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RESOURCE OF HEALTH SYSTEM ACTIONS ON SOCIALLY DETERMINED HEALTH INEQUALITIES

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Category / Field	Definition / Source
1. Country	Spain
2. National / subnational / local or mixture	Subnational
3. European Union status	Member
4. Title of example	Health Promotion among Navarre Ethnic Minorities Programme

5. Summary

In 1987, the Health Promotion among Navarre Ethnic Minorities Programme was established. It was initiated by the Saint Lucia Foundation Patronage (a nongovernmental organization) and its management was subsequently taken over by the Public Health Institute of Navarre. The Programme aims to reduce health inequities by improving the health of the Roma community. The approach used is assets-based: people from within the Roma community are trained as mediators and then act as peer educators and as a liaison between the community and the central health, social and education services. The mediator plays a key role in documenting the health history of families in the health implementation zone and drawing up a health plan in cooperation with the appropriate service providers.

Over a period of 20 years the geographic scope of the programme has significantly expanded. In 1987, it was implemented in four basic health zones. By 2005, it had expanded to 15 zones and was in direct contact with more than half of the 6000-7000 Roma living in Navarre. At different times, it has been implemented in 23 of the 55 health zones in Navarre. Evaluation has shown that the Programme has resulted in improvements in health for the Roma community in Navarre, including higher levels of primary health care coverage, improved health for women and children and increased participation by the Roma community in health education and prevention programmes. It has also resulted in increased school attendance for Roma children aged under 12 years. Evaluation has, however, highlighted a number of areas where progress can still be made. Overall, the Programme has been identified as a pioneering initiative which has paved the way for other similar initiatives. In 2004, it was recognized by Eurohealthnet as a European good practice model for equity in health.

6. Why is this example potentially of interest to policy-makers?

The Health Promotion among Navarre Ethnic Minorities Programme is an important example for policy-makers because it demonstrates how long-term commitment to engagement and working with a community can make a difference to health inequities. In place for over 20 years, the Programme has grown substantially in its geographic scope since first established. It is also a good example of how a programme can thrive even though it is initiated at a time when the broader economic, social and political environment may not be receptive to addressing health inequities.

The Navarre Programme models the principles of effective participation and engagement, one of the four features identified as critical to health systems in addressing health inequity. Remedying health disadvantage takes time and, often, a long-term perspective. While this approach meant working more slowly than is usual in mainstream health promotion programmes, it has proved critical to the success of the Navarre Ethnic Minorities Programme. The approach is also unique and therefore of interest to policy-makers because of its focus on assets *(1)* (such as community cohesion) within the Roma community as well as its aim to address health disadvantage.

The Programme is also one of the few to be evaluated for their actual impact on health. Evaluation has taken place at several different levels and has yielded evidence of its impact on the health of the Roma community in Navarre. Finally, a range of tools has been developed to support the Programme, including a training package for cultural mediators and a local health census. These tools may be of interest to other policy-makers and provide models for implementing similar programmes.

7. Description	Programme

The Health Promotion among the Navarre Ethnic Minorities Programme is a pioneering initiative designed to reduce health inequities by improving the health of the Roma community. The programme has three main partners: the Public Health Institute, Gaz Kalo (an

association bringing together 15 Roma associations of Navarre) and the central health and education services. In each implementation zone an intersectoral commission has been established to represent the Programme.

In the area of health, the Roma population is generally characterized by worse outcomes and behaviour than the general population. Challenges encompass poor follow-up of prevention programmes by the community, an increased tendency toward health-damaging behaviour, improper use of medications and a higher incidence of accidents and unintentional injury such as burns, falls, pedestrian traffic accidents, bone fractures and cuts. The Roma are also a high-risk group for congenital malformations. In the literature, health inequalities have been explained by genetic and cultural factors as well as by poor socioeconomic conditions, although there have been some improvements in these in recent years.

The Roma community is, however, underpinned by certain strengths or assets such as a high level of community support and cohesion (particularly through the extended family), some norms of behaviour, customs and habits that are beneficial to health, the central role of women as caretakers and transmitters of knowledge, and the high level of respect for the elderly which has an influence on young people. To capitalize on these strengths, an assets-based approach was adopted from the beginning with the ultimate aims of improving health outcomes, addressing the socioeconomic and environmental determinants of health and increasing access to health services.

The activities and work strategies adopted include: health mediation using Roma mediators, coordination and collaboration with local and central authorities, peer education, empowerment and participation of the community, and extensive training of Roma mediators. Section 8 includes more specific examples of the activities undertaken with Roma communities to improve health.

8. Examples of specific activities

The mediators are central to the Programme. Selected by the Public Health Institute according to certain criteria (educational level, respect within their own community, adaptability, commitment to health promotion and respect for confidentiality), the mediators receive substantial training in: (i) the necessary administration and management procedures, as well as in the health needs of the Roma people and aspects of personal empowerment; (ii) the functioning of other services used by the Roma community (social, education, housing and employment services); and (iii) aspects of health education. During the first year, 50% of a mediator's time is dedicated to individual or group training. The time allotted for training is subsequently reduced to 20–30%.

When a programme begins within a community, the mediator first carries out a census of all families to assess their needs and requests, followed by a confidential health history of every family. Based on the information from the local/community census, the mediator and the social and health services develop a work plan. The educational services are also involved, for example through the schools attended by Roma children, although this may be at a later stage of development.

In the first year of implementation, priority is usually given to vaccinating children and family planning. Gradually other aspects of the work plan, such as programmes for disease prevention, chronic diseases, dental health and mental illness, are implemented. The mediator works with the appropriate health and social services to deliver the activities in the work plan.

9. Status of example

The Health Promotion among Navarre Ethnic Minorities Programme began in 1987 as a response to the health and social inequalities experienced by the Roma community. The initiator of the Programme was a nongovernmental organization, the Saint Lucia Foundation Patronage, who also initially coordinated it. The Programme was subsequently incorporated into public services, first under the management of the Directorate for Primary Health Care and later within the Health Promotion Service of the Public Health Institute of Navarre, under the direction of a social worker.

In 1987, the Programme was implemented in four basic health zones *(2)*. By 2005, it had expanded to 15 zones with the largest Roma populations and was in direct contact with more than half of the 6000–7000 Roma living in Navarre.

10. Equity categorization	Remedying Health Disadvantage

The case study states explicitly that the aim of the Health Promotion among Navarre Ethnic Minorities Programme was to reduce health inequities by improving the health of the Roma community. The Programme is, therefore, categorized as **remedying health disadvantage** by seeking to improve the health of a specific population group. It is also important to note that the Programme was started in 1987, well before the above categories of equity objective were expressed in this way.

Life expectancy in Spain is one of the longest in Europe: in 2003 it was 83.15 years for women and 76.42 years for men *(3)*. People who are socioeconomically disadvantaged are, however, more at risk of illness. In the 1980s, before the Programme started, the Roma community in Spain and in the autonomous community of Navarre experienced poverty and social exclusion, unhealthy housing and environmental conditions, inadequate access to public services, prejudice and discrimination.

The case study cites literature which shows that in the area of health, the Roma population generally is characterized by worse outcomes and behaviour than the general population. For example, infant mortality is generally 1.4 times higher than the national average and life expectancy is between eight and nine years below the average *(4)*. There is also a higher incidence of infectious disease *(5),* mainly hepatitis B and C, with frequently observed transmission from mother to child *(6)*.

Within the Roma community, women experience an increased incidence of certain diseases or risk factors. These are related to their traditional roles as mothers and wives. For example, they have a high fertility rate, with pregnancies starting at a very young age and

continuing into middle age *(7)*. There is very little prevention of gynaecological diseases *(7)* and the burdensome role of caretaker also causes symptoms of depression, anxiety and stress. Thus when the Programme was first established, it initially focused on women.

11. Type of health systems action	Combination (addressing inequalities in access to health services, preventing or ameliorating damage to health, stewardship and direct action on wider SDH)

The Health Promotion among Navarre Ethnic Minorities Programme seeks to reduce health inequities by improving health outcomes, addressing the socioeconomic determinants of health and increasing access to health services. A **combination** of all three types of action for health systems has been taken.

The Programme has a strong focus on **addressing inequalities in access to health services** by providing culturally appropriate health services without fiscal, social or cultural barriers.

It also emphasizes the **prevention or amelioration of damage to health caused by living in disadvantaged circumstances.** For example, the appointment of mediators seeks to reduce cultural and communication barriers to access to primary care services. The Programme has also set in place a number of prevention and health promotion activities for the Roma community in Navarre, including:

- vaccinations
- the introduction of appropriate health education programmes
- a focus on women's health.

The Programme has the specific aim of increasing rates of school attendance by Roma children. Results from one of the evaluations show an increase in school attendance by children aged under 12 years to 90%. Improved health outcomes enable better school attendance. According to the study, an improvement in educational levels within the community has to run in parallel with efforts to improve Roma health. In this way, it can be seen as also taking action directly to **address some of the social determinants** which affect health outcomes. It has sought successfully to improve educational standards for Roma children – an important social determinant of health.

Conclusions from the programme evaluation (covering 1987-2006) showed that future health needs or issues for the Roma community will fall within the second and third categories. For example, in terms of prevention and ameliorating health damage caused by social determinants, factors identified as needing particular emphasis include unhealthy nutrition, lack of proper physical activity, obesity and stress, as well as better diagnosis of mental health problems, especially depression. In terms of direct action on social determinants, the evaluation also highlighted a need to:

- increase levels of school attendance up to the age of 16 years, especially among girls, including ensuring better coordination between health and scholarship programmes;
- address unsafe working conditions, particularly for men;
- tackle or improve housing and employment conditions.

12. Health systems functions addressed by the example	Combination (Creating Resources + Financing + Service Delivery + Stewardship)

Combination: this programme is primarily an example of a health system improving its **service delivery through improved stewardship (health intelligence, policy guidance)** to reach a marginalized, poor and socially vulnerable group more effectively. It also reflects a combination of the four health systems functions.

In terms of **service delivery**, the engagement of mediators from within the community and the designing of a participatory process for clients have resulted in services becoming more client-oriented. There has been an increase in primary health care coverage, which ensures that family doctors and other primary health care workers can improve their protection of members of the Roma community from disease and promote healthy lifestyles. The Programme has also led to improvements in the monitoring of the health status of the Roma community and their use of services.

The Programme is a very good example of **creating resources for health**. The Roma community have particular cultural perceptions of health and disease. They also often face barriers with regard to communication or prejudice when using health services. The Programme aims to reduce those barriers by providing a network of trained mediators from within the community who are knowledgeable about a specific community. The investment in training the mediators has resulted in an improvement in health service performance. Efforts are continuing to strengthen the Programme by training primary care teams (medicine, nursing, paediatrics and social work). During 2008/2009, meetings took place involving all professional teams within the health zones, including sexual health and family planning services. New and emerging needs require the Programme to be updated, strengthened and presented to health professionals. Also because of frequent staff turnover among health professionals, specialized briefings to update knowledge about equity and vulnerable groups are essential.

The Programme addresses the **financing** of health care services for a particularly vulnerable segment of the population. Funding for the Programme has ensured that trained mediators are employed; these are an essential element of the Programme and key to its success. The financing of the Programme has also been sustained over a long period which would indicate that it is a core health initiative. The capacity to fund a Programme of this type also indicates a high degree of flexibility and responsiveness within the financing system.

The Programme is an important example of health systems **stewardship** in action, particularly in relation to policy guidance, health intelligence and oversight, coalition-building and transparency and accountability. Section 17 outlines in detail the investment that has been made in monitoring and evaluating the Programme. Health intelligence generated through activities such as the local/manual census has been used both to improve the Programme and quality of services and to contribute to improved policy development for Roma communities in Spain. For example, it has contributed to the development of a national strategy for health equity for the Roma population *(8)* (see Section 19). In future, data collected for monitoring will be standardized across the zones to enable improved reporting and evaluation. The Programme is an example of an intersectoral initiative that requires joined-up government working at all levels. It is a participatory initiative, based originally on some initial coalitions between sectors, governmental and nongovernmental organizations and civil society. Since its beginning it has built on and strengthened these coalitions for improved health for the Roma population.

13. Critical features of the health system that address health inequity	Combination (Participation and Engagement + Intersectoral action + Revitalisation of PHC approach)

Primarily this is an important example of **participation and engagement,** which are critical to action by health systems to address inequity. The Navarre Ethnic Communities Programme includes a **combination** of three of these features, the other two being intersectoral action and a primary health care approach.

In terms of **participation and engagement**, it is a very good example of how to empower and promote participation by a vulnerable minority group. This has been achieved in a number of ways, for example by appointing mediators from within the community, by eliciting feedback from the community through the health census, and through peer education. The Programme has succeeded in empowering Roma communities through their active participation and the control they gain over their health and its determinants. The authors of the case study state that choosing this type of community-based approach has meant working at a somewhat slower pace, but the approach is deemed to be essential to the continued success of the Programme. It is also consistent with the principles of ethical and effective engagement and participation *(9)*.

Increasing access to **primary care services** for vulnerable groups is an important feature of the health system for addressing health inequity. In the case study, it is explicitly stated that the principles of the Alma-Ata International Conference on Primary Health Care *(10)* were considered very important among health promotion professionals and largely inspired the development of the Programme. Alma-Ata had the importance of primary health care as *essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community though their full participation and at a cost that the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (10).* The evaluation has also shown that the Programme achieved positive results with regard to **primary health care.** Among Roma families 90% are now covered, 80% have had their clinical histories recorded, 80% of children have been vaccinated against childhood diseases and 70% of adolescents have been vaccinated against hepatitis B, and 39.7% of children attend the dental prevention programme.

Intersectoral action mainly with the education and social services sectors as well as intrasectoral action within the health sector are critical features of the Navarre Programme in achieving the health objectives. The main focus to date has been on establishing cooperation between the health and education sectors. School absenteeism is handled by the Roma mediators in cooperation with social workers from the primary health care team, the social services and educational support staff.

While the central level of coordination is comprised of the Public Health Institute, Gaz Kaló (an overall association bringing together the Roma associations of Navarre) and the central health, social, and education services, an intersectoral commission also represents the Programme in each health zone. This local commission analyses the community situation, records Roma requests and needs, monitors local activities and objectives and evaluates the Programme. A local commission normally includes representatives from primary health care, education, social services, a Roma association and a Roma mediator. Evaluation has shown positive results with regard to the contribution made by intersectoral collaboration to reducing mutual prejudices and increasing mutual comprehension and acceptance.

14. Other principles

Since the establishment of the Programme, other resolutions, mandates and/or directives have been developed that reflect principles relevant to the approach used in it. For example, in keeping with EU Directives 2000/43/CE *(11)* and 2000/78/CE *(12)* related to the equal treatment of all people independent of their ethnic affiliation or race, the Council for Equal Treatment and against Discrimination (Consejo para la promoción de la Igualdad de trato y no discriminación de las personas por el origen racial o étnico) was established. (For more information see Section 19 .)

15. Implementation

The Programme has been in place for over 20 years. Since 1987 it has not only been implemented in the four basic health zones but has developed into a broader programme of action for Roma health (see Section 19).

There are three main partners at the central level of coordination:
1. The Public Health Institute, responsible for:

- coordinating activities and providing technical support for social and health workers and Roma mediators in the health zones (see section 8 for further information on mediators or the explanation below);
- selecting and training mediators;

- general monitoring and evaluation,;
- financing activities and hiring and training mediators.

2. Gaz Kaló (an overall association of 15 Roma associations in Navarre), which shares responsibility for training and providing technical support for mediators.
3. The central health, social and education services.

In each implementation zone, the Programme is represented by an intersectoral commission which has a key function in guiding its operational management and direction.

The mediators are key to project implementation. They are the first point of contact between the community and the health care system. As they are based within the community, they are in a position to bring valuable insights which can inform the development of the Programme. When the Programme is to be implemented in a new zone, if a Roma association does not already exist, one must be created. In each zone, the Roma association assumes local coordination of the Programme.

Choosing an approach based on the use of health mediators and emphasizing community participation has meant working at a different and slower pace than that normally used in implementing programmes. This is, however, a critical component of the Programme's structure and is well-established as a best practice approach for working with vulnerable groups. Finally, it is one of the reasons that the Programme has been successful – it has been identified by the Health Systems Knowledge Network as a critical feature of success. Effective participation takes time.

16. Monitoring and evaluation

Staff in the Public Health Institute are responsible for evaluation. The mediators have a pivotal role to play as a liason between the Roma community and the administration.
Continuous training of the mediators is regularly evaluated.

Data on specific indicators are obtained through collaboration between mediators and primary health care professionals. The health census of the Roma community is carried out manually by mediators in their health zones and contains very detailed information on the health of families. This information is analysed by health professionals and used to determine health needs. Specific records are also collated on school attendance.

In each implementation health zone, an intersectoral commission represents the Programme. The commission analyses the community situation, records the Roma people's requests and needs, monitors local activities and objectives and evaluates the Programme. While no specific health targets were set, evaluation has shown that positive results have been achieved in the following diverse areas.

- **Primary health care.** Among Roma families, 90% are now covered, 80% have had their clinical histories recorded, 80% of children have been vaccinated against childhood diseases and 70% of adolescents have been vaccinated against hepatitis B, and 39.7% of children attend the dental prevention programme.
- **Women's health.** Among women of reproductive age, 62% attend family planning centres, 75% control their pregnancies in primary health care centres, 25% attend prebirth courses, and 72% go to the breast cancer prevention programme.
- **Health education.** In 85% of the 15 implementation health zones, group education projects have been convened covering health topics identified through the assessment of community needs.
- **School attendance.** Among Roma children, 90% attend school until they are 12 years old (primary school), although only 33% continue to attend compulsory secondary education until 16 years. Also, high levels of absenteeism are recorded.(2)

The study also makes reference to qualitative results from the Programme including the empowerment of the Roma community, the increase in health education and benefits of intersectoral action (2).

Research is continuing into the health of Roma women in Navarre. Preliminary quantitative results, based on an analysis of data from 320 women, have revealed new information about their attitudes to education, marriage, family, childbirth, birth control and personal development. A parallel process analysing and considering the role of men is also a fundamental part of the Programme. Thus the Programme is trying to work on men's responsibility for their health, on risk-taking attitudes (mainly traffic accidents and substances abuse) and on encouraging them to share domestic and family responsibilities.

A complete evaluation of the Programme (covering 1987–2006) has highlighted some lessons for the future. It has been successful in creating a real concern about health in Roma communities, and health services are increasingly responding to their health needs. To start with the focus tended to be on children's and women's health but, as a result of the health census and family histories, new issues are coming to the fore such as:

- unhealthy nutrition, lack of proper physical activity, obesity and stress, which are among the more challenging health-damaging patterns within Roma communities;
- the importance of increasing school enrolment until the age of 16 years (especially among girls) and reducing absenteeism and drop-out rates, and the need for better coordination between health and education programmes;
- under-diagnosis of mental health difficulties, particularly depression in women and self-medication;
- occupational health issues for men, such as the use of sub-standard tools or vehicles, and the lack of security measures and interventions to reduce such activities (2).

Efforts are now required to standardize the monitoring system across the different zones, and to pay particular attention to Roma perceptions of health when prevention programmes are designed.

17. Health systems context	Taxation-based

The 1986 General Health Care Act outlines the main principles of the Spanish national health system. This system, created from the social security health services, provides universal coverage with free access to health care, is publicly funded (mainly through taxation) and has a regional organizational structure. The taxation-based system was adopted in 2001 and is intended to guarantee financial sustainability *(3)*.

Spain is a parliamentary monarchy. The 1978 Constitution brought about a major transformation of the state and its political structure. The country is organized with a central state and 17 highly decentralized regions (Communidades Autonomas, autonomous communities) with their respective governments and parliaments. Every four years each autonomous community elects a regional parliament, which in turn elects the President by majority. There are 50 provinces and almost 8000 municipalities *(3)*. The programme is being implemented in health zones. Basic health zones are the smallest units of the organizational structure of the health care system. They are usually organised around a single primary care team which is also the main management unit of the zone, coordinating disease prevention, health promotion, treatment and community care activities.

At central level the Ministry of Health and Consumer Affairs assumes responsibility for certain strategic areas, including general coordination and basic health legislation, definition of a benefits package guaranteed by the national health system, international health, pharmaceutical policy and undergraduate and postgraduate education. The 17 autonomous communities hold health planning powers as well as the capacity to organize their own health services. The Interterritorial Council of the national health system is composed of representatives of the autonomous communities, and the state promotes cohesion of the system.

Since 1986, the national health system has undergone considerable development. The focus of reforms in the 1980s was on rationalization of the system and cost-containment, while in the 1990s emphasis was directed towards managerial issues, the internal market and competition. During 2001-2003, the importance of governance and clinical management was highlighted, among other issues *(3)*.

18. Context for development of example

The Roma population in Spain is between 650 000 and 700 000 people *(13),* accounting for an estimated 1.6% of the country's total population (44 million). In the health area, the Roma population is generally characterized by worse outcomes and behaviour than the general population. Evidence has shown that within the community there tend to be poor follow-up of prevention programmes *(14)* and an increased tendency towards health-damaging behaviour *(15)*. Other issues include improper use of medications and a higher incidence of accidents and unintentional injury *(16)* such as burns, falls, pedestrian traffic accidents, bone fractures and cuts. The Roma are also a high-risk group for congenital malformations.

In the early 1980s, before the Health Promotion among Navarre Ethnic Minorities Programme commenced, the Roma population in Spain and in the autonomous community of Navarre experienced poverty and social exclusion, unhealthy housing and environmental conditions, inadequate access to public services, prejudice and discrimination. As a result, they incurred higher mortality, morbidity and prevalence of unhealthy behaviour than the general population.

Primary health care reform began in 1984 and important achievements were made, including the setting-up of a network of primary care centres *(3)*. The reform taking place in Navarre was seen as an opportunity to improve the Roma community's access to health services. In 1985, the First Plan for Roma Development (Primer Plan de Desarrollo Gitano) was approved. This Plan has received €3 million annually since 1989 and is managed by the autonomous communities and town councils. Subsequently development has been continuing with regard to policy initiatives aimed at reducing inequalities. Also in 1989, an initiative began to provide financial support to nongovernmental groups through projects focusing on life opportunities and social inclusion among the Roma people.

Health services often have difficulty in differentiating clearly between the cultural and socioeconomic aspects of the Roma health situation. They are also occasionally inflexible when confronting *differences*; for example, within the Roma community, the concepts of health and disease transcend the individual and extend to the group and community, leading to lack of comprehension by the medical establishment of the importance of relatives and their possible involvement. Furthermore, members of the Roma community trying to access health services may face communication barriers, including language, written communication and mutual prejudices.

The Health Promotion among Navarre Ethnic Minorities Programme began in 1987 at a time when there was no specific programme for the Roma population and when the concept of inequitable access to health services by the Roma population was not acknowledged. It was an innovative approach to promoting active participation by a socially vulnerable minority in health services development. The Programme also introduced a model of health needs assessment (through the health census and family histories) that was appropriate for the Roma community and culture. Since its inception, the Programme has played a pioneering role in informing and orienting the development of policies for the Roma community, including the national strategy for health equity for the Roma population *(8)*.

19. Related policies, background documents and initiatives

This section describes related and key policy developments since 1987 and the commencement of the programme (some of the related policies and initiatives are outlined in Section 19).

In 2003, in response to evidence showing disparities between the use of the health system by the Roma community as compared with the general population, the National Strategy for Health Equity for the Roma Population was launched *(8)*. The Strategy incorporates the following measures:

- the establishment of an Expert Working Group on Health and the Roma Community to assess, mediate and build capacity for Roma health issues, targeting health professionals and administrators as well as representatives of civil society;
- training and awareness-raising for hundreds of professionals and the creation of the *Handbook for action in the area of health services with the Roma Community (13),* targeting health professionals;
- national seminars on health services and the Roma community;
- a National Survey on the Health of the Roma Population (to be compared with the National Health Survey for the general population; the data are forthcoming).

The Strategy has been endorsed and adapted by some of the autonomous communities, which have expanded its scope and increased its effectiveness. The nongovernmental organization, Fundacion Secritariado Gitano, is now coordinating a European-wide project, which has been inspired by the National Strategy for Health Equity for the Roma Population and which involves eight countries *(16)*.

Also in 2003, in keeping with EU Directives 2000/43/CE *(11)* and 2000/78/CE *(12)* related to the equal treatment of all people independent of their ethnic affiliation or race, the Council for Equal Treatment and against Discrimination (Consejo para la promoción de la Igualdad de trato y no discriminación de las personas por el origen racial o étnico) was established.

In 2005, the State Council of the Roma Community (Consejo Estatal del Pueblo Gitano) was created as a mechanism for consultation and assessment, with a specific working group on health. That year also saw the establishment of the Foundation Institute of Roma Culture (Fundación Instituto de Cultura Gitana). The purpose of the Foundation is to increase awareness of Roma issues and to foster an appreciation of the Roma culture by the general population.

In 2008, the document *Roma community and health: conclusions, recommendations and proposals (18)* was published. The report includes the first results of the Roma National Survey on Health and makes proposals and recommendations for reducing health inequities.

20. Funding and resources

Currently the Programme has 12 Roma health mediators and a coordinator, in addition to a professional from the Health Promotion Section of the Navarre Public Health Institute who is responsible for the management of the Programme. All staff members work part-time. Funding comes entirely from the Public Health Institute (Servico Navarro de Salud/Osasunbidea) of the Government of Navarre. The budget is assured through grants for health promotion approved annually by the Institute. The budget in 2007 was €143 499, most of which was destined to cover the salaries of the mediators.

21. Capacity-building, existing skills, etc.

There has been significant investment in building capacity within the Roma community. The central actors in the Programme are the mediators from the community (one in each implementation zone), who are selected according to specific criteria deemed important for this role and extensively trained to liaise between the community and the health services. They also participate in the intersectoral commission and are a valuable resource for the Programme.

The Programme increases mediators' opportunities for education, emphasizes and gives importance to their skills and assets, and strengthens their leadership abilities, all of which also have a positive impact for the community and the Programme. In addition, it aims generally to value and strengthen the role of Roma women, who are educators and caretakers of children and the elderly, and primarily responsible for passing on Roma cultural norms. Improving their health has a multiplying effect, with benefits for other family members.

Training is adapted to the needs of the Roma communities. The mediators highlight areas where they need more information or education, as identified through the Roma associations, e.g. for outbreaks of communicable diseases or issues related to lifestyle, life transitions, chronic diseases and prevention.

In addition, the Andraize family planning centre, which has been collaborating since training started, assists in training aspects related to family planning.

Each September, staff from the Institute of Public Health, Gaz Kaló and Andraize meet to incoporate additional items into the annual training programme.

22. Source(s) of example

The following are the main sources used for this summary profile.

1. Jarauta MJP, Arive MAG, Merino BM. Spain: Health Promotion among Navarre Ethnic Minorities programme.In: *Poverty and social exclusion in the European Region: Health systems respond.* Copenhagen, WHO Regional Office for Europe *(2)*.

Full text of the case study for Spain, one of the series of case studies developed as part of the follow-up to WHO Regional Committee for Europe resolution EUR/RC52/R7 of 2002 on Poverty and Health. The objective of the case studies was to profile a programme or intervention to increase the performance of health systems for one or more of the following groups: immigrants facing poverty and social exclusion, under- and unemployed people, children living in poverty and Roma exposed to poverty and social exclusion. Of the 22–24 case studies, 8 are profiled in this web-based resource. These case studies have been through a process of external peer review and editing.

2. European Observatory on Health Systems and Policies. *Health systems in transition. HiT summary. Spain.* Copenhagen, WHO Regional Office for Europe, 2006 *(3)*.

Summary of the 2006 health systems in transition (HiTs) report for Spain. HiTs are country-based reports that provide a detailed description of each health care system and of reform and policy initiatives in progress or under development. Each profile is produced by country experts in collaboration with the Observatory. In order to facilitate comparisons between countries, the profiles are based on a template which is periodically revised. This profile on Spain was written by Antonio Durán, Juan L Lara and Michelle van Waveren (Técnicas de Salud, Spain) and edited by Vaida Bankauskaite (European Observatory on Health Systems and Policies).

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24. Other information

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