

**COMMUNITY MONITORING
OF HEALTH CARE SERVICES**
in Veliko Turnovo and Pavlikeni Municipalities

January 2012

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Introduction

The condition and tendencies in the health status of the nation, including the persons belonging to ethnic minorities, can be evaluated considering the demographic processes, illnesses and risk factors, the physical growth and capability, as well as, the self health assessment. Main reasons for the health impairment of the Bulgarian citizens, especially Roma people, are poverty, unhealthy way of living related to malnutrition, constant distress combined with other risk factors such as smoking, alcohol dependency, drug dependency, low motor activities, etc. Complementary to these factors are the problems appearing in the implementation of the national healthcare reform system. These unpleasant processes are deepening in moment, when the state can not afford to increase subsidies for the healthcare. On account of the low purchase ability, the majority of the Roma and Turkish minority households can not afford to pay healthcare services and medicaments. The poverty among people from Roma and Turkish background appears to be an additional obstacle for delivery of the necessary healthcare services and for their social adaptation.¹

The health status of Roma community in Bulgaria is significantly lower than the one of majority Bulgarian population. For example, the national figures show that the life expectancy of Roma is 10 years shorter than the one of ethnic Bulgarians. Several surveys carried out by OSI – Sofia, World Health Organization, World Bank, Amalipe and others reveal serious problems that deteriorate the health status of Roma.

In addition, the health care service provision in Roma community at grass-root level also meets serious problems, especially in the rural areas (in which live around 66% of Roma in Bulgaria), as

¹ Health strategy for socially excluded people belonging to ethnic minorities.

well as, in the biggest Roma city neighborhoods (ghettos). The insufficient number of GP practices in Roma populated areas limits the chances of Roma to receive permanent health care close to their places of living: for example, in some villages mainly populated by Roma, the GP works two days a week, etc. Discrimination against Roma is a frequent occasion among medical staff. In addition, since many Roma do not have health insurances, they could not use health care services except in emergency cases.

There are some policy developments for addressing Roma health issues. For example, in 2005 Bulgarian government adopted Health Strategy for Integration of disadvantaged Persons belonging to Vulnerable Ethnic Minorities. All general integration documents, such as: the Framework Program for Integration of Roma in Bulgarian Society, the Action Plan for the Decade of Roma Inclusion, as well as, the newly adopted National Strategy for Roma Integration²) contain Health care chapter. Nevertheless, as a whole, the policy attention to ensuring equal access of Roma to health care remains low. Although certain improvement in this direction was achieved in 2011 (owing to, among others, the activeness of Amalipe and other Roma NGOs) health care is still weak part of the entire policy for Roma integration. The implementation of the documents listed above is close to zero: there is clear lack of proper financial and administrative backup, as well as, lack of mechanisms for participation of Roma community and civil society in implementing the documents for Roma integration. As a result, the activities directed at improving the health status of Roma are implemented only formally or not implemented at all.³

² Approved by the Council of Ministers on 21.12.2011.

³ In July 27, 2011 Action Plan for Implementation of the Health Strategy 2011 – 2014 was approved by the Council of Ministers. It was financially backed up with 5 mln BGN that was a strongly positive fact. At the same time, the Plan was not consulted in advance with Roma NGOs, it does not contain any mechanisms for monitoring and evaluation. It is too early to judge whether the Action Plan will significantly change the implementation of the Health Strategy. Nevertheless, activities for community monitoring and advocacy will facilitate it.

One of the main reasons for this is the lack of proper monitoring and evaluation (M&E). Until now the “official” M&E of all Roma integration policy (including the one in health field) is carried out within the frames of the so-called “administrative monitoring” that means it is done by the same institutions that should implement the activities. Roma community is engaged in no way in this process. There is clear need of introducing different approach for M&E that allows Roma community to be active part in the process.

Finally, Roma people’s concern / awareness and initiative in health at present is low, especially at grass-root level. The big majority of Roma lacks knowledge about their rights and obligations in health field: the experience from the project implementation in 2011 showed that even middle-class Roma lack such a knowledge. As a result Roma are not aware what kind of health services they should receive and with what quality. They are also unaware of many aspects of the recommendable health condition checks, e.g. vaccination transmittable diseases, child nutrition related, identification and care-seeking for health related problems, etc. This limits the opportunities for community monitoring and advocacy, as well as, for improving the quality of health care provision in this way.

Having in mind all these challenges, in 2011 Center Amalipe implemented the project “Community Monitoring for Health Care Services in Roma Community: Strengthening Community Mobilization and Advocacy” supported by Open Society Institute – New York. Its overall purpose was to introduce community monitoring of the health care services among Roma and other vulnerable ethnic groups in Bulgaria in order to strengthen bottom up advocacy which will enable local communities to engage in policy and governance processes at local level, improve health service delivery and improve health outcomes in the long run.

Essential part of the project was to introduce community based monitoring following the method of “community inquiry” developed by professor Abhijit Das from the Public Health Institute in India. The present report presents the main stages, findings and conclusions from the two stages of the community inquiry carried out in 2011.

Another important part of the project was to introduce proper mechanisms at grass-root level for carrying out community based monitoring, as well as, for strengthening community mobilization and self-organization. This part appeared as important as the inquiry itself since community monitoring could not be reduced to sociological / demoscophic survey but it is a means by which community takes ownership of the process. That is why within the project we established structures on two levels for supporting the community monitoring implementation:

- In every pilot community, Local club for community development was formed: this was a volunteer club that brought together young people, women, informal leaders to discuss certain community issues and together with the community moderator to implement volunteer activities on community interest;
- Community Support Centers were formed at municipal level: municipal coordinators worked in them in order to coordinate and support the activities of the Local clubs for community development.

These structures proved to be the efficient framework for implementing the community inquiry and the activities for improving the health care services delivery at grass-root level.

The current two-stage research was conducted by Center “Ama-lipe” project team and by volunteers from the villages of Varbovka and Batak from Pavlikeni municipality, and villages of Balvan and Vodoley from Veliko Tarnovo municipality. The report presented summarized respondent views, attitudes and evaluation of community access to primary health care, emergency and hospital medical care, as well as child and women’s healthcare; the report registers also the change in the parameters of the access to healthcare system as a result of the undertaken project intervention.

The report aims to illustrate the real situation and to evaluate the access to healthcare services that people from vulnerable ethnic groups have in the project areas, which subsequently will enable local communities to demand its further improvement in a long term perspective. The report contains basic information for the

project places, including the present situation of the local Roma community. Potential local human resources are identified and they express readiness for partnership when field work is foreseen.

The report answers questions related to the healthcare services access and formulates conclusions and recommendations that are necessary to initiate change in reliance to the existing practices of service delivery at national level.

As a final result of the report a proposal for conducting an advocacy campaign will be suggested to all interested parties, based on community allegations defending the right of having access to healthcare services.

Methodology used and work approach

1.1. Goals and objectives of the research

The main goal of the research is to evaluate the access of vulnerable ethnic communities to healthcare services in the project-settled geographic places using the method “Community inquiry”, thus allowing the development of effective strategies for improvement of the practices of the healthcare service delivery in a long term perspective.

Specific objectives of the research:

- To enquire about respondent views, attitudes and assessment in terms of the healthcare problems within their communities.
- To describe the real situation in the project places thus enabling the team to create opportunities for new strategy interventions within the community.
- To give a feedback to healthcare institutions at all levels in order to inform them about the necessity of developing and implementing new polices and working practices concerning vulnerable communities thus increasing the access and quality of healthcare.

Main tasks of the research:

- To develop a necessary methodology that includes approach justification, activity timeframe for conducting the field work and questionnaire for the respondents, as well as to set quantity and quality parameters of the research. In a special training targeted at municipal coordinators, community moderators and local activists from the project places a draft of questionnaire has been elaborated that contains questions mainly in the following three sectors – child healthcare, women’s healthcare and access to hospitalization. This determined the profile of the potential respon-

dents – *the team decided to conduct the inquiry only among women older than 18 years from the four project villages.*

- To conduct the field work (to process the inquiry) in the project places. *The first inquiry* was conducted within the period 26th of July – 2nd of August 2011. It was fulfilled by volunteers from the clubs for local development in the four villages, assisted by the project team and community moderators. The questionnaire refers mainly to quantity information; as the inquiry forms were standardized, the questions were of closed type and respondents could choose answers from several options. The position of the respondents for each question is coming out directly as a result. The data analysis from the first inquiry was systemized in August – September’;
- Activities for improving the access to health services in the four project places: on the basis of the first inquiry, the local clubs for community development, community moderators and the project team conducted out an information campaign “Health to everybody”, as well as advocacy activities before the local and regional institutions responsible for provision and monitoring of health services.
- *The second inquiry of respondents* was conducted within the period 14–18th November 2011, using the same methodology and inquiry form. The data analysis of the second inquiry and the comparison with the first one were conducted in December 2011.

1.2. Methodology of the research

In the current research we applied mainly quantity methods. For the purposes of **quantity research** at the first stage of the inquiry the team collected and processed totally 515 standardized questionnaires, and at the second stage – 500 question forms.

The standardized **question forms** were filled in by the volunteers when conducting the inquiry with the respondents. About 50 local volunteers were recruited for the two-stage inquiry, and the number of the respondents in the project places is as follows:

First stage Project place	Number of respondents	Second stage Project place	Number of respondents
Village of Varbovka	310	Village of Varbovka	297
Village of Vodoley	66	Village of Vodoley	62
Village of Batak	120	Village of Batak	124
Village of Balvan	19	Village of Balvan	17

The total number of respondents – 515 in the first stage and 500 in the second stage, comparatively related to the total number of inhabitants in the four villages and particularly related to the number of women older than 18 years, is sufficient for the inquiry validity.

This type of question form had the purpose not only to register the respective answers but also to check the extent to which the respondents understand the questions and can answer them adequately. All question forms are anonymous.

The received quantity data from the two-stage research is codified by the project team and is presented in the report under chart graphic.

1.3. Hypotheses of the research

- The high rate of unemployment and poverty in the project places determines high rate of people lacking health insurance;
- The people lacking health insurance have no access to free prophylactic medical and dental examinations;
- People can not pay the costs for medicaments;
- The paid medical services are too expensive for the respondents;
- Concentrated on their survival, the community is unable to care for themselves at all;
- The poverty determines high rate of people who try self-care;
- High rate of insured women who have not visited gynecologist for a long period of time;
- Pregnant uninsured women are lacking care during the pregnancy.

1.4. The research team

The current research has been conducted by the following team members:

- Lyubomir Lazarov – project coordinator
- Anka Andreeva – project assistant
- Tanya Andreeva – municipal coordinator from Veliko Turnovo Municipality
- Valentin Vassilev – municipal coordinator from Pavlikeni Municipality

The research project team expresses its gratitude to all local activists and volunteers from the local clubs for community development in the four project places for their active participation and contribution to the research. We express also our gratitude to Teodora Krumova, Deyan Kolev and Yavor Hristov for their unconditional support and for the provided technical assistance. Special gratitude to prof. Abhijit Das and Sunita Singh from the Institute for Public Health in India and to Erin Howe from the Open Society Institute – New York for the theoretical materials provided and for the serious methodological support to the project.

II. CHAPTER

Basic information about the project places

2.1. General characteristic of Veliko Tarnovo and Pavlikeni Municipalities

The project settlements are from two neighboring Municipalities. These are the villages of Balvan and Vodoley in Veliko Tarnovo Municipality and the villages of Batak and Varbovka in Pavlikeni Municipality.

The Municipality of Veliko Tarnovo (that includes the project target places, the villages of Balvan and Vodoley) is situated in the region of Central North Bulgaria and it falls within the administrative borders of District of Veliko Tarnovo. The town of Veliko Tarnovo is situated at equal distance from the biggest towns of the country – Sofia, Plovdiv, Varna and Burgas. The Municipality of Veliko Tarnovo is the biggest Municipality within the District and it spreads over 885 sq. km. The Municipality of Veliko Tarnovo is situated in the south of the District of Veliko Tarnovo, and in terms of territorial & administrative jurisdiction it has borders with the following Municipalities – Pavlikeni, Polski Trambesh, Lyaskovets, Gorna Oryahovitsa, Zlataritsa, Elena, Gurkovo, Tryavna, Dryanovo, Sevlievo.

According to the last census from 2011, the inhabitants of Veliko Tarnovo Municipality are 88 670 people. The Municipality includes 3 towns and 74 villages.

The Municipality of Pavlikeni (that includes the project target places, the villages of Batak and Varbovka) is situated in Central North Bulgaria and it represents tertiary type of municipality. It occupies the west central part of the District of Veliko Tarnovo and it has as its borders the Municipalities of Veliko Tarnovo, Svishtov, Polski Trambesh, Sevlievo, Suhindol and Levski. It spreads over

622,569 sq. km, which is 13.1% of the total District territory. The town is an important railway center serving the Sofia – Varna railway route. The road network connects the town with other residential areas: Veliko Tarnovo, Sevlievo, Pleven, Svishtov, Polski Trambesh and Rousse.

According to the last census in 2011 the inhabitants of Pavlikeni Municipality are 23 869 people. The Municipality consists of 2 towns and 18 villages.

2.2. Cards of the project places

The “cards” of the project places have been prepared on the basis of the information collected by means of two small inquiries conducted at the beginning of the project; the “cards” give a wider picture of the characteristics of the local communities, their problems, their incomes, as well as their readiness to delegate rights to the community leaders in local problems solving and taking steps to improve standard of living. The collected information will continue to be updated but at this stage it is handful enough for this report purposes.

Village of Balvan, Municipality of Veliko Tarnovo

- **Inhabitants** – there live around 700 people, 20% determine themselves as millet – Muslims, who celebrate Muslim Kurban Bayram and Sheker Bayram, and also celebrate some Christian Roma feasts like Ederlezi, Easter, Bango Vasili, etc. In the village there are a few Roma – about 10% of the total population – mainly woodworkers who are settled and some Turkish Roma.
- **Neighborhoods** – people from the ethnic minorities in Balvan village live dispersed among the majority settlers and do not have their own neighborhoods.
- **The main three problems for the people of Balvan** – the main problem is unemployment. According to what local people say, the early marriages are not a problem. Most of the teenagers are independent and more responsible because their parents are abroad.

- **Spoken language at home** – the millet community speaks Turkish, Roma woodworkers speak Romani.
- **Community representativeness at the local authority institutions** – there are no minority representatives, but people want to have such ones in the Municipality Hall, as well as at the local school, apart from cleaners.
- **Educational status, local school conditions** – most of the people have primary school education, there are a few with secondary school education. The local school educates 70 kids, 5% are from the ethnic minorities. There are no drop outs. After the regular classes, students attend the established crisis center “Open your eyes” with administrator Rumyana Hristova who is a primary school teacher. The centre is equipped with computers, tables and chairs for the youngest students, and there are separate rooms equipped with sports facilities. Several times per month healthcare lectures are presented to the youngsters. After finishing primary education, pupils continue studying in Veliko Tarnovo or Sevlievo. Students enrolled at secondary schools outside the village are 6.
- **Incomes** – the lack of incomes forced many families to look for a job abroad, mainly in Belgium, Italy and Germany. Men are working mainly in construction, and women as cleaners. As mentioned above, the kids are independent, most of them stay with the grandparents, and in case the whole family immigrates, the houses remain empty. Only 10 persons are registered at the Labor Office and are due to receive social care subsidies.
- **People to trust when defending their interest** – the community considers Tanya Andreeva as trustworthy.

Village of Vodoley, Municipality of Veliko Tarnovo

- **Inhabitants** – there live around 800 people, half of them identify themselves as millet Muslim Roma. They celebrate Muslim and Christian traditions.
- **Neighborhoods** – the village has 2 Roma neighborhoods but they are not isolated, which does not allow difference in the access to infrastructure. People possess high sense of identity and they are not divided in different groups.

- **The main three problems for the people of Vodoley** – unemployment is the main problem for the community, even though people are hardworking and responsible. The other two problems are poor or no access to healthcare and to social care benefits. The problem with early marriages is also reported.
- **Spoken language at home** – people speak mainly Romani, Turkish and Bulgarian.
- **Community representativeness at the local authority institutions** – there are no recruited Roma in local institutions, and people who take on the responsibility to talk about the community problems. Many Roma people had a wish that more Roma are employed at the local administration.
- **Educational status, local school conditions** – the village has satisfactory number of secondary school graduates, there is one university graduate, but even people with education can hardly get a job. The village has a primary school with 90 pupils and it is 100% Roma. The percentage of drop out is very low. The few drop outs are students who have migrated once with their families but when they come back without the necessary certification they are forced to repeat the same grade. The local school intends to work with the parents in order to guarantee their involvement thus open classes are delivered for them. Once the primary education is over, pupils go to study mainly in Veliko Tarnovo. There are 4 pupils who study in village of Borush.
- **Incomes** – the unemployment rate is high. People who have permanent jobs and receive regularly salaries are very few. There are 30 people registered at the Labor Office. Some people make their living by collecting herbs. Usually, young families are working abroad, while elderlies look after the kids. Preferred destinations for immigration are Greece, Portugal, Germany and the Netherland.
- **People to trust when defending their interest** – Angel Yankov is highly educated and though his education makes him suitable for representing the local community, people refuse to rely on him.

Village of Batak, Municipality of Pavlikeni

- **Inhabitants** – there live around 1000 people, half of them identify themselves as millet Muslims and a few identify themselves as Turkish Roma. They celebrate Muslim, as well as, Christian traditions.
- **Neighborhoods** – there is a segregated Roma neighborhood divided in two smaller ones both of which are in the village borders. Hence, there is no difference in the access to infrastructure.
- **The main three problems for the people of Batak** – the unemployment is the hardest problem. No more than 10 people are registered at the Labor Office. The issue of early marriages exists as well.
- **Spoken language at home** – the community speaks Romani, Turkish and Bulgarian.
- **Community representation at the local authority institutions** – there are no employed community members
- **Educational status, local school conditions** – the majority are primary and secondary school graduates. The local school is almost 100% segregated. As per data, 79 pupils are minority children and one child is Bulgarian. The school does not offer any extra-curricular classes. The percentage of the dropouts is very low. Once the primary education is over pupils continue their study in Pavlikeni. The percentage of pupils who enroll in secondary school is about 80%.
- **Incomes** – only a small number of people are permanently employed. The majority of people are working in the agriculture cultivating rose plant seeds and sapling fruit trees. People are working in small private firms as well. Local services are well developed. As everywhere, here the immigration processes are frequent occurrence and main destinations are Greece and Germany.
- **People to trust when defending their interest** – within the community, people find Valentin Vassilev a trustworthy person.

Village of Varbovka, Municipality of Pavlikeni

- **Inhabitants** – there live around 1300 people, half of them identify themselves as millet and nearly 10% as Kalderash Roma. The village celebrates all traditions.
- **Neighborhoods** – there are 2 neighborhoods – Turkish and Roma and both neighborhoods are within the borders of the village. People have common sense of community belonging. Mixed marriages can be seen among local Roma and Roma from other places.
- **The main three problems for the people of Varbovka** – the unemployment, the poor quality of healthcare services and the problems with the newcomers from other places are the basic problems encountered.
- **Spoken language at home** – people speak mainly Turkish and Bulgarian and Romani and Bulgarian.
- **Community representation at the local authority** – there is one Roma who works at the village Municipality Hall – Zlatan Iliev but people want to have more representatives within the local administration. The Mayor of the village is also Roma and he is an undoubted leader who supports the activities of the local Club for community development.
- **Educational status, local school conditions** – the majority of the population under 50 years of age has primary and secondary education. There are 5 persons who have university degrees. The local school has 180 students and they are dominantly from Roma background. The school does not work with parents and it does not provide any extracurricular school activities. A few problems with dropouts can be seen, mainly because of economic reasons.
- **Incomes** – the high unemployment rate is the main reason for the intensive immigration abroad, mainly to Germany and the Netherlands. People who remain collect herbs and work in small private firms. There are 15 people registered in the Labor office.
- **People to trust when defending their interest** – the community is ready to delegate representative responsibilities to the Mayor Anton Antonov, and also to Radoslav Rozinov, Aleksandar Asenov and Zlatan Iliev.

2.3. Conditions of the health care system in Veliko Tarnovo District (according to data of RHIF – Regional Health Insurance Fund – Veliko Tarnovo)

A. Primary off hospital medical care

Primary off hospital medical care is being delivered in dispensaries – individual and group practices for medical and dental care which for the District of Veliko Tarnovo are marked in Table 1.

Individual practices are dominant trend in the healthcare service provision. This practise is applied by about 70% of the GP doctors and dentists (122 GP doctors reported activities for 2010). There is a tendency to increase the number of group practices. Their greatest number is reported in Veliko Tarnovo Municipality – 9 group practices for IMA where 56 GP doctors are working. This provides opportunity for 24-hour service delivery including the emergency aid services.

Table 1. *Healthcare institutions for Primary medical care in District of Veliko Tarnovo up to 31.12.2010*

Type of healthcare institution	2010	2009	2008	2007	2006
Individual practices medical aid	150	150	151	149	157
Individual practices dental aid	183	180	180	188	187
Group practices medical aid	17	16	14	14	14
Group practices dental aid	12	12	10	7	6

The District reported number of GP doctors and dentists who work in the health centers for primary outpatient medical and dentist care exceeds the determined by the **National Health Care Map (NHCM)** (see Table 2), but there should be considered the fact that part of the registered doctors do not run activities or they work

mainly in the hospitalized and emergency medical care system thus their involvement in the primary outpatient medical care system is minimal. The number of registered GP doctors is lower than the number allowed for the District only in the municipalities of Elena and Strazhitsa. The distribution of dentists is disproportional. These are mainly concentrated in the two municipal centers – Veliko Tarnovo and Gorna Oryahovitsa and for the rest of the municipalities their number is lower than the one predetermined by the NHCM.

Table 2. *Healthcare institutions for primary off hospital medical and dental care distributed among municipalities in District of Veliko Tarnovo in 2010*

Municipality	Number according to the NHCM		Number of the persons registered in the regional center for healthcare			
			In individual practices		In group practices	
	Doctors	Dentists	Doctors	Dentists	Doctors	Dentists
1. Municipality of Veliko Tarnovo	47	61	32	80	46	28
Including in towns	35	50	27	76	42	28
in villages	12	11	5	4	4	-
2. Municipality of Gorna Oryahovitsa	31	36	31	39	4	-
Including in towns	21	28	25	37	4	-
in villages	10	8	6	2	-	-
3. Municipality of Elena	10	9	8	6	-	-
Including in towns	5	6	7	6	-	-
in villages	5	3	1	-	-	-
4. Municipality of Zlataritsa	4	4	5	2	-	-
Including in towns	2	3	3	2	-	-
in villages	2	1	2	-	-	-
5. Municipality of Lyaskovets	9	11	7	8	2	2
Including in towns	4	6	3	8	2	2
in villages	5	5	4	-	-	-
6. Municipality of Pavlikeni	19	21	21	14	2	2
Including in towns	9	11	15	13	2	2
in villages	10	10	6	1	-	-
7. Municipality of Polski Trambesh	12	13	11	9	-	-
Including in towns	4	5	4	5	-	-
in villages	8	8	7	4	-	-

8. Municipality of Svishtov	29	31	30	16	2	4
Including in towns	17	19	19	15	2	4
in villages	12	12	11	1	-	-
9. Municipality of Strazhitsa	12	12	9	4	-	-
Including in towns	4	6	5	3	-	-
in villages	8	6	4	1	-	-
10. Municipality of Suhindol	2	3	2	1	2	-
Including in towns	2	3	2	1	2	-
in villages	-	-	-	-	-	-
11. District of Veliko Tarnovo	175	201	156	179	58	36
Including in towns	103	137	110	166	54	36
in villages	72	64	46	13	4	-

According to data of the Regional Health Insurance Fund, 74 GPs have specialized in “General medicine”, 48 doctors are enrolled in the specialization “General medicine”. The total number of GP doctors (entitled to work as such) at the District territory is **195**, which means that 37% have specialty “General medicine”, 25% are enrolled. 27 doctors have specialty “Internal diseases” and “Pediatrics”. The physicians who have not enrolled in the specialization “General medicine” and have not specialized in any of the two options (“Internal diseases” or “Pediatrics”) are **46**. 30 doctors are not working as such.

Conclusions: As a general trend, concentration of GPs in big inhabited places is observed – the municipality centers where the vast majority of these doctors are chosen by patients who live in faraway villages situated at a large distance. This hampers the provision of prompt medical aid services to patients from villages in a way that these patients face more difficulties approaching the doctors than the town inhabitants. Examples can be given with the municipalities of Elena and Strazhitsa and with the municipality of Svishtov where GP doctors live in the town centers and they visit villages only according to established schedules.

B. Specialized outpatient medical care

The specialized outpatient medical care delivery in the District is carried out by 284 healthcare institutions:

- 217 ambulatories (individual and group practices) for SMDC - specialized medical and dentist care;
- 26 medical centers; 1 dental center;
- 2 DCC-diagnostic consultative centers;
- 38 medico-diagnostic and medico technical labs.

Table 3. *Healthcare institutions for specialized off hospital medical care according to their type*

Type of the healthcare institution	2010	2009	2008	2007
IPSMC individual practice for specialized medical care	214	217	215	219
IPSDC individual practice for specialized dental care	2	2	2	3
GPSMC group practice for specialized medical care	1	1	1	1
GPSDC group practice for specialized dental care	-	-	-	-
MC Medical centre	26	23	23	25
MDC Medical dental centre	-	-	-	-
DCC Diagnostic consultative centre	2	2	2	2
DC Dental center	1	1	1	1
SMDL specialized medical diagnostic lab	19	18	17	18
MTL pecialized medical and technical lab	19	19	18	18

Table 4. *Healthcare institutions for specialized outpatient care distributed among municipalities toward 31.12.2010*

Municipality	IPSMC	IPSDC	GPSMC	MC	MDC	DCC	DC	SMDL	SMTL	hospices
Veliko Tarnovo	79	2	1	14	–	1	1	9	10	2
Gorna Oryahovitsa	60	–	–	2	–	1	–	5	4	–
Elena	5	–	–	1	–	–	–	–	–	1
Zlataritsa	–	–	–	–	–	–	–	–	–	–
Lyaskovets	1	–	–	1	–	–	–	–	1	–
Pavlikeni	14	–	–	4	–	–	–	3	1	1
Polski Trambesh	11	–	–	–	–	–	–	–	1	–
Svishtov	41	–	–	4	–	–	–	2	2	1
Strazhitsa	3	–	–	–	–	–	–	–	–	–
Suhindol	–	–	–	–	–	–	–	–	–	–
District:	214	2	1	26	–	2	1	19	19	5

Conclusions: About 90% of the healthcare institutions for specialized aid are located mainly in the three biggest municipalities of the District of Veliko Tarnovo (Veliko Tarnovo, Gorna Oryahovitsa and Svishtov) where the three biggest hospitals are situated (see table 4).

According to the NHCM, the minimal number of contracted by the NHIF – *National Health Insurance Fund* specialists (excluding the paraclinical specialties) is 149, while the signed in 2008 contracts with IPSMC are 361, in 2009 these are 377, and in 2010 their number is 364. The data shows that for the most of the specialties the number of the contracted NHIF specialists is higher than the minimal one according to the NHCM. Exceptions are the specialties “Allergology” where the execution of the *Health desk* is 100%, “Internal diseases” – 93%, “Anesthesiology” – 57.1%, and for the specialty “Clinical toxicology” no contract has been signed.

C. Hospital health care

The hospital medical care in the District has been delivered by the following healthcare institutions:

- 6 Multifunctional hospitals for an active healthcare – **MPHAT**-public property:

MPDHAT “Doctor Stefan Cherkeзов”, Ltd., Veliko Tarnovo – a District hospital which delivers services to the District of Veliko Tarnovo – total population of 271 400 people.

MPHAT “St. Ivan Rilski”, Gorna Oryahovitsa – a Municipal hospital which delivers services directly to the municipalities of Gorna Oryahovitsa, Lyaskovets and Strazhitsa – total population of 75 974 people.

MPHAT “Doctor D. Mollov”, Elena – a Regional hospital which delivers services both to municipalities of Elena and Zlataritsa – total population of 14 829 people.

MPHAT, Pavlikeni – a Regional hospital which delivers services both to municipalities of Pavlikeni and Suhindol – total population of 28 884 people.

MPHAT “Doctor M. Minkovski”, Polski Trambesh – a Regional hospital which delivers services to the municipality of Polski Trambesh – total population of 14 920 people. Since 01.03.2010, the hospital has been closed.

MPHAT “Doctor D. Pavlovich”, Svishtov – a Regional hospital which delivers services to the municipality of Svishtov – total population of 48 351 people.

- 2 specialized hospitals – state property

State psychiatric hospital – Tserova Koria – delivers services mainly to patients from the region but it accepts also patients from other districts.

“Specialized hospitals for rehabilitation – National Complex” Ltd., branch Ovcha mogila – it is not regional but accepts patients from all over Bulgaria.

- 1 specialized private hospital

SHAT – Specialized Hospital for Active **Cardiology** Treatment – **Veliko Tarnovo** – it is not regional but accepts patients from District of Veliko Tarnovo and neighboring districts (Gabrovo and Targovishte).

- 4 dispensaries which were re inscribed at the end of 2010 in compliance with the §70 of final Law amendment and criterion for the healthcare institutions.

DDODS – Veliko Tarnovo with interdistrict functions serves the District of Veliko Tarnovo and the District of Gabrovo, it delivers services to a total number of 399 150 people. Since 06.01.2011, it is reinscribed as “General oncologic centre” Ltd. – Veliko Tarnovo.

DDPDS – Veliko Tarnovo with regional functions serves the District of Veliko Tarnovo, it provides services to a total number of 271 400 people. Since 20.12.2010 it is re inscribed as “Centre for psychiatric health – Veliko Tarnovo”, Ltd.

DDPPDS – Veliko Tarnovo with regional functions serves the District of Veliko Tarnovo, it provides services to a total number of 271 400 people. Since 28.12.2010, it is reinscribed as SHAT – Specialized Hospital for Active Treatment of pneumo-physiatriac diseases “Doctor Trayman”Ltd.”

DDDVDS – Veliko Tarnovo with regional functions serves the district of Veliko Tarnovo, it provides services to a total number of 271 400 people. Since 15.12.2010 it is newly registered as “Centre for dermatological and venereal diseases – Veliko Tarnovo” Ltd.

The opening of the private cardiologic hospital in 2008 increased the number of healthcare institutions with hospital beds from 12 to 13 (6 MPHAT- *Multi-profiled hospitals for active treatment*, 3 specialized hospitals – 1 private and 4 dispensaries). In 2009 the cardiologic hospital increased its beds from 34 to 52. In 2010, with the modifications of the Healthcare Institutions Law and the introduced reform in the hospitalized aid system, the number of the beds, as well as the number of the hospitals in the District was reduced in fact. All hospitals and dispensaries in the District have been reinscribed according to the requirements of the Law for the healthcare institutions, except the hospital in Polski Trambesh,

Table. 5. *Healthcare institutions as to 31.12.2010*

Type of healthcare institutions	2010		2009		2008	
	Number	Beds	Number	Beds	Number	Beds
Healthcare institutions for hospital care – all	12	1688	13	1885	13	1867
Public healthcare institutions	11	1634	12	1833	12	1833

Multi-profiled hospitals	6	1033	6	1142	6	1142
MPDHAT – Veliko Tarnovo	1	395	1	395	1	395
MPHAT – Gorna Oryahovitsa	1	274	1	274	1	284
MPHAT – Elena	1	64	1	64	1	54
MPHAT – Pavlikeni	1	110	1	150	1	150
MPHAT – Polski Trambesh			1	50	1	50
MPHAT – Svishtov	1	140	1	209	1	209
Specialized hospitals	1	160	1	160	1	160
SHAT - Specialized hospital for active treatment						
SHCCT - Specialized hospital for cure and continuous treatment						
SHCCTR - Specialized hospital for cure, continuous treatment and rehabilitation	1	160	1	160	1	160
SHR - Specialized hospital for rehabilitation						
Dispensaries – former	4	351	4	381	4	381
For pneumo-phtisiatic diseases	1	50	1	75	1	75
For dermatological and venereal diseases	1	10	1	15	1	15
For oncologic diseases	1	206	1	206	1	206
For psychiatric diseases	1	85	1	85	1	85
Psychiatric hospitals	1	140	1	150	1	150
Private health institutions	1	54	1	52	1	34
Multi-profile hospitals						
Multi-profile hospitals for active treatment						
Specialized hospitals	1	54	1	52	1	34
SHAT - Specialized hospitals for active treatment	1	54	1	52	1	34
SHCCT - Specialized hospitals for cure and continuous treatment						
SHCCTR - Specialized hospitals for cure, continuous treatment and rehabilitation						
SHR - Specialized hospital for rehabilitation						

Conclusions: The general conclusion is: The multi-profile hospitals for active treatment deliver services tailored to the needs of population but for its further optimization is necessary to introduce an internal restructuring, effective management and a financial control.

The hospitals deliver traditional treatment to patients who need hospitalization but very often hospitals fulfill additional functions which consumes their financial resources. Some healthcare institutions carry out social functions, such as taking care of incurable patients, long term medical care, continuing rehabilitation, to make up for the lack of the District HCCTR – *Hospital for cure, continuous treatment and rehabilitation*.

D. Emergency health care

The system of emergency medical aid in the District includes:

- **CEHC** – *Centre for emergency health care* Veliko Tarnovo with 7 opened branches: Gorna Oryahovitsa, Svishtov, Elena, Pavlikeni, Polski Trambesh, Strazhitsa, and RCC - regional consultative centre in Veliko Tarnovo. The total staff of the CEMA – *Centre for emergency medical aid* is 243 people – composed by 56 doctors and 84 people healthcare assistance staff. Only the branches in Veliko Tarnovo and Gorna Oryahovitsa have a reanimation team, the transport team is only one and it belongs to the branch of Veliko Tarnovo.
- **An emergency ward** incorporated within the structure of MPGHAT – *Multi-profile general hospital for an active treatment* Veliko Tarnovo. The emergency division staff consists of 34 people and it is composed of 7 doctors and 19 people healthcare assistance staff.
- The emergency aid in the District has available 20 sanitary motor vehicles (18 ambulances and 2 cars) which are in a good technical maintenance.

Indicator	2010	2009	2008
Ambulatory examinations	38 337	37 659	35 603
Fulfilled calls –of them	26 868	27 243	27 750
– for emergency aid	20 158	19 888	18 956
– for emergent medical aid	900	853	964
– for sanitary transport	6810	6502	7830
Served patients as per calls	20 738	20 345	19 504
Of them – number children 0-17 years	3434	3839	3046
– directed to hospitalization		8031	7444
Served patients – ambulatory examinations	38 337	*	*
Of them – number children 0-17 years	4173		
– directed to hospitalization	4238		
Staff – total number,	243	243	243
Of them – doctors	56	56	56
– medical auxiliary	75	75	76
– nurses	6	6	5
– midwives	3	3	3
Vehicles	20	21	23

In 2010 the number of the emergency calls is 26868, (the number is 27243 in 2009, 27750 in 2008, 27263 in 2007 and 28 270 in 2006), 75.02% out of them are for emergency aid (73.00% in 2009, 68.31% in 2008, 69.21% in 2007 and 68.86% in 2006), 3.34% for emergent aid (3.13% in 2009, 3.47% in 2008, 3.66% in 2007 and 4% in 2006) and 25.35% –for sanitary transport (23.87% in 2009, 28.22% in 2008, 27.13% in 2007 and 27.17% in 2006).

Activities of the emergency ward in the hospital

Ambulatory examinations for 2010 are 21103 (the number is 20617 in 2009 and 18911 in 2008). The number of children is 3961. The number of directed for hospitalization is 6701 (6757 in 2009 and 6204 in 2008)

The situation analysis, the system and the structures of functioning within the EMC – *Emergency Health Care* identifies many essential problems that should be solved.

* There is no statistic data from 2008 and 2009 reports.

The aim of providing clear definition of the emergency aid functions and responsibilities in the system is not fulfilled. The demand for medical aid in CEHC – *Centre for emergency health care* and in the Emergency ward increased because patients have difficulties accessing a GP. This is observed especially in the small and isolated settlements. For specific groups of population as people with no health insurances, people from ethnic minorities, vulnerable and socially disadvantaged, etc. the emergency aid system appears to be the most convenient and in some cases the only alternative for receiving a medical aid.

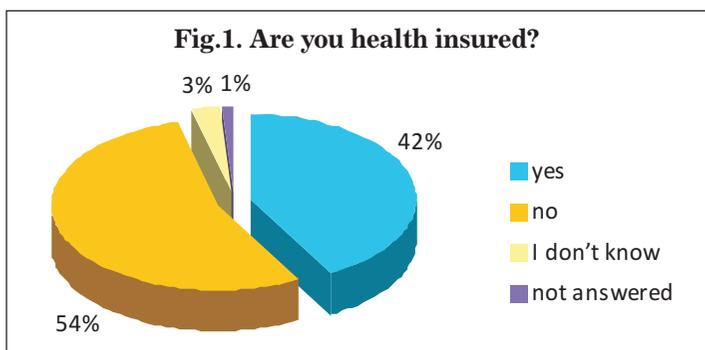
Results from the first stage of the research

3.1. Access to primary health care

The first block of questions from the question form for access to healthcare services in vulnerable ethnic communities has the purpose to reveal the health insurance status of respondents and their families and the consequences thereof; to give an idea of how people from the community communicate with local medical specialists and healthcare institutions, as well as to identify the possibilities of securing an individual and a family health insurance, treatment and prophylaxis.

As illustrated in the beginning of the report, the total number of inquired people was 515 women older than 18 years from the project places – the villages of Balvan, Vodoley, Batak and Varbovka.

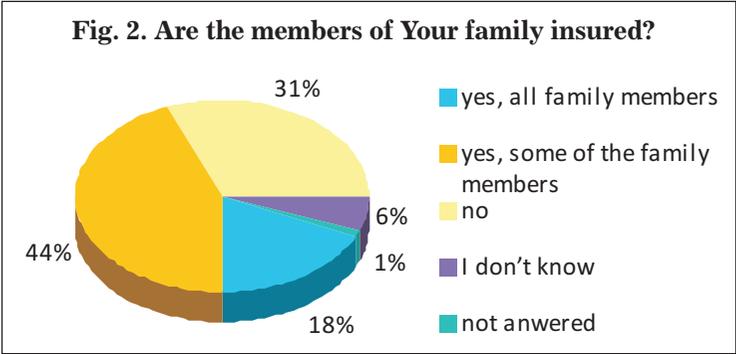
Fig.1. Pie chart demonstrates the respondent replies to the question “Do you have a health insurance?”.



More than the half of the respondents confess they are not permanently insured, and we can add to this result those respondents

who did not answer, as well as those who “do not know”. Also, a given percentage of the respondents who answered they are health insured at the moment might be unaware that they are not considered insured if they have not deposited any payments in the last 36 months. If we assume that this accounts for 10% of the respondents, we will get a *percentage of the health insured women older than 18 years in the project places between 54% and 70%*. Through the next questions we will try to determine this percentage.

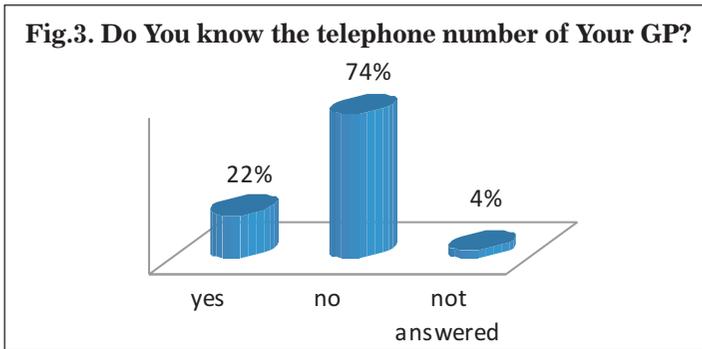
Almost the same picture can be observed when determining the health insurance status of the rest of the family members.



With answers as “yes, some” it is very possible that respondents had in mind the elder family members – retired ones who according to the Law are insured. As the graphic illustrates, the sum of the sure negative answers as “no”, “I do not know”, “not answered” is very discouraging – *almost 40% are health uninsured, so that the percentage of health uninsured persons at active age from the respondent families is too high.*

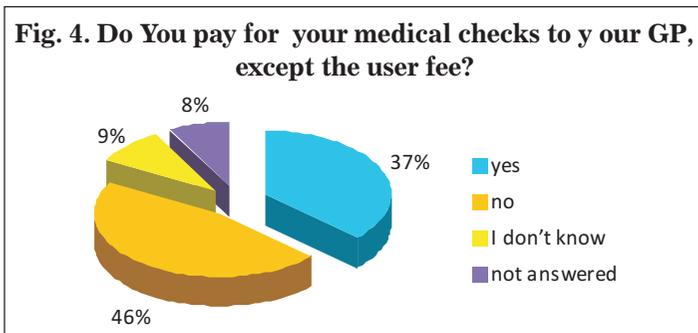
Almost all respondents are convinced that there is a health centre in their village but they do not answer so convincingly when we require information about their GP doctors. 83% of the respondents are sure they have a GP doctor, they know him and they are registered, while the remaining 17% honestly answer that they do not know at all if they have or do not have a GP doctor.

Worrying is the fact that a too big part of the respondents neither know their own nor their kids' GP phone number – see Fig. 3.



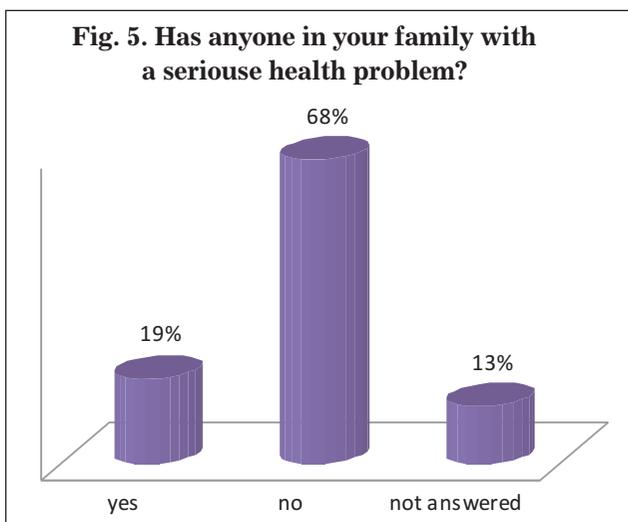
It is not clear what happens when people need a GP help out of the fixed working hours, even when *half of the respondents are informed that GP doctors are coming only twice per week in the project places for examinations and for delivery of primary medical care.* Another is the question what happens once they have phoned to require a GP doctor. *Barely 40% of the respondents answer that the GP doctor responds to patients' calls and provides aid.*

Fig. 4 presents a diagram which illustrates the percentage of those respondents who confess they pay for their examination when they visit the GP doctor. If we collect the percentages of those who answered “yes”, “I don't know” and “not answered”, we will get a result showing that *54% of respondents probably pay for a GP examination, except the user fee. This result represents the feasible*



percentage of health uninsured women above the age of 18 in the project places, i.e. in this case we cannot talk about the existence of corrupt practice.

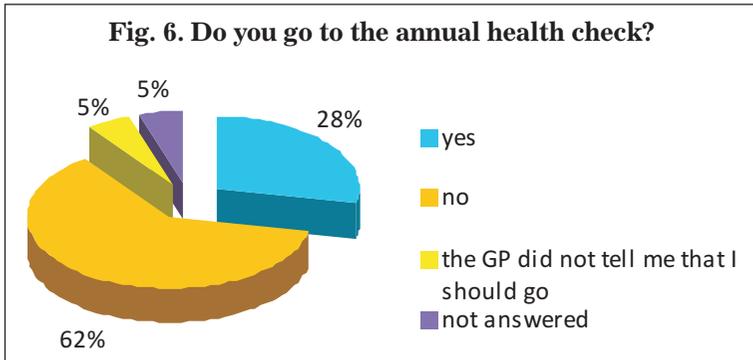
The self health evaluation and other family members' health evaluation within the Roma communities are often unreasonably increased. The respondent answers to this question do not make an exception. Often, under "ill" person they understand "a person confined to bed" and other conditions differing from that one are not considered serious. On the other hand, very often within the Roma communities it is not accepted to talk free about the ill family members. Having family members with serious, socially known diseases is considered to be a shame and no discussion on this topic is allowed – see the percentage of "not answered" on Fig. 5. In this case it will not be exaggerated to think that the lack of answer is a sign of presence of a sick person in the family.



The socio-economical changes in the transition period and the introduced reforms have deprived the Bulgarian citizens of one of the best achievements of the former system – the free of charge

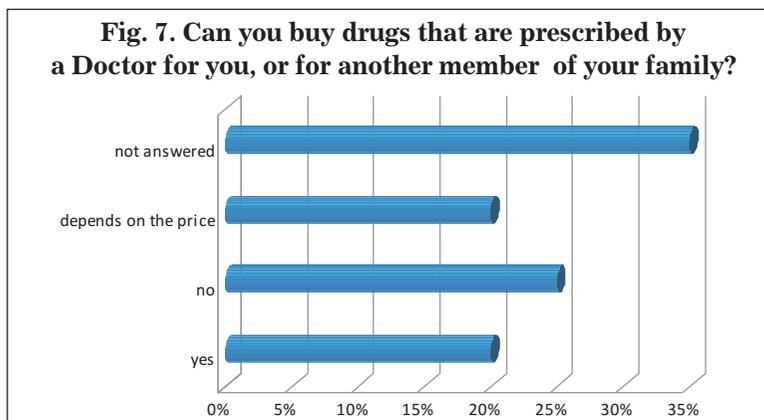
access to healthcare and the right of health examinations and prophylaxis. The former healthcare structures guaranteed workers and employees the access to obligatory prophylactic medical examination detecting in this way the early diagnosis of socially known diseases. With the beginning of the transition period firstly the Roma had lost their jobs and the individual healthcare assessment and examination have been left aside, *survival has become a main goal*.

The next graphic on Fig. 6 clearly describes the individual health care situation respectively describes respondent attitude toward the annual medical prophylactic examinations. 72% of the respondents confess they do not practice that. The reasons for that are many, and diverse and we consider paying them more attention in our recommendations.



The poverty among the Roma community is the main reason for the lack of medicament treatment of already detected and existing chronic diseases. For a large part of the population, especially for socially excluded people, retired and low income ones the prices of the medicines turn to be a barrier.

On Fig. 7 it is seen that a large part of respondents cannot afford themselves to buy medicines. The biggest here is the percentage of people who did not answer the question do they have the possibility to buy prescribed medicines for themselves or for other family members – 35%, probably because they are shy – a feature that is characteristic of many poor Roma.



This fact gives us grounds to believe that 60% of respondents cannot buy medicines. Even for those 20% of respondents to whom the price of the medicines is the determining one, we can not be sure they would buy prescribed medicines and would start an immediate medication if they find an accessible price, thus *80% of the respondents under one or another form declare impossibility afford to buy medications for themselves or family members.*

3.2. Access to emergency and hospital health care

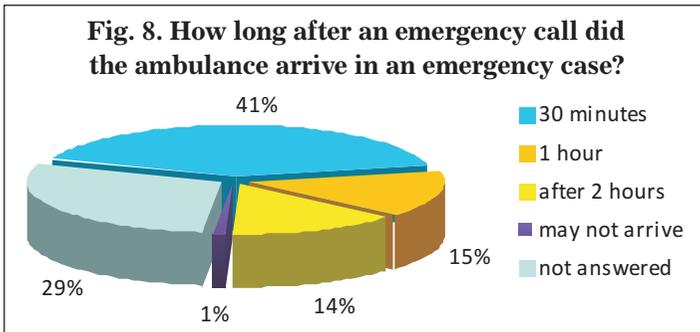
The second block of questions from the question form aims to find out how the local healthcare institutions react when there is an emergency call, what financial parameters determines the stay in the hospital, as well as what is the attitude of the medical staff in the hospital.

Because of the huge number of health uninsured persons in the project places, the emergency aid system appears to be almost the only alternative for receiving a medical aid⁴. That is why the respondents are so sensitive when talking about visible discrimina-

⁴ That is valid on national level as well: due to the high percentage of uninsured persons, for many groups of Roma, Turks, as well as for poor ethnic Bulgarians (especially in rural areas), the emergency aid system performs certain social functions.

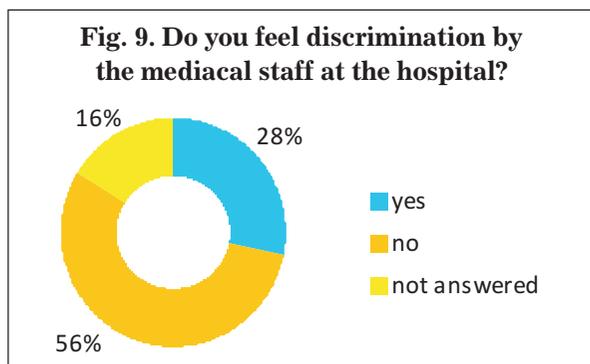
tion acts from the local divisions of emergency aid, considering the inadequate emergency reaction to local communities. Death cases of young people are reported to be caused by unjustified emergency aid delay.

On the diagram of Fig. 8 it is seen that in the most cases the emergency aid arrival takes from 30 minutes to an hour and we insist that this time of interval is not valid for the four project places. The worse is the emergency aid situation in the village of Varbovka where beside the answers “up to 30 minutes” and “up to one hour” we register 44% of answers as “after 2 hours”, “it may not come”, “I do not know”, and “not answered”. Actually, this is the village where the ambulance with the emergency aid was delayed and where the death cases were registered. The answers “up to one hour” are also unacceptable considering the parameters for contemporary emergency reaction, thus we can be sure that *in 59% of the cases the emergency aid does not react adequately*. This is a serious problem that should be addressed in an appropriate way to and before the corresponding healthcare institutions.



The general access to hospital care can be considered to be normal within the country indicated frame. Embarrassing is the fact that 28% of the people declared they have been victims of discrimination by the medical authorities in the hospital. Other 16% of the respondents did not answer, mostly to avoid the additional humiliation in front of interviewers, or in other words – *almost every second inquired woman older than 18 years who belongs to ethnic*

minority from the four project places, to one or another extent, has been exposed to discrimination by the hospital authorities – see fig. 9.



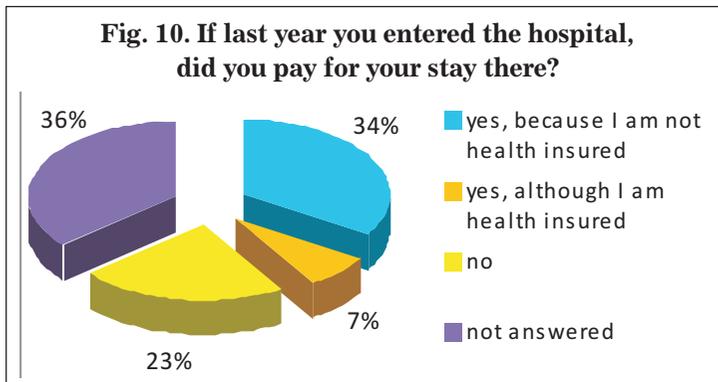
This rate is alarmingly high, especially taking into account that a lot of the discrimination acts are not perceived as such by the local Roma: for example, there is a common practice Roma mothers giving birth to be accommodated in separate “Gypsy” rooms, in which Bulgarian and Turkish women are not accommodated, this is not perceived as discrimination, but taken for given.

By the law determined requirement for stay in a hospital, *independently of the personal health insured status*, the patient should pay a hospital customer fee of 2% calculated on the minimal insured income and for a no longer period of 10 days in one calendar year. That means that after the ten days stay in the hospital the patient does not have to pay any longer. Even in case he is hospitalized for second time within the same calendar year, the patient is not required to pay a second hospital customer fee – it is enough to present the invoice from previous payment that proves the first 10 days stay in the hospital. Patients with particular diseases are listed apart and they are free from paying hospital customer fee.

We asked respondents have they paid for stay in a hospital in the last year. The results showed the following picture (Fig. 10).

- 34% of the respondents consider they paid for their stay in a hospital because they are health uninsured;

- 23% did not pay for their stay, probably because they have one of the listed diseases or because they are hospitalized for second time within the same calendar year;
- 36% of the respondents did not answer this question. Probably, these patients paid for their stay in a hospital but they are not convinced that it was correct or they are not aware of the procedures so that they preferred not to answer.
- Only 7% of the respondents declare they paid for the stay in a hospital although they are health insured. This is the real percentage of people who are informed about the rules of hospitalization.



These results illustrate the urgent need to inform local communities about the law prescriptions concerning the access to hospitalized aid.

3.3. Child healthcare

The third block of questions from the question form is related to the child healthcare. Services here seem to be better off, as far as children aged up to 18 are health insured by the state according the law and the GP doctors generally are taking care of sticking to immunization calendars.

In order to analyze the situation of the child healthcare in the project places we should clarify since the very beginning the following:

36% of the respondents declare they do not have children aged under 18 years, so that a subject of a child healthcare analysis has to be only that 64% of the respondents who have children within this age group, and these are totally 324 *mothers*.

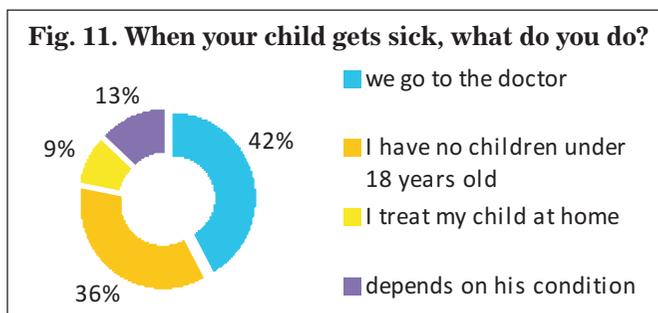
All respondents with children aged up to 18 years of age declare their children have a GP and they know his name.

In regard to the health situation of the children who are under 18, the picture is as follows:

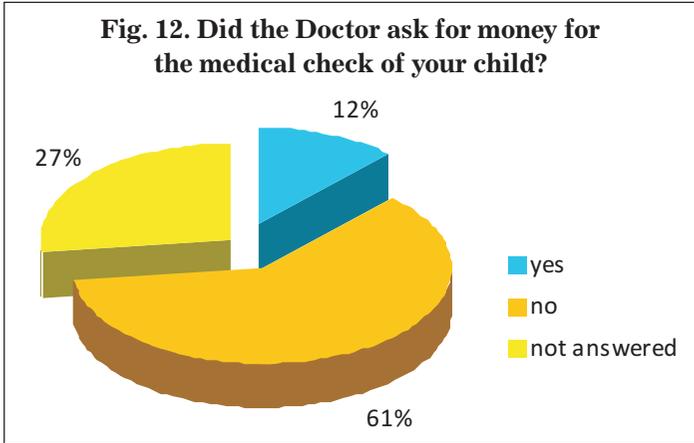
- 30% of the mother respondents announce their children are frequently ill;
- 14% of the mothers have chronically ill children;
- 73% of the mothers assure their children attend an annual prophylactic examination

When a child from a family is getting ill, usually the mother is taking it to the doctor but there are additional practices which cause worries.

A significant percent of mothers decide on their own what kind of treatment to undertake, depending on the child condition – see Fig. 11. Treatment is normal behavior for 14% of mothers.



GP doctors required money for children examination from 19% of the mothers or totally it makes 63 mothers. And once again, probably it is not about the regular user fee payment. This problem has to find its place within the project team advocacy activities in the nearest future – see Fig. 12.



40% of the mothers claim they have taken their children to preventive dental examination in general and at the same time almost all mothers unanimously confess their children have not attended dentist within the same calendar year and in the cases when this was necessary the services used to be paid. Only 8 kids utilized free of charge services within the same year and it used to be only one. At the same time from the replies of the question related to the number of the dental services free of charge becomes clear that the real percentage of children who did not attend dentist during the year is 63%, and the remaining 36% of the children used to visit a dentist not for a prophylactic examination but for a concrete problem, as the procedures only used to be paid. It appears that dental prophylaxis of children is strongly restricted.⁵

33% of the mothers consider their children are healthy nurtured in the kindergarten (school) and the opposite opinion share almost the same percentage of mothers – 30%; 36% declare their child is not attending school. As far as we know, this is about not attending a kindergarten and the related to this requirement to pay a fee which parents can not afford.

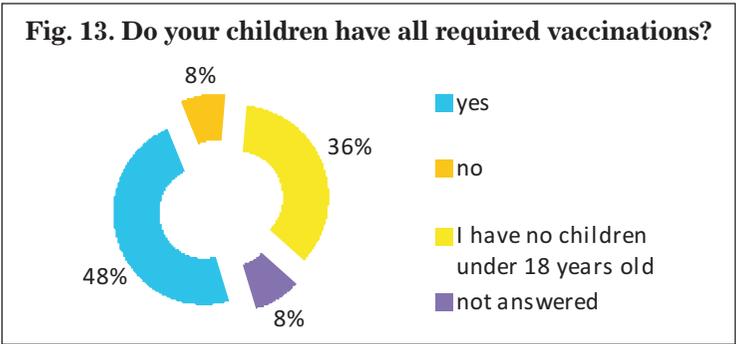
⁵ That is valid on national level also and regards not only the Roma, but also the poorer sections of the ethnic Bulgarians.

Nearly 80% of the mothers try to secure for their children a frequent consumption of meat, eggs, milk and dairy products, and this appears to be a problem by 16% of the mothers.

Embarrassing are also the answers of the mothers in reliance to the regular school attendance of the children; 37% declare their kids do not attend school regularly because of many different reasons.

Nearly 80% of the mothers claim their GP has informed them about the children immunization calendar, while another 11% of the mothers announce their GP is not doing that.

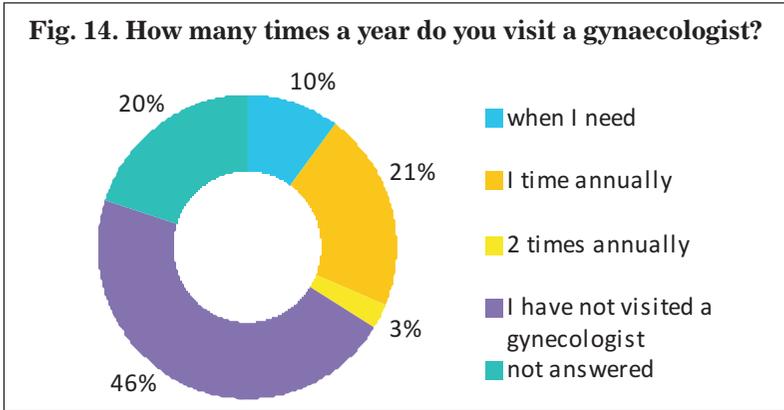
There is a direct link between the percent of the informed parents who see the necessity of the obligatory children immunization and the real percent of the immunized children. On Fig. 13 is shown the similar percentage of immunized children compared to that percentage among the parents who are informed by the GP doctor. The issue with the unimmunized children has to be addressed to the GP doctors in the project places, only after discussing and clarifying with parents the reasons for this lack of information.



3.4. Women healthcare

The last block of questions from the question form is related to the women healthcare problems. The importance of these issues within vulnerable ethnic communities determines the profile of potential respondents – women older than 18 years old.

The annual gynaecologic prophylaxis screenings are very important for the early detection of malformation and gynaecologic diseases among women which determines their effective treatment. Fig. 14 presents graphic that is answering the question how many times respondents attend gynecologist.

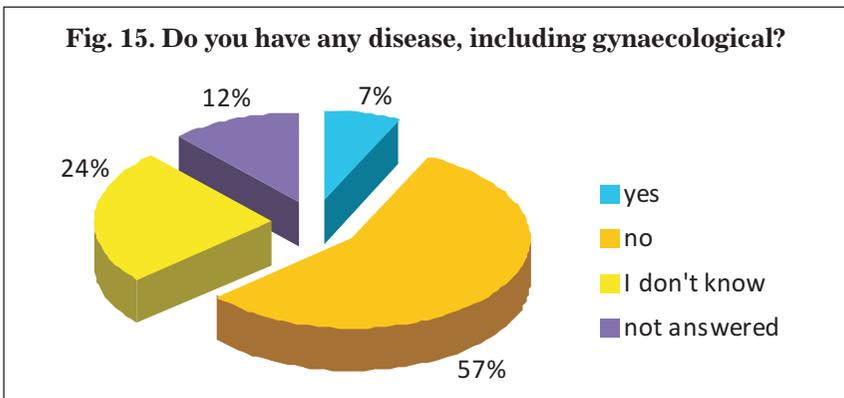


The graphic makes evident that *only 21% of the respondents are used to attending gynaecologic prophylactic screening at least once per year, even worse, 46% declare they did not attend a gynecologist in the last year, and 10% of the women attended gynaecologist only in case of need.* It is not difficult to find out the negative result concerning the problem of women healthcare. The reasons for that might be sought in the high rate of health uninsured who can not afford to pay for the medical examination thus neglecting their own health. On the other hand, there are other reasons, subjective in our view, that impede this kind of prophylaxis within a determined part of the respondents and these reasons are related to the ethno-cultural idiosyncracies of the local communities:

- First, among the more conservative families is unacceptable to talk about these types of problems and they are perceive as “shameful”, so it is not common trend to go to the doctor before the problem leads to a serious health risk.

- A dominant part of respondents *declare they do not mind if the gynecologist is male or female, but for 16% of the respondents this comes to be a problem because they feel ashamed and uncomfortable, and in other cases because the husband is jealous.*

Half of the respondents determine their health as good without any indications of serious diseases including the gynaecologic ones, but embarrassing is the significant percentage – 43% of the answered respondents with ‘yes’, ‘no’, ‘I do not know’, and ‘not answered’. *That means these respondents are not aware of their own health conditions, at least they have not undergone through any medical examination recently, or in the case of the “yes” answer – respondents realize they have a health problem but it is not clear if they take any cautions for its treatment – see Fig. 15.*

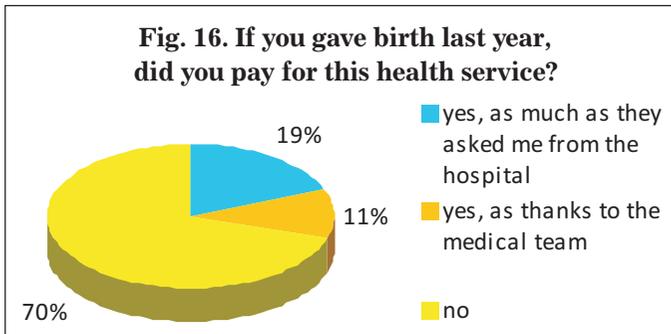


Considering these inquired women who gave a birth within the last calendar year and the type of medical services they used, the picture is the following:

- From all 515 inquired women, only 54 have gave a birth within the last calendar year. *17% of them or 9 women who gave a birth in the last year declare they have not used medical services during the pregnancy, i.e. their pregnancy has not been monitored by a medical specialist.*

- Probably the same 17% of birth giving women who have not monitored their pregnancy declare they have not used any medical services for two months after giving a birth.

Let's see what the picture looks like with the women who gave a birth within the last calendar year and the cost of this medical service – Fig. 16.



Here it is interesting to observe these 70% of women who declared they did not pay anything when they gave a birth and these 11% of women who paid some amount to the medical team as mark of gratitude. It is obvious that in each case of the two separate target groups it was not necessary to pay for this medical service. At the same time those 19% of inquired women who gave birth and who said they pay for this service pose real concern. It is unclear whether they paid for the hospitalization or for other type of payment (which would be illegal). Therefore, we can claim that:

- Among some birth giving women there is lack of awareness on the rights of hospital care;
- 81% of the birth giving women used to be health insured and they benefited a free of charge birthgiving but *almost all of them have monitored their pregnancy and probably they paid for gynecologic examination;*
- 17% of the health uninsured birth giving women benefited a free of charge birthgiving but *their pregnancy has not been monitored by a medical specialist* and once they gave a birth they have not utilized any other medical services.

The problem with health uninsured pregnant women in the project places will continue extending and this question should be discussed locally because of the hidden risks that the unmonitored pregnancy brings when short of money patients restrain to utilize a medical parturition service.

This can be seen in the last inquiry question when the respondents answer to the question do they know about a pregnant woman from the village who is not health insured, who has not attended a doctor but she needs that. *15% of respondents say they know about such women in the village, therefore we will be witnessing almost the same percentage birth giving women who will not be able to secure a monitoring to their pregnancy by a specialist, who will give a birth free of charge and will not utilize any medical services after birthgiving.*

IV CHAPTER

Assessment of the access to healthcare after the first stage of the research

The methodology which we use for the so called “assessment” of the access to healthcare services is based on “the traffic light methodology” but except the traditional sections – red, yellow and green, in our case, for a better results we included one additional section – an orange one between the red and the yellow sections.

For the assessment we take into account the average value of all percentage results of the research which affect in a negative way the access to healthcare in the different spheres. The obtained result is correlated with “traffic light” which is separated in 4 sections characterizing the level of healthcare access. The bigger the average percentage, the more limited the access to the respective service is, as follows:



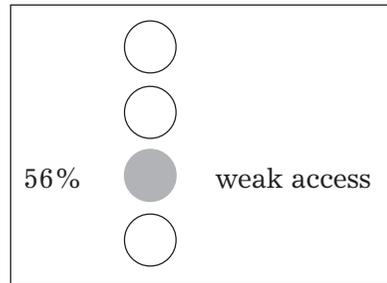
Short assessment of the access to healthcare of vulnerable ethnic communities in the project places

Considering:

1. The access to *primary health care*:
 - 54% of the respondents (women older than 18 years) in the project places are health uninsured.

- Over 40% of the respondents' family members are also health uninsured.
- 17% of the respondents do not know if they have a GP doctor at all.
- 74% of the inquired do not know the GP doctor's phone number or their kids GP doctor's phone number.
- 50% of the inquired do not have information about the days when doctors visit the village and their schedule.
- 72% of respondents confess they do not attend prophylactic examinations.
- 80% of inquired cannot afford buying medicines prescribed by doctors.

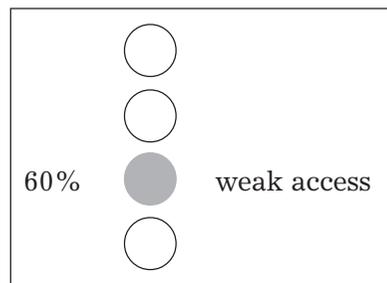
The average value of the above stated negative results describing *the healthcare access to initial medical aid* is 56% and is evaluated as “**weak**”.



2. The access to *emergency and hospital health care*:

- In 59% of the cases the emergency aid does not react adequately when solicited.
- Almost 50% of the inquired women have been exposed to discrimination by hospital authorities.
- 70% of the respondents are not informed if they have to pay for the stay in the hospital.

The average value of the above stated negative results describing *the healthcare access to emergency and hospitalized aid* is 60% and is evaluated as “**weak**”

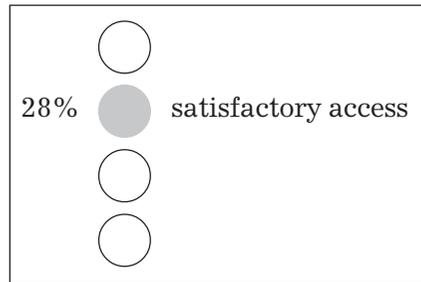


3. The access to *child healthcare*:

- 24% of the children within the families of the inquired women do not attend an annual prophylactic examination.

- 33% of the mothers determine by themselves what kind of treatment to undertake, depending on the child's condition.
- 19% of the mothers have been required to pay for their kids medical examination.
- 63% of the children have not attended a dentist within this calendar year with a concrete reason – prophylactic examination or another dental procedure.
- 30% of the mothers consider their children do not receive healthy nutrition in the kindergarten.
- 16% of the mothers can not supply their children with healthy food.
- 11% of the mothers are not informed about the immunization calendar of their kids.

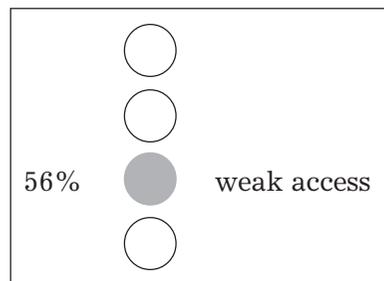
The average value of the above stated negative results describing *the child healthcare access* is 28% and is evaluated as **“satisfactory”**.



4. The access to women's healthcare:

- 79% of the respondents have not attended prophylactic gynaecologic screening.
- 46% of the respondents have not attended gynaecologist in the last year.
- 43% of the inquired are not aware of the own health condition.

The average value of the above stated negative results describing *the women healthcare access* is 56% and is evaluated as **“weak”**.



Conclusions and directions after the first inquiry. Campaign “Health to everybody”

The above presented evaluation of the healthcare access using the “community inquiry” method, form an overall “**satisfying**” assessment, which is on the border between “weak” and “satisfying” – exactly 50%. However, the assessments can be defined more as ‘weak’ access – not only from a formal point of view, but also because in three of the four researched spheres, the access is weak. Satisfactory is only the state of child health, and the best rate in this area - 28% are trying to shift the overall assessment from “weak” to “satisfactory.” In addition, we should also say that in general all our preliminary hypotheses have been confirmed in the research.

Within the first 10 days of August, after we had finished the first stage of the research, we organized a Volunteer camp with the participation of community moderators and volunteer inquiry agents. We presented the results from the first stage of the research and we asked the inquirers to give a feedback based on the observations on inquiry process flow asking their opinion on the received results.

The following conclusions have been made:

- The first stage of the research run smoothly without any significant difficulties: despite the initial skepticism, the local minorities / Roma communities have realized the importance of community monitoring on health services and they have been actively involved in the community inquiring process.
- In order to avoid ambiguity of some preliminary set questions, we decided to reformulate the questions before the second stage of the research.
- A plan for improving the access to health care in the project places has been developed - with a view that the monitoring of health services is not made for the sake of making, but has as main goal to present a clear picture of the situation and

appropriate guidelines for its improvement. Community moderators, local volunteers and Centre Amalipe flagged several types of activities that need to be implemented. They include both information campaigns and advocacy activities to local and regional institutions.

Considering the fact that the received results with negative attitude toward the healthcare access are rooted in the *low awareness of the people*, the team set as a short term advocacy goal **to increase the sensibility and awareness of the people in the project places in regard to the law requirements that refer to delivery of different healthcare service, as well as about the patients' rights and obligations**. The planned awareness raising activities of the communities in the project places grew into information campaign conducted under the slogan "Health to Everybody".

The participants in the camp decided that all remaining problems of access to healthcare that require change in the community behavior and in the policies and practices of service delivery at regional and national level should be formulated as long-term advocacy goals requiring a large-scale targeted work. It will be reasonable to formulate these goals at a next stage.

The campaign started in an untraditional way. The activists from the local community development clubs in the villages of Varbovka, Batak and Balvan with the support of Center "Amalipe" developed and presented to over 1000 people in the above mentioned inhabited places, a theatrically stage music show entitled "Where are you, doctor?". The staging was full of wittiness and humor, the script, costumes, sets and make-up were entirely volunteers' contribution and some of the played scenes were based on real cases.

The idea for this show was spontaneously generated when volunteers determined that the theater is the best mean for explaining people in a simple way the healthcare access problems. The numerous public (in all three villages halls were full), as well as the spontaneous public reaction to this performance in the three villages shows that people understand and think about problems in this sphere, when the problems are represented through artistic means.

As a second step, in October we decided to “enter” the 4 local schools in order to make reading on healthcare issues. For the 1st to 4th grade pupils we prepared lectures on individual hygiene and the “dirty hand” diseases. For all the 280 pupils from 1st to 4th grades from the four schools we bought a tooth brush with tooth paste and the trainers demonstrated how to brush teeth.

Young volunteers from Center “Amalipe” carried out interactive discussions with youngsters from 5th to 8th grade on topics related to the sexual growth to maturity, the gender relations, the early marriages, the undesired pregnancy, the contraceptives and sexually transmitted diseases.

For the majority of people the team prepared and distributed among 600 houses in the four project places accessible information handouts about the access to emergency and hospital care, explaining what and how much to pay, and diffusing the special card containing GP doctors contact information.

We organized meetings with GP doctors in the target places and we made them familiar with the results of the first community inquiry. During the meetings we emphasized on the measures which should be taken by them immediately in order to increase the target access to health services.

We organized a meeting with the Regional Health Inspectorate – Veliko Tarnovo and with the management of the two emergency ward divisions in Pavlikeni and Veliko Tarnovo, and we made them familiar with the results from the research and we discussed the necessity to take measures with view to increase the quality of medical services, in particular – “the emergency aid”.

The main conclusions of the first community inquiry were presented at a conference, organized by Amalipe and students, participating in the Program for supporting of Roma in medical universities on 2 September. The conference was attended also by the RHI – Veliko Tarnovo and RHIF – Veliko Tarnovo, as well as the Minister for Management of EU Funds Tomislav Donchev. Participants discussed ways to improve health services and quality of life of Roma in Bulgaria’s rural areas⁶.

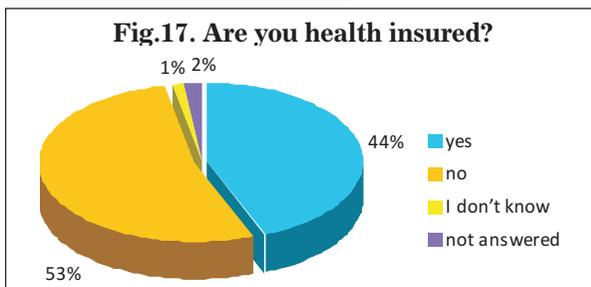
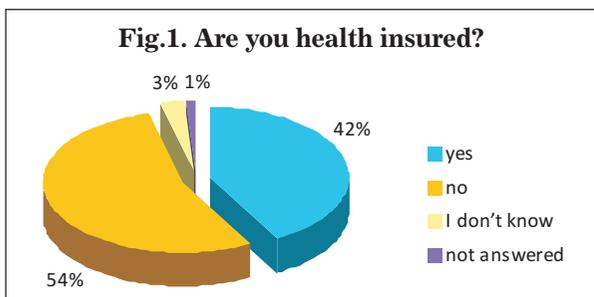
⁶ Information about the conference is available at:
<http://www.amalipe.com/index.php?nav=news&id=896&lang=1>

Comparison of the results from the first and second stage of the research

6.1. Access to primary health care

On the second stage of the research using the method “community inquiry” we interviewed the 500 respondents in total; women older than 18 years, from the project places – the villages of Balvan, Vodoley, Batak and Varbovka, using the same methodology and inquiry form.

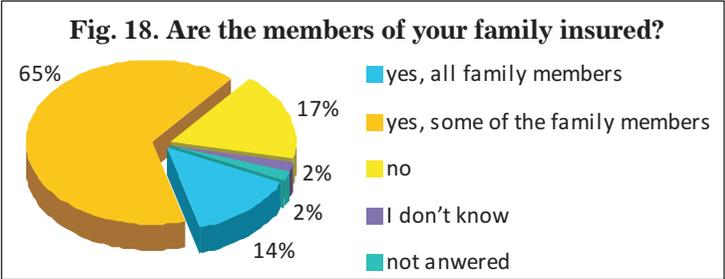
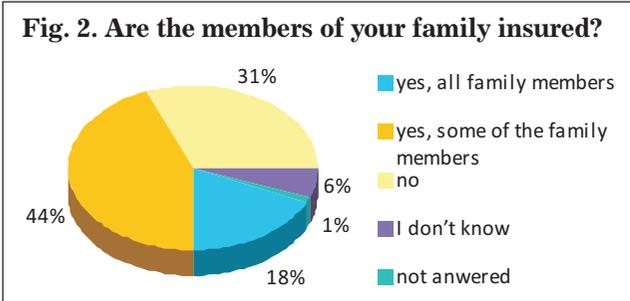
On the figures below there are presented the respondent answers to the question “Are you health insured?” Below, to illustrate the project contribution, we will compare graphics from the two stages of the research and we will put on the left side the graphic from the first stage and on the right – from the second stage.



Impressive is the 2% growth within the percent of health insured women older than 18 years and the 1% reduction within the percent of health uninsured women within the short period between the two inquiries in the project places. These close results draw a stable picture of target health status of respondents, which means they have been giving correct, informed answers, and they have become aware of an uninterrupted health status maintenance.

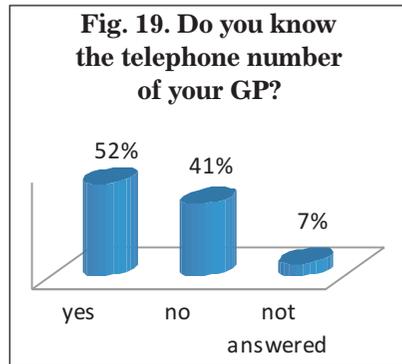
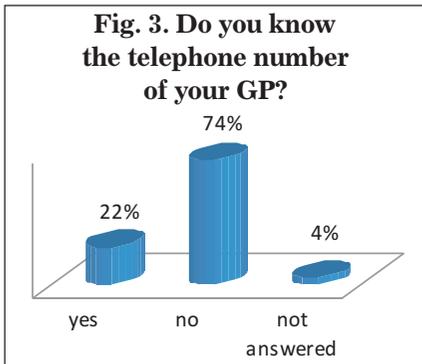
A change in the parameters is observed when registering the health status of the remaining target family members.

On Fig. 18 can be observed a significant growth in the answers “yes, some of the family members” where the respondents might have reported more correctly (in comparison with the first inquiry) the health status of the elder family members such as retired people and the children up to 18 years old, and once again it can be accounted for by the increased levels of information. The percentage of respondents with “no” answer has been reduced almost in half which comes to show awareness in terms of the family members health status.



Once more, almost all respondents declare their village has a health centre, and they convincingly answer the question asking for information about their GP doctors. 94% of the respondents are sure they have a GP, (11% more in comparison with the first inquiry), they know their GP doctor and his name, only 6% declare they do not know anything about having a GP.

A substantial progress is observed when answering questions that require specific information concerning the GP doctors. 52% firmly declare they already know the phone number of their GP doctor – the result has grown by 30% in comparison with the first inquiry and this might be a consequence of the distributed card information containing the contact information of all practising doctors in the project places – see Fig. 3 and Fig. 19.

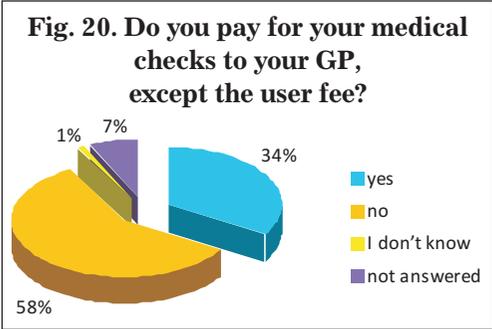
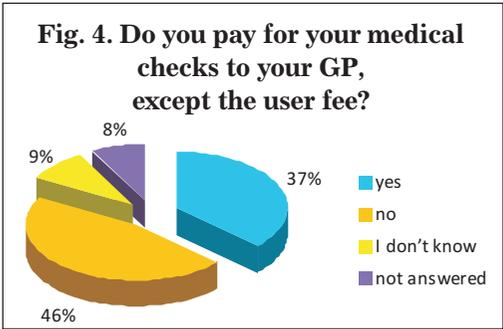


A tendency is observed to seek the help of GPs in case of necessity even out of working hours.

The second inquiry illustrates that 2/3 of the respondents are informed that the GP is available only twice per week for medical examinations and primary medical care delivery in the project places (a growth with nearly 25% compared to the first inquiry), *but unfortunately a smaller number of respondents – 38% confirm their GP arrives when people call him for emergency aid.*

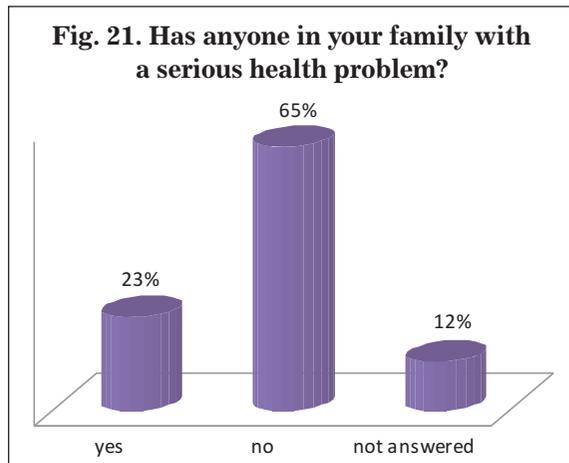
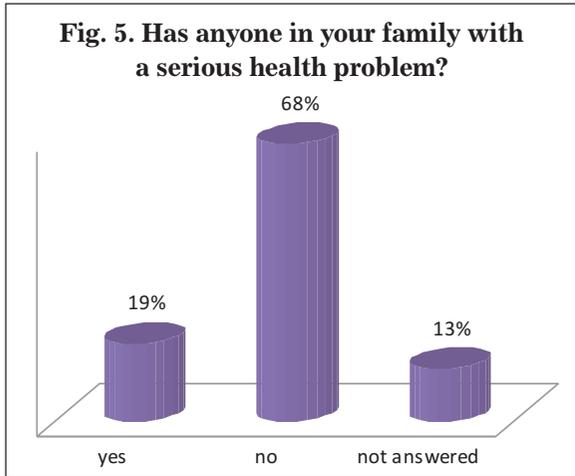
Let's see what is happening with payments for GP examination. On Fig. 4 and Fig. 20 there are shown charts of the percentage of those respondents who confess they pay for the examination. We

see the second graphic (November 2011) shows increase with 12% of the woman older than 18 years old, which do not pay for their medical examinations. The increase is due to two factors: the better awareness about respondent payment obligations (the comparison between the two tables shows a sharp decrease in the response “I do not know”) and possibly the reduction of illegal payments (better health awareness usually leads to higher accuracy in the collection of user fees by doctors).

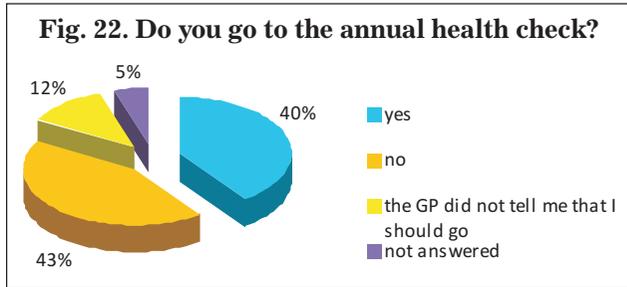
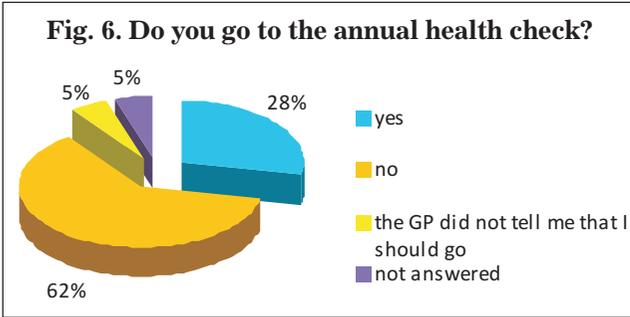


The individual evaluation of the respondents' health condition including the family members' health condition continues to be unreasonably high. The answers to this question practically do not register any change. The percent of those who answered in the affirmative question “Do you have a family member with a serious health problem?” is slightly increased, which can be accounted for

by the increased trust in the local inquirers and willingness to share their concerns on such a sensitive problem like having socially noted diseases among family members.



The next two graphics on Fig. 6 and Fig. 22 show how the situation changes concerning the annual prophylactic examination attendance.

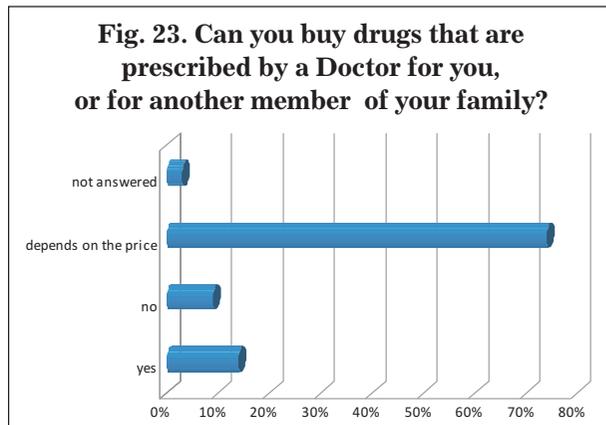
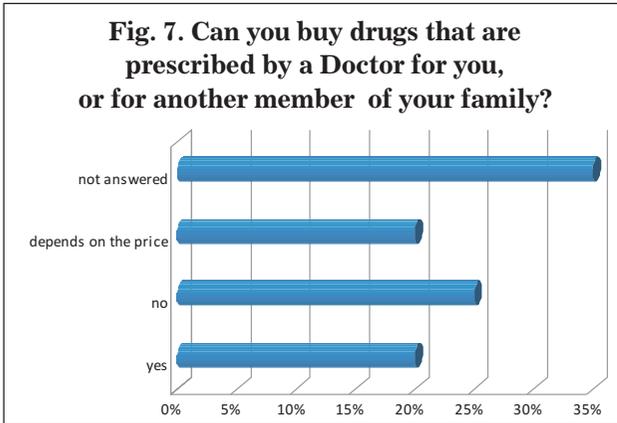


The first stage of the research registered 72% respondents who recognized they have not passed prophylaxis examinations. On the second stage of the research we registered deduction to 60% of the respondents who have not attended annual prophylaxis examinations. This result can be explained with the disciplining effect, which the health campaign has provoked in the project places in regard to the obligations of the GPs and the activation of their work on the resumption of the planned annual prophylactic medical checks.

Of course, there is still much to do (nearly half of the respondents do not pass annual prophylactic medical check), but it is important, that the positive change after the first implemented campaign is undisputed.

On Fig. 23 we can see that a huge part of respondents can afford to undertake only such a medication treatment determined by the price of the prescribed medicaments. On the first inquiry it became clear that the total of 80% of the respondents under one or another form declared impossibility to buy medicaments for individual or for family members use. On the second inquiry it was

evident that worries among respondents have been already disappearing and they have clearly acknowledged opinions on the topic. The economic crises put an additional pressure on these anyway scarce budgets that families dispose, and here we already observe a growth of up to 86% of the respondents who declare they can not afford to buy medicaments, under different circumstances.



6.2. Access to emergency and hospital health care

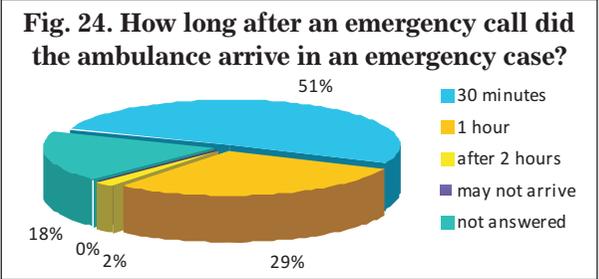
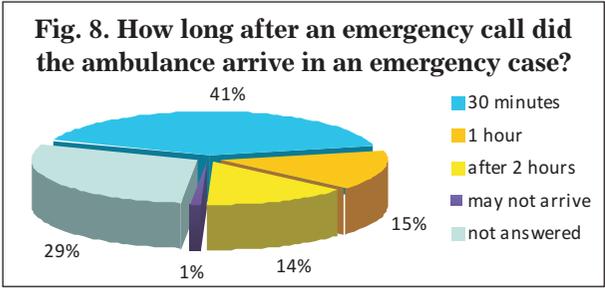
The second block of inquiry questions has as an objective to verify how the local healthcare institutions react when an emergency is reported and an emergency aid is requested, how is finan-

cially determined the stay in the hospital, as well as what are the attitudes of the staff in the hospital.

As it becomes clear so far, the emergency health care system appears to be almost the only alternative for receiving a medical aid among health uninsured people. On the first stage of the research it was indicated there is an evident sign of discrimination among the local emergency aid divisions which do not react adequately when local communities request help. There are registered death cases in some of the project places because of delayed and not in time emergency medical interferences.

From the diagram of Fig. 8 (July 2011), there is no doubt that in 59% of the cases the emergency care does not react adequately when it is requested.

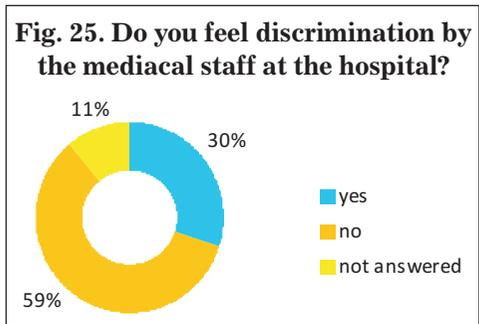
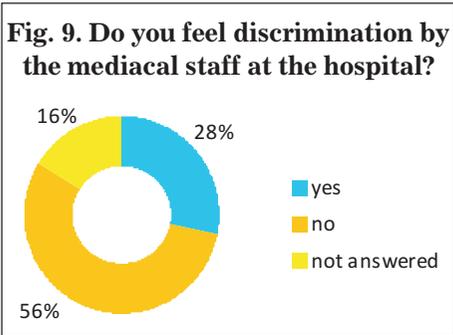
On Fig. 24 it is presented the result from the second inquiry and the following change is registered: 10% more respondents answer that the ambulance arrives up to 30 min., almost a double percent answer that the ambulance arrives up to one hour once it has been requested, and almost seven times less respondents answer that the ambulance arrives after two hours.



These results indicate some progress compared to the results from the first inquiry, not doubt, but yet the registered situation is far away of the contemporary idea of adequate “emergency care”. As a summarized evaluation of the answers we conclude – yet within 49% of the cases the emergency care does not react adequately when solicited.

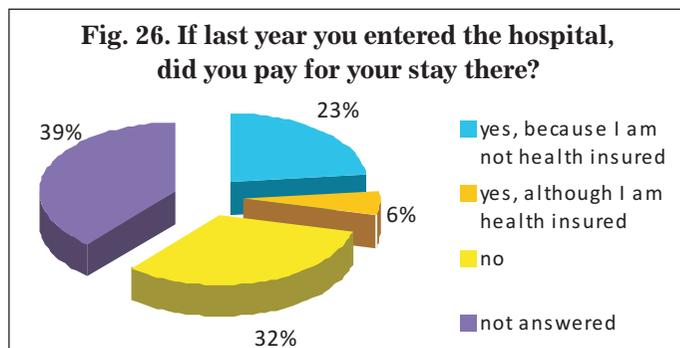
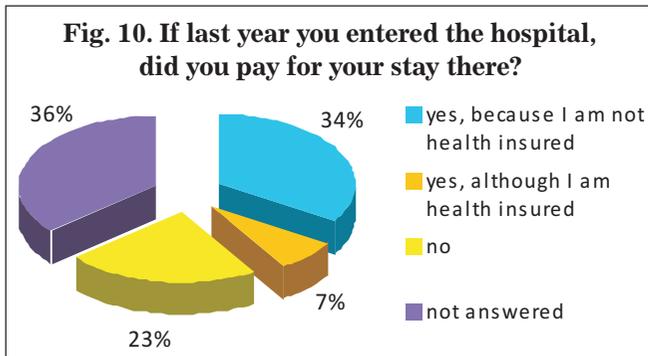
The parameters of the access to hospital care continue to be within the normal frame for the country. Serious troubles are observed with the increased number up to 30% (with 2% more compared to the first inquiry) of respondents who declare they have been subjected to discrimination by the medical authorities in the hospital recently.

With other words, after the second inquiry, **the statement** – *almost every second inquired woman older than 18 years and belonging to ethnic minority from the project places has been subjected to discrimination to one or another extent by the hospital authorities in the last year* **has been confirmed** – see Fig. 9 and Fig. 25.



Once again we asked respondents did they pay for their stay in a hospital in the last year. The results show the following picture: Fig 26.

- 9% less respondents they paid for their stay in a hospital because they are health uninsured.
- At the same time 9% more respondents did not pay for their stay – these might be the respondents who have a disease from the particular list or these who entered the hospital for second time within the same calendar year frame.
- 3% more respondents did not answer this question.
- 1% less respondents (6%) announce they paid for the stay in a hospital, although they are health insured. In general this percentage of people is informed about the rules and requirements when entering to be hospitalized, it remains unchanged.



These results demonstrate clear change, as in the same time the respondents need to spend an additional time on the inquiry studying the conceded hand out materials with detailed information about the rules for being hospitalized; handouts were disseminated in each house.

6.3. Child healthcare

For the analysis of the results in this section is important to make several clarifications:

The inquired women older than 18 years in the second inquiry are in total 500, the project team has not set a requirement to inquire the same respondents on the first and the second stage which means that the registered profile of the respondents on the second stage differs from the first one. Thus on the contrary of the target profile from the first inquiry where the picture is:

36% of the respondents declare they do not have kids under 18 years old, therefore a subject of childcare analysis are only those 64% of respondents who have kids within this age frame, or in total 324 mothers.

The respondents profile from the second stage of the research is the following:

54% of the respondents declare they do not have kids under 18 years old, therefore a subject of the child healthcare analysis have to be only those 46% of respondents who have kids within this age frame, or in total 229 mothers.

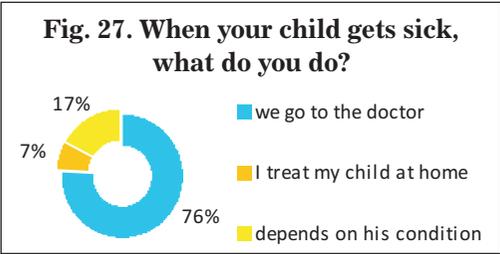
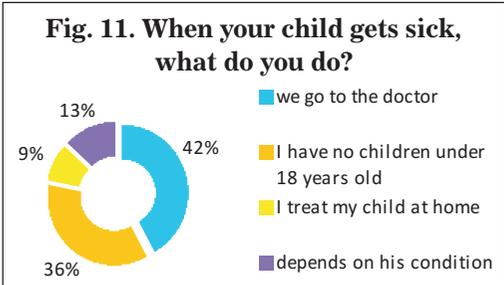
This logically comes to demonstrate *that it is not appropriate to make a comparative analysis of the results of the two inquiries* on some questions – those that consider mainly personal conditions and target status of the respondents from this and the next section of the women healthcare – because in the long run it is about different respondents.

On the second stage of the research, as well as on the first one, all the respondents with children under 18 years declare their kids have GP doctor and they know his name.

In terms of health condition of children up to 18 years old the picture from the second inquiry is the following:

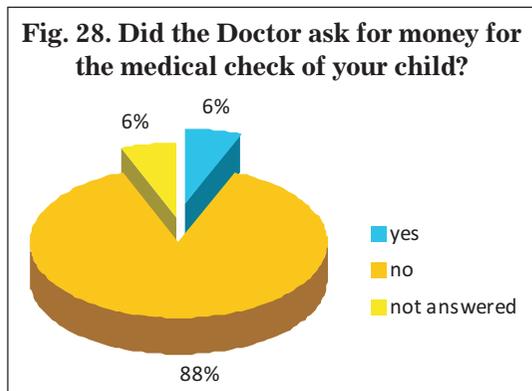
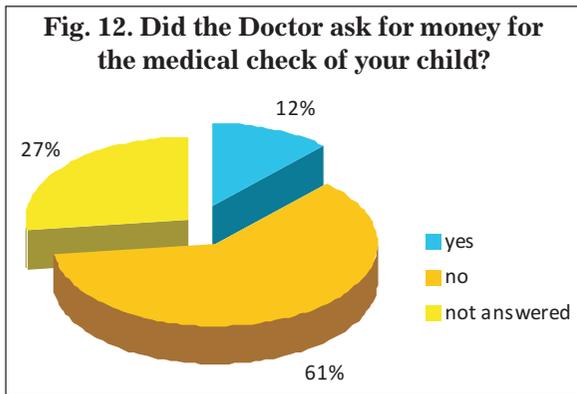
- 25% of the inquired *mothers* announce their kids are getting ill often.
- 8% of the *mothers* have chronically ill children.
- 84% of the *mothers* claim their children attend an annual prophylaxis examination, here it is observed a growth of the result with 11% compared to the first inquiry.

The second inquiry proved the general practice - the mother in usually taking the kid to the doctor once it is getting ill; here we observe a growth of 9% of the mothers who act in this way but once again we evidence embarrassing practices even though in a less extend – Fig. 27.



This time the GP doctors required money for children examination from “only” 6% of the *mothers* or in total 13 *mothers*. Most probably here the issue is not about the regular payment of the

hospital user fee. Although this indicator has a 13% reduction, there exist respondents who refused to answer this question thus imposed us to set a new option “not answered” urging to correct the result, i.e. we can consider actually that **this indicator** that considers the payment to the GP for the children examination is **reduced only with 7%**. These facts continue causing embarrassment and they should be addressed to the corresponding institutions in the nearest future.



The second inquiry demonstrated that only 15% of the mothers announce to take their children to prophylactic dental examination – this is even worse result compared to the first inquiry where the percentage of the mothers who announce to take their children to prophylactic dental examination was 40%. This result can be

explained by one side, with the different profile of the respondents on the second stage of the inquiry, as well as with the fact parents do not trust GP dentists and the free of charge services they offer but prefer paid services.

This claim is supported by those respondents who answered the question have their children attended a dentist within this calendar year. On the contrary to the first inquiry where 63% of the respondents announce they did not attend a dentist during the year, the second inquiry registered a considerable higher percent of parents who have not taken kids to a dentist within this year – 74%. In the cases when it was necessary the procedures used to be only paid.

68% of the mothers consider their kids are healthy nurtured in the kindergarten (school) which registers twice higher growth. Now, the contrary opinion is shared hardly by 10% of the mothers.

Only 12% of the mothers declare their kids are not attending a school institution which represents triple reduction of this result in comparison with the first inquiry. Probably once again it is about not attending kindergarten and the related to it requirement to pay fees.

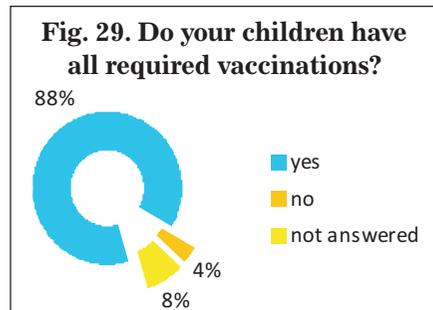
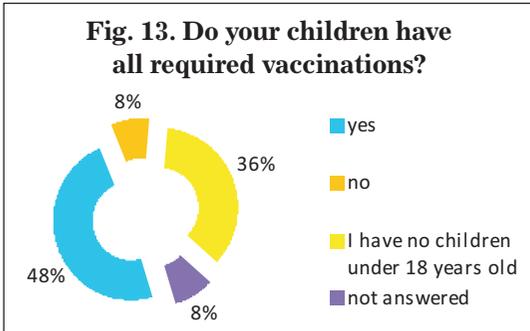
66% of the mothers are making efforts to supply their children with a frequent consumption of meat, eggs and dairy products which presents 14% reduction of this indicator in comparison to the first inquiry, this consequence can be probably explained with economic crises but the frequent supply with meat, eggs and dairy products appears to be once again a problem to about 16% of the mothers.

In terms of the regular school attendance – at this stage we register “only” 12% mothers who declare their kids do not attend school regularly because of one or another reason, and this presents 11% reduction in comparison to the first stage of the research.

92% of the *mothers* already claim their GP doctor is informing them about the children immunization, we can explain that once again with the increased level of information and the improved work of the GP doctors. For 8% of the mothers the condition of being informed appears to be once again a problem.

Direct link between the percentage of the informed parents who are aware of the importance of children immunization and

the real percentage of immunized children can be better seen on Fig. 13 and Fig. 29. On the both figures it is presented the similar percentage of immunized kids compared to the percentage of the informed parents.

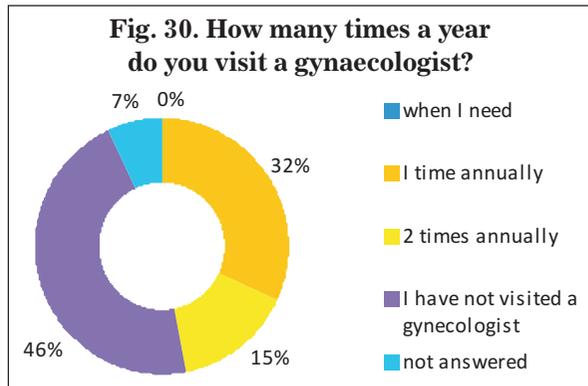
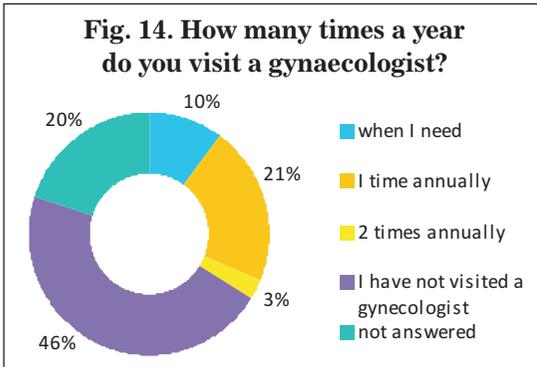


7.4. Women’s healthcare

The significance of the women healthcare determined the profile of the respondents for the two stages of the research – these used to be women older than 18 years.

The first inquiry registered disturbing data regarding the women healthcare conditions in the project places. During the period between July and November the project team implemented the activities under the campaign “Health for everybody”, which included free gynecological checks performed by Dr. Mavrodi Kaleyanski. The campaign led to a change in women’s health indicators recorded during the second community inquiring.

On Fig. 30 it is presented a graphic, answering the question how many times annually respondents have attended a gynecologist.

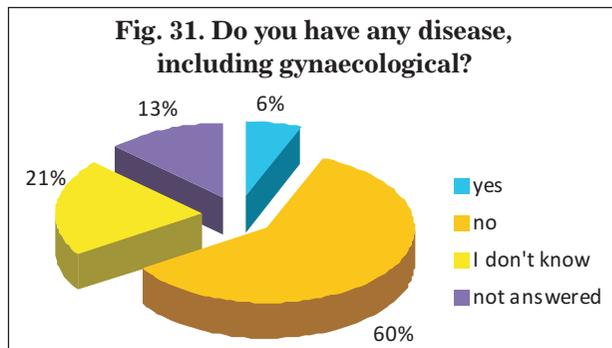
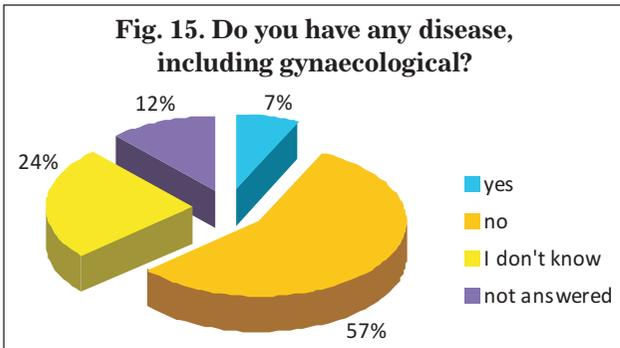


The graphic shows that the percent of women who attended a gynecologist this year has increased – it is 32% and we can compare it to the 21% registered on the first inquiry.

The result of 46% of women who declare they have not attended a gynecologist in the last year is being kept absolutely the same on the second inquiry. Probably the reasons once again are rooted in the high percent of health uninsured women and the impossibility to afford paying for gynecological checks. Once more, this fact makes us regard team efforts such organizing free of charge gynecological checks in the project places as very needed for a considerable part of the respondents.

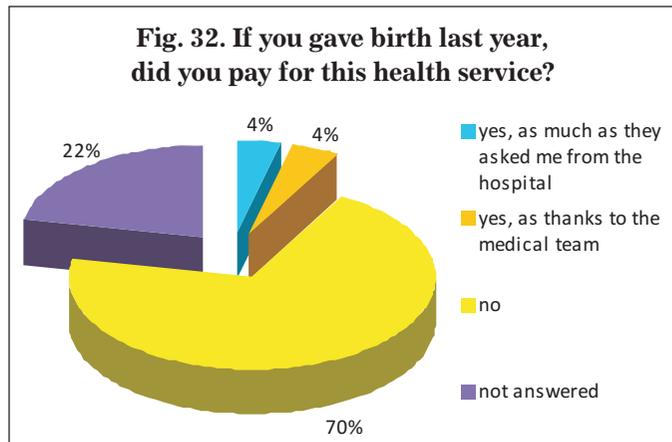
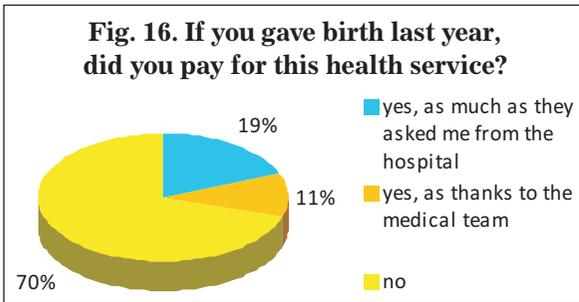
By other side, once again there are, although in a lees extent ethno-cultural barriers impeding that type of health prophylaxis among one part of the respondents. For example the predominating part of the respondents – 90% declare *they do not matter if the gynecologist, who performs the medical check is male or female, but for 10% of the respondents it continues to be a problem because of known already reasons.*

This time also, more than the half of the respondents determines the personal health condition as good without any serious diseases, either gynecologic ones. There is a slight increase in this percentage, which is at the expense of reducing the percentage answered “I do not know”. Embarrassing is once again the significant percent – the total of 40% of answered with ‘yes”, “I do not know” and “not answered” (reduction with 3% in comparison to the first inquiry). *This surely means that those respondents have not paid attention to their health recently* – see Fig. 31.



In terms of these inquired women who gave a birth within the last calendar year and the type of medical service they used to utilize, the picture is the following one:

- From the all 229 inquired women who answered they have children younger than 18 years old, only 26 gave a birth in the last calendar year. 3% of them or 8 birth giving women in total declare they have not used medical services during the pregnancy in the last year, i.e. their pregnancy has not been monitored by a medical specialist.
- The same 3% of birth giving women who have not monitor their pregnancy declare they have not used either any other medical services within the period of two months after the birth giving.



On Fig. 32 make impression these stable 70% of women who say they have not paid anything for the birth service, which is completely identical to the registered in July. At the same time causing worry those 22% of respondents, who have refused to answer the question regarding the payment of the service “birth giving”. That makes us think those respondents used to pay under one or another form, most probably irregularly in order to secure normal conditions and monitoring of the birth giving process; this is a practice which we consider has received publicity not only among the minorities, but the majority also.

Based on the received data we can claim that:

- There are indications of irregular payments among some of the mothers (whether they are voluntary, i.e. “for gratitude” or requested): In essence, the sum of the percentages of answered that have paid for the birth and the no answered, in July and November is similar – although it is a different set of female respondents. This indicates a relatively widespread practice of informal payments, which cover between one quarter and one third of mothers of Roma;
- 74% of the birth giving benefited a free of charge medical service of birth giving; *but almost all of them have monitored their pregnancy and probably they have paid gynecologic examination, because they are health uninsured.*

We asked the respondents to answer the last inquiry question – do they know about a pregnant woman in the village who is not health insured, either has attended a doctor but needs that.

25% of the respondents (a growth with 10% in comparison to the first inquiry) say they know about such women in the village, therefore once again we will be witnessing seven times more birth giving women who would not be able to assure monitoring of their pregnancy by a medical specialist; they will give a birth free of charge but they will not utilize any other medical service after the birth giving.

VII CHAPTER

Assessment of the access to healthcare after the second stage of the research

The current report does not pretend to be a “last authority” in the analysis of the gathered and processed information. It is necessary to mention, while conducting the assessment the team might have been predisposed in some cases in its approach but we consider the approach as working and as appropriate for the goals of the report at this stage i.e.:

To evaluate the access of vulnerable ethnic communities to healthcare services in the project places using the method “Community inquiring”, allowing this way the development of effective strategies for improvement the practices of the delivered healthcare services in a long term plan.

The Methodology we use for the so called “assessment” of the access to healthcare services is based once again on “the traffic light methodology”, described in chapter IV. Following this methodology, we reached the following conclusions.

Short assessment of the access to healthcare of vulnerable ethnic communities in the project places

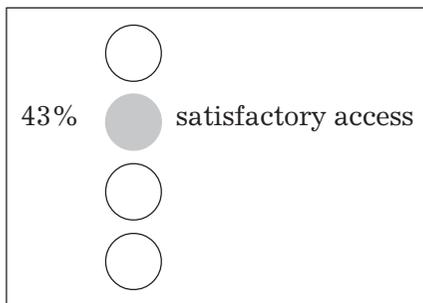
Considering:

1. The access to *primary health care*:

- 53% of the respondent (women older than 18 years) in the project places are not health insured.
- 21% of the respondents family members are also health uninsured.
- 6% of the respondents do not know if they have a GP doctor.
- 41% of the inquired do not know the GP doctor phone number or their kids GP doctor phone number.

- 34% of the inquired do not have information about the days when GP doctors visit the village and their schedule.
- 60% of the respondents confess they do not attend prophylactic checks.
- 86% of the inquired can not afford buying medications prescribed by doctors.

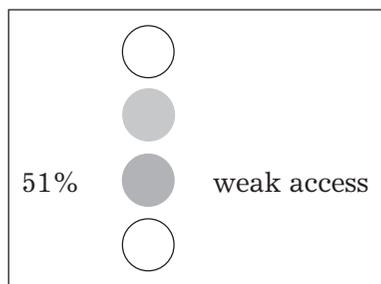
The mid-arithmetic value of the above stated negative results describing *the healthcare access in the primary health care* is 43% and the determined mark for the access is “**satisfying**”.



2. The access to *emergency and hospital health aid*:

- In 49% of the cases the emergency care does not react adequately when solicited.
- 41% of the inquired women have been subjected to discrimination by hospital authorities.
- 62% of the respondents are not informed if they have to pay for the stay in the hospital.

The mid-arithmetic value of the above stated negative results describing *the healthcare access to the emergency and hospitalized aid* is 51% and the determined mark



for the access is evaluated as **weak**, but in the boundary area between “weak” and “satisfying”.

3. Considering the access to *child healthcare*:

- 16% of the children within the families of the inquired women do not attend an annual prophylactic check.
- 24% of the mothers determine by their own what kind of treatment to undertake, depending on the child’s condition.

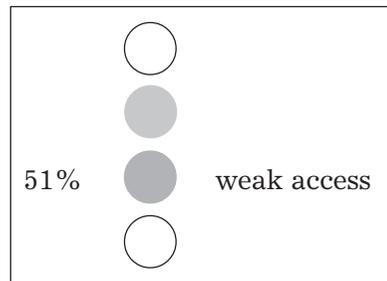
- 12% of the mothers have been forced to pay for their kids medical examination.
- 74% of the children have not attended a dentist within this calendar year with a concrete reason – prophylactic check, or another dental procedure.
- 10% of the mothers consider their children are not healthy nurtured in the kindergarten.
- 16% of the mothers can not supply their children with healthy food.
- 8% of the mothers are not informed about the immunization calendar of their kids.



The mid-arithmetic value of the above stated negative results describing *the child healthcare access* is 23% and the determined mark for the access is **“good”**.

4. The access to *women’s healthcare*:

- 68% of the respondents have not attended prophylaxis gynecologic examinations.
- 46% of the respondents have not attended gynecologist in the last year.
- 40% of the inquired are not aware of the own health condition.



The mid-arithmetic value of the above stated negative results describing the women healthcare access is 51% and the determined mark for the access is evaluated as

“weak”, but in the boundary area between “weak” and “satisfying”.

VIII CHAPTER

Conclusions and recommendations

The conducted assessment on the access to healthcare after the second stage of the research indicated several important conclusions:

1. It is registered an improvement in the access to healthcare in the project places in almost all spheres as follows:

- Access to primary health care – from mark “weak” on the first stage of the inquiry, the access was improved to “satisfying”. The main reason for this improvement is due to significantly higher patient awareness about the phone and how to contact the GP, and as well as due to the larger percentage of patients who have passed prophylactic checks. Both factors are a result of the campaign “Health to everybody”: we can confidently say that this campaign has led to significant improvement in access to primary care;
- Access to emergency and hospital care – from mark “weak” on the first stage of the inquiry improved to boundary access limited between “weak” and “satisfying”, but still remains weak. The improvement is due as to higher awareness of local communities and as well as to the more rapid and adequate response to emergency teams. i.e. in this case the improvement is due as to the campaign “Health to everybody” and as well as taken actions by RHI and RHIF and as a result of the advocacy activities of the project team;
- Access to child healthcare – from mark “satisfying” on the first stage of the inquiry improved to “good” access. Here remains alarming the conditions of dental services: urgent measures to improve dental prophylaxis are needed;

- Access to women’s healthcare – in this area there is only slightly improved, which is over the statistical mistake, but the overall mark still remain “weak”, although that is already in the boundary area between “weak” and “satisfying”. The improvement is due mainly to the free gynecological checks, organized within the project. Systematic and purposeful actions to improve access to women’s health among the Roma communities in rural areas are needed.

2. The project team decided to choose the information strategy as a possible advocacy strategy in its aim to carry out a quick intervention in project the project places in order:

- To eliminate subjective obstacles having informative character.
- To bring tangible improvement of the informative parameters of the access to healthcare services which to be registered even on the second inquiry stage.
- To demonstrate that similar activities are within the duties and the responsibilities of the local healthcare institutions.

3. The carried information campaign “Health to everybody” between the two stages of the research played a vital role for registering the improvements in the access to healthcare, so that it helped to fulfill the short term advocacy goal, i.e.:

To increase the sensibility and awareness of the people in the project places in regard to the law requirements in delivery of different healthcare service, as well as about the patients’ rights and obligations.

In order to achieve an effective and a sustainable improvement in the access to healthcare in the project communities it is necessary to develop and to implement long term advocacy activities at all levels addressing the registered problems in an appropriate way.

At local level it is necessary:

- To continue to inform people explaining how the health system works and what patients’ rights and obligations are in order to attack the edge stone problem of the healthcare system – the high rate of health uninsured. People from communities do not understand this joint system and they do not

agree to pay things they do not use; we can not expect a visible improvement of the access to healthcare without addressing the payment problem for health insurance.

- To encourage people who are health uninsured and socially excluded to fill application forms that will allow them to use health social benefit – at the moment they are not informed about this possibility and they cannot benefit from it. Within the project the team helped a woman from the village of Balvan to get health social benefit. There are many administrative obstacles to get this benefit. The potential beneficiaries for sure will need help in the filling of the necessary documents.
- To continue the community monitoring of the work of GPs towards compliance with their professional obligations, improve the quality of services and strict calendar fulfillment of prophylaxis medical examination among health insured people including the immunization calendar of children. Is necessary to investigate the cases where money for the medical checks of children less than 18 years are requested and to demand the guilty individuals.
- To initiate meetings with GPdentists and to impose monitoring on the services of dental prophylaxis and examination, and the free of charge dental procedures.

At regional level it is necessary:

- To address problems related to the inadequate “emergency aid” service delivery by the Emergency aid centers in Pavlikeni and Veliko Tarnovo.
- To initiate joint activities with the hospital authorities in Pavlikeni and Veliko Tarnovo which to result in a better understanding of ethno-cultural peculiarities of the ethnic communities and in a reduction of the level of prejudices and discrimination among the medical staff.

At national level it is necessary to:

- To initiate an advocacy campaign for a thorough review of the health insurance system for Disadvantaged: changes in this direction would be benefited a wide range of Bulgarian

citizens – both ethnic minorities and majority. Some of the possible changes may be towards the creation and implementation nationally of a minimum package of health services for disadvantaged persons, application of foreign experience in the introduction of modern social networks with health focus of disadvantaged and others.

- To initiate legislation and - if necessary - legal changes facilitating better quality and access to health services in rural areas. Almost all persons living in rural areas are disadvantaged on the base of quality health services. It is needed the introducing of a system of incentives for the development of quality health care in rural areas of Bulgaria.
- Regarding women's health care, legislative changes are needed to equalize the status of the pregnant woman and the woman with a child until 12 months after giving birth to the status of health insured. This will allow for adequate medical care for the fetus and newborn, which will dramatically reduce child mortality and malformations.
- With regard to access to emergency and hospital care is necessary to ensure that the hospital network optimization / in particular – in the drafting of a new National Health Card / will be mentioned the need of the residents from the small cities to receive timely emergency care. Currently this is not so.
- With regard to access to primary health care are necessary legislative and regulatory changes that allow more involvement of GPs in rural areas and areas with high concentrations of Roma and other ethnic minorities. A more serious control over the work of GPs and implementation of a national training program for GPs to work with representatives of the Roma and other ethnic minorities.
- In terms of improvement of the overall health status of the Roma community is needed nationwide to be extended the network of the community and the health-social centers health and social centers. The checked within the project model for creation of municipality and local centers for community development, demonstrated its effectiveness on improving of

the health indicators in all four researched areas / see the results of comparison between July and November / even within the relatively short time period of 5 months. This model should be developed and implemented nationwide.

- In terms of improvement of the overall health status of the Roma community is also necessary to engage more Roma in the health system / as doctors, nurses, health mediators /. This need comprehensive state policy.

Legend

GP	General practicing doctor
NHIF	National health insurance fund
RHID	Regional health insurance fund
RCH	Regional center for healthcare
DDODS	District dispensary for oncologic diseases with stationary
DDPDS	District dispensary for psychiatric disease with stationary
DDPPDS	District dispensary for pneumo-phtisiatric diseases with stationary
DDDVDS	District dispensary for dermatological and venereal diseases with stationary
MPDHAT	Multi-profiled district hospital for an active treatment
MPHAT	Multi-profile hospital for an active treatment
SHAT	Specialized hospital for an active treatment
HR	Hospital for rehabilitation
HC	Hospital for cure
HCCT	Hospital for cure and continuous treatment
PHC	Primary health care
SMDC	Specialized medical and dental care
HMC	Hospital medical care
SOMC	Specialized off hospital medical care
SODC	Specialized off hospital dental care
POMC	Primary off hospital medical care
PODC	Primary off hospital dental care
IP	Individual practice
GP	Group practice
MC	Medical centre
DC	Dental centre
MDC	Medical and dental centre
DCC	Diagnostic-consultative centre
CPH	Centre for psychiatric health
COC	Complex oncologic centre
CDVD	Centre for dermatological and venereal diseases
MCPPD	Medical centre for pneumo-phtiziatrie diseases
IMDL	Independent medico-diagnostic laboratory
IMTL	Independent medico-technical laboratory
CEMC	Centre for emergency medical care

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in Veliko Turnovo and Pavlikeni municipalities**

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