health services.	Need for parental consent to access services when less than 18 years of age or if unmarried. Informal payments for SRH services are a barrier for adolescents, as they cannot afford to buy family planning.	Lack of health insurance coverage for Roma. Roma mothers often cannot afford the co-payment and informal costs linked to regular ante-natal care visits, delivery and post-natal care visits, even for the health services that are free and subsidised by the vertical preventive programmes. Also family planning is not covered by health insurance. Women without identification cannot get health insurance.	Need for parental consent to access services when less than 18 years of age or if unmarried.	High costs for medications for internally displaced people. Internally displaced people have also been denied green cards, which would entitle them to get free health consultation and hospital accommodation, though the costs of medication are not covered.
Health-systems related barriers	Unequal coverage of resources; emergency obstetric care may be limited in some areas (provided only in secondary level facilities); women in remote areas may be accessing primary health	Discrimination against Roma and internally displaced people by health staff.	Discrimination against Roma by health staff. Lack of Roma health professionals.	Dilapidated health infrastructure; shortage of doctors and nurses in many areas where internally displaced people live; inadequate provision of health services.	Scarcity of specialised youth-friendly services. Low level of confidentiality and acceptance among health providers (not sensitised on adolescents' issues). Negative attitudes of	Discrimination against Roma by health staff. Lack of Roma health professionals.	Negative attitudes of providers towards adolescents having premarital sex; providers tend to discourage youth asking for condoms or family planning information.	Poor quality of health care for internally displaced people. Many health staff do not speak the language of the internally displaced people and interpreters are not available.

<p>Lack of information and awareness</p>	<p>care centres, which provide ante-natal and post-natal care (but no basic emergency obstetric care); health professionals are concentrated at secondary level care, with few professionals at primary health care; primary health care with low trained staff and limited drugs, thus very poor quality of care provided.</p>	<p>Lack of knowledge of and/or access to family planning methods.</p>	<p>Lack of information on welfare support provisions for uninsured internally displaced people and Roma, who can only access services through users' fees.</p>	<p>Lower educational level among Roma people.</p>	<p>Lack of information about welfare support provisions, particularly for the uninsured.</p>	<p>Low awareness of maternal health issues and services and poor health seeking behaviour limit access to SRH care.</p>	<p>Low awareness (because of high illiteracy) among Roma mothers of the need to use health services, especially in rural and poor urban communities. Low education levels and conservative cultural norms can contribute to low access to ante-natal care.</p>	<p>Poor awareness, education and knowledge about SRH, which leads to low family planning and ante-natal care use among youth.</p>	<p>Lack of adequate infrastructure and shortage of medical personnel, in particular Kurdish-speaking personnel also make it difficult to combat the health problems linked with poverty.</p>
<p>Discrimination</p>	<p>Racial discrimination of Roma.</p>	<p>Lack of information on welfare support provisions for uninsured internally displaced people and Roma, who can only access services through users' fees.</p>	<p>Lower educational level among Roma people.</p>	<p>Lack of information about welfare support provisions, particularly for the uninsured.</p>	<p>Low awareness of maternal health issues and services and poor health seeking behaviour limit access to SRH care.</p>	<p>Low awareness (because of high illiteracy) among Roma mothers of the need to use health services, especially in rural and poor urban communities. Low education levels and conservative cultural norms can contribute to low access to ante-natal care.</p>	<p>Poor awareness, education and knowledge about SRH, which leads to low family planning and ante-natal care use among youth.</p>	<p>Lack of adequate infrastructure and shortage of medical personnel, in particular Kurdish-speaking personnel also make it difficult to combat the health problems linked with poverty.</p>	
<p>Gender inequalities</p>	<p>Discrimination of internally displaced people by health providers. Mono-ethnic composition of the health staff. Discrimination against Roma in accessing health benefits, as they lack the status of a national minority.</p>	<p>Discrimination of internally displaced people by health providers. Mono-ethnic composition of the health staff. Discrimination against Roma in accessing health benefits, as they lack the status of a national minority.</p>	<p>Not available.</p>	<p>Stigma associated with internally displaced person status by medical personnel: internally displaced people prefer to go to special clinics for internally displaced people.</p>	<p>Stigma attached to young people having sexual relations before marriage.</p>	<p>Some general practitioners do not accept Roma women: 1/3 of Roma do not have a general practitioner, despite most of them having health insurance.</p>	<p>Stigma attached to youth accessing SRH services.</p>	<p>Not available.</p>	
<p>Gender inequalities</p>	<p>Low decision-making power among Roma women.</p>	<p>Not available.</p>	<p>Not available.</p>	<p>Strict gender roles and lack of family support make internally displaced women susceptible to gender-based violence and to poorer SRH outcomes.</p>	<p>Gender inequalities, leading to gender-based violence (e.g. bride-kidnapping).</p>	<p>Traditional gender roles, with patriarchal society and strong sense of masculinity.</p>	<p>Traditional patriarchal society where head of household makes budget and health decisions. Girls forced to leave school early for marriage. Low decision-making power among young girls, limiting access to family planning. Gender-based violence, especially domestic violence.</p>	<p>Traditional gender roles, especially in rural areas.</p>	

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