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EUROPEAN SOCIAL CHARTER

GOVERNMENTAL COMMITTEE

REPORT CONCERNING CONCLUSIONS 2009 OF THE EUROPEAN SOCIAL CHARTER (revised)

(Albania, Andorra, Armenia, Azerbaijan, Belgium, Bulgaria, Cyprus, Estonia, Finland, France, Georgia, Ireland, Italy, Lithuania, Malta, Moldova, Netherlands (Kingdom in Europe), Norway, Portugal, Romania, Slovenia, Sweden, Turkey and Ukraine)

Detailed report of the Governmental Committee established by Article 27, paragraph 3, of the European Social Charter[1]

Written information submitted by States on Conclusions of non-conformity for the first time is of the responsibility of the States concerned and was not examined by the Governmental Committee.

[1] The detailed report and the abridged report are available on www.coe.int/socialcharter.

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I. Introduction

1. This report is submitted by the Governmental Committee of the European Social Charter made up of delegates of each of the forty-three states bound by the European Social Charter or the European Social Charter (revised)[3]. Representatives of international organisations of employers and workers (presently the European Trade Union Confederation (ETUC) and the International Organisation of Employers (IOE)) attend meetings of the Committee in a consultative capacity. BUSINESSEUROPE is also invited to attend but did not participate.

2. The supervision of the application of the European Social Charter is based on an examination of the national reports submitted at regular intervals by the States Parties. According to Article 23 of the Charter, the Party "shall communicate copies of its reports […] to such of its national organisations as are members of the international organisations of employers and trade unions". Reports are published on www.coe.int/socialcharter.

3. Responsibility for the examination of state compliance with the Charter lies with the European Committee of Social Rights (Article 25 of the Charter), whose decisions are set out in a volume of "Conclusions". On the basis of these conclusions, the Governmental Committee (Article 27 of the Charter) draws up a report to the Committee of Ministers which may "make to each Contracting Party any necessary recommendations" (Article 29 of the Charter).

4. In accordance with Article 21 of the Charter, the national reports to be submitted in application of the European Social Charter (revised) concerned Albania, Andorra, Armenia, Azerbaijan, Belgium, Bulgaria, Cyprus, Estonia, Finland, France, Georgia, Ireland, Italy, Lithuania, Malta, Moldova, the Netherlands (Kingdom in Europe), Norway, Portugal, Romania, Slovenia, Sweden, Turkey and Ukraine. Reports were due on 31 October 2008 at the latest; they were received between October 2008 and October 2009. The Governmental Committee repeats that it attaches great importance to respect for the deadline by the States Parties.

5. Conclusions 2009 of the European Committee of Social Rights were adopted in October 2009 (Albania, Andorra, Armenia, Azerbaijan, Belgium, Bulgaria, Cyprus, Estonia, Finland, France, Georgia, Ireland, Italy, Lithuania, Malta, Moldova, the Netherlands (Kingdom in Europe), Norway, Portugal, Romania, Slovenia, Sweden, Turkey and Ukraine).

6. The Governmental Committee held two meetings (3-6 May 2010, 11-14 October 2010), which were chaired by Mrs Alexandra PIMENTA (Portugal).

7. Since a decision of the Ministers' Deputies in December 1998, other signatory states were also invited to attend the meetings of the Committee (Liechtenstein, Monaco, San Marino and Switzerland).

8. The Governmental Committee was satisfied to note that since the last supervisory cycle, the following signatures and ratifications had taken place:

- on 3 March 2010, Montenegro ratified the European Social Charter (revised).

9. The state of signatures and ratifications on 3 March 2010 appears in Appendix I to the present report.

II. Examination of Conclusions 2009 of the European Committee of Social Rights

10. The abridged report addressed to the Committee of Ministers only contains summaries of discussions concerning national situations in the eventuality that the Governmental Committee proposes that the Committee of Ministers adopt a recommendation or renew a recommendation. No such proposals were made in the current supervisory cycle. The detailed report is available on www.coe.int/socialcharter.

11. The Governmental Committee continues the improvement of its working methods by applying the new rules of procedure adopted at its 117th meeting (16 May 2009). In applying these measures, it deals with Conclusions of non-conformity in the following manner:

Conclusions of non-conformity for the first time: States concerned are invited to provide information in writing on the measures that have been taken or have been planned to bring the situation into conformity. This information appears *in extenso* in the reports of the meetings of the Governmental Committee (see Appendix II to the present report for a list of these Conclusions);

Renewed Conclusions of non-conformity: These situations are debated in Committee with a view to taking decisions regarding the follow-up (see Appendix II to the present report for a list of these Conclusions);

The Governmental Committee also takes note of Conclusions deferred for a second time for lack of information as well as conclusions deferred because of questions asked for the first time, or due to additional questions, and invites the States concerned to supply the relevant information in its next report (see Appendix III to the present report for a list of these Conclusions.

12. The Governmental Committee examined the situations not in conformity with the European Social Charter (revised) listed in Appendix II to the present report, it used the voting procedure for 2 of them, and adopted 1 warning (see Appendix IV). The detailed report which may be consulted at www.coe.int/socialcharter contains more extensive information regarding the cases of non-conformity.

13. During its examination, the Governmental Committee took note of important positive developments in several States Parties. It also asked governments to take into consideration all previous recommendations adopted by the Committee of Ministers.

14. The Governmental Committee urged governments to continue their efforts with a view to ensuring compliance with the European Social Charter (revised).

15. The Governmental Committee proposed to the Committee of Ministers to adopt the following Resolution:

Resolution on the implementation of the European Social Charter (revised) (Conclusions 2009, provisions articles related to health, social security and social protection)

(Adopted by the Committee of Ministers on ....
at the .... meeting of the Ministers' Deputies)

The Committee of Ministers,[1]

Referring to the European Social Charter (revised), in particular to the provisions of Part IV thereof;

Having regard to Article 29 of the Charter;

Considering the reports on the European Social Charter (revised) submitted by the Governments of Albania, Andorra, Armenia, Azerbaijan, Belgium, Bulgaria, Cyprus, Estonia, Finland, France, Georgia, Ireland, Italy, Lithuania, Malta, Moldova, the Netherlands (Kingdom in Europe), Norway, Portugal, Romania, Slovenia, Sweden, Turkey and Ukraine;

Considering Conclusions 2009 of the European Committee of Social Rights set up under Article 25 of the Charter;

Following the proposal made by the Governmental Committee established under Article 27 of the Charter,

Recommends that Governments take account, in an appropriate manner, of all the various observations made in the Conclusions 2009 of the European Committee of Social Rights and in the report of the Governmental Committee.

EXAMINATION ARTICLE BY ARTICLE[2]

Conclusions 2009 – Revised Charter (CSR)

Albania, Andorra, Armenia, Azerbaijan, Belgium, Bulgaria, Cyprus, Estonia, Finland, France, Georgia, Ireland, Italy, Lithuania, Malta, Moldova, Netherlands (Kingdom in Europe), Norway, Portugal, Romania, Slovenia, Sweden, Turkey and Ukraine

Article 3§1 – Health and safety and the working environment

[1] At the 492nd meeting of Ministers' Deputies in April 1993, the Deputies "agreed unanimously to the introduction of the rule whereby only representatives of those states which have ratified the Charter vote in the Committee of Ministers when the latter acts as a control organ of the application of the Charter". The states having ratified the European Social Charter or the European Social Charter (revised) are: Albania, Andorra, Armenia, Austria, Azerbaijan, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Moldova, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Russian Federation, Serbia, Slovak Republic, Slovenia, Spain, Sweden, “the former Yugoslav Republic of Macedonia”, Turkey, Ukraine and United Kingdom.

[2] States in English alphabetic order.

RSC 3§1 ALBANIA

The Committee concludes that Albania is not in conformity with Article 3§1 of the Revised Charter on the grounds that there is no clearly defined policy on occupational health and safety.

16. The representative of Albania provided the following written information:

"To complete the legal and the existing policies framework to the best practical extent in the area of safety and health at work, Albania took the initiative of drafting the Policy Paper on Safety and Health at Work. The Paper was adopted upon the Council of Ministers Decision No. 500 of 06 May 2009 "On some additions to the Council of Ministers Decision No. 751 of 07 November 2009 "On the adoption of the employment sector strategy and its implementation action plan". Chapter VI "Policy Paper on Heath and Safety at Work" is added as a new chapter after Chapter V in the Sector Strategy of Employment. The Policy Paper on Safety and Health at Work is a paper drafted in the frame of commitments laid down in the government program and in the frame of implementing Article 70 of the Stabilization and Association Agreement with Albania, which defines the obligation of aligning national legislation with the Community legislation and National Implementation Plan of the Stabilization and Association Agreement.
The purpose of this paper is to build a clear path for the development in the future of safety and health services at work. In addition, the aim is to involve through it more institutions and opinion in order to make the workplace more productive, from which all people benefit, and not let only the State Labor Inspectorate contribute to the achievement of safer and healthier workplaces.
The paper sets forth the improvement of the inspection system by means of the following: i) approximation of the legal framework to the "Acquis Communautaire"; ii) building of a modern and unique system of labor inspectorate service across the whole country; iii) development of partnership with social stakeholders; iv) development of an information and communication system with the enterprises; v) development of a culture of preventing risks at work. When drafting this document, the EU Strategy 2007-2012 "On safety and heath at work" and other international acts, which the Republic of Albania has ratified in the Parliament, were taken into consideration.

When defining the vision of the Policy Paper on Safety and Health at Work, the vision of the National Strategy of Development and Integration (NSDI) was also taken into consideration for the coming years in way, which personifies the wish of each Albanian citizen to see Albania as a country with high living standards, integrated into the European and Euro-Atlantic structures, to be a democratic country and ensure the fundamental human rights and freedoms of all of its citizens.
To achieve this vision, strategic priorities, as referring to the strategic objectives, are focused on the following areas:

a. Relevant legislation
b. Institutional effective framework
c. Appropriate education and training in the area of safety and heath at work.
d. Raising of awareness and social motivation on safety and heath at work.
e. Application of new tools for effective measures to enhance safety and heath at work and effective cooperation with other organizations, social partners and international organizations.

a. In the frame of the implementation of the Policy Paper, the Ministry of Labor, Social Affairs and Equal Opportunities undertook the initiative to draft the Law No. 10237 of 18 February 2010 "On safety and health at work".
The drafted Law reflects provisions of Acquis Communautaire in the area of safety and health at work, EU recent recommendations, especially of the Frame Directive of European Council (89/391/EC of 12 June 1989) "On the Introduction of Measures to Encourage Improvements in the Safety and Health of Workers at Work", 31989L0391, Official Journal 183, Series L, of 29 June 1989, page 0001-0008, and it meets the commitments in relation to the International Labor Organization upon ratification of Convention No. 155 "On safety and health of workers and conditions at work (for more detailed information about this Law refer to Answers provided to Question No. 65).
b. Proper education and training for Safety and Health at Work.
Education and training regarding Safety and Health at Work systematically helps to create and develop professional knowledge, opportunities and skills in addition to building positions and behaviors as expected by the employers, employees and self-employed persons and, in particular, concerning appropriate introduction of Safety and Health at Work issues into a permanent education system, which is linked with the vocational education, deepening and refining of training, retraining, further education and learning of new skills. Elementary and primary schools may play an important role in terms of education on Safety and Health at Work, because reactions against risk prevention may be learned more easily during childhood.

Being aware of the importance of health protection and prevention of damages, these principles must be provided starting from the elementary and primary education.

c. Raising of awareness and social motivation on safety and heath at work.

European and national information campaigns represent an important means in achieving the positive changes concerning prevention. Their objective is to exchange experience in specific fields of work risks, as well as, spreading of best practices in terms of identifying the risks and elimination or reduction of their impact on employees health and safety. Effective application of information means, especially between employers, serves to raise awareness on safety and health at work and to create and uphold a positive approach vis-à-vis the employers, employees and self-employees. Knowledge about best practices of safety and health at work is distributed through informing and advising activities, as well as, through procedures, which lead towards the improvement of work conditions and workers' health so that they do not risk performance at work.

d. Application of new tools for effective measures regarding safety and health at work.

An identification, evaluation and permanent management system of the existing risks or of the risks that may emerge is the main preventive basis in the area of safety and health at work. It is particularly necessary for the employers, self-employed and employees to be motivated through economic initiatives. Integration of safety and health at work into the enterprises management system, mainly in SMEs, bears a special importance. The role of the workers' representatives in solving issues of safety and health at work, technical assistance and providing of the information opportunity for all parties involves, vocational advising and education are also very important.

e. Effective cooperation.

Cooperation between the relevant state administration and social partners is one of the substantial requirements regarding prevention and fulfillment of international principles. Such cooperation must be performed in compliance with the national and international regulations and the legislation of all levels – at company level, at local and regional level through social dialogue and participation of social partners in the settlement of issues concerning safety and health at work and through the discussion of goals and proposals regarding legal improvements. It is also important to support bilateral cooperation at company level when drafting the internal rules of corporations, during risk prevention, employer's control activity and collective agreement. The Commission of the National Labor Council on Safety and Health at Work has an important role to play in terms of encouraging cooperation across all levels. Bilateral agreements between major partners in the area of safety and health at work must form the basis of cooperation at national level.

Monitoring of the Policy Paper on Safety and Health at Work it is envisaged to be carried out by the policymaking structure, which is responsible for safety and health at work in the Ministry of Labor, Social Affairs and Equal Opportunities, as well as, by the structures, technical inspectorates, which operate in the line ministries. Moreover, Article 36 of Chapter VII of the Law on safety and health at work provides the establishment of an Interministerial Council on safety and health at work to best coordinate all laws and policies to be drafted and implemented by all responsible institutions in this area. (See website of the Ministry of Labor, Social Affairs and Equal Opportunities http://www.mpcs.gov.al/images/stories/ministria/mpcsshb/legislation/ where the Policy Paper is available)."

17. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 3§1 ITALY

The Committee concludes that the situation in Italy is not in conformity with Article 3§1 of the Revised Charter on the ground that it has not been established that there is an appropriate national policy on occupational health and safety.

18. The representative of Italy provided the following written information:

"With regard to the conclusion drawn by the European Committee of Social Rights concerning the lack of an appropriate national policy on occupational health and safety, we wish to point out that, following the recent reform of occupational health and safety standards, a national system for discussing, framing and implementing guidelines and policies in the field of health and safety at work has been put in place. This system is duly established by law and is designed to provide a common framework for the activities to be carried out in this area, so as to make them more effective.

Thanks to the recent reform, Italy now has a set of preventive rules which are strictly in line with the key international and EU texts as well as the relevant constitutional provisions. Under the latter,

central government and regional authorities have joint jurisdiction, in order to combat accidents at all places of employment, both public and private, as effectively as possible.
The reform in question was introduced first through **Legislative Decree No. 81/2008** (also known as the Consolidated Text on Occupational Health and Safety) and later **Legislative Decree No. 106/2009.** This last decree supplemented and improved the legislative framework created by the 2008 initiative, having particular regard to the proposals for amendments made by the social partners and the competent administrative bodies in this area.

In any event, all the measures proposed guarantee compliance with the levels of protection currently enjoyed by workers and their representatives throughout the country and the balance of powers and responsibilities between central and regional government in this area.
Under Legislative Decrees Nos. 81/2008 and 106/2009, compliance with these levels of protection and the guarantee of uniformity in public prevention measures are ensured through the existence of a national system for discussing, framing and implementing occupational health and safety guidelines and policies.

The "Consolidated Text" on occupational health and safety identifies and regulates a series of bodies whose ongoing task is to pave the way for:
1)the preparation of a national strategy for the prevention of industrial accidents and occupational diseases thanks to discussion between central government, the central public administrations (APUCs) competent in this area and the regions, and consultation with the social partners;
2)the implementation at first regional and then provincial level of the nationally agreed guidelines on prevention;
3)the dissemination and sharing of data on accidents at work, occupational diseases and occupational health and safety inspections with the participation of the social partners;
4)discussion on topics related to occupational health and safety and further exploration of these issues within a tripartite framework, i.e. with equal numbers of representatives from the public administrations, employers and workers, and the development of guidelines and good practices within this framework, with special attention being given to training in occupational risks and their assessment;
5)the introduction of national policies to provide support, including financial support, for prevention measures, with particular emphasis on training and the dissemination of models for organising and managing safety.

In connection with the first point, we should point out that Article 5 of the "Consolidated Text" on occupational health and safety identifies a national body whose job it is to "direct" national prevention policies, thus enabling the priorities, aims and timeframes required for prevention activities to be agreed through ongoing discussion between the various members of the body.
The strategic approaches agreed by the above-mentioned Committee guide the activities of the administrations, with the focus on sharing and exchange and hence economy and efficiency in the activities concerned. More specifically, under point 2) above, the national guidelines on inspection activities (as agreed by the above-mentioned Committee in Article 5 of the "Consolidated Text") are duly implemented across the country via the territorial (regional) committees referred to in Article 7 of Legislative Decree No. 81/2008, as subsequently amended.
The regional guidelines are relayed to each Italian province by a provincial committee in order to ensure uniformity in the supervision exercised across the country as a whole, with due regard for the specific features of the different areas (these features are discussed in the regional and provincial committees).
The creation of a unified national information system for prevention is the main aim of the reform of Italy's health and safety legislation. In this respect, Article 8 of the "Consolidated Text" provides that a national information system for prevention (SINP) is to be set up at INAIL (National Insurance Institute for Occupational Injuries) to "provide relevant data for the purpose of guiding, planning and evaluating the effectiveness of activities to prevent occupational accidents and diseases and also for guiding supervisory activities".
The ministries with responsibilities in the field of health and safety (namely the Ministry of Labour and the Ministry of Health but also the Interior Ministry and the Ministry of Defence, according to their respective powers), INAIL, the regions and the autonomous provinces of Trento and Bolzano all play a part in this system.
Under Article 8, paragraph 6, of Legislative Decree No. 81/2008, as subsequently amended, all members of the national information system for the prevention of accidents at work (SINP) are required to provide a constant flow of data on:

- a) production and employment conditions;
- b) the situation with regard to risks, with particular attention being given to the gender issue;
- c) the situation with regard to the health and safety of workers;

- d) action taken by the competent institutions;
- e) supervisory measures taken by the competent institutions;
- e-bis) data on occupational accidents which fall below the INAIL compensation threshold. These data are likewise discussed with the social partners.

The social partners' involvement in the process of framing occupational health and safety strategies in Italy is fully guaranteed thanks notably to the clause that requires them to be permanently represented on the Advisory Commission on Occupational Health and Safety, as provided for in Article 6 of the "Consolidated Text", and thanks also to the presence of representatives of the social partners on the regional committees, as provided for in Article 7 of Legislative Decree No. 81/2008 and preventive consultation on the activities of the Committee, which help to ensure their participation in the above-mentioned process. The advisory commission comprises 10 central government officials, 10 regional government officials, 10 representatives of employer's associations and 10 trade union officials.
The commission was formally established by ministerial decree of 3 December 2008 and has considerable powers and responsibilities in the field of occupational health and safety.
Examples of its tasks include preparing standard procedures for assessing risk in small and medium-sized firms, drawing up methodological guidelines for assessing risks related to occupational stress and identifying qualification criteria for trainers.

Having an effective strategy for combating accidents at work involves more than simply updating the relevant legal framework described above and ensuring the participation of both sides of industry. It also requires the implementation of a series of public and private measures to improve prevention and raise the level of protection in all workplaces.
That is why Italy is currently seeking to step up co-operation between all the parties involved in the public and private sectors with a view to improving the effectiveness of the respective activities, with particular regard to the aims mentioned in point 5).
For example, setting employment criteria and allocating funds for activities designed to promote health and safety (approximately 50 million euros) form part of the same strategic vision following the agreement concluded on 20 November 2008 by the State-Regions Conference[1]. Among the above-mentioned activities are a €20 million **advertising campaign** on health and safety at work (to be launched shortly) and **regional training activities** (to the tune of €30 million). The funds have been duly released and made available for the activities in question. In addition, each region has been asked to submit a programme of training activities consistent with the terms of the agreement as a condition for receiving funds from the Ministry of Labour. The Ministry of Labour has already made payments to those regions which have submitted programmes in line with the said agreement.

As regards the funds granted for 2009 (more than 37 millions euros), an interministerial decree has been tabled for the purpose of distributing funding for activities designed to promote occupational health and safety in the following areas:

a) **planned investments in the occupational health and safety field and development of safety management models for small and medium-sized businesses** (5 million euros);
b) **funding for training projects** in the occupational health and safety field (27 million euros);
c) **funding for activities in schools, universities and training institutions with a view to incorporating occupational health and safety into their curricula** (5 million euros). The document in question was discussed with the regions and social partners within the framework of the Advisory Commission on Occupational Health and Safety in June and July 2009. It has been officially approved by the Ministry of Economy and Finance and the Ministry of Education.

In the light of the above, we believe that the situation of non-conformity with Article 3§1 of the Social Charter due to the lack of an appropriate national policy on occupational health and safety has now been remedied."

19. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 3§1 ROMANIA

The Committee concludes that the situation in Romania is not in conformity with Article 3§1 of the Revised Charter on the ground that it has not been established that the national policy on health and safety includes training, information, quality assurance and research in a satisfactory manner.

[1] The State-Regions Conference is tasked with promoting co-operation between central government and the regions and autonomous provinces within a national framework. The Conference thus provides an ideal forum for political negotiations between central government and the system of autonomous regions.

20. The representative of Romania provided the following written information:

"Training in health and safety is not only an objective of this policy and strategy but is a continuous process for all players in this field: public authorities, employers, workers and external services for prevention and protection.
Thus, in accordance with the Law no. 319/2006 on health and safety and Government Decision no. 1425/2006 approving the Methodological Norms for applying Law no. 319/2006, each worker must receive adequate and sufficient training in the field of health and safety. The legislation also establishes minimum requirements for training in this area:

- Basic level (at least for employers who can organize prevention and protection activities and the members of the Committees on Health and Safety at Work) – course less 40 hours;
- Medium level (at least for workers appointed by the enterprises, workers in the Internal Service for Prevention and Protection and the External Service for Prevention and Protection) - course of 80 hours;
- Upper Level (at least for the chiefs of External Services for Prevention and Protection and the Internal Services for Prevention and Protection) – course of 80 hours, and postgraduate course on Risk Assessment with a duration of at least 180 hours.

We underline the fact that except for the postgraduate courses, which must be in line with the requirements for the higher level courses on health and safety, the courses are provided by training providers licensed in accordance with Government Ordinance no.129/2000 on adult training, approved with amendments by Law no. 375/2002, republished with amendments and completions.
We also highlight that the National Institute on Research and Development in the field of Labour Protection "Alexandru Darabont" (INCDPM), trained a number of about 4,000 experts on health and safety (basic, medium and advanced level), out of which 1,090 in the past three years (2007-2009).
As provided in the strategy for 2004-2007, the setting up of structures on insurance for work accidents and occupational diseases, required the training of personnel as follows:

- There were delivered 30,000 hours of training. A mixed team of local and EU experts have provided a good basis of knowledge to 117 counselors on prevention, technicians and physicians;
- There were delivered 56 theoretical training modules , followed by 31 practical tests in 24 areas of the country;
- 17 counselors on prevention were enrolled in training courses for trainers, and will ensure the training of the personnel newly entered in the system.

The Labour Inspection has its own training center for the labor inspectors, where there are trained other specialists as well.
The Romanian Policy and Strategy on Health and Safety at Work for 2004-2007 includes the objective of "training and improvement of skills for specialists in the filed of occupational health".
In this regard, given the crucial role of health surveillance of workers, the number of occupational physicians increased over this period from 262 in 2004 to 579 in 2010.
Moreover, the Order of General Nurses, Midwives and Nurses in Romania organized and conducted numerous training courses for nurses in the field of health and safety.

Concerning the **dissemination of information on safety and health**, MLFSP by the Focal Point of the European Agency for Health and Safety at Work, which operates inside the INCDPM in Bucharest, organized conferences and symposia in most counties, dedicated to the campaigns established by the European Agency on the following topics:
2008 - 2009: The European Campaign for Health and Safety at Work. Safe and healthy workplaces.
2007: Reduce the effort – muscular and skeletal disorders
2006: Safe Start - young workers
2005: Reduce Exposure to Noise!
2004: Building in safety
2003: Dangerous Substances - Handle With Care!
2002: Stress at work
2001: Success without Accidents
2000: Turn back to muscular-skeletal disorders
Each year during 2007 – 2012, the Labour Inspectorate will conduct 5 information and raising-awareness sessions for the employers and workers in SMEs with a view to promote best practices on health and safety at work, as a continuation of Phare Project RO 04/IB/SO-01 in which a *Guide for risk assessment in SMEs was developed*. The Guide was printed in 150,000 copies and can also be accessed on the web page dedicated to SMEs developed in the same project (http://www.inspectiamuncii.ro/ssmimm/).

The **information and dissemination of knowledge** are achieved on websites, both of the institutions in charge with this area of responsibility, and of the non-governmental organizations, local governments or advisory service operating in the field of health and safety. Among these websites we can mention:

- Ministry of Labour, Family and Social Protection: www.mmuncii.ro for consulting the legislation, the database of external services on prevention and protection, as well as any news in the field of health and safety at work;
- The Focal Point in Romania, whose website is www.protectiamuncii.ro, which is available both in Romanian and English, especially for good practices in other EU Member States. There is also a special site for SMEs http://imm.protectiamuncii.ro/;
- The Labour Inspection: it created the website at central level (http://inspectmun.ro/) and for each of the 42 territorial inspectorates. It provides a series of guides on best practices translated in Romanian, forms for employees and employers, other useful information;
- The National Institute for Research and Development in the field of Labour Protection "Alexandru Darabont" www.inpm.ro;
- The National Institute for Safety and Anti-Explosion Protection in the Mining Sector - INSEMEX - Petrosani: www.insemex.ro
- ARSSM – an NGO including experts in the field of health and safety.

Moreover, through the Information Center for Documentation and Publishing inside the INCDPM there were printed and distributed to enterprises a significant number of instructions, guides, catalogues, manuals, brochures, posters, films etc.

According to Law no. 108/1991 - Article 6 (1), (b), **the Labour Inspection** also co-ordinates the activity of raising awareness and information of the employees in the field of health and safety at work and monitors the training of the specialists in charge with the health and safety at work.

In this regard, the territorial labour inspectorates organize occupational training courses, for the personnel in charge with the health and safety at work, employed by the legal and natural persons, and also for the members of the health and safety committees, for those employed in specialized departments, for the trade unions and employers' organizations representatives as well as for employees from various fields of activity. Thus, 1,855 persons graduated these occupational training courses, during 2004-2006, as follows: in 2004 – 838 persons, in 2005 – 734 persons and in 2006 – 238 persons.

Research activities

The 2009-2012 Sectoral Plan on R&D was developed by the MLFSP, for the due area of responsibility, i.e. item 5 " Health and Safety at Work" structured in accordance with the Order no.668 of 02.10.2008 issued by the Minister of Labour, Family and Social Protection no.760 of 11.11.2008 published in the Official Gazette, Part I.

Currently there are developed preventive tools available to businesses based on research studies funded by the National Authority for Scientific Research, through the Program "2006-2009 Health and Safety at Work":

- Developing an integrated package of tools for HSW management in SMEs (PIMES);
- Guidelines for identifying, preventing and addressing risk factors in physical working environment;
- Methodological guide for monitoring and evaluation of exposure to chemical agents;
- Assessment indicators for the performance of management systems on health and safety according to SR OHSAS 18001: 2008;
- Developing the management in the field of health and safety by integrating the dimension of "control of psychosocial risks at enterprise level (methods, tools);
- Develop a method of economic and financial substantiation of investments in health and safety at work;
- Guide on health and safety at work for SMEs;
- Guidelines for achieving training on health and safety at work in special situations: (re)integration on the labour market of inactive people and long-term unemployed, multilingualism, new forms of employment contracts;
- Evaluation of on-line public services on health and safety at work;
- Methodological basis for the identification, analysis, evaluation, expertise and monitoring of occupational risks at workplaces in accordance with the provisions set by law, and
- Guidelines for the prevention and control of noise exposure of workers in music and entertainment environment, as required by the Community legislation in force.

[1] Law no 108/1999 on the set-up and organization of the Labour Inspection

The **Institutes of Public Health in the subordination of the Ministry of Health** have also initiated studies and research on the identification of new risks: best practices guidelines available to SMEs (The guide on workers' health *What do we need to know about periodic medical examination?*)

The **Labour Inspection elaborated the Strategy on health and safety at work 2008-2012** and the objectives set out in the 2007-2012 Community Strategy on health and safety at work are included on the agenda as well as among the current actions and tasks assumed by the institutions with responsibilities in this area. "

21. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

Article 3§2 – Safety and health regulations

RSC 3§2 ALBANIA

The Committee concludes that the situation in Albania is not in conformity with Article 3§2 of the Revised Charter on the ground that the self employed are not covered by health and safety at work legislation

22. The representative of Albania provided the following written information:

"The Council of Ministers Decision No. 100 of 02 March 2008 "On hazardous substances" (Official Gazette: 2008, No. 19, page 679, published on 22 February 2008). The scope of this decision consists in defining the hazardous substances in order to protect health and provide safety at work when using them. This decision is binding on all production and import natural and legal entities, which are obliged to respect the norms of the workplace.

Republic of Albania has signed Stockholm Convention of 05 December 2001 and it has ratified it upon Law No. 9263 of 29 July 2004 "On the accession of the Republic of Albania to Stockholm Convention", therefore undertaking the commitment to prevent using most part of Organic Undissolvable Pollutants, restriction of DDT (Dichlorodiphenyltrichloroethane). In this frame, the Ministry of Environment, Forestry and Waters Administration in cooperation with the Project "Drafting of the National Plan to Implement the POP Convention" (2004-2006), funded by the Global Environment Fund - GEF, United Nations Development Program - UNDP, drafted the National Action Plan and adopted it upon the Council of Ministers Decision No. 860 of 20 December 2006 "On the adoption of the national action plan about discarding and elimination of undissovable organic pollutants", Official Gazette No. 145of 2006, Page 5723, published on 09 January 2007.

Concerning a number of important issues as identified in the Action Plan for Organic Undissolvable Pollutants, Albania has a made significant progress in solving them upon the support of international organizations and bilateral agreements. In this context, it is worth mentioning the removal from the country of all pesticide Organic Undissolvable Pollutants. The last stock of pesticide Organic Undissolvable Pollutants was removed in 2006. Hexachlorane and Lindane leftovers of Durres former chemical plant will be deposited in a CDF (confined disposal facility), the building of which is planned to be carried out by 2010.

The Council of Ministers Decision No. 824 of 11 December 2003 "On the classification, packaging, labeling and safe storing of hazardous substances and preparations", Official Gazette No. 130 of 05 September 2009, page 6078, aims at regulating the production, trading, storing and distribution of hazardous substances and preparations by respecting the Albanian legislation and the international rules. The producer, importer and distributor of hazardous substances and preparations may bring them to the market only if it makes sure that in case of leaking of the hazardous substances and preparations out of the packaging, they shall not pose a threat in terms of causing harm to human health or to the environment.

According to Paragraph 5.1 of this decision, the producer, importer and distributor may bring to the market hazardous substances and preparations only if they shall bear the labels, which provide data about their hazardous characteristics, according to this decision.

Depositing and storing of chemicals, which are dangerous for the health and environment, shall become subject to the permit and registration procedure. Applications for permits shall be addressed to the Ministry of Economy, Trade and Energy, while for registration, to the Ministry of Environment, Forestry and Waters Administration. The Commission for issuing the permit for depositing and storage of hazardous chemicals will be established in the Ministry of Economy, Trade and Energy consisting of representatives from this Ministry, form the Ministry of Health, Ministry of Interior and the Ministry of Environment, Forestry and

Waters Administration. The procedure of acquiring a permit and the regulation of the functioning of the commission shall be adopted by the Ministers of the assigned ministries.
The Council of Ministers Decision No. 824/2003 partially transposes Directive 67/548/CEE of 27 June 1967 "On the approximation of laws, regulations and administrative provisions concerning classification, packaging and labeling of hazardous substances", 31967L0548, Official Journal No. 196, Series L, of 16 July 1967, Page 0196-0198 and its amendments.
Chapter 4 of the manual in support of the State Sanitary Inspectorate provides the list of accepted limits of poisonous gases, steams and dusts in the air of work facilities, according to the table obtained from the "Legal provisions of hygiene at work", Tirana 1974.
In the frame of the legislation on safety and health at work, the Ministry of Labor, Social Affairs and Equal Opportunities has drafted Law No. 10237 of 18 February 2010 "On safety and health at work[1].

- Acquis Communautaire provisions on the area of safety and health at work, recent EU recommendations, especially those provided in the Frame Council Directive 89/391/EEC of 12 June 1989 "On the introduction of measures to encourage improvements in the safety and health of workers at work", 31989L0391, Official Journal 183, Series L, of 29 June 1989, page 0001-0008, have been fully transposed into the Law.
- In addition, Council Directive 94/33/EEC of 22 June 1994 "On the protection of young people at work", partially fulfills the commitments vis-à-vis the ILO with the ratification of Convention No. 155 "On safety and health of workers and environment at work".

The scope of this Law consists in ensuring safety and health at work for workers and the responsibilities of workers to achieve an appropriate level of the protection of people's health against dangers at work by means of drawing up coherent, coordinated and effective measures to prevent risks at work.
Article 3, Paragraphs 1, 2 and 3 of Law No. 10237/2010 "On safety and health at work" lays down the area of implementation of this Law across all sectors of private and public activity (thus, including here the self-employed). The exemptions here include the corresponding fields when the other legal provisions provide more advantageous treatments regarding protection of workers' safety and health at work. Moreover, this law is not applied to a number of specific services of Armed Forces, when the service specifics do not comply with the provisions of this law. In such cases, safety and health at work must be provided as much as practical in compliance with the requirements of this Law. The innovation of this Law includes the obligation of employers to draft the risk assessment and prevention paper, which contains measures of technical, organizational, hygiene and sanitary character, which will be implemented according to the specific conditions of the activity job positions.
In addition, it has been envisaged to establish and operate the services of protection and prevention and of the safety and health Council at enterprise level, services which have not existed to date even as a notion in the Albanian legislation. These structures, which comprise also the social bipartisan dialogue at enterprise level, will serve for the implementation of preventive measures and they will ensure balanced participation of workers when drafting the risk assessment and prevention document for work-related risks.
More specifically, Article 13 of Law No. 10237/2010, provides that the employer shall allow the workers and their representatives to participate in discussions for all issues that are related to safety and health at work according to Articles 10 and 11 of this Law and bylaws, issued pursuant to it, in the Council of Safety and Health at Work.
Article 14, Paragraph 2 of the Law provides the Council of Safety and Health at Work is a partnership and advisory body with representatives of employers and workers, who are equally represented and the purpose of which is to regularly consult about the enterprise activity to prevent risks at work. Another innovation of this draft law is the introduction of the notion of specialized services outside the enterprise, which are provided by persons who are trained to carry out protection and prevention services.
Chapter V of this Law "Inquiry of accidents at work" is a novelty as it classifies accidents into 4 categories based on the consequences that the accident causes and the number of affected persons. Chapter VI provides the groups that are vulnerable to risks and, particularly, special protection of pregnant women, breastfeeding women, minors, disabled persons, as well as, specific measures to be taken by the employer to adjust the workplace with this category of workers in order to prevent risks that derive from work.
Article 19, Paragraph 1(a, b, c) of the Law sets out when workers shall be trained. This is reflected by the fact that the employer, before employing someone and during the employment itself, makes sure that every worker (either with a fulltime or part-time contract) shall receive the necessary training in new technologies or work devices when they are introduced or, when the work process changes in a manner that the hazard affects the level of health and protection at work, as well as, cases of job transfer and change. Consulting of social partners about issues that are connected with the workers' health and safety at work shall be conduced in the institution of the social dialogue, which is the National Labor Council, as well as, in its three-party specialized commission for safety and health at work. Article 200, Paragraph 3 of the Labor Code provides that consultations shall be conducted especially in relation to preparations and

[1] http://www.mpcs.gov.al/images/stories/ministria/mpcsshb/legislation/laë_nr__10_237_on_safety_and_health_at_ëork__2_.pdf

implementation of labor legislation, amendments of this code and the content of bylaws and, in relation to the policies and international organizations, which have to do with … workers' protection, hygiene and technical safety …, as well as, with the enforcement of the norms of ILO. Moreover, one of the most expressed forms of consultation with the social partners about issues of safety and health at work occurs during the negotiations of concluding the collective work contracts. The outcomes of these consultations consist in stipulations concerning rights and obligations of the parties concerning safety and health at work as one of the highly considered issues of the collective work contracts in compliance with Chapter VIII of the Labor Code of the Republic of Albania."

23. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 3§2 CYPRUS

The Committee concludes that the situation in Cyprus is not conformity with Article 3§2 of the Revised Charter on the ground that domestic workers are not covered yet by any occupational health and safety regulations.

24. The representative of Cyprus stated that legislation on health and safety at work is currently in the process of being amended in order to cover domestic workers. Adoption by the Parliament is expected as soon as legal vetting has been obtained from the competent parliamentary commission.

25. The Committee invited the government of Cyprus to bring the situation into conformity with Article 3§2 of the revised Charter.

RSC 3§2 FRANCE

The Committee concludes that the situation in France is not in conformity with Article 3§2 of the Revised Charter on the ground of the insufficient protection of self-employed workers.

26. The representative of France indicated that an assessment of the legal problems faced by self-employed workers had been carried out in 2007. However, the results of this assessment did not make any recommendations insofar as health and safety are concerned. She added that an action plan on health at work will run from 2010 until 2014 to improve the health and safety of different categories of workers, including the self-employed.

27. The Committee invited the Government to provide all the relevant information in its next report, and decided to await the next assessment of the ECSR.

RSC 3§2 MOLDOVA

The Committee concludes that the situation in Moldova is not in conformity with Article 3§2 of the Revised Charter on the grounds that it has not been established that there is specific legislation on the main occupational risks, and that temporary workers and self-employed workers are adequately protected by occupational health and safety regulations.

28. The representative of Moldova provided the following written information:

"The Occupational Health and Safety Act was implemented through the adoption of Government Decision 95 of 2 February 2009, endorsing the Regulation on the arrangements for protecting employees in the workplace and preventing occupational hazards and the Framework Regulation on the organisation and functioning of Occupational Health and Safety Committees.

The Regulation on the arrangements for protecting employees in the workplace and preventing occupational hazards sets out the rules on the organisation of protection and prevention activities, the qualifications required of persons appointed to carry out protection and prevention work, the procedures for establishing and running internal and external protection and prevention services and designating workers' representatives with special responsibility for health and safety issues and the minimum education and training requirements in the area of occupational health and safety.

Under this Regulation, the type of protection and prevention activities to be carried out is determined by the results of occupational risk assessments and they are conducted in accordance with a company action plan.
Under the Framework Regulation on the organisation and functioning of Occupational Health and Safety Committees, the Committee's task is to ensure that employers and employees co-operate to identify measures to secure employees' health and safety in the workplace. Committees are set up at the instigation of any of the parties concerned while observing the principle of parity between employer representatives and workers' representatives with special responsibility for health and safety issues. Where a company has several branches spread throughout the country, several separate committees may be set up.
On 5 May 2010, Government Decision **353** endorsing the minimum occupational health and safety standards was adopted.
No distinction is made in the Occupational Health and Safety Act between temporary and permanent workers. Occupational health and safety legislation and regulations are applied in public and private sector activities to:
- employers;
- employees;
- employees' representatives;
- jobseekers performing tasks for a company with the employer's authorisation subject to prior verification of their professional skills;
- people carrying out unpaid community work or activities under volunteer schemes;
- persons without individual written employment contracts but for whom proof can be provided by other means that they have provided certain services and should have been covered by contractual clauses;
- prisoners working in prison workshops or other workplaces during their prison sentences;
- unemployed people taking part in occupational training.

Currently the Government is amending and adding to national legislation on occupational health and safety so that it will also cover self-employed workers.
To complete the measures for the application of the Occupational Health and Safety Act, the following standards are being drawn up:
- minimum occupational health and safety standards;
- minimum health and safety standards with regard to exposure of employees to risks caused by vibration;
- minimum health and safety standards with regard to exposure of employees to risks caused by noise;
- minimum health and safety standards with regard to exposure of employees to risks caused by electromagnetic fields;
- minimum heath and safety standards for the handling of loads which pose risks to employees, particularly risks of back problems;
- minimum standards for activities intended to protect employees in the workplace and prevent occupational hazards;
- standards to protect the health and safety of employees against risks connected with the presence of chemical agents in the workplace;
- standards to protect the health and safety of employees against risks connected with exposure to asbestos;
- standards to protect the health and safety of employees against risks connected with exposure to carcinogenic or mutagenic agents in the workplace;
- standards to protect employees against risks connected with exposure to biological and other agents."

29. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 3§2 ROMANIA

The Committee concludes that the situation in Romania is not in conformity with Article 3§2 of the Revised Charter on the ground that domestic workers are not covered by occupational health and safety regulations.

30. The representative of Romania indicated that the extension of the applicability of occupational health and safety legislation to cover domestic workers was under consideration. She added however that there was currently no time frame for amending this legislation.

31. The Committee invited the government of Romania to bring the situation into conformity with Article 3§2 of the revised Charter.

Article 3§3 – RSC Enforcement of safety and health regulations

RSC 3§3 ALBANIA

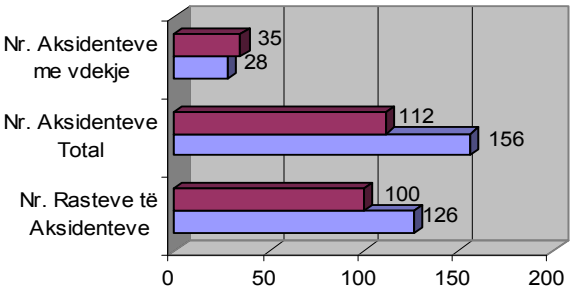
The Committee concludes that the situation in Albania is not in conformity with Article 3§3 of the Revised Charter on the ground that there is no efficient labour inspection system.

32. The representative of Albania provided the following written information:

"To protect workers against hazardous substances, the Decision of the Council of Ministers No. 100 of 02 February 2008 "On defining hazardous substances" was approved. This decision of the Council of Ministers applies to fulltime and part-time workers. All labor inspectors have been trained with regard to the implementation of this Decision.

Data on the accidents at work and the enterprise doctor.
Number of accidents registered at the State Labor Inspectorate in 2009 and the first couple of months of 2010 is low, because employers do not report all accidents. Implementation of the law on safety and health at work will lead to a real situation in terms of accidents registration. This because the Law provides that the Council of Safety and Health at Work will be established in the enterprise or that there will be Workers' Representatives. Their existence will not allow employers top hide accidents anymore.

During 2009, in all kinds of activities, 100 accidents were registered, in which 112 workers were involved, 35 of which died. The following graph indicates a comparison of accidents that have occurred in 2008 and 2009.

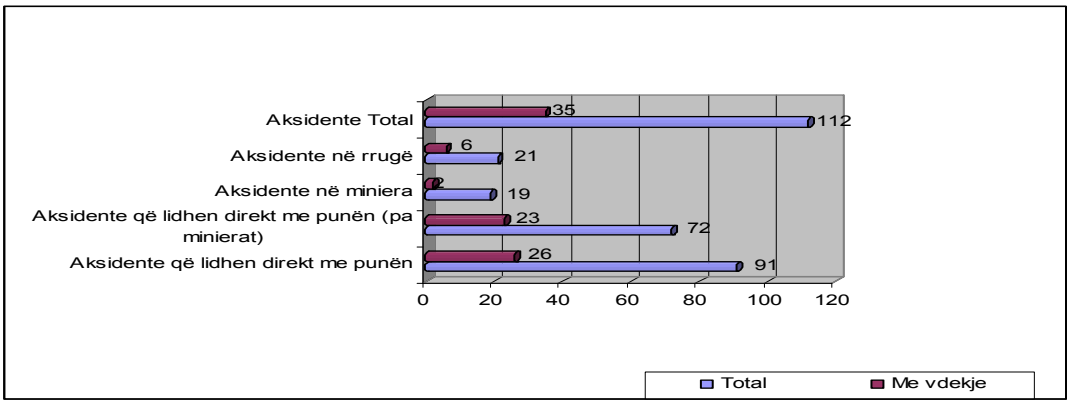


	Nr. Rasteve të Aksidenteve	Nr. Aksidenteve Total	Nr. Aksidenteve me vdekje
Viti 2009	100	112	35
Viti 2008	126	156	28

Translation of the graph: Nr. i aksidenteve me vdekje – number of fatalities
Numri i aksidenteve total – total number of accidents
Nr. i rasteve te aksidenteve – number of accident cases

Another classification of accidents will be as follows:

Type of accident	*Total accidents*	*Fatalities*
1. Accidents directly linked to work	***(81.2 %)***	***26 (74.3 %)***
2. Accidents directly linked to work (Without the mines)	***72 (64.3 %)***	***23 (65.7 %)***
3. Accidents in mines	***19 (17%)***	***3 (8.6 %)***
4. Road Accidents	***21 (18.7%)***	***6 (17.1%)***
TOTAL	***112***	***35***



Graph translation: aksidente tota – total accidents

aksidente ne rruge – road accidents
aksidente ne miniera – mine accidents
aksidente qe lidhen direkt me punen - Accidents directly linked to work (without mines)
aksidente qe lidhen direkt me punes - Accidents directly linked to work
total – total
me vdekje - fatality

Road accidents

21 road accidents happened during 2009 (automobile accidents) or, 18.7% of the total number of accidents, 6 of which were fatalities or 17.1% of the total number of fatalities. Compared to 2009, total number of accidents is the same, whereas the number of road accidents ending up in fatality has doubled (from 3 to 6 cases).

Classification of accidents by type of entities activity:

Type of activity	***Number of accidents***	***Fatalities***
1. Agriculture, forestry, fishery	-	-
2. Mines, carriers	19	3
3. Production enterprises	27	5
4. Electricity, gas, water	11	4
5. Trade, BRH	8	4
6. Construction	25	13
7. Transport	3	-
8. Finance, services	3	2
9. Other activities	16	4
TOTAL	**112**	**35**

So, it can be observed that the most effected sectors, which have registered high number of accidents include: ***construction, production enterprises, and mines*** whereas in the case of fatalities, the highest number was registered **in construction** or about 37.1% of the overall number of fatalities. ***It must be emphasized that for the most part, the cause of accidents that have happened in the constructions sector was falling from the height, because the entities had failed to take sufficient measures for the collective and individual protection of workers.*** Accidents that have happened on the road are mainly registered under the category “other activities”:

Accidents classified by 12 prefectures where they have happened:

Prefecture	No. of Cases	No. of persons Involved in accident	Fatalities
1. Berat	6	6	3
2. Dibër	15	18	2
3. Durrës	7	7	3
4. Elbasan	15	20	3

5. Fier	3	3	1
6. Korçë	6	6	1
7. Kukës	4	4	3
8. Lezhë	5	6	2
9. Gjirokastër	2	2	1
10. Shkodër	4	4	3
11. Tirana	21	23	9
12. Vlorë	13	13	4
T O T A L	**100**	**112**	**35**

Accidents at work classified by month when they have happened are as follows:

Month	***Total number of persons involved in accidents***	***Fatalities***
1. January	15	2
2. February	9	4
3. March	8	2
4. April	7	2
5. May	11	3
6. June	5	1
7. July	14	6
8. August	17	4
9. September	9	2
10. October	9	5
11. November	5	2
12. December	3	2
TOTAL	***112***	***35***

Fatalities

35 cases of accidents ending up in the worker's death were registered. This made up 30.9% of the total number of registered accidents. Fatalities have mainly happened in the construction sector (13 cases or 37.1% of the total number of fatalities), in the mining sector (3 cases or 8.6% of the number of fatalities), in the production enterprises (5 cases or 14.2% of the number of fatalities), in electricity, gas, water (4 cases or 7.2% of the number of fatalities).

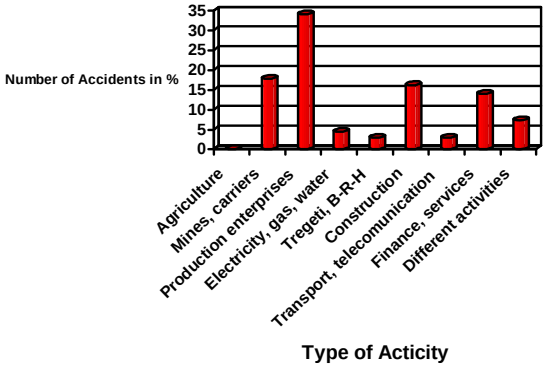
During 2009, 21 persons were involved in road accidents, 6 of whom lost their lives.

According to gender classification, 9.6% of the overall number of persons involved in accidents is women, while 90.4% are males.

Classifying accidents by type of activity, it results that in 2009, the most affected sectors include ***construction, production enterprises and mines***. 24.1% of accidents were registered in the production enterprises, 22.3% in the construction sector and 17% in the mines and carriers sector.
Based on the accidents inquiry, it comes out that the main causes of accidents include falling from height essentially in the construction sector, hits by various items, gas explosions, damages when operating the machineries, electrical shocks, slipping, etc.

The following graph presents a classification of accidents by type of activity.

Classification by type of activity



The number of missing days per accident at work classified according to ESAW (European Statistics on Accidents at Work) comes out based on to date information:

No.	Code	Time period	Number of accidents
1	A-01	4-6 days	2
2	A-02	7-13 days	4
3	A-03	14-20 days	4
4	A-04	21 day - 1 month	5
5	A-05	1 -3 month	21
6	A-06	3-6 months	14
7	A-07	over 6 months	4
8	A-08	Fatalities	35
9	A-09	No information	24

Sanctions

During 2009, 201 sanctions were imposed amounting to 32 538 000 Albanian Leks, where 128 sanctions (or 63.7%) with a value of 22 162 000 Albanian Leks (or 68.1%) were imposed for infringements of safety and health provisions at work. 30 sanctions (or 14.9%) with a value of 6 308 000 Albanian Leks (or 19.4%) were imposed for cases of accidents at work.

Accidents statistics for January - February 2010

During February 2010, 13 cases of accidents involving workers were registered, 7 of which were fatalities including 1 which was a road accident. The following provides a presentation of the entities and districts, in which accidents have happened.

	Type of Activity	*No. of persons involved in Accidents*	*Fatalities*
1.	Agriculture, forestry, fishery	-	-
2.	Mines, carriers	3	1
3.	Production enterprises	3	1
4.	Electricity, gas, water	1	1
5.	Trade, BRH	1	-
6.	Construction	4	3
7.	Transport	-	-
8.	Finance, services	-	-
9.	Other activities	1	1
	TOTAL	**13**	**7**

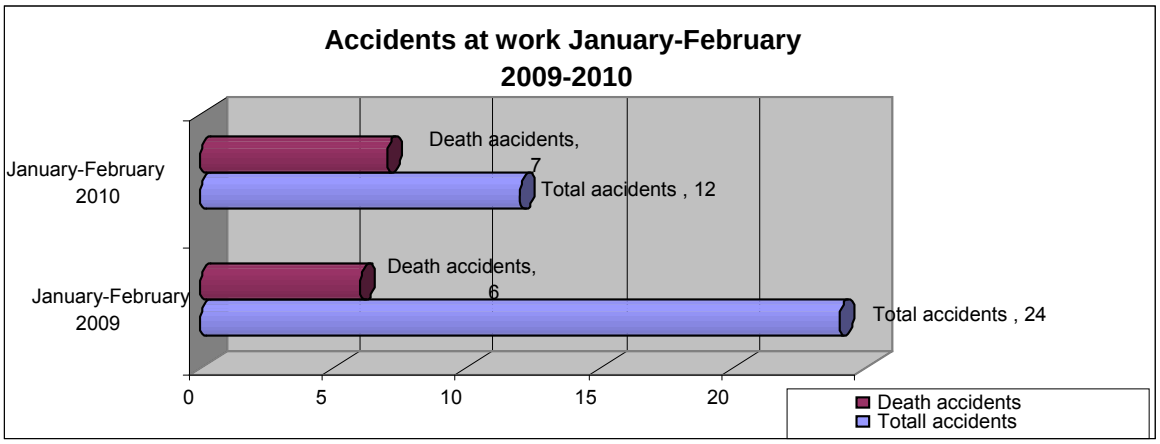
Accidents classified by 12 prefectures where they have occurred:

Prefecture	No. of cases	Number of persons	Fatalities

		Involved in accidents	
1. Berat	-	-	-
2. Dibër	2	2	-
3. Durrës	3	3	3
4. Elbasan	-	-	-
5. Fier	-	-	-
6. Korçë	2	2	1
7. Kukës	1	1	1
8. Lezhë	-	-	-
9. Gjirokastër	1	1	-
10. Shkodër	1	1	-
11. Tirana	2	2	1
12. Vlorë	-	-	-
13. Saranda	1	1	1
T O T A L	**13**	**13**	**7**

According to months when they have happened, accidents at work as classified are as follows:

Month	***Year***	***Total number of persons involved in accidents***	***Fatalities***
January - February	2010	13	7
January - February	2009	24	6



Death accidents- Fatalities

Based on the data comparison of January-February 2009 – 2010, it may be observed that number of persons involved in accidents has decreased to 45.8%, whereas number of fatalities has increased by 14.2%.

Another classification of accidents could be as follows:

Type of accident	***Total number of persons Involved in accidents***	***Fatalities***
1. Accidents directly related to work	***12***	***4***
2. Accidents directly related to work (without mines)	***10***	***6***
3. Accidents in mines	***2***	***-***
4. Road accidents	***1***	***1***
TOTAL	***13***	***7***

Activity of State Labor Inspectorate: Achievements of the State Labor Inspectorate during 2009 compared to 2008 and, at the same time, increasing of inspection indicators during the first 2-moths of 2010 compared to first 2-moths of 2009.
State Labor Inspectorate has 167 employees, 122 of which are inspectors and work controllers.

- During 2009, all inspection indicators at work have increased. For example,
- During 2009, 11 724 entities with 128 395 workers were inspected, which means 1304 more entities compared to 2008.
- Number of employed doctors in the entities with more than 15 workers has kept increasing and specifically only during the first 2-months of 2010, it has increases by 30%.
- Due workers' awareness, number of complaints addressed to PHI has increased, therefore 74 complaints were filed in 2009, 90% of which was solved in workers' favor.
- In 2009 and during the first 2-months of 2010, more tan 90% of fines were imposed because of safety and health conditions at work.
- The aim was to achieve increasing of the number of inspections in economic entities, which pose high risk for the workers, as it is the case of carriers. In this manner, in 2009, three times more entities with carrier activity were inspected compared to 2008 (from of 68 entities in 2008 to 218 in 2009), gas, electricity 1.5 times more (from 75 entities in 2008 to 117 in 2009).
- During the first 2-months of 2010, compared to the same period of 2009, number of inspections has increased and, more specifically: 2532 entities with 21 117 workers are inspected in 2010, whereas in the first 2-months of 2009, there were 1825 inspections with 17679 workers.
- First 2-moths of 2010: 116 fines imposed with a value of 14.960.000 Albanian Leks, whereas during the first 2-moths of 2009, 26 fines were imposed with a value of 4.097.000 Albanian Leks.
- First 2-moths of 2010: 13 inspections conducted because of complaints, whereas during the first 2-months of 2009, 9 inspections were carried out because of complaints. (This indicates increased awareness).
- First 2-moths of 2010: 7 inspections conducted after 22:00 hours, whereas the fist 2-moths of 2009, only 2 inspections were carried out after 22:00 hours.
- During the first 2-moths of 2010, compared to the same period of 2009, the number of accidents has decreased by 45.8%.
- CARD-s Project laid the foundations of a modern Labor Inspectorate in accordance with the rules as required by the European integration.
- PHI has already a modern action plan, which sets out a number of tasks to be carried out and the platforms how to achieve that.
- Based on this action plan, health and safety at work as one of the most advanced and most important fields of EU social policy, has turned into a priority field for the Labor Inspectorate.
- In this frame, the National Strategy of Safety and Health at Work has been drafted.
- The Law on Safety and Health at work has been drafted.
- To match the increasing needs of the Public Health Institute (PHI), a new structure is prepared at central and local level.
- Programming and Analysis Directorate has been added to the new structure.
- IT job position is also part of this directorate.
- Public Health Institute (PHI) website has been developed (www.sli.gov.al).
- To build institutional capacities and to enhance effectiveness of inspections at work, establishing of a training system for inspectors and labor controllers has been initiated.
- A guiding manual has been drafted for labor inspector to help them with increasing the inspection quality and effectiveness.
- Guiding manuals regarding accidents investigation and risk assessment have been drafted.
- A number of printings including posters, laws, strategies, different manuals, which are used not only by the labor inspectors, but also by the workers and employers.
- The Public Health Institute (PHI) through its Focal Point is a part of the European Network of Safety and Health at Work.
- To increase awareness, a number of workshops and training events were organized not only in Tirana but also in the districts across the country. "

33. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 3§3 BULGARIA

The Committee concludes that the situation in Bulgaria is not in conformity with Article 3§3 of the Revised Charter on the ground of the manifestly high level of fatal occupational accidents.

34. The representative of Bulgaria provided the following written information:

"During the period 2003 – 2007 a trend for constant increase of the level of fatal occupational accidents was reported. After 2008 the number of fatal occupational accidents decreases significantly and in 2007 their number is 179, in 2008 it is 161 and in 2009 it is 91.
Operational data of the National Insurance Institute shows that in 2009 in the country there are registered 2956 occupational accidents, with 781 less then in 2008.
For 2009 from all occupational accidents 91 were fatal and 15 lead to permanent disability. The fatal occupational accidents decreased with 70 in comparison to 2008.
Altogether, in 2009, the occupational standard decreased with 963 in comparison to 2006, with 855 in comparison with 2007, and with 781 in comparison with 2008.
In comparison to 2006 the fatal occupational accidents in 2009 have decreased with 48, in comparison to 2007- with 88, and in comparison with 2008 – with 70.
The accidents that provoked disability according to operational data of the NII decrease in 2009 with 16 in comparison with 2008.
In 2009 in the Plan of action of Executive Agency General Labour Inspection (GLI) was included the making of inspections of companies with high occupational traumatism, established in the inspections in 2008.
670 inspection in 628 companies were made. Altogether 3466 violations were found: from them 2483 are violations of the standard in the field of health and safe working conditions, 982 – violations of the provisions of the Labour Code and one violation of the provisions of the Promotion of Employment Act.
For the elimination of the found violation, altogether a 3449 compulsory administrative measures were prescribed. 3416 compulsory prescriptions were given and 14 machines and equipment was stopped from exploitation.
During the year (2009) people who have violated the provisions of the labour legislation were held responsible with penal administrative liability – 166 actions were composed.
The follow-up control on the execution of the prescribed measures in companies and the strictness of the labour inspectors towards the violators of the standards for safe work is e key factor for the limitation and decrease of the occupational accidents.
Taking into account the impact that the labour control has on the participants in the labour process, GLI in its long-term aims puts the amelioration of the administrative services and quality of their overall activity for the increase of the level of observance of the legal labour norms and increase of the contribution of the Inspection in providing of safe, just and decent work in Bulgaria. With view of this, a Strategic plan of action of EA GLI 2008 – 2012 was created.
The human resources of the Agency, its commitment and professional capacity have a decisive contribution to the efficiency and effectiveness of the control that will be provided by better management.
The long-term Action plan of the GLI for the period of 2008 – 2012 will help for achieving the following:
- pursuing the goals of the Agency by its actions, as well as of every single employee in its structures;
- better quality and effective executions of the set by law powers of the labour inspection;
- compatibility between the community opinion and the expectations, and the results of the agency's actions;
- better coordination with state institutions and organizations;
- stimulating the initiative of the social partners for their inclusion with ideas and projects for achievement of safe, just and decent work;
- better understanding of the citizens of the functions and actions of the GLI and increase of the institutional image of the Agency;

Achievement of the set strategic goals is previewed through the following operational aims:
- Increase of the efficiency and the effectiveness of the control activity;
- <u>Increase of the administrative capacity of the agency and the professional capacity of the labour inspectors</u>:

This operational aim includes the managerial actions that will help the effective functioning and the institutional validation of the GLI. The increase of the administrative capacity of the Agency is connected with the introduction of up-to-date management systems, study of the experience of the similar institutions as well as validations of the good practices in the system of the Labour Inspection.
GLI undertakes the commitments to ensure appropriate labour conditions and professional development of its employees so that they are personally involved in achieving the strategic goals of

the Agency. The aim of the GLI is to create a highly motivated and adaptive human resources with high professionalism and competencies. This could be achieved through continuing vocational training and development in the system of knowledge management.
The GLI will work for ensuring the adequate payment of the work of the inspector for increasing their motivation.
- Increase and strengthening of the institutional image of the labour inspection;
- Broadening of the international cooperation for ensuring the fruitful interaction and experience sharing with the labour inspections in the EU and the region."

35. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 3§3 ITALY

The Committee concludes that the situation in Italy is not in conformity with Article 3§3 of the Revised Charter on the ground that it has not been established that labour inspection, insofar as it concerns occupational health and safety, is effective.

36. The representative of Italy provided the following written information:

"The Committee has complained about the absence of information specifically on health and safety activities of labour inspection authority.
We report the following data provided by the Department for Prevention of Local Health Board for the reference period 2005-2006-2007, in order to show the effectiveness of labour inspection.

Data	(2005)	(2006)	(2007)
Total number of inspections dealing with health and safety	94.348	154.422	174.711
Number of enterprises subject to inspection (building industry, agriculture and other sectors)	68.343	98.002	111.800
Total number of noticed violations by Legislative decree N°758/94	43.366	63.301	69.901
Total number of violations remedied	*Data not available*	40.108	56.385

Legenda:
Total number of inspections:
This is the total sum of inspections (first and second inspection, inspection to carry out release from seizure, inspection to hold an inquiry in the event of occupational accidents and diseases).
Total number of enterprises subject to inspection
This is the total number of enterprises subject to inspection services irrespective of the result and of the inspection's reason."

37. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 3§3 MALTA

The Committee concludes that the situation is not in conformity with Article 3§3 of the Revised Charter on the ground that it has not been established that the labour inspection services are effective.

38. The representative of Malta provided the following written information:

"Official statistics on Occupational injuries and diseases are collected by the Department of Social Security and collated by the National Statistics Office. Data based on occupational injuries at work are transcribed into rates (number of injuries per 100,000 workers) – these in effect have shown a consistent downward trend, as indicated hereunder:
2008: 2296 injuries per 100,000 employees
2007: 2774 injuries per 100,000 employees
2006: 3004 injuries per 100,000 employees

2005: 3105 injuries per 100,000 employees.

These figures are actual figures based on NSO's corrected data with regards to the number of people in employment.

Fatal accident numbers (not rates, in view of the small number of incidents recorded, are as follows:

2008: 3 fatalities
2007: 7 fatalities
2006: 7 fatalities
2005: 6 fatalities.

(The numbers were even higher in 2004 and 2003 – 12 and 13 fatalities respectively).

It is a well-recognised fact that the number of notifications officially made with regards to occupational diseases remains low. This fact will be addressed by the research commissioned by OHSA as part of the ESF project (to which reference has already been made).

Under Act XXVII of 2000, OHS Officers may give an order, verbally or in writing, to safeguard occupational health or safety, and every person shall obey such order forthwith until such time as it is revoked by an officer or until it has been revoked by the Appeals Board. The law further empowers Officers to close off a work place or part of a work place.

This information is not currently collated during OHS visits by the OHSA. It will be once the Authority has its electronic Management Information System in place – the software for this MIS is currently being developed.

Staffing resources of the OHSA (2009):

- total staff: 26;
- managerial positions: 7;
- clerical / support staff: 8;
- OHS Officers (Various grades): 11.

	2007	**2008**	**2009**
Total number of visits	1274	2022	2022
Number of improvement notices issued	240	64	N.A.*
Number of cessation of work activities	53	105	N.A.*
Number of cases presented to the public prosecutor	118	128	191

* N.A. – these figures are not as yet collated since they still have to be extracted from the filing documents in respect of each workplace visited.

OHSA comment: it is considered that effectiveness can be measured on the basis of achievements. It is accepted that accident rates and reported injures are on the decrease. Awareness on the subject is increasing; this is also confirmed by a recent EU survey which found a high level of awareness amongst Maltese respondents about the benefits of occupational health and safety - Malta scored second amongst the Member States with regards to the rating given to occupational health considerations when making a career decision. A majority of Maltese respondents also claim that the levels of occupational health and safety have improved over the last five years (72% of respondents, placing Malta fourth amongst the Member States), while only 17% seem to think that such levels have deteriorated). 41% of Maltese respondents expect ohs levels to deteriorate to any appreciable degree because of the current economic scenario (compared to a European average of 61%). 59% of Maltese respondents claim to be well-informed about occupational health and safety risks (compared to a European average of 66%).

OHSA was also visited by a team of Evaluators sent by the Senior Labour Inspectors Committee acting on behalf of the EU Commission. In their final report, the Evaluators reported that OHSA is in compliance with SLIC's Common Principles of Inspection, which also integrate the role and functions of an inspectorate system with its effectiveness.

1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

The Authority considers enforcement as one of its key core functions – the purpose of enforcement is to ensure that duty holders effectively control risks at their place of work. This can be achieved if duty holders take action commensurate with the degree of risk. When no such action is taken, it is the duty of the enforcing authority to take legal action or any other action permitted by law.

The term 'enforcement' has a wide interpretation, but is often taken to include all interactions between the enforcing authority and the duty holders, which may include employers, employees, the self-employed, appointed competent persons, workers' health and safety representatives and others. The term should not be taken to mean exclusively punitive action, as for example through prosecution, but can also mean the provision of advice or information, or the issue of a warning or an order by an OHS Officer.

It remains the Authority's current policy to focus on those work activities that give rise to the greatest risk – this effectively means that the Authority cannot satisfy all demands made for enforcement action to be taken. The Authority has also stepped up its actions related to the last step within the hierarchy of available enforcement actions, namely the commencement of judicial proceedings.
Prosecutions by the Authority are conducted mainly before the Court of Criminal Judicature. The OHSA has also assisted the Executive Police in criminal proceedings instituted against all those concerned before the Court of Criminal Inquiry and has testified in a number of civil suits, instituted by third parties before the Civil Courts.
At the same time, it is also realized that the Officers of the Authority, limited in number as they are, cannot be everywhere all the time, so the Authority periodically carries out inspection campaigns focusing on specific issues.
Through the provisions of the OHS Authority a number of OHS Officers were appointed by the OHSA. These OHS Officers are deemed to be Public Officers under the Criminal Code and thus are protected by law while on duty. OHS Officers have a number of powers at law, including:
1) To enter freely and without previous notice in any work place at any time of day or night;
2) To inspect any document the keeping of which is prescribed by any OHS regulation and
3) To issue orders to any person to preserve OHS and
4) To carry out inspections to verify that OHS levels are being maintained.
1. **Occupational *Accidents*** – Statistical data for the number of occupational accidents claims for the reference period are being included in Annex II.
2. **Occupational *Fatalities* –** a full list of occupational fatalities for the reference period is being enclosed as per Annex III.
3. **Occupational *Diseases*** -The incidence of cases of ill-health remains somewhat blurred. It is a known fact that a considerable amount of cases of ill health remain unreported for various reasons, including a lack of awareness of legal obligations, and more importantly, the lack of appreciation of the association between work and the resulting ill health together with the vague legal framework on work related diseases
4. ***Activities of the labour inspectorate*** for the reference period may be found at Annex IV.

In terms of existing legislation, the setting up of a system for health surveillance and monitoring is the responsibility of an employer who has the option of either making arrangements for such workers to be evaluated within the context of the national health system or to make arrangements with suitably qualified privately engaged medical practitioners.
Within the national health system, workers can be examined either by medical specialists or can be referred to a dedicated Occupational Health Unit which operates within the Health Division.
The latter also has the option to refer workers to medical specialist attention should the need results.
The role of OHSA is to provide a consultative role and to ensure that such arrangements for the medical examination of workers are in place. It has also provided training for medical doctors (at both undergraduate level as well as for doctors contracted by enterprises.
To further enhance postgraduate medical training, the OHSA is working with the University of Malta for the launch of a Postgraduate Certificate Course in Occupational Health – so as to facilitate the process, the course will be provided through distance learning.
The Health Division has also set up a system for the accreditation of medical specialities – OHSA has helped in the system for the accreditation of occupational medicine as a speciality in its own right.
In the case of particular risks (such as exposure to asbestos and ionising radiation), there are also specific control measures that are implemented by OHSA, including the registration of workers exposed to such hazards, ensuring their training and health surveillance to monitor for early signs of disease that can be caused through exposure.
OHSA also organises specific training courses in Chemicals Safety, Occupational Stress and has published guidance material aimed at reducing the risks of occupational ill-health. It also continuously organises awareness-raising events that stress the association between work and health and vice versa."

39. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 3§3 MOLDOVA

The Committee concludes that the situation in Moldova is not in conformity with Article 3§3 of the Revised Charter on the grounds that it has not been established there is an efficient reporting system of occupational accidents nor an efficient labour inspection system.

40. The representative of Moldova provided the following written information:

“The Labour Inspectorate does its work under Act 140-XV of 10 May 2001 in accordance with the Regulation on the Labour Inspectorate. In accordance with these rules, the Labour Inspectorate carries out checks on compliance with labour legislation by companies, institutions and organisations, irrespective of their ownership or legal form of organisation, and by central and local government authorities.

A list of the staff and the organisation chart of the Labour Inspectorate are appended.

Under the aforementioned rules, labour inspectors performing their duties have the following rights, on presentation of their credentials:

- to freely enter service and production buildings to inspect workplaces at any time of the day or night and without previously informing employers;
- to request and receive from employers the documents and information they need for their inspections;
- to request and receive statements from employers and employees, within the limits of their functions;
- to ask for the immediate or phased cessation of violations of legislation on the working conditions and the protection of employees performing their duties;
- to draw up reports on infringements of labour law or health and safety regulations.

Labour inspectors are also entitled to halt the operations (where appropriate by affixing seals) of companies, institutions, organisations, workshops, departments, buildings, premises or technical equipment and to halt work and technological processes which do not comply with labour protection standards and pose the imminent threat of an accident.

In March 2010, parliament amended the Labour Inspectorate Act. The amendments related to the methods, conditions and procedures for state supervision of compliance with labour legislation and occupational health and safety regulations.

Following the amendments, the purpose of state supervision of compliance with labour law and regulations was now to check the ways in which employers (or their representatives) complied with labour and occupational health and safety regulations, to offer employers (or their representatives) advice and assistance on means of applying the relevant legislation properly, to find means of ending violations that had been identified and to punish offenders.

Compliance with labour legislation is monitored by means of different types of inspection. The first is the full inspection, whose aim is to check that all labour and health and safety regulations are being observed. The second is the specific inspection, whose aim is to check that the regulations were being observed over a certain period or in certain sectors of activity, or to check that certain aspects of labour or health and safety rules are being observed. The third is the unannounced inspection, which takes place under the following circumstances:

- when the inspectorate is investigating complaints involving infringements of labour or health and safety regulations;
- where the inspectorate is attempting to directly rectify a clear violation of labour or health and safety legislation;
- to investigate a work accident.

Follow-up inspections may be made when a time limit set by the inspector at a previous inspection has expired for the violation to cease, an order to be executed or action to be taken to bring the situation back into line with the relevant rules. Such inspections may be repeated as many times as necessary to ensure compliance with the relevant regulations.

Full and specific inspections are made in accordance with the Labour Inspectorate’s annual work programme, which is adopted by the Inspector General after consultation with the Ministry of Labour, Social Protection and Family Affairs.

They may also be conducted at the request of employers (or their representatives), employees or trade unions.

Labour inspections are organised on the basis of an order issued by the Inspector General or his or her deputy or the head or deputy head of the regional labour inspectorate.

No such orders are required for unannounced inspections, which may be conducted at the instigation of an ordinary labour inspector. Following such inspections, inspectors are required to notify their immediate superiors thereof.

Inspectors must inform employers (or their representatives) of their presence within the company before carrying out their inspection, save where they have information that the employer is infringing labour legislation, is making no effort to remedy violations identified during previous inspections or has not reported work accidents that have occurred within the company.

At the end of all labour inspections, a report must be drawn up in the form approved by the Inspector General. The report must briefly describe any infringements that have occurred, indicate which

legislation or regulations have been breached and order measures to comply with the legal rules, either immediately or within a reasonable time according to the circumstances.
At the end of the inspection, if any infringements of labour legislation have been detected, the labour inspectors must put a halt to any irregularities by including details of infringements of health and safety regulations in their reports and referring these cases to the judicial authorities.
Where it is clear to inspectors that the use of the buildings, installations and technical equipment or any ongoing work or technological processes pose an imminent threat of accident, they may issue an order in a form approved by the Inspector General for operations to be halted, staff to be evacuated from the workplace and the threat to be removed. Orders of this sort must describe the infringement which poses an immediate threat of accident and the legislation and regulations with which failure to comply has resulted in the potential accident. Orders must be signed by labour inspectors and employers (or their representatives).
Where the use of the buildings, installations and technical equipment have been suspended along with the work and technological processes posing an immediate threat of an accident, the labour inspector must note this fact in his or her report and append a copy of the suspension order to the report.
Where time is needed to eliminate the danger, inspectors place official seals on connecting equipment, electrical power sources, control panels, movable and immovable parts of buildings, installations and technical equipment posing the imminent threat of an accident. Seals are affixed to prevent them from being switched on or used again. Inspectors only allow access for work to eliminate the danger. In the suspension order, inspectors must state that official seals have been affixed and give the number and the location of these seals. They must also inform the person in charge of the workplace and the employer (or employer's representative).
Inspectors may also include provision in the suspension order to be informed in writing when the infringements causing the threat of an accident have been eliminated.
To achieve its objectives, the Labour Inspectorate takes measures to prevent irregularities in the occupational health and safety field and comply with the rules mentioned above.
In 2009 and January to May 2010, the Labour Inspectorate and its local branches monitored compliance with labour and occupational health and safety legislation and regulations by carrying out 10011 inspections on companies employing over 340 000 employees including 173 000 women and 132 minors. Of the total amount, 5 083 of these inspections where intended to check that health and safety regulations were being applied.
Although certain preventive measures had been taken because of safety defects, according to the statistics, over 550 employees were involved in work accidents over this period, meaning that the frequency index (the number of accident victims per one thousand employees) was 1.07. Work accident trends over the periods from 2005 to 2009 and January to May 2010 are set out in the appendix.
Every year, inspectors investigate an average of 170 accidents, 130 of which are classified as work accidents.
In 2008 and January to May 2010, in accordance with the Regulation on the arrangements for investigating work accidents approved by Government Decision 1361 of 22 December 2005, the Labour Inspectorate registered 567 accident declarations (including 27 declarations relating to accidents that occurred in previous years), of which a total of 612 people had been victims.
More than ten of the work accidents recorded over this period (four of which were fatal) involved people who had no fixed statutory employment relationship.
During the reference period the National Labour Inspectorate arranged for 235 investigations by inspectors into accidents involving a total of 270 people. Company-based committees of enquiry looked into 332 accidents followed by temporary incapacity for work.
138 of the accidents investigated by labour inspectors were classified as work accidents; 44 of these were fatal, causing the deaths of 46 people, 90 were serious, involving a total of 115 victims, and 23 resulted in temporary incapacity for work.
A breakdown of work accidents in 2009 according to type of occupation shows that most accidents occurred in the agriculture and forestry sectors, were there were 20 serious accidents and 10 fatal ones. Following this was the construction industry, with 10 serious accidents and 11 fatal ones, then the business sector, with 13 serious and 5 fatal accidents.
Labour Inspectorate data show that the most common causes of work accident were as follows:
- employee – 33 serious and 19 fatal accidents;
- nature of the work – 33 serious and 12 fatal accidents;
- means of production – 16 serious and 6 fatal accidents.

Most of the accidents in 2009 occurred under the following circumstances:
- falls from a height – 26 serious and 9 fatal accidents;

- same-level falls – 13 serious and 3 fatal accidents;
- failure to comply with safety standards when using tools or machinery (employees trapped/caught, hit or crushed in or by working tools or machinery) – 11 serious accidents;
- employees trapped/caught, hit or crushed in or by motor vehicles on public highways – 11 serious and 6 fatal accidents.

The causes and circumstances in which the accidents occurred stemmed from a lack of knowledge and ability to organise work processes and to devise and implement working tasks in safe conditions. In 2009 fewer people were involved in serious or fatal accidents than in 2008 (? fatal and 13 serious accidents). In January to May 2010 there were fewer serious or fatal accidents than in the equivalent period of the previous year (6 fatal and 16 serious accidents).

A survey of occupational morbidity carried out by the Ministry of Health shows that in 2009 in the Republic of Moldova, there were 14 cases of acute or chronic occupational diseases (intoxications) compared to 34 in 2008. The occupational morbidity index was 1.46 per 100 000 employees (compared to 3.8 in 2008).

The number of persons affected by these diseases broken down according to the industrial risk involved were as follows: Vibrations – 9 cases (2008 – 17); biological factors – 1 case (2008 – 6); toxic chemical substances – 1 case (2008 – 2); pesticides – 3 cases (2008 – 6); others – 2. The breakdown according to ministry or government department and disease type appears in the following table.

Name of ministry or department	Diseases and intoxications (along with an indication of the industrial hazard causing the condition)	Acute occupational diseases and intoxications				Chronic occupational diseases and intoxications	
		Number of cases	Groups	Number of persons affected		With loss of capacity for work	Without loss of capacity for work
				With loss of capacity for work	Without loss of capacity for work		
1	2	3	4	5	6	7	8
Ministry of Agriculture and Food (12 cases)	Osteochondrosis (vibrations)	-	-	-	-	7	-
	Encephalopathy (pesticides)	-	-	-	-	1	-
1	2	3	4	5	6	7	8
	Toxic hepatitis (pesticides)	-	-	-	-	1	-
	Acute poisoning (pesticides)	1	-	1	-	-	-
	Arthrosis deformans (vibrations)	-	-	-	-	1	-
	Radiculopathy (vibrations)	-	-	-	-	1	-
Ministry of Health (1 case)	Tuberculosis (mycobacteria tbc)	-	-	-	-	1	-
S.A. „Nufărul” (1 case)	Chronic obstructive bronchitis (airborne vapours)	-	-	-	-	1	
Total		1	-	1	-	13	-

41. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 3§3 PORTUGAL

The Committee concludes that the situation in Portugal is not in conformity with Article 3§3 of the Revised Charter on the ground of the manifestly high level of fatal occupational accidents.

42. The representative of Portugal indicated that there had been significant improvement in the collection of data on work accidents. She underlined that prevention of fatal accidents remains a major concern for labour inspection, in particular in sectors of the

economy more prone to serious and fatal accidents (e.g. construction, transport). Analyses of how these accidents take place have been made to improve prevention. In 2007 a recruitment procedure was initiated to hire 100 new labour inspectors, bringing the number of inspectors at 453. Efforts are being made in co-operation with social partners with whom an agreement has been reached. She claimed that the number of fatal accidents had decreased in 2009 as a result of this strategy.

43. The Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 3§3 ROMANIA

The Committee concludes that the situation in Romania is not in conformity with Article 3§3 of the Revised Charter on the ground that it has not been established that statistics on occupational accidents are reliable.

44. The representative of Romania provided the following written information:

"Occupational accidents and diseases

Data system

There are several institutions which work on various statistics and which keep records on a number of issues, such as the **frequency index of industrial hazards**, i.e. the number of accidents per 1,000 workers. According to the statistics provided by the Labour Inspectorate, this index declined steadily from 0.85 ‰ in 2006, to 0.84 ‰ in 2007, to 0.80 ‰ in 2008, and to 0.62 ‰ in the first nine months of the year 2009.

Also it is registered the number of days of temporary work incapacity (TWI) due to industrial hazards.

Number of days TWI

2007	2008
16205	15310

The exact situation in 2009 will be fully in April 2010.

The National Institute of Public Health in Bucharest registers the annual number of new occupational diseases, by industry and causes.

Year	Total number of new cases nationally
2004	990
2005	1.002
2006	910
2007	1.353
2008	**1.286**

Regarding the concerns raised by occupational diseases, the Health Ministry took the following measures:

- at national level the Ministry of Health organized prevention programs in the field of occupational health such as: the National Program on monitoring the determinant factors in the living and working environment, aiming to protect health and prevent diseases associated with occupational risk factors, with a view to knowing and being aware of the risks of occupational diseases at the workplace;

- it was set up the Committee of Experts on Occupational Medicine (by Order of the Minister of Health no.1256/2008 on approving the composition and the tasks of the Committee of Experts accredited by the Ministry of Health and Ministry of Labour, Family and Social Protection. The Committee has prerogatives to analyze all complaints to the inquiries in cases of occupational disease or to the fiches filled in accordance with Government Decision no.1425/2006 for approving the methodological norms for application of Law no. 318/2006 on safety and health, to the technical or organizational measures formulated and to the final resolution of their development.

- it was introduced the European statistical reporting system of occupational diseases EUROSTAT. The National Centre for Monitoring the Risks at Community Level – the Department for Occupational

Health and Working Environment inside the National Institute of Public Health in Bucharest, introduced the European statistical reporting system of occupational diseases EUROSTAT. Thus, the database on occupational diseases at national level is established in accordance with EODS requirements, including characteristics on sex, age, disease severity, the company, economic branch, causative agent, all these being done in cooperation with the National Institute of Statistics;

- under the Government Decision no.355/2007 it was introduced the concept of health promotion at workplace, which provides that in order to raise awareness on health and safety at work, specialized physician shall carry on specific activities on promoting health at work, based on identifying the existing problems. The occupational health services participate in the drafting and implementation of programs on information, education and training on health and safety for workers who were surveyed through preventive medical examinations.

- there were carried out training courses for specialists on occupational medicine and public health in order to cooperate on promoting occupational health.

As regards the difficulty of conducting specialized investigations and regular medical exams we may say that:

- all institutions were endowed with advanced equipments under PHARE Project on improving the efficiency of supervision and control of occupational diseases, of workplace related illnesses and injuries due to occupational risk in the field of occupational medicine;

- the European AID /1196/D/SV/RO allowed higher quality of specialty investigations in prophylactic medical examinations, as regards monitoring the health of those who were exposed to asbestos fibers, to dust, physical, chemical and physical and chemical agents, as well as management of stress at work.

Concerning the differences among counties on the average number of workers exposed/occupational physicians, it was revealed

- an increased number of specialists on occupational medicine who graduated occupational specialization in major university centers of Romania: Bucharest, Iasi, Timisoara, Sibiu;

- an increased number of specialists on occupational health by graduating training programmes in a 2nd specialty, which lead to a better medical supervision of workers in all industries.

The National Institute of Statistics registers data on health and safety at work by EUROSTAT methodology.

The **Labour Inspection** manages the OSH accidents database. As for the occupational diseases, the database is managed by the Public Health Directorates, which are under the subordination of the Ministry of Health.

It happens that, after certain periods of time, of at least a quarter, the number of accidents at work recorded for the same reporting interval differs, sometimes quite significantly. We do not consider this being under-reported for several reasons, such as:

a) The procedure of communicating and investigating the events, as well as the registration and the recording of the accidents at work and of the dangerous incidents, implies covering some stages. These stages are established through the Methodological Standards for the application of the provisions of the Law no 319/2006 of safety and health at work, approved by the G.D. no. 1425/2006.

b) The investigation of the events is aimed at determining the circumstances and causes that led their occurrence, the regulations that have been trespassed, the responsibilities and measures to be taken to prevent the emergence of other similar events and, of course, at establishing the type of the accident.

c) The Methodological Standards approved by the GD no 1425/2006 provide a certain period of time during which the investigation of the events has to be carried out, and it is of:

c.1) 5 working days at most from the day the event was produced, for those events that resulted in the worker's temporary incapacity to work;

c.2) 10 working days at most from the day the event was produced, for an event evolving in decease, manifest invalidity, collective accident or missing person(s), as well as for the investigation of dangerous incidents.

d) For the situation provided at (c.1), the investigation file, drawn up by the commission the employer had appointed, is submitted, for being checked upon and endorsed, to the territorial labour inspectorate in the circumscription where the event was produced. This has to be done in 5 working days following the conclusion of the investigation. Then the territorial labour inspectorate has to

examine the file, endorses it and sends it back to the employer in 7 working days at most from the day of its reception.

e) For the situation provided at (c.2), the investigation file, drawn up by the territorial labour inspectorate, has to be submitted for endorsement to the Labour Inspection (the central body) in 5 working days at most from the conclusion of the investigation. The Labour Inspection endorses the files and sends them back in 10 working days at most from the day of their reception.

In addition to the abovementioned points (a–e), there are also situations, especially those related to events that resulted in the death or missing of workers during the working process, when the delay that the Methodological Standards stipulate the conclusion of an investigation is overrun for objective reasons related to:

- situations in which sample drawing or carrying out of expertises are necessary, and for these operations an extension of the investigation deadline may be required in writing;
- situations in which the delivery of a legal medicine certificate is needed;
- situations when the Labour Inspection gets to the conclusion that the investigation had been carried out inappropriately and requires to have the file updated and have a new investigation report drawn up;
- situations when persons are missing as a consequence of an event and in circumstances justifying the belief they are dead. The territorial labour inspectorate that had carried out the investigation shall keep the file in its custody until a judicial sentence is issued by which the missing persons are declared dead, according to the legal provisions in force. After a final judicial sentence is given, the file is sent for endorsement to the Labour Inspection.

The cases abovementioned lead to the fact that the number of workers involved in accidents at work is recorded after a period of time that sometimes overruns more than a year from the day the event had been produced.

This is the reason why the number of accidents reported at the end of a calendar year has to be modified during the following year; the number of accidents increases by approximately 5% as referred to the total number of accidents and by 25% at most, as far as the deceased workers are concerned.

After a twelve-month time from the previous reporting period, the number of workers involved in accidents at work taken into account for the reporting period does no longer suffer significant variations.

All these evolutions in the number of accidents at work are emphasised in the accidents database, which is updated on a quarterly basis.

This database is managed at national level by the IT system within the Labour Inspection; in their turn, each territorial labour inspectorate has such a database at its disposal which emphasises the number of accidents in each county and in Bucharest.

In Romania, the type of an event can only be determined after covering the procedures related to its investigation and only after that an event is registered and statistically reported as such.

All the abovementioned explain the way in which the number of accidents is being reported at national level.

As for the **Order no 3/2007** of the minister of Labour, Social Solidarity and Family, this approves the form used for recording an accident at work (in short, Ro.: FIAM). The codification used in this form is in compliance with the Eurostat methodology.

The employer's failure to comply with its obligation to report an accident at work to the territorial labour inspectorate, as well as to the insurer is considered a contravention and is sanctioned, according to Law no 319/2006 – Article 32(2), with a fine that runs from 4,000 RON to 8,000 RON (about 1,000 – 2,000 Euro).

The fact that the incidence rate of the fatal accidents at work in 2005 was of 5.9, which is by far over the EU average (UE 27) has the following explanations:

- most of the undertakings have not been modernised from the technological standpoint, their equipment being highly worn out, both physically and morally; this is obvious especially in the economic sectors where most of the accidents at work occur (constructions, extraction and processing of coal, manufacture of furniture, food and beverage industry, manufacture of wood and of wood and cork products, manufacture of straw and other material products, manufacture of metallic structures and metal products, except for machines, equipments and installations);
- according to the Labour Inspection statistics, in Romania there is a high rate of workers injured in road accidents. Thus, in 2005, approximately 10% out of the total number of workers injured in accidents come from the road accidents. The proportion of victims of road accidents from the total accidents at work was of approximately 14% in 2006 and of 15% in 2007.

Activities of the Labour Inspection

A. Organisation and functioning of the Labour Inspection

The Labour Inspection is a specialised body of the central public administration, under the subordination of the Ministry of Labour, Family and Social Protection.

The fields of competence of the Labour Inspection are labour relations and safety and health at work.

To achieve its duties, the Labour Inspection has under its subordination 42 territorial labour inspectorates; these are legal persons organised in each county and in the municipality of Bucharest. The Centre for Vocational Training and Refreshing Courses of the Labour Inspection (Ro.: C.P.P.P.I.M.) is a public institution organised as a legal person, seated in Botoşani, and in subordination to the Labour Inspection.

To exercise its duties, the Labour Inspection co-operates, on the grounds of the protocols concluded, with ministries, control authorities in other fields, public and private institutions, with employers and trade union organisations or it may ask for the services of some experts or specialised organisms, under the terms set out by its own regulation of organisation and functioning.

With that end in view, the Labour Inspection has concluded cooperation protocols with the Ministry of Health, the "Alexandru Darabont" National ***Research*** and ***Development Institute*** on ***Labour Protection***, the National Institute for Research and Development in Mining Safety and Anti-Explosive Protection in Petroşani (Ro.: INSEMEX), the State Inspectorate for the Control of Boilers, Vessels under Pressure and Lifting Outfits (Ro.: ISCIR), the Ministry of Justice – the National Trade Register Office, the National Institute of Statistics, the National Authority for Consumers Protection, the National Centre for Managing Databases regarding the Persons Records, General Inspectorate of the Romanian Gendarmerie and the Romanian Office for Immigration, etc.

In its control activity, the Labour Inspection collaborates with the National Environmental Guard, the Financial Guard, the State Inspectorate in Constructions, the Customs National Authority, the General Directorate for Public Health, the State Sanitary Inspectorate and the Sanitary-Veterinary Police.

Number of labour inspectors with control attributions on safety and health at work during 200-2008

2005	2006	2007	2008
510	487	516	505

B. Controls and sanctions

1. covering of about 40% of the total labour force, by means of inspections

The inspection procedure provides that during the controls, labour inspectors fill in a *Fiche on the undertaking* (Annex) in order to set up/update the database managed by the territorial labour inspectorate. One of the sections of this form requires the filling in of the total number of employed of the company. Therefore, even though the inspection is carried out at random, to a limited number of workplaces, the measures ordered by the labour inspector shall take effect on the entire company.

The reports the territorial labour inspectorates submit to the Labour Inspection do mention the total number of employed in the undertakings/enterprises controlled. This is the figure stipulated in Romania's National Report and, in respect with those previously mentioned, we appreciate the percentage of 40% as being correct.

Failure to report events is deemed as contravention and is sanctioned by the labor inspectors, in accordance with Art. 39 paragraph 5 of **Law no. 319/2006** on health and safety.

Art. 39 para. 5 reads as follows:

"It is deemed contravention and is sanctioned with fine from 3,000 RON (approx. 750 Euro) up to 7,000 RON (approx. 1,750 Euro) the infringement of the provisions set in art. 7 para. (4) – (6), art. 8, art.11 para. (1) and (3), art. 13 letter q) and s) and art. 27 para. (1) letters a) and b).[1]

[1] Art 7
(4) Notwithstanding other provisions of this law, considering the nature of the enterprise's and/or unit's activities, the employer is obliged:
a) to assess the health and safety risks, including the choice of work equipment, substances or chemicals used and the layout of workplaces;
b) that following the assessment referred to at letter a) and, if necessary, the prevention measures as well as the working and production methods applied by the employer to ensure safety and improve the level of health protection and be integrated into all enterprise's and/or unit's activities and at all hierarchical levels;
c) to consider the workers' capacity as regards safety and health, when it delegates tasks;

Order no. 3 of 3rd January 2007 of the Minister of Labour, Social Solidarity and Family on approving the form for registration of work accidents - FIAM presents the forms that need to be filled in when an accident happens or that are needed to register the ending of the temporary incapacity of work. All these forms started to be used from 1st January 2007.

Art. 3 para. 1 of this Order stipulates that these forms must be filled in and sent to the territorial labour inspectorate where the accident took place within 5 working days since the ending of the temporary incapacity of work of the injured person.

Para. 2 of the same article provides for the employer's obligation to submit the documents that prove the length of temporary incapacity of work and to fill in the termination modality thereof.

2. number of controls and sanctions

An increase in the number of controls and sanctions is justified by the objective set out by each territorial labour inspectorate to achieve its evaluation indices for the control activity, as established by the management of the territorial inspectorates in agreement with that of the Labour Inspection, as it follows:

IFC – control indicator = C (number of controls by month) / FC (fund of control duration, with the remark that the imposed level is of 12 to 17 controls/month per labour inspector).

IS2 – sanction indicator = NA (number of fines applied) / C (number of controls by month).

IS3 – sanction indicator = NA (number of fines applied) / NAV (number of warnings applied).

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d) ensure that planning and introduction of new technologies to make the object of consultations with workers and/or their representatives regarding the consequences on safety and health of workers, determined by the choice of equipment, working conditions and environment;
e) take appropriate steps to ensure that in high and specific risk areas to be allowed access only to workers who have received and have learned the appropriate instructions.
(5) Notwithstanding other provisions of this law, when at the same workplace there are workers from several companies and/or units, their employers have the following duties:
a) to cooperate in order to implement the provisions on safety, health and hygiene at work, considering the nature of activities;
b) to coordinate their actions in order to protect workers and prevent occupational risks, considering the nature of activities;
c) inform each other on occupational hazards;
b) inform workers and/or their representatives about occupational hazards.
(6) The security, health and hygiene at work should not imply in any situation any financial obligations for workers.
Art. 8
(1) Without prejudice to the obligations stipulated in art. 6 and 7, the employer shall designate one or more workers to handle the tasks of protection activities and occupational risk prevention in enterprise and/or unit, hereinafter called "designated workers".
(2) Designated workers should not be prejudiced as a result of their protection and prevention activities.
(3) Designated workers must have sufficient time to enable them to fulfill their obligations under this law.
(4) If the company and/or unit cannot organize prevention activities due to the lack of appropriate staff, the employer must employ external services.
(5) If the employer appeals to external services under par. (4) they must be informed by the employer on the factors known to have effects or likely to have effects on health and safety of workers and should have access to the information provided in Art. 16 para. (2).
(6) Workers must be assigned mainly on health and safety responsibilities at work and, at best, complementary tasks.
Art. 11
(1) The employer must:
a) inform, as soon as possible, all workers who are or may be exposed to a grave and imminent danger of the risks involved, and on the actions taken or that must be taken for their protection;
b) take measures and give instructions to offer the workers the opportunity to stop working and/or immediately leave work and head to a safe area in case of serious and imminent danger;
c) refrain from asking workers to resume work in case there is still a serious and imminent danger, except in exceptional cases and for justifiable reasons.
(3) The employer must ensure that in case of a serious and imminent danger to their or other people's safety, when the next upper hierarchical level can not be contacted, all workers are able to apply appropriate measures in accordance with their knowledge and technical resources that they dispose of, in order to avoid the consequences of such danger.
Art. 13 - In order to ensure health and safety conditions at work and to prevent work accidents and occupational diseases, employers have the following duties:
q) to ensure work equipment without danger to the health and safety;
s) mandatory provide new personal protective equipment in case of degradation or loss of protective qualities.
Art. 27
(1) The employer is obliged to communicate the events immediately, as follows:
a) to the territorial labour inspectorates all the events as defined in Art. 5 letter f)
b) to the insurer, according to Law no. 346/2002 on insurance for work accidents and occupational diseases, with subsequent amendments, events followed by temporary work incapacity, disability or death, to their confirmation.

The reported number of controls is justified by the means of the following calculation formula:
500 labour inspectors that carry out controls in the occupational safety and health field x (an average of) 15 controls/month x 11 months* = 82,500 controls/year (* since the annual leave is of 20-25 working days/year).

Evidence of inspections carried out in the OSH field, of employees controlled, of the contravention fines applied and of the cessation of activities, during 2005-2008

Indices of safety and health at work	2005	2006	2007	2008
No of enterprises/ undertakings controlled	68,745	83,493	77,399	84,845
No of controls carried out	70,181	87,220	81,049	87,429
Total no of employees on economy	5,907,662	5,898,501	5,767,440	5,728,134
Total no of employees of the employers controlled	2,424,041	2,394,506	2,447,348	2,855,182
No of employees of the employers controlled as compared to the total no of employees on economy (%)	41.03	40.60	42.43	49.84
No of contravention sanctions applied	8,521	22,045	28,572	40,383
Amount of fines applied (lei)	10,272,610	40,853,710	49,969,300	55,427,872
No of installations stopped from working	1,440	3,580	5,691	12,574
No of undertakings/enterprises whose activity was ceased	85	138	479	814
No of referrals to criminal courts	177	172	132	161

Dynamics of sanctions applied, on fields of economic sectors, during 2005 – 2008

Sectors of economic activity	No of sanctions applied			
	2005	2006	2007	2008
Agriculture	341	1,068	1,028	1,419
Mining	126	264	212	390
Transports	126	991	1,399	1,342
Industry, commerce and other sectors	7,928	19,722	25,933	37,232

45. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 3§3 SLOVENIA

The Committee concludes that the situation in Slovenia is not in conformity with Article 3§3 of the Revised Charter on the ground of the manifestly high level of fatal occupational accidents.

46. The representative of Slovenia indicated that the number of accidents – including fatal accidents – had decreased in 2008, essentially in the construction sector. She stated that this decrease resulted from a strategy which privileges more strict and focused inspections. She added that employers have been encouraged to adopt preventative action. Other aspects of health and safety at work have been explored, including the training of employers, the details of which will be presented in next report.

47. The representative of the ETUC asked for information that would explain that the level of accidents would remain so high and underlined that preventative measures must go hand in hand with stricter control.

48. The representative of Slovenia explained that part of the problem stemmed from the fact that small employers, in particular in the construction sector, do not respect safety

regulations, and that for this reason the frequency of controls on temporary construction sites had been increased. An increase in the number of inspectors was also envisaged.

49. The Committee invited the government of Slovenia to bring the situation into conformity with Article 3§3 of the revised Charter.

Article 3§4 – Occupational health services

RSC 3§4 SLOVENIA

The Committee concludes that the situation in Slovenia is not in conformity with Article 3§4 on the ground that it has not been established that there are adequate occupational health services.

50. The representative of Slovenia provided the following written information:

> "In Slovenia, preventive activities relating to occupational safety and health are distinguished from curative activities deriving from injuries at work and occupational diseases.
> The legal foundations of preventive activities relating to occupational safety and health at work or relating to the occupational medicine service include:
> - Occupational Health and Safety Act,
> - Health Services Act,
> - Rules for carrying out preventive health care at the primary level,
> - Rules on preventive medical examinations of employees and other implementing regulations in the field of preventive medical examinations for different occupations.
>
> Article 20 of the Occupational Health and Safety Act determines that an employer, who is also the payer of these services, must ensure that occupational health care tasks are carried out by an authorised physician. Under the Occupational Health and Safety Act, an authorised physician is an occupational medicine specialist. Occupational medicine specialists are exclusively in charge of tasks relating to ensuring occupational safety and health as defined by Article 20 of the Occupational Health and Safety Act. Their major tasks include:
> - cooperation in risk assessment within the framework of drafting a Declaration of safety at a working post and in the working environment and
> - identification and examination of the causes of occupational and work related diseases.
>
> There are approximately 135 active occupational medicine specialists in the Republic of Slovenia. In view of the fact that they perform only activities imposed by law and that, according to data for 2006, the active working population in Slovenia numbers approximately 830,000 (which means that one authorised occupational medicine specialist is responsible for approximately 6149 employees), we believe that the number is appropriate and by no means too low. At the same time, we emphasize that the majority of workers in Slovenia are employed in small and medium-sized companies with a fairly small number of employees, so employing occupational medical specialists at the registered offices of companies is not economical. An employer has a statutory obligation to provide the services of occupational medicine specialists for employees. The implementation of these provisions is monitored by the Labour Inspectorate.
> The geographic distribution of occupational medicine specialists in Slovenia is appropriate, so their services are sufficiently accessible to employers.
> Curative activities are regulated by the Health Care and Health Insurance Act. Article 13 of this Act determines that compulsory health insurance shall include insurance against work-related injuries and occupational diseases and insurance against disease and injuries out of work. Compulsory health insurance guarantees insured persons the payment of health services to a defined extent and wage compensation during temporary absence from work. In compliance with Article 15 of this Act, compulsory health insurance applies to all persons who are employed in Slovenia, persons employed by employers with registered office in Slovenia who are sent to work or undergo further professional training abroad, if they do not have compulsory insurance in the state to which they have been sent, persons employed in foreign or international organisations and institutions, foreign consular and diplomatic representative offices with registered office in Slovenia, if this is not otherwise defined by international agreement, persons with permanent residence in Slovenia employed by foreign employers who are not insured by a foreign carrier of health insurance, persons who perform economic or professional activities on the territory of Slovenia as their only or main profession, persons who are owners of private companies in Slovenia if they are not insured in

another manner, farmers, members of their households and other persons who perform agricultural activities in Slovenia as their only or main profession.
The aforementioned rights deriving from compulsory health insurance are exercised by insured persons through their **personal general or family physician at the primary level of health insurance,** which they chose themselves**.** On average, one chosen personal doctor looks after 1743 persons (data from the Health Statistical Yearbook of Slovenia for 2008, IVZ). This is a physician who takes care of the entire curative treatment of persons who have chosen him/her as their personal physician, both for diseases and injuries, whether at work or outside work.
Finally, we wish to stress once more that occupational medicine physicians, who perform occupational healthcare tasks in Slovenia do not perform curative activities (i.e., treatment and establishing incapacity for work), but are only engaged in preventive activities. We therefore believe that in this context, the number of occupational medicine specialists is entirely satisfactory. As mentioned above, all inhabitants of Slovenia, including employed persons, are covered by compulsory health insurance within the framework of compulsory health insurance and have the right to choose their personal general or family physician. This is the physician who carries out curative activities for them."

51. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

Article 11§1 – Removal of the causes of ill-health

RSC 11§1 ALBANIA

The Committee concludes that the situation in Albania is not in conformity with Article 11§1 of the Revised Charter on the ground that it has not been demonstrated that adequate measures have been taken to reduce the maternal mortality rate.

52. The representative of Albania provided the following written information:

"**Population health condition – General indicators: Concerning the question, which the Committee has asked in Article 11 about regulations, guidelines and documents that include altogether mother and childcare services under one-umbrella,** we hereby provide the following explanation:
Mother and child health services in Albania include healthcare services for women, they are provided free of charge at three levels of service and they are integrated after 1996 (adoption of Action Plan of the International Conference of Population and Development of 1994) into three levels of healthcare service as follows:
1. Primary healthcare service
This is provided at the health clinics and centers in the rural and urban areas.
In the rural areas, these services are organized as follows: a) clinics where midwives follow up the woman throughout pregnancy, during normal birth and after it and, who care about the proper upbringing and development of children; b) health clinics at commune level where the family doctor, nurses and midwifes attend reproductive health of women including also mother health, family planning, as well as, proper upbringing and development of children.
In the urban areas: health clinics and specialties polyclinics, which include mother counseling centers, family planning centers, children counseling centers and daycare pediatric services for children.
2. Secondary healthcare service
Service for mother and child is provided by the maternity and pediatric hospitals included in all district hospitals.
3. Tertiary healthcare service
University Obstetric and Gynecological Hospitals No. 1 and No. 2 in Tirana and the Pediatric Hospital in the University Hospital Center "Mother Teresa" in Tirana.
Concerning mother and child service regulations and guideline, which indicate that these services are an integrated part of healthcare infrastructure, we may mention a number of laws, regulations and guidelines that define integration of these services in the healthcare service.
Law No. 7870 of 13 April 1994 "On health insurance", published in Official Gazette No. 15, page 500 of 1994, as amended in some articles by Law No. 8961 of 24 October 2002, "*On some additions and amendments to Law No. 7870 of 13 April 1994 "On health insurance in the republic of Albania"*, published in 2002 in Official Gazette No. 80, page 2313, defines the overall framework of

health sector funding by setting out the funding resources and the relevant financial responsibilities of different funding agencies.
It also defines the Public Health Institute as an independent public institution with independent budget.

Whereas, Article 8, paragraph 2 of this Law provides that the State shall contribute for inactive persons including: a) **children, fulltime pupils and students;** b) pensioners c) **disabled (mentally and physically disabled);** c) unemployed; d) persons receiving economic aid and social assistance; e) **mothers on maternity leave;**
Law No. 9106 of 17 July 2003 "On hospital service in the Republic of Albania", published in the Official Journal No. 65, page 2907 of 2003 regulates all aspects of hospital care and hospitals administration. It additionally regulates planning of hospitals at central and regional level and stipulates that hospitals shall be managed by a regional hospital authority.

Article 35 of this Law defines services of public hospitals that must be provided at municipal level and Subparagraph "d" of this Article additionally defines the obstetric and gynecological services, which include specialized hospital service for pregnant women, birth and care for newborn babies.
The Council of Ministers Decision No. 84 of 13 February 2003 "On administration and covering of services by the medical staff included in the health insurance scheme", published in Official Gazette No. 12, page 362, of 2006 defines that:

Paragraph 1:"Primary healthcare shall be provided by the general practitioner, family doctor, specialized doctor and nurses who work in the primary healthcare service".

Paragraph 2: "The general practitioner shall provide general health service to all persons over 14 years of age. General practitioner for ages of 0-14 shall provide health service to all children of this age".
Paragraph 2/a of the Council of Ministers Decision No. 383 of 19 June 2004 "On the adoption of procedures, fees and the coverage extent of the single tertiary exanimation services included in the health insurance", published in the Official Gazette No. 44, of 2004, page 3195, defines that the Healthcare Insurance Institute shall cover expenses of these examinations services as follows: a) 100 percent for children of 0-12 years old, fully disabled persons, war disabled, veterans, TBC and CA sick persons.
The Council of Ministers Decision No. 857 of 20 December 2006 "On funding of primary healthcare services", published in Official Gazette No. 147 of 2006, page 5943. This decision defines funding through the health obligatory insurance scheme of the Primary Healthcare Service (PHS) as provided in Appendix 1, which is attached to this decision.
For the first time, independent healthcare clinics have been established as primary healthcare service providers and, they operate as a team of professionals subcontracted by the health insurance to provide a well-defined package of health services, with a special bank account and status.
The purpose of the independent healthcare clinic is to provide qualitative health services based on the principles of family medicine to serve the population all over the area, which is covered by the clinic. These clinics provide health service based on the services package, which is adopted upon the **Order of the Minister of Health No. 95 of 16 February 2009, where care about mother and child, reproductive health and promotion and health education are an important part of this package. This package provides prevention services** (monitoring of child's growth and development, immunization) **and ambulatory treatment for sick children and pregnant women.**

A clearly defined package includes the following:

- service to be provided for the pregnant women and children, its purpose,
- following up and care about women during pregnancy and after giving birth,
- management of common situations during childhood,
- preventive care and promotion of children/family,
- skills that the health staff must enjoy to provide this service, the referral system, services to be provided to the community,
- standards that this service must have in compliance with the clinical practice guidelines as drafted by the university departments of family medicine and pediatrics,
- Equipments and pharmaceuticals that the clinic must have to provide this service for mothers and children and the unified medical documentation.

Law No. 10138 of 11 May 2009, "On public health", adopted by the Parliament of the Republic of Albania and published in Official Journal No. 87 of 2009, page 3803, as a frame Law of public health domain, aims at promoting healthy life of the population by means of organized actions, the effect of

which is equally distributed across all groups of population. This Law has defined the basic services of public health, which are ensured by the state and, in which reproductive health, mother and child health are included (Article 54).

Law No. 8876 of 04 April 2002 "On reproductive health", as adopted by the Parliament of the republic of Albania and published in the Official Journal No. 15 of 2002, page 446, defines and ensures protection of reproductive rights of every individual in the Republic of Albania. It regulates organization, functioning and supervision of all activities, which are carried out in the area of reproductive health, in the public and private health institutions; it ensures equal distribution of resources across institutions to achieve the defined goals and to accomplish the reproductive rights.
This Law regulates relations between health workers, individuals and institutions and public and private persons that work in the area of reproductive health, by having at its focus the principles of choice, non-damage, confidentiality, nondiscrimination and providing of qualitative healthcare.

Article 3 of this Law defines reproductive healthcare services, which are provided by our health system and, which include the following:

a) Services and counseling, information, education and communication for family planning;
b) Services and advice about pre-birth care, safe delivery and post-birth care, especially breastfeeding.
c) Services and education for children, teenagers and healthcare for women.
d) Prevention and treatment of sexually transmitted diseases, HIV/AIDS, infections and diseases of reproduction tract.
e) Safe abortion and management of complications related to abortion.
f) Information, education and advice on sexuality and reproductive health;
g) Referral services about family planning, pregnancy complications, abortion, infertility, reproductive tract infections, breast cancers and reproductive system cancers, menopause, sexually transmitted diseases, including HIV/AIDS;
h) Prevention and appropriate treatment of infertility.

Article 24 of Law No. 8876 of 04 April 2002 "On reproductive health" provides that all pregnant women shall benefit free of charge periodical follow up of their pregnancy, birth and post birth, especially prenatal and postnatal examinations, which are obligatory and, which are defined upon an act of the Minister of Health. All pregnant women have the right to carry out obligatory examinations, as defined by the physician, without any charge and to get without charge, too, the pregnancy follow up booklet.
Next, Article 25 defines that: "**All children of 0-6 years old shall benefit from preventive measures, as well as, medical screening and follow up at no charge at all".**

Regulation of Reproductive Health Services in Primary Healthcare Service, as adopted by the Minster of Health upon Instruction No. 147 of 11 April 2003, which defines the structures and services in reproductive health in Primary Healthcare Service, rules of their functioning and the tasks of health staff , which works in these services. Part of this regulation includes also description of assignments concerning woman follow up during pregnancy, delivery and post delivery, following up and controlling of the proper upbringing of the child of 0-6 years.

Pursuant to the International Convention on Child Rights, the Minister of Health adopted upon **Order No. 115 of 29 March 2006 the Charter of Rights of Hospitalized Children.**
This charter, which has already been distributed and recognized by all pediatric and maternity hospitals of 36 districts of the country, defines the rights of every sick child in 13 aspects including: a) the right to have by them one of their parents or the legal custodian during their hospitalization; b) the right of the parents and children to be informed about the disease and its treatment; c) the right of parents and children's participation in all decisions concerning healthcare that is provided to them, protection against every kind of unnecessary examination and treatment; d) the right to have a specifically designed premise, which is equipped and safe to meet not only medical needs, but also the needs for games, entertainment and education activities in accordance with their age and health condition. This Chart is already available in all pediatric and maternity hospitals, which, in order to implement it, must make the necessary adjustments and improvements in premises, rules, staff training, etc.

Life Expectation at Birth in Years

Years	**Total**	**Male**	**Female**
1950 - 1951	53.5	52.6	54.4
1951 - 1956	57.8	57.2	58.6

1960 - 1961	64.9	63.7	66.0
1979 - 1980	69.5	67.0	72.3
1980 - 1981	70.2	67.7	72.2
1984 - 1985	71.5	68.7	74.4
1985 - 1986	71.9	68.7	75.5
1986 - 1987	72.0	68.8	75.5
1987 - 1988	72.2	69.4	75.5
1988 - 1989	72.4	69.6	75.5
1989 - 1990	72.2	69.3	75.4
1990 - 1995	71.4	68.5	74.3
1999	74.0	71.7	76.4
2001 - 2005*	75	72	77

*) Calculation by Projection of Population
Source: INSTAT 2006

Healthy Life Expectancy (HALE)

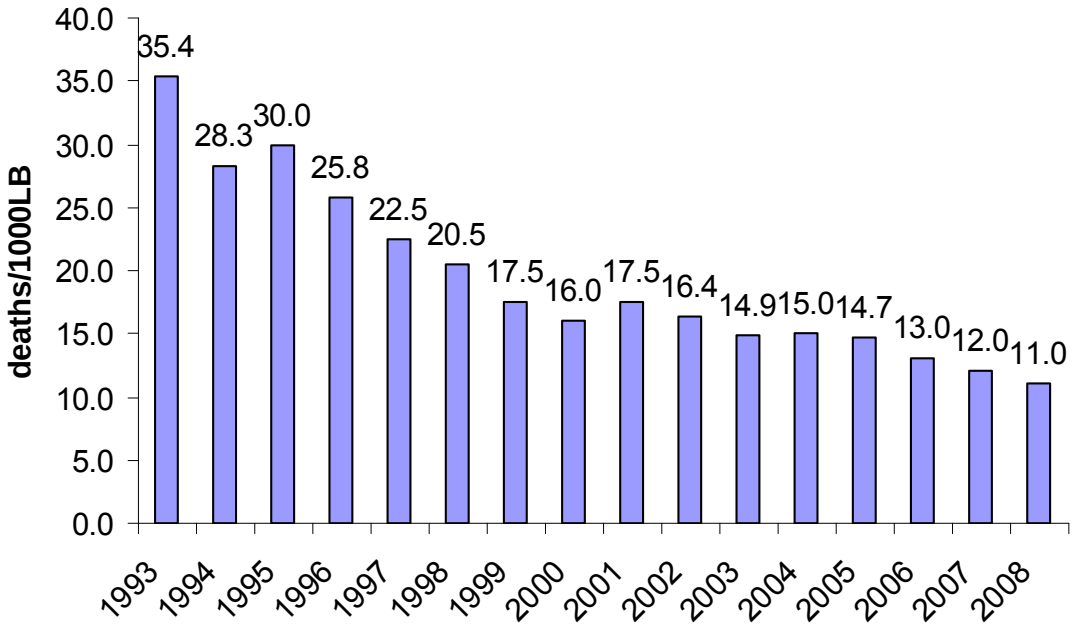
	HALE (years)					**Total life expectancy lost (%)**	
	At birth			**At age 60**			
	Total	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**
Albania	61	60	63	11	14	12	15

Source: INSTAT 2006

Public Health Institute has designed a new model of services in relation to Family Doctor with the purpose of early detecting the potential causes of cardiovascular diseases and their timely treatment (mainly counseling and following up). The aim of this program is to encourage early detection and appropriate treatment with counseling or treatment of risk factors related to coronary and cardiovascular diseases with the purpose of preventing health consequences on Albanian population. A guideline, which is drafted to assist physicians (but also nurses, if necessary), is in the center of the program. The guideline schematically includes, *inter alia*, also the standards of classification and advising of individuals for each of the 8 variable, major and minor factors of cardiovascular diseases. The program envisages regular assessment of a set of indicators related to the behavior, as well as, with individual biological parameters for all users of Family Doctor services. Every insured person is entitled to the right to benefit from new services.
Actually, the medical screening model has been tested across most of the districts of the country and the relevant health authorities are made aware of it. This program will be followed by other initiatives of the Ministry of Health, such as the following:

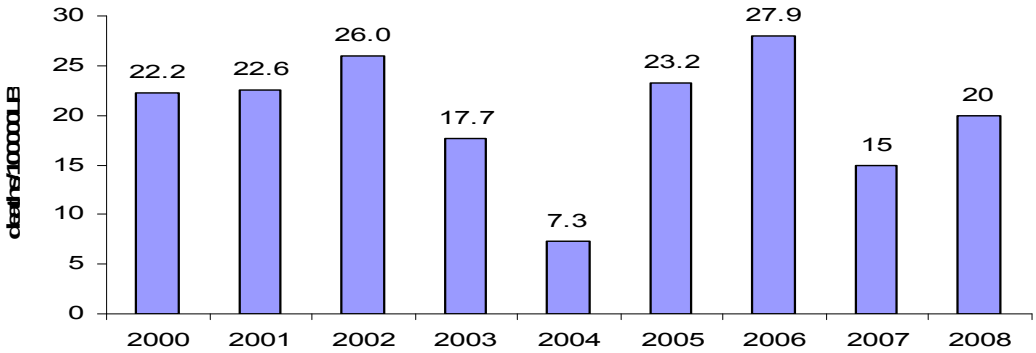
- Regulation of the referral system to ensure involvement of specialist doctors in this process.
- Establishing of protocols regarding management of cases with cardiovascular diseases.
- Developing of a global strategy for the controlling of cardiovascular diseases in Albania.

Maternal and infant mortality
Infant mortality over years



Source:
MoH 2009 unpublished

Maternal mortality over years



Operating figures of the health statistics sector of the Ministry of Health, as based on the public health institutions reporting, indicate a permanent decline of infant mortality rate in each year. In 2009, mortality, as reported by this sector, is 10 per 1000 Live Birth cases.

The latest national research called Albanian Demographic and Health Survey ADHS 2008-2009, as carried out by the MoH in cooperation with UNICEF, WHO, UNFPA, USAID, upon the technical assistance of MACRO, USA, indicated a decline of infant and child mortality rate during the past 15 years, too.

In particular, the rate of infant mortality has decreased to more than a half, which is from 35 death cases per 1000 born Live Birth cases for the period of 10-14 years before the survey to 18 death cases per 1000 Live Births as an average of 5 years together, which were included in the survey (2003-2007).

Concerning infants death causes resulting from acute respiratory diseases (ARD) during these recent years it must be emphasized that over years this has decreased by 50% compared to 1990.

The Albanian Demographic and Health Survey 2002-2008 (ADHS), as mentioned above, indicated that only 6% of infants of 0-5 years of age had symptoms of respiratory acute diseases.

Measures taken to improve infant mortality

Constant decrease of infant and child mortality and diseases has been before and continues to remain a priority of the work and strategies and policies of the Ministry of Health.

To improve this situation, the work of the Ministry of Health has focused on the following:

- Improvement of the mother and child health services quality across three levels of service by means of unifying standard and updated protocols on the evidence based medicine with regard to mother and childcare follow-up.
- Improvement of the scientific and technical level of health staff knowledge by means of training all health staff who work in these services.
- Completion and improvement of the legal framework concerning protection of women and children health by means of drafting legislation, regulations and guidelines.
- Awareness, education and mobilization of the entire society, mass media, etc., to understand that care about women and children comprise a main priority for the country and it is not only a task of healthcare institutions.

To implement these measures, a list of concrete actions has been undertaken as follows:

Drafting of guidelines, regulations, unified standards of mother and child health in healthcare services.
Several standards and guidelines have been drafted in terms of following up proper upbringing and development of child in the frame of National Program of Childhood Diseases Integrated Management, which has started since 2000 in Albania. During 2004-2008, the protocols of breastfeeding, antenatal care, upbringing and development follow-up of child 0-6 years of age, etc., have been reviewed.
During 2009, work has started in cooperation the WHO Cooperation Center, Burlo Garofalo Trieste, Italy to draw up pediatric and neonatal care protocols.
In 2009, protocols were drafted about prevention and protection of woman and child against abuse, abandonment, exploitation and violence in addition to prevention of domestic practices, which stimulate gender based discrimination. During 2007-2009, about 800 health workers (family, pediatric and obstetric-gynecologic doctors and nurses) worked on prevention and referral of domestic violence and, especially on prevention of violence against woman and child and, gander-based violence.

Training of health staff providing childcare services to enhance their knowledge and skills in relation to mother and childcare
Training of health staff has been constantly carried out by including family, pediatric and obstetric-gynecologic doctors and nurses with regard to different issues of childcare, care about pregnant woman, breastfeeding according to the National Programs that the Ministry of Health has had in cooperation with organizations and UN Agencies such as UNICEF, WHO, UNFPA, etc.
Therefore, about 600 doctors and 500 nurses from the Northeastern part of the country including Kukës, Dibër, Mat, Bulqiza, Burrel, Has, Tropoja and Korça were trained about the Childhood Diseases Integrated Management.
All staff of child counseling clinics in 36 districts and in all maternity units of districts was trained on breastfeeding.
Establishing of a system, which monitors provision of services of basic package of primary healthcare and, which reviews mother and child service structures of the primary healthcare service in support of new conditions.

The list has been drafted about screening and monitoring of the performance of mother and child services by the monitoring structures, which have been established in the public health directorates of all (36) districts of the country (based on a set of indicators of mother and child health, as well as, follow-up and controlling of antenatal and postnatal checks, family planning, vaccinations, maternal deaths, death cases of children 0-5 years of age, health of newborn babies, breastfeeding, etc.).
It is practically these structures, which conduct periodical monitoring of the performance of the health clinics in the city and in the village, which provide childcare services in the primary healthcare.

Ministry of Health has drawn up the national dietetic guide based on the WHO and FAO recommendations. The guide contains specific recommendations regarding babies feeding and pregnant women.
Drafting and implementation of national programs about mother and child health improvement.
Additionally, a number of national programs function in cooperation with WHO, UNICEF, UNFPA, USAID and these programs include the following:

The Program: Making Pregnancy Safer MPS/Promoting Effective Prenatal Care (WHO/UNICEF/UNFPA)
PEPS Program, as developed by WHO for Europe Region, comprises nowadays one of the major components of the WHO Global Initiative “Making Pregnancy Safer” in this region. PEPC Strategy in our

country focuses on the critical period of prenatal care, which covers the period consisting of 22 weeks of pregnancy up to 7 postnatal days and its aim is to provide **a healthy start of life for children by reducing maternal and prenatal mortality by means of promoting safe motherhood.**
This program, which started in 2002 in our country as a national program, has the following major components:

- Training of Primary Healthcare Services staff concerning mother and newborn baby, essential antenatal and postnatal care, as well as, essential care about the newborn baby and breastfeeding.
- Drafting of protocols concerning prenatal and postnatal care, care about the newborn for the primary healthcare.
- Improvement of the management and supervision system of mother and child services in the Primary Healthcare Service.

During the implementation of this program over 2004-2008, training activities were conducted with the health staff in several districts of the country including Shkodra, Vlora and Korça. A total number of 70 family doctors and 30 health staff members were trained. The protocols of antenatal care for pregnant women were drafted.
Promotional materials and activities concerning mother health and the health of newborn baby have been drafted and conducted with the communities in a number of districts of the country including Shkodra, Malesi e Madhe, Vlora, Korça, Dibra, Kukës, etc.

***UNFPA National Program*: "Support for Reproductive Health and Family Planning in Albania".**
5-year cooperation programs have been developed in cooperation UNFPA since 1993. Actually, the implementation of cooperation program for the period 2006-2010 is ongoing. The main objectives of this program include:

- Support of the Ministry of Health in developing the primary healthcare services package for mother and child and family planning, including the monitoring and supervision standards, as well as, data indicators.
- Support for the establishment of systems to improve performance by backing up training of human resources and performance appraisal with the aim of providing a wide range of qualitative services, including family planning, in order to respond to the uncovered needs (Logistics of Information System Management on contraceptives, abortion surveying, STDs surveying, and surveying of congenital anomalies).
- To implement these activities, the Public Health Institute since 2008-2009 has established a national system of monitoring the incidence of Sexually Transmitted Diseases (STDs), abortion surveying and surveying of congenital anomalies.
- Support for permanent training of family specialist and nurses, communes nurses and family doctors on Reproductive Health.
- Improvement of Reproductive Health component in the medical schools curricula, especially for the aforementioned categories. During 2008-2009, the curricula of teens' reproductive health obligatory education were drafted and the discussion is ongoing with the Ministry of Education to introduce them.
- Promotion and strengthening of partnerships between governmental institutions, NGOs and funding agencies to ensure coordination in the area of Reproductive Health, through the thematic working groups under the management of the National Committee of Reproductive Health and other interministerial bodies.
- Campaigns on advocacy, education, family planning promotion, mother care, STD, etc., including drafting and distribution of IEK materials, posters, leaflets, etc.

National program "On Integrated Management of Infant Diseases" in cooperation with WHO and UNICEF started in 2000 and it was initially piloted in the northeastern areas of the country where indicators of infant mortality were twice higher compared to those of the national level.

The following are among the important interventions, which have been applied in the frame of this strategy:

- Training of health staff about following up, treatment and counseling of children of 0-5 years of age.
- Implementation of 10 golden rules in the community for a better health of mother and child aiming at involvement of the entire community in the area of mother and childcare.

The achievements over these years of the implementation of this program in those areas include the following:

- Enhancement of contemporary knowledge of health staff, which works in the mother and childcare services in these districts,
- Involvement and cooperation of the community in the mother and childcare area.

- Enhancement of the knowledge of the families concerning child healthcare, proper upbringing and development.

This has led to the improvement of child health situation in these areas, where a significant decline of infant and child mortality has been observed. For example, Tropoja district, which was one of the remote northeastern districts with an infant mortality rate of up to 30 per 1000 Live Births (2-3 times higher than the national one) in 2000, in 2007 the infant mortality rate went down to 11 per 1000 Live Births.

National program of promoting breastfeeding and the establishment of baby friendly hospitals in 1996 and beyond: UNICEF-Ministry of Health

The objective of this program is to improve breastfeeding and follow up implementation of Albanian Law No. 8528 of 23 September 1999 "On encouragement and protections of breastfeeding" , the purpose of which is to ensure a healthy feeding of children by means of regulating trading practices of breast milk alternates based on the International Marketing Code of Breast Milk Alternates.

Additionally, expansion of the imitative regarding the establishment of *Baby Friendly Hospitals*, which encourage and support breastfeeding, has started since 1996 with the support of UNICEF and WHO. Actually, Albania has 10 regional maternities (out of 12 regional maternity hospitals that the country has), which are certified or, which are in a certification process to take the name Baby Friendly Hospitals.

Achievements:

- Training every year of the staff about breastfeeding for 36 districts of the country.
- Drafting of materials regarding health education about breastfeeding.
- Rating and certification of baby friendly hospitals every two years.
- Monitoring of breastfeeding indicators in the country every 5 years.

The cooperation program between the Ministry of Health, WHO and Spanish Agency for Cooperation and Development "Reform of Mother and Child Health 2008-2010".

Main objectives of this Project include the following:

- Improvement of Albanian women, babies and children health condition by strengthening:
- Capacities and leading function of the Ministry of Health.
- Mother and child health services in the primary and secondary healthcare.

To achieve this objective, interventions and activities are implemented at central and regional level and they are focused essentially on the following:

- Reformation and reorganization of mother and child health services.
- Improvement of the quality and continuation of mother and childcare services.

At national level, the following are the main interventions:

- Strengthening of the Ministry of Health capacity to monitor and manage mother and child health.
- Reviewing and development of standards and clinical manuals concerning mother and child health.
- Reviewing of university and post-university curricula about child health.
- Reinforcement of ongoing training and education for healthcare workers.
- Reinforcement of the information system on mother and child health included in the national system of health information.

At regional level, the Ministry of Health has selected three following regions where the pilot interventions will be applied: Shkodra (Shkodra, Puka, Malësi e Madhe Districts,) Vlora region (Districts of Vlora, Saranda, and Delvina), Korça Region (Districts of Korça, Pogradec, Kolonja, Devolli).

The main activates organized during this period include the following:

- Assessment of the hospital care service as provided for mother and child. Quality assessment of maternity hospitals and pediatric units has been carried out in the districts of Shkodra, Vlora, and Korça (by the international raters' team of WHO Copenhagen Office based on the tool as drafted by this office).
- Training of maternity hospital and neonatology unit of the districts of Shkodra, Vlora, and Korça (with WHO international trainers).
- Training of managers, heads of mother and child service about mother care lead by WHO/Copenhagen experts.
- Beginning of work to reorganize health service in schools.
- Beginning of work to reorganize the referral system concerning mother and childcare.

National program "Reduction of malnutrition of Albanian children 2009-2012", funded by the Spanish Government, implemented upon the technical assistance of UNICEF, FAO, WHO, approved as of 14 December 2009 by the Minister of Health and the Minister of Agriculture, Food and Consumer Protection.

The purpose of this joint program on nutrition is to prevent and address malnutrition and food unsafety in Albania between groups of population with children at high risk by means of strengthening national policies of development and technical capacity building at national and local level.
The program sets the focus on nutrition based on the permanent achievements with the support of WHO, UNICEF and FAO in terms of fulfilling the Millennium Development Goal.
The Joint Program is in line with the "One UN" Program in Albania, since it contributes in terms of a more transparent and accountable governance, development of more effective national policies and the quality of public services. It particularly encourages progress towards OZHM1 (poverty eradication and malnutrition reduction in half), OZHM4 (reduction of infant mortality) and OZHM5 (improvement of mother health).
The Joint Program is linked with several strategies and objectives of National Strategy of Development and Integration (NSDI). It directly supports the Strategic Priority of NSDI regarding an economic, social and human development, which is fast, balanced and sustainable and, which additionally aims at reducing infant mortality rate by 2015.
The Joint Program will be implemented by the Ministry of Health, Ministry of Agriculture, Food and Consumer Protection, INSTAT-it, specialized institutions, regional authorities and civil society organizations, under the support of UNICEF, WHO, FAO. Ministry of Health will be responsible for the achievements of the general goals of the program and coordination of its implementation with the Ministry of Agriculture, Food and Consumer Protection and other key stakeholders.
The intervention will be implemented in five districts of the Northern Albania (in the prefectures of Shkodra and Kukes) and in two pre-urban municipalities in Tirana. These areas are the most affected ones by malnutrition of children (especially in terms of being short by size) and they have a considerable number of Roma populations, they are either poor (in rural areas) or they have high rates of unemployment (in urban areas).
Selected areas in the northern part of Albania, which have already received the support of "One UN" Program, are included in the scope of topics concerning Young People Employment and Migration of the Achievements Fund OZHM (UNDP-Spain) and they are under the scope of the WHO Program on Mother and Child Health supported by the Spanish Government.
The Program aims at integrating several purposes and priorities of the Government of Albania in the areas of health and agriculture, by means of the following:

- Support for policies development,
- A coordinated set of actions (direct implementation of interventions and training of key service providers) to prevent and address undernutrition of children an women in highly affected areas including both rural and pre-urban areas, as well as, incorporation of a number of sectors under the management of Ministry of Health.

Measures envisaged for the future to improve the mother and child health situation
To improve child health over 2010-2015 and to achieve the Millennium Development Goals, the Ministry of Health has set a number of targets and objectives, which are included in the **Strategic Paper and the Action Plan of the Reproductive Health Strategy 2010-2015, as adopted upon the Order of the Minster of Health of 17 November 2009.**
Targets until 2015

- Decreasing of infant mortality by 10 percent per 1000 Live Births.
- Decreasing of infant mortality less than 5 years of age by 10 percent per 1000 Live Births.
- Deceasing of newborn babies' mortality rate by ½ of the existing level.
- Percentage of children exclusively breastfed to reach to over 60% (existing level 35%)
- Percentage of 6-months children who begin complementary feeding in time to reach over 90% (existing level 70%).
- Percentage of children who continue breastfeeding in the second year of their life to reach 80%.
- Reduction by 30% of the existing level of acute respiratory diseases for children of up to 5 years old.
- Reduction by 30% of the existing level of diarrheic diseases for children of 0-5 years old.
- Percentage of children vaccinated with routine calendar vaccines to reach over 98%.

The following are among the goals set to achieve these targets:

- Providing of essential healthcare for each newborn baby.
- Establishing of a national system to monitor and evaluate mother and newly born baby health services.
- Making sure that each mother and child healthcare institution provides effective and contemporary care about breastfeeding by applying 10 steps of a successful breastfeeding.
- Prevention of malnutrition and of deficits caused by micronutrients in early childhood.
- Prevention of contagious diseases and other diseases through vaccination of children by increasing vaccine coverage of children against preventable contagious diseases by means of vaccines.

- Reduction of cases of main childhood diseases, which are the main causes of infant mortality and diseases through MISF strategy.
- Prevention of diseases and infections related to food and nourishment.
- Prevention of maltreatment and violent behavior problems between children and teenagers.
- Ensuring of early detection and management of children's development problems.
- Prevention of use and abuse with substances, smoking, alcohol and drugs by children and youngsters.

Main interventions to achieve these include the following:

- Regionalization of neonatal care at regional level according to the levels of care.
- Training of staff, which provides obstetrical and neonatal service on practices (evidence based) of care about newborn baby.
- Incorporation of indicators of perinatal care in the national system of health indicators as disaggregated by social and economic condition, gender equity, sex, geographical division.
- Encouragement of all maternity services in the district hospitals, which apply the initiative "Baby Friendly Hospitals" of WHO/UNICEF in relation to 10 steps of breastfeeding.
- Drafting of unified protocols regarding regular follow up of children upbringing and development by the primary healthcare service staff.
- Permanent monitoring and assessment of nutritional condition of children and pregnant women.
- Providing of promotion and health education for families' and community awareness about the healthy styles of feeding and physical activity sensitive vis-à-vis gender.
- Full and timely vaccination of children according to the national calendar of vaccination and expansion of the vaccination scheme by means of introducing new vaccines.
- Promotion and application of Main Infancy Disease Integrated Management to follow up and treat children of 0-5 years of age in all services of childcare.
- Promotion of education programs with regard to reducing maltreatment and violence in schools, family and communities.
- Providing of social and psychological support in the services of healthcare services for children and teenagers who are exposed to violent environments.
- Promotion of children early cognitive and psychosocial stimulation programs by paying special attention to groups of children with special needs and in disadvantage.

Maternal mortality rate trend and the measures

Maternal mortality rate indicators trend in our country indicates a decrease of the rate from one year to another. Ministry of Health data as collected by our health institutions and INSTAT and data collected from the death cards indicate that number of maternal deaths has suffered decline each year. In 2009, no maternal death was reported in our country.

Antenatal care indicators, as reported to the Ministry of Health and, according to the latest ADHS 2008 – 2009 survey indicated that 98% of women received antenatal care during pregnancy. 98% of deliveries happened in health institutions and about 2% had happened with medical assistance at home.

Measures taken to reduce maternal mortality

Measures about legal and regulating framework regarding mother health include the following:

- Article 2 (Definitions) of Law No. 9198 of 01 July 2004 "On gender equity in society" provides that, "special protection of women during pregnancy, birth and sickness shall in no way be a discrimination or violation *of equal rights between man and woman".*
- Law No. 8876 of 07 April 2002 "On reproductive health" guarantees a special protection of mother and child health in specific articles of it.
- The Council of Ministers Decision No. 397 of 20 May 1996, as amended by Council of Ministers Decision No. 185 of 03 May 2002, has adopted the Decision "On the special protection of pregnant women and motherhood". Paragraph 5 of this decision, when referring to working time for pregnant women and breastfeeding mothers, defines that *they shall not start work earlier than 05 o'clock in summer (06 o'clock in winter) and they shall neither continue work after 20.$^{00.}$ Pregnant women and breastfeeding mothers shall have the right to have paid leave at intervals during the day, although not less that 20 minutes for each three uninterrupted hours of work.*
- According to Article 108 of the Labor Code, *work during nighttime for pregnant women shall be prohibited thereof.*
- The Labor Code stipulates special rules concerning protection of working woman. Article 54/3 provides that, *pregnant woman who works continuously standing must have a break of 20 minutes every for hours.* In addition, it prohibits employment of pregnant women and breastfeeding women in activities, which expose them against work conditions and factors of high risk for their health. List of jobs, which pose a threat in terms of exposure against agents or, work conditions, which threaten safety and health

of pregnant women, puerperal women or breastfeeding women was adopted upon Decision of the Council of Ministers No. 207 of 09 May 2002 "On defining difficult or dangerous jobs".

- Albanian legislation provides special protection about women reproductive health. Working 35 days before and 42 days after the birth is strictly prohibited and, when the woman is pregnant with more than one baby, this timing is even longer. After elapsing of these days, the worker has the right to choose whether she wishes to return to work or, to continue to care about her child. If she chooses the second option, the employer is obliged to save the job for 12 months. Leave is guaranteed also fro mothers who adapt children.

Improvement of maternal care services quality

Drafting of the basic package of primary healthcare services (mentioned above). The package has clearly defined the following:

- Service to be provided for the pregnant woman, its purpose.
- Following up and management of pregnant woman during pregnancy and after birth.
- Preventive care and promotion of maternal health in family and community.
- Capacities to be possessed by the health staff to provide this service, the referral system, and services to be provided to the community.
- Standards that this service must have in accordance with clinical practice guide as drafted by the university departments of family medicine and pediatrics.
- Equipments and pharmaceuticals that the clinic must have in order to provide this service to mother and child and the unified medical documentation.

Enhancement of health staff knowledge about care during maternal period: Training events have been organized with family doctors, with obstetric and gynecological doctors, nurses and midwives about following up, treatment and referral of women during pregnancy, breastfeeding, antenatal and postnatal care.

To analyze the situation of maternal and infant mortality, the National Committee of Reproductive Health was reorganized upon the Minister of Health Order No. 58 of 15 February 2008. The tasks of this Committee, *inter alia*, include: Continuous assessment and analyzing of the reproductive health situation in the country with a special focus on mother and child health, that is, maternal and infant illness and mortality rate.

The Committee, as chaired the Deputy Minister of Health, has in its composition representatives of main health institutions and of line ministries who work in this area including the Ministry of Education and Science, Ministry of Labor, Social Affairs and Equal Opportunities, Ministry of Tourism, Culture, Youth and Sports. Moreover, members of this Committee come also from several national and international partner organizations and from United Nations, which work in child health area, such as, for instance, WHO, UNICEF, USAID, UNFPA, etc. The Committee convenes regularly four times a year.

Education and health promotion in family and community about safe motherhood: Some of these promotional activities include the following:

- Carrying out of awareness activities for a safe motherhood.
- Media training about various problems of reproductive health such as family planning, mental health, STD, etc.
- Application of all mass-media approaches including TV and radio talk shows, articles in different newspapers of the country about different issues that are related to mother and child health.
- Leaflets or booklets concerning breastfeeding, woman and baby in her abdomen, brochures about using of iodized salt, etc., have been distributed to the communities and schools of the districts of the country.
- Information activities in the community organized by organizations (projects) including USAID, UNICEF, UNFPA, American Red Cross, Peace Corpse, Albanian Caritas, etc., as well as, different NGOs, which operate in health area. Their activities have essentially focused on the importance of breastfeeding, breast milk advantages, family planning, prenatal and postnatal care, etc.
- Training of the education cabinets staff in 36 Districts of the country about mother and child health issues.
- Since 2008, Ministry of Health has continued to publish every three months the Reproductive Health Magazine, the focus of which consists in the health of mother, child and teenagers, in pregnancy, in their feeding, in child development, etc.

- Training by the education cabinets' staff in five regions of the country including Shkodra, Berat, Korça, Lezha and Dibra in cooperation with the Pro-Health-USAID Project in community with problems of children nutrition, antenatal care and family planning.

Future measures to improve maternal health
To improve maternal health over 2009-2015 and to achieve Millennium Development Goals, Ministry of Health has set these targets and objectives, which are included in the **Strategic Document and the Action Plan of the Reproductive Health Strategy for 2010-2015, as adopted upon the Minister of Health Order of 17 November 2009.**

Targets to be achieved by 2015 include the following:
Maternal mortality rate to decrease to 11 deaths per 100 000 Live Births.
- Perinatal mortality rate to decrease to 10 deaths per 1000 Live Births.
- Prevalence of anemia in pregnant women (hemoglobin level under100g/l) to reduce to less than 30% of them.
- Percentage of women receiving prenatal care to reach to 95%.
- Percentage of pregnant women who receive 4 basic checks of antenatal care to be >:90%.
- Percentage of mothers who perform, at least, a postnatal check to be 85%.
- Percentage of births assisted by skilful health staff to reach > 98%.
- Decreasing *of obstetrical complications percentage by 50%.*
- *Percentage of induced abortions to reduce by 30%.*

Main objectives will be the following:
- Provision of a qualitative service for woman pregnancy including preconception care, pregnancy care and postnatal care.
- Prevention and early detection of complications and dangerous symptoms during pregnancy, birth postnatal period in order to manage to have all births safe and assisted by a professional health staff.
- Improvement of nutritional situation of woman before and during pregnancy, during birth and during post birth.
- Education, communication, information of the woman, family and community about the importance of care about woman before pregnancy, during pregnancy, during birth and post birth.
- Improvement of management, supervision, monitoring, analysis and information system about maternal health.

Main interventions about achieving these objectives will aim at the following:
- On job training (continuous education) to build doctors' and nurses' capacities about preconceptional and prenatal care, as well as, care during and after pregnancy.
- Establishing of a referral system in 12 regions to detect, to manage and/or refer highly risked cases and complications during pregnancy, during birth and after birth from the community to the health clinic of the Primary Healthcare Service and to the region hospitals.
- Development of standard protocols concerning preconceptional, antenatal and postnatal care for the primary and hospital healthcare service.
- Enhancement of financial support of health services for mothers in the poor areas, rural areas, marginalized groups and social groups in need (Roma population, unmarried women with children, etc.).
- Reinforcement of nutrition services for women included in the prenatal and postnatal services as integrated in the basic package of Primary Healthcare Service.
- Defining of mechanisms to include women and community in the processes of quality improvement and their participation in the process of drafting and implementation of the programs concerning maternal health.
- Establishing of a unified system of indicators to rate the performance of maternal healthcare services.
- Organization of media and community campaigns about special needs during the period of pregnancy, during breastfeeding and about appropriate taking of nutritional items, safe birth, leave, postnatal care.

Healthcare System
Health Service in Albania
Health Service in Albania is mostly public. State remains the main provider of health services, health promotion, prevention, diagnostication, and treatment of the population of Albania.
Private sector continues to develop, but actually, it covers pharmaceutical and dental sector, a number of ambulatory clinics for specialized examinations, notably located in Tirana and three hospitals.

The Ministry of Health plays the main role in the public sector concerning development of health policies and strategies by playing the role of the regulator and coordinating all participants inside and outside the system.
Diagnosticating and curative services in our health system are organized in three levels: Primary Healthcare, Secondary Healthcare, which includes regional hospitals and Tertiary Healthcare, which includes more specialized services, practically the University Hospital Center "Mother Teresa", 2 Obstetrical and Gynecological Hospitals and Lung Diseases Hospital.
Public Health Services are provided via budgetary structures in 36 districts of the country (Public Health Directorates) and State Sanitary Inspectorate, as supported and supervised by the Public health Institute. Other important national health institutions, which provide services, include National Center of Blood Transfusion, Center for Child Upbringing and Development, National Center of Health Institutions Quality and Accreditation, University Clinic of Stomatology, National Center of Sustainable Education, National Biomedical Center, national Center of Drugs Control.
Healthcare Insurance Institute is the single health insurance fund in Albania.

Equality concerning access to healthcare
Law No. 10107 of 30 March 2009 "On healthcare in the Republic of Albania, sets out that: "*This law shall be applied by all natural or legal entities, Albanian or foreign, which operate in the healthcare system".*

Article 37
Healthcare service for foreign citizens.
1. Healthcare service, as provided in the healthcare institutions for foreign citizens, who reside in the republic of Albania, is carried out based on the relevant international agreements or based on the reciprocity principle.
2. In the absence of an international agreement or of the conditions where the reciprocity principle applies, foreign citizens benefit healthcare services based on the provisions contained herein in this law and based on law on healthcare funding.
3. Foreign citizens, who are in need of healthcare, under the conditions of medial emergency, receive healthcare in equal conditions with those conditions that are applied for the citizens of the Republic of Albania.
4. In case of death of a foreign citizen in a health institution, the head of this institution informs immediately the ambassadorial official of the country in question.

Management of waiting list and waiting time
The referral system of the public health system is established based on Minister of Health Order (No. 52 of 12 October 2009 "On the application of patients' referral system in the health service). The aim of it is to discipline the medical doctors' activity, to discipline patients transfer from one level of service to another, to strengthen the family doctor role, to relieve the pressure and load in the hospital care and reduction of the corruption phenomena.

Health Care Professionals and Facilities
Public hospital system in Albania consists of 50 hospitals and 9000 beds. In 1992, the public hospital system counted 160 hospitals and 14 000 beds. Rate of bed utilization is 50-55%.
The Study on "Reconfiguration of Health Sector", World Bank 2008, recommends reduction of the number of hospitals to one hospital per region. Albania is organized in 12 regions. At the same time, it is recommended to reduce the number of beds in the regions by, at least, 586 beds aiming at a bed utilization level of 68% compared to 43% at present (except Tirana). The analysis is based on population by regions, on rate of bed utilization and on illness rate. We highlight that demography of Albanian population is characterized by population evident movements from northeastern and mountainous areas to the coastal and plain areas. Therefore, in some regions, it is needed to add the number of beds while, in some other areas, it is needed to decrease this number. Meanwhile, development of private sector is encouraged and this implies increasing of the number of beds. Actually, private sector counts about 400 beds, mainly in Tirana.
In order to deinstitutionalize mentally sick individuals, as laid down in the Mental Health Strategy, gradual reduction of chronic diseases beds is taking place in favor of community centers of mental health."

53. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§1 AZERBAIJAN

The Committee concludes that the situation in Azerbaijan is not in conformity with Article 11§1 of the Revised Charter on the grounds that :

– the rate of infant and maternal mortality is manifestly higher than in other European countries;
– the health care budget is significantly lower than that of other European countries.

54. The representative of Azerbaijan provided the following written information:

First and second grounds of non-conformity

> "Concerning the conclusion of the European Committee of Social Rights that the situation in Azerbaijan is not in conformity with Article 11§1 of the Revised Charter on the grounds of high infant and maternity mortality rate and low budget spending for health care, we would like to present the information on the actions taken by the Government of Azerbaijan.
> On September 15, 2006 "Action Plan on the protection of maternity and child health" was approved by the Cabinet of Ministries of the Republic of Azerbaijan. Action Plan aims to enhance the scope and quality of medical services and ultimately reduce the child and maternity death. The Program envisages establishment of 7 modern perinatal centers throughout the country and 5 of them have already been delivered for service.
> According to the Order of the Ministry of Health dated on 16th of November 2007 Regional centers have been organized to improve the medical assistance to the birth process. Instructions on rendering maternity-gynecological services at maternity welfare clinics and policlinics (approved by the Order of the Ministry of Health dated on 5th of December 2008), as well as The National Strategy on Reproductive Health and Family Planning (approved by the Order of the Ministry of Health dated on 5th of December 2009) have been adopted. National Strategy on Reproductive Health and Family Planning includes the areas of maternity and neonatal health, family planning, sexually transmitted infections, reproductive health of teenagers and etc. Instructions on antenatal care for pregnant women, efficient neonatal care, neonatal resuscitation, and neonatal transmission have been elaborated. According to the recommendations on introduction of criteria of the WHO for birth alive proposals for relevant legal and methodical documents are being prepared.
> As a result of these measures maternal mortality rate has been reduced to 24, 3 per 100000 live births, infant mortality rate has been reduced to 11, 3 per 1000 live births in 2009.
> Budget spending for health care has been increasing. Comparing with 2007 (358 mln. manats), Government of Azerbaijan allocated 502 mln. manats for health care in 2009. Budget for health care increased 50% in comparison with 2008."

55. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§1 BULGARIA

The Committee concludes that the situation in Bulgaria is not in conformity with Article 11§1 of the Revised Charter on the grounds that:

– the authorities have failed to take appropriate measures to address the health problems faced by Roma communities stemming from their often unhealthy living conditions and difficult access to health services;
– the medical services available for poor or socially vulnerable persons who have lost entitlement to social assistance are not sufficient.

First and second grounds of non-conformity

56. The representative of Bulgaria provided the following written information:

> "- One of the provisions of the Bulgarian legislation complained is art. 12c of the Social Assistance Act. Since the provision is subject to another collective complaint No. 48/2008 against Bulgaria, the Ministry of Labour and Social Policy has formed a working group which work was aimed at preparing proposals to amend this provision of the SAA - /see information about complaint No. 48 below/. The expert report was brought to the attention of the Minister of Labour and Social Policy and as a result of it art. 12c has been revoked in March 2010. The amendment enters into force on 01.01.2011.

- The Social Assistance Agency carries out weekly monitoring of persons who drop out of social assistance and it takes measures together with the National Employment Agency to promote their professional realization, as a long term solution. There are specific measures that are aimed at unemployed Roma registered at the Bureaus of Labour - National Programme for Literacy and Education of Roma, the National Programme From Social Assistance to Employment and the National Programme Activate the Inactive Persons. There are Roma mediators working in the Bureaus of Labout who assist the work with Roma in the process of seeking employment or involvement in various programs to improve their skills. There have also been organized special job fairs for Roma.

- Many of those who have lost the right to monthly social assistance, receive targeted assistance for heating. This means that even they lost the right to monthly social assistance, these individuals will continue to be exempt from paying health insurance contributions (which are borne by the state budget).

- Furthermore, in accordance with the Health Insurance Act all Bulgarian citizens have access to emergency care and obstetric care for women, regardless of the scope of mandatory medical insurance.

- Decree No. 17 of the Council of Ministers of January 31st, 2007 setting out the procedures for spending of targeted funds for diagnosis and treatment in hospitals for inpatient care of Bulgarian citizens who do not have any incomes and/or personal property to ensure their personal involvement in the health insurance process determines a mechanism to pay for hospital treatment of Bulgarian citizens without incomes. In this case, the treatment in is covered by the budget of the Ministry of Labour and Social Policy. The temporal extent of the Decree was initially extended for another year, i.e. for 2008 and subsequently by Decree No. 27 for the implementation of the state budget, the time limits were completely eliminated on February 9th, 2009, i.e. its provisions apply to each financial year.

Situation in the beginning 2010:

- Work continues on the execution of the "Health Strategy for persons in disadvantaged situation, belonging to ethnical minorities 2005 – 2015". For 2009 in execution of project under the Strategy, 4197 examinations by mobile medical cabinets including general and prophylactic, gynecological, children's examinations were made. Many laboratory and biochemical tests as well as screening examinations for socially important illnesses were also made. In the budget of Ministry of Health there are set 750 000 leva for the Strategy for 2009. For the period of 2006 – 2009 altogether 80 000 examinations were made. These activities are part of the commitments for ensuring access to prophylactic and medical care for the health uninsured persons in disadvantaged situations.

- at the end of march 2008 successfully was accomplished a twinning project under the PHARE Programme BG 04/IB/SO/04 "Restructuring of pilot multi-profile hospitals and developments of emergency health care with view amelioration the access to healthcare of vulnerable groups of the population with special focus to the Roma community", realized in two pilot regions.

Close aim was the development of the model of pilot units for emergency healthcare in tow pilot regions. In then frame of the project a review of the real needs of health services and analyses for the necessary medical services was made; an informational system and electronic data base was created, a methodology was developed and given for training, training seminars of the personnel in the centers for emergency medical care were done, Roma leaders were trained that may become mediators on health and healthcare system so that they can compliment and facilitate the healthcare specialists when working with Roma.

The Project incorporated a pilot model that will be the base for the general restructuring of the whole system for emergency medical care in the country and thus ameliorate the quality of service through inclusion of qualified staff in the hospital on a 24 hour regime of duty and lower the mortality from risk groups of the illness.

- A key figure for the amelioration the access of vulnerable groups including the Roma to healthcare is the reinforced figure of the health mediator. (In its nature the health care mediator is a intermediary between the community in which the general practitioner, the medical staff and representatives of other local or central institution work). For 2010 resources were insured for wages for medical mediators (111 in 2008 and 106 for 2009) through delegation of resources from the centralized state budget to the budgets of the municipalities.

- "Prevention and control of HIV/AIDS" Programme, executed with the aid of the Global Fund for Combat of AIDS, tuberculosis and malaria, develops and executes effective interventions aimed to prevention of HIV/AIDS through the most vulnerable in relation to the illness groups. The sum of the aid for the first five years period (2004-2008) is in the amount of 15 711 822 leva.

Since the beginning of 2009 a continuation of the programme started which will be for the period of 2009 – 2014. Component 5 of the Programme is completely aimed to "Prevention of HIV/AIDS in the Roma community". Under the programme were developed 5 medical and social centers in Roma

neighborhoods and 3 medical and social centers are maintained, 12 mobile medical cabinets work and develop the capacity of the local communities in execution of activities and provision of services.
Under component 5 only in 2009, 85 associates were trained for work on the ground, 8 medical and social centers in Roma communities were built or supported, 6 mobile medical cabinets work in the Roma community, 15 896 persons were reached with a package of preventive services and 5 721 persons are tested for HIV.
"Improvement the control over tuberculosis in Bulgaria" Programme finances activities on prevention and control of tuberculosis in the whole country including in relation the risk groups. One of the five operational aims of the Programme is: "Improvement the finding of cases and the success of treatment of tuberculosis in the Roma community". Prophylactic activities are performed – screening tests on place of the neighborhoods, populated mainly with Roma community. In execution of these actions participate NGO's including Roma ones. In preliminary data the quantative results from the work on the operational aim, connected with the Roma community in 2009 are the following: 20 827 direct contacts/meetings on grouns, 2 170 persons, received medical examination in the municipal healthcare institution from which 217 were diagnosed with tuberculosis. The latter were forwarded for free of charge treatment in the municipal healthcare institutions for diagnostics and treatment of tuberculosis and when necessary the units of the Roma NGOs accompany them and consult them for sticking with the treatment."

57. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§1 GEORGIA

The Committee concludes that the situation in Georgia is not in conformity with Article 11§1 of the Revised Charter on the ground that it has not been established that measures taken to reduce infant and maternal mortality rates, which are significantly higher than in other European countries, are adequate.

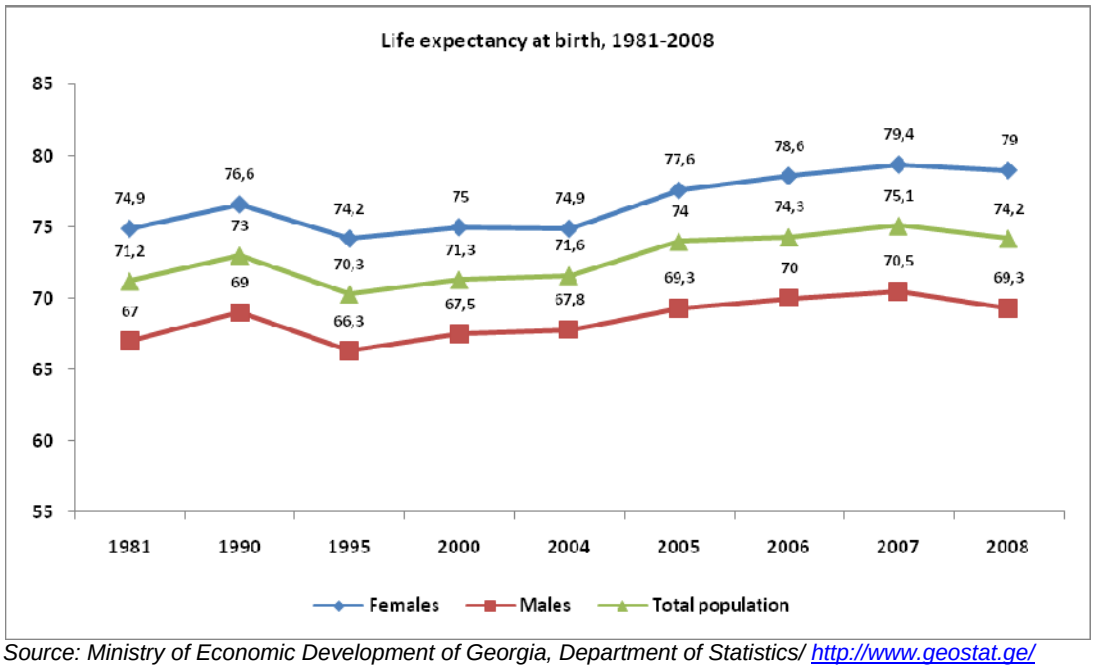
58. The representative of Georgia provided the following written information:

"Life expectancy and principal causes of death

The average life expectancy at birth, giving the picture of general state of health, is presented in illustration 1.

The diagram shows that the average life expectancy at birth in Georgia dramatically decreased in Georgia in the 90s, though since then it increased on the whole. In 2006 the given figure comprised 74 years, and in 2007 it reached 75,1 years, although in 2008 there was observed insignificant decrease. The given figure is less than the average figure of the European Union countries (78,5 years), it slightly exceeds the average figure of WHO European region (74,6 years) and significantly exceeds the average figure of the CIS countries in 2005 (67,0 years; 61,6 years in men and 72,9 years in women) (WHO/ European Bureau, Health for Everyone, Data base, July 2008).

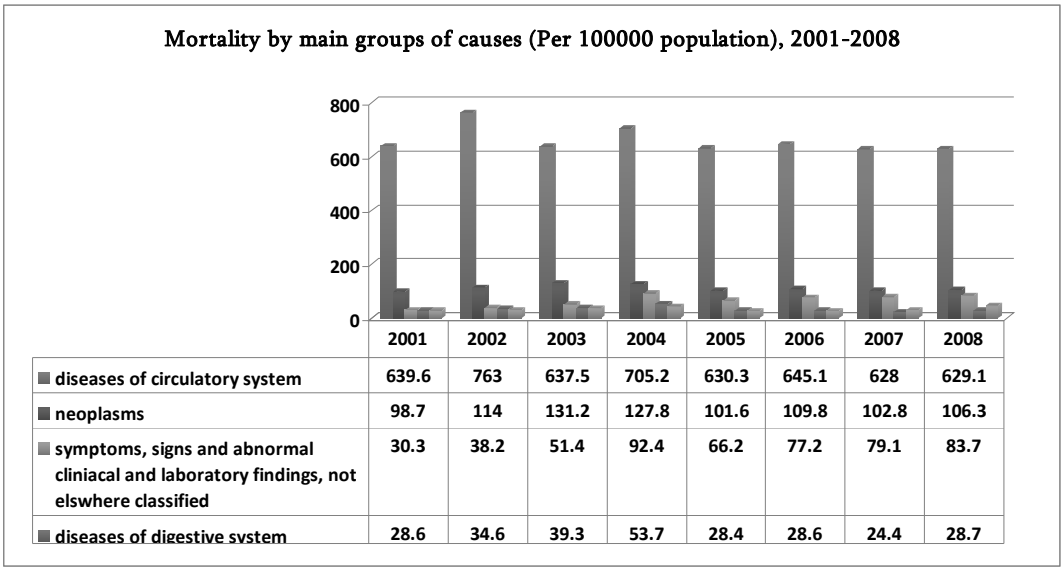
Illustration 1. Life expectancy at birth, 1981-2008



Source: Ministry of Economic Development of Georgia, Department of Statistics/ http://www.geostat.ge/

The nature of mortality and incidence shows that cardiovascular diseases have a leading place among the reasons of mortality by this moment. (Illustration 2). In 2001-2006 the given figure did not change per 100 000 population and comprised about 640. In 2008 it made up 629.1. The given rate of mortality seems to have a relatively good position among the figures of the CIS countries, although it exceeds the average figures of the WHO European region and the EU countries. (See illustration 3). The rate of mortality from cancerous growth is also high. According to the dynamics, there was an increase of the rate in 2001-2003, and since 2004 the given figure decreased significantly and in 2008 it made up 106,3.

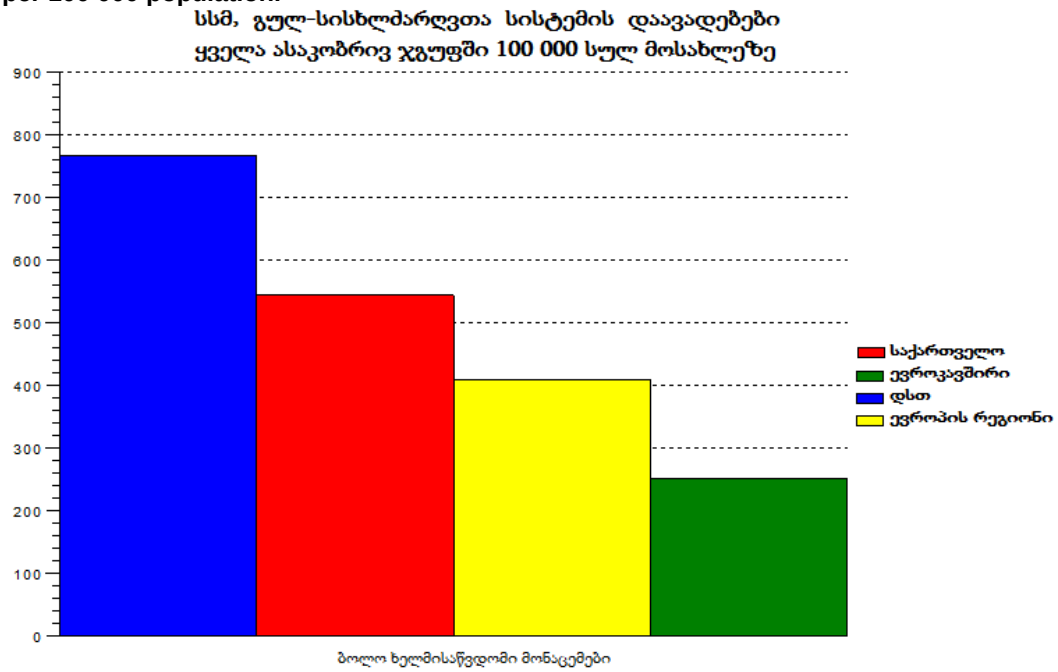
Illustration 2. Mortality by main groups of causes (per 1000000 population) 2001-2008



	2001	2002	2003	2004	2005	2006	2007	2008
diseases of circulatory system	639.6	763	637.5	705.2	630.3	645.1	628	629.1
neoplasms	98.7	114	131.2	127.8	101.6	109.8	102.8	106.3
symptoms, signs and abnormal cliniacal and laboratory findings, not elswhere classified	30.3	38.2	51.4	92.4	66.2	77.2	79.1	83.7
diseases of digestive system	28.6	34.6	39.3	53.7	28.4	28.6	24.4	28.7

Source: Ministry of Economic Development of Georgia, Department of Statistics/ http://www.geostat.ge/

Illustration 3. Standardized figure of mortality from cardiovascular diseases, in all age groups per 100 000 population.

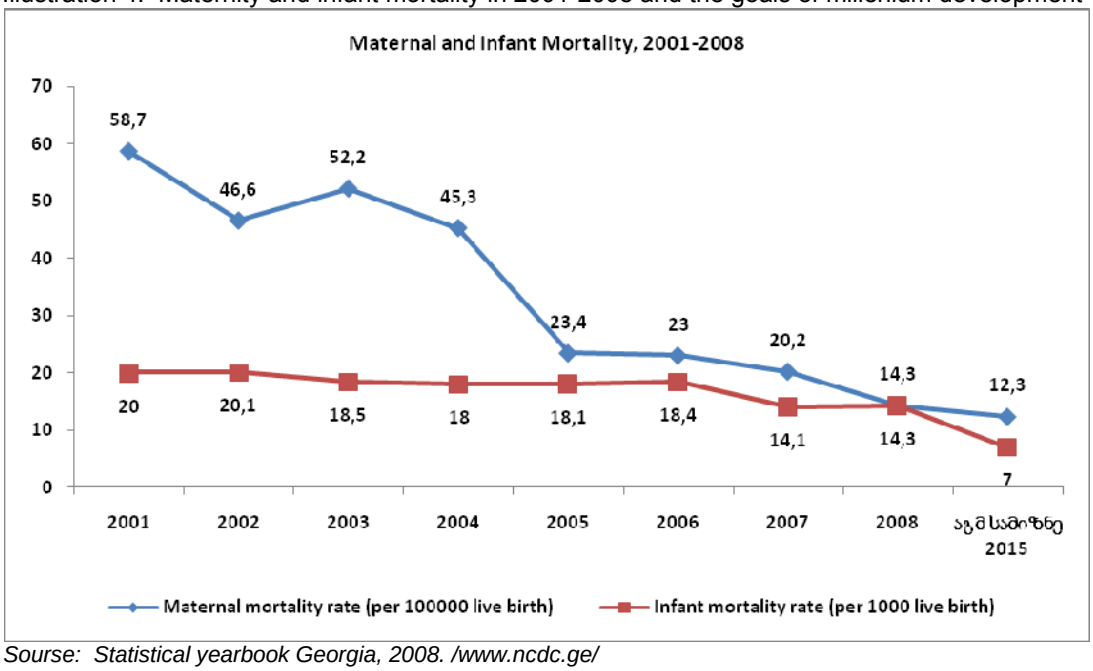


Source: WHO, Health for everyone, data base, 2009.

Infant and maternal mortality

Generally there is a progress observed in infant and maternal mortality from the point of view of the decrease of the main international indicators of health status. Child mortality decreased from 2001 to 2008 from 20 to 14. Notwithstanding this fact, there is still to be done in order to reach the goal indicator determined ,,with the view of millennium development" (7 per each 1000 live-born). In the period from 2001 to 2008 maternal mortality decreased from 58,7 to 14,3 and at this moment it reaches the goal indicator determined ,,with the view of millennium development" (12,3 per each 100 000 live-born). (See illustration 4).

Illustration 4. Maternity and infant mortality in 2001-2008 and the goals of millenium development



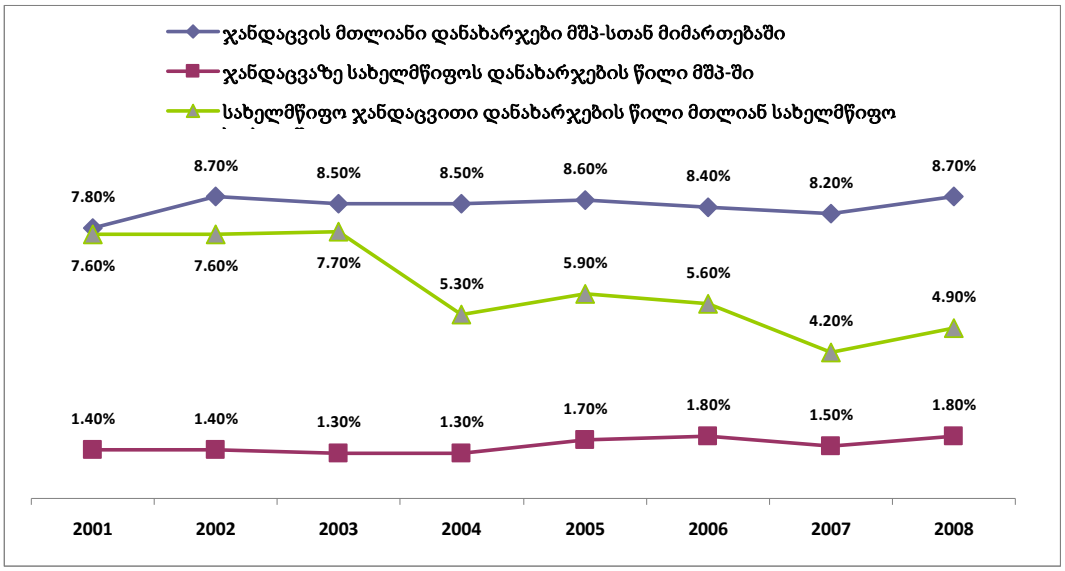
Sourse: Statistical yearbook Georgia, 2008. /www.ncdc.ge/

In connection with the comment provided by you concerning the difference between the maternity and infant mortality rate presented by us and the figures found out by you, we inform you that we became unable to comment on the above-mentioned, since there was no source pointed out in your comment. We also inform you that the indicators represented by us in public health sector have been provided by the National Center of Disease Control.

Access to health care

According to the national reports of the WHO, the share of the total health care costs in ---- increased moderately from 7,8% (2001) to 8,7% (2008) and can be compared to the similar average figures of the EU countries- 8,9% (2006) (WHO data base (WHO EURO.2008). Notwithstanding the tripling of the state expenses for health care in absolute numbers, the total amount of the given expenses is relatively low- by 2007 their share was 1,5%, and in total state expenses -4,2%. 2008- 4,9%.

Illustration 5. Health care costs - the change of the total health care expenses and state health care expenses in - and the change of the share of state expenses of health care in total state expenses



წყარო: ჯანდაცვის ეროვნული ანგარიშები 2009

The state of Georgia assumes responsibility to purchase from insurance companies the necessary medical service for poor population and certain categories of state employees (eg. teachers, police, military persons) and to additionally carry out subsiding private voluntary insurance for the basic medical services. The purpose of state subsiding of private voluntary medical insurance basic package (emergency medical aid and primary health care basic services) is popularizing of medical insurance and increasing of financial availability by means of creating a national scheme of risk insurance, stimulating the citizens to widen their insurance in the companies, in which they are insured. It will decrease the total private costs of health care, and it will turn the practice of preliminary payment into the preferred means of private expenses for health care instead of paying from one's pocket, which is generally considered to be an unjust mechanism of financing health care SERVICES.

Table 1 represents the data concerning the number of the persons insured (voluntarily or by an employer) privately or by means of state financed medical insurance, as well as the percentage of the persons possessing health insurance policy, who are not entitled to the state financed medical/insurance voucher.

Table 1. The number of the persons insured (voluntarily or by an employer) by state programs, employers or privately and the percentage of the persons possessing health insurance policy, who are not entitled to the state financed medical or insurance vouchers September 2008.

Insured by state program	808,501
Insured by (state or private) employers	235,969

Voluntarily insured	28,296
Privately insured, in all	264,265
Population, in all	4,382,100
Percentage of the population included in a particular type of insurance	24.5%
Percebtage of the population possessing medical insurance policy, who are not antitled to the state financed medical or insurance voucher	7.4%

Source: Financial supervision agency, 2009წ.

The given data shows that during 2008 nearly 24,5% of the population was insured with different forms of insurance, and about 265000 persons or 7,4% of the whole population who were not entitled to state medical insurance package, were insured in private insurance voluntarily or that financed by an employer. In 2009 the number of the people insured by state programs increased and the following categories of population were provided with free medical service at primary health care level as well as at the hospital level: those being below the poverty line- 960 000 persons, teachers- 187 000, IDPs- 18 000, children without parent care - 3 000, the state prize winners, artists, performers- 200. Apart from that, in 2009 there was initiated ,,A special State Program of Facilitating Voluntary Health Insurance" (Decree of the Government of Georgia #33 of February 26, 2009), the beneficiaries of which became the citizens and residents of Georgia within the age group from 3 to 60 years old except for the citizens having already been insured by means of the state or/and autonomous entity budget funds. With the help of the given program the citizens of Georgia (the self-employed, the unemployed) had an opportunity to be integrated in the insurance affairs with state participation. All the above mentioned points out the increase of the amount of population included in state insurance programs in the recent years.

Health care professionals and facilities

The rational distribution of resources is a significant aspect of effective work and it assists the effectivity of health care system and the improvement of its accessibility. The figures of the usage of medical institutions, bed fund and the provision of medical personnel have been shown in Table 2, Table 3 and Table 4.

Table 2 Health care facilities network, Georgia, 2008

	Total number of health care facilities
In-patient facilities	269
Dispensaries	72
Independent facilities	
Polyclinics	250
Including: Stomatologic	*79*
Women consultancies	21
Ambulance stations	73
Rural doctor ambulatories	220
Blood transfusion stations	6
Infant nurseries	2
Scientific research institutes	19
Health centres	47
Dependent facilities	
Co-social with hospitals	*72*
Doctor health posts	*9*
Rural doctor ambulatories	*474*
Nurse–midwife health posts	*301*

Source: Statistical yearbook Georgia, 2008. /www.ncdc.ge/

Table 3 Hospital beds: performance indicators, Georgia, 2008

	Number of beds per 100000 population	Occupancy rate	Average length of stay	Bed rotation rate
Georgia	320.9	156.1	6.8	22.9

Source: Statistical yearbook Georgia, 2008. /www.ncdc.ge/

Table 4 Medical personnel, Georgia, 2008

	Number of physicians, physical	Number of physicians per 100000 population	Number of mid-level medical staff	Number of mid-level medical staff per 100000	Number of low medical staff	Number of low medical staff per 100000 population

	persons			population		
Georgia	20253	462.0	19593	446.9	5834	133.1

Source: Statistical yearbook Georgia, 2008. /www.ncdc.ge/"

59. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§1 ITALY

The Committee concludes that the situation in Italy is not in conformity with Article 11§1 of the Revised Charter on the ground that it has not been established that waiting time does not exceed a medically acceptable period having regard to the patient's condition and clinical needs.

60. The representative of Italy provided the following written information:

> "With regard to this instance of non-conformity, we wish to point out that within the national health service, the provision of services within appropriate time-limits constitutes a structural component of the Basic Levels of Assistance (LEAs) based on pathology and clinical needs.
> A close look at the progress made in introducing the Plan to reduce waiting lists adopted by the regions, in line with the agreement concluded between central government and the regions on 28 March 2006, shows that all the regions and autonomous provinces have prepared plans with a view to introducing the national plan to reducing waiting times by identifying the services that are subject to monitoring and the maximum times both for services provided by health care centres and for hospital admissions. In addition, the general criteria for access to services based on the main clinical categories have also been identified, together with the main areas of intervention, such as oncology, cardio-vascular, mother and child, geriatric medicine and particularly important specialist visits for patients and other services.
> It is clear from the above, therefore, that there is real determination on the part of the regions and the public administration (A.P.) to work together closely to resolve the problem of waiting lists in order to provide patients with better health protection.
> The signing of the agreement on the national guidelines for the unified booking system (CUP) by the State-Regions Conference on 29 April 2010 merely confirms what has been stated above. Prepared by the Ministry of Health in close consultation with the regions, these guidelines address the need for co-ordinated action in order to steer the further development and harmonisation of CUP systems at national level, so as to provide a comprehensive and fully integrated vision of health care provision and offer citizens a better service, with more choice and shorter average waiting times.
> The guidelines also take account of functional aspects, including "circular" health service bookings management, i.e. through all points of access to the CUP system, irrespective of affiliation to a particular health care structure, with due regard for the local and regional
> guarantees that exist for a particular type of service for the persons receiving assistance.
> In 2009, the Ministry of Health followed up the 2005 and 2007 surveys with a third survey on the use of the internet as a way of relaying data about waiting times and waiting lists over the websites of the regions and public administrations, local health care structures (ASLs), hospitals, research hospitals (IRCCSs) and university polyclinics.
> The survey reveals that 34% of the websites examined provide information about waiting times and waiting lists, with respective increases of 11% and 12% in relation to the findings of the 2005 and 2007 surveys. (See "waiting times on the websites of the regions, public administrations and national health service institutions: 3rd national report" – (http://www.salute.gov.it/imgs/C_17_pubblicazioni_1240_allegato.pdf)."

61. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§1 LITHUANIA

The Committee concludes that the situation in Lithuania is not in conformity with Article 11§1 of the Revised Charter on the ground that it has not been established that significant efforts are being made to increase life expectancy, which is significantly lower than in other European countries and which is not increasing sufficiently.

62. The representative of Lithuania provided the following information:

"The numbers of measures have been taken to remove as far as possible the basic causes of ill-health in order to increase life expectancy in Lithuania:
1) The National Drug Addiction Prevention and Drug Control Programme for 2004–2008 was approved by the Seimas (Parliament) of the Republic of Lithuania in 2004. The Programme gives priority to primary prevention of drug use in families as well as among the children and the youth. (More detailed information concerning this program has been provided in the 6th report of Lithuania under paragraph 3 of Article 11 in the response to the question raised by the European Committee of Social Rights concerning measures to combat smoking, alcoholism and drug addiction);
2) In 2007 the Seimas (Parliament) of the Republic of Lithuania adopted the State Strategy on Mental Health. In 2008 m. the Government approved the implementation programme for 2008-2010 of this strategy;
3) In 2007 the Seimas of the Republic of Lithuania announced the year 2008 as the Year of Abstinence. The Programme of the Year of Abstinence was approved by Government on 9th January 2008. It is aimed at building up the public's, especially children's and the youth's abstinence attitudes, encouraging to live a sober life, developing cooperation among the state and municipal institutions and agencies, non-governmental organizations and community in disseminating the ideas in the public and in building up value-based attitudes of healthy lifestyle among children and young people. (More detailed information concerning this program has been provided in the 6th report of Lithuania under paragraph 3 of Article 11 in the response to the question raised by the European Committee of Social Rights concerning measures to combat smoking, alcoholism and drug addiction);
4) Action Plan of the State Tobacco Control Programme of 2007-2010 was approved by the Government of the Republic of Lithuania in 2007. (More detailed information concerning this program has been provided in the 6th report of Lithuania under paragraphs 2 and 3of Article 11);
5) Infrastructure of health care institutions is being updated in accordance with the Programme for Reduction of Morbidity and Mortality from the Basic Non-Infectious Diseases for 2007-2013, approved by the Minister of Health of the Republic of Lithuania. It is planned to use the finance of the ES funds for establishment of 5 complex assistance centres for children and families, mental day centres, crises intervention centres for monitoring of the mental health care services and modernization of infrastructure.
6) In 2008 the Programme for Improvement of Qualification of Health Care Specialists, Contributing to Reduction of Morbidity and Mortality from Basic Non-Infectious Diseases was approved by the Minister of Health of the Republic of Lithuania. This programme stipulates improvement of qualification for the staff and it is aimed at reduction of morbidity and mortality from basic non-infectious diseases in 2007-2013."

63. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§1 MALTA

The Committee concludes that the situation in Malta is not in conformity with Article 11§1 of the Charter as it has not been established that the health care system is fully accessible to the entire population.

64. The representative of Malta provided the following written information:

"The main causes of death remain cardiovascular disease followed by cancer. Government has just published A Strategy for the Prevention and Control of Non-Communicable Diseases, and in the coming months will be publishing a National Cancer Strategy. Both documents include a number of measures to combat these causes of mortality. In the past months Government launched a National Breast Screening Programme. Statistical Information may be found in Annex 1 called NSR Updates. Life expectancy at birth for Malta during 2008 for males was 77 years for males and 82 years for females (source: Demographic review 2008, National Statistics Office). The overall standardised death rate for Malta was 5.97 per 1000 population. The main causes of death are still circulatory diseases (40%) followed by cancers (26%).

Infant mortality per 1000 live births:

Year	Number of deaths	Rate/1000 live births in Malta	EU-15**	EU-27**	Infant mortality with malformations	Infant mortality without malformations
2005	23	5.96	4.03	8.27	30%	70%
2006	14	3.61	3.93	7.67	43%	57%

2007	22	5.7	3.84	7.19	59%	41%
2008	34	8.1	-	6.89	41%	59%
2009	22	5.3	-	-	55%	45%
5 year average	23	5.8	-	-	45%	55%

*source: Malta National Mortality Registry
**source: WHO: HFADB (March 2010)

Due to small numbers infant mortality rate in Malta fluctuates over the years and a 5-year average gives a more stable picture. Average 5 year infant mortality is slightly higher than EU-15 but rates are better than EU-27. Infant mortality rate due to malformations represents 45% of the total number of deaths. Termination of pregnancy is illegal in Malta and may have an impact on infant mortality rate.

Maternal Mortality
There were 3 deaths over the past 10 years (2000-2009). The causes of death were deep vein thrombosis, Pulmonary embolism and diseases of digestive system complicating pregnancy.
Statistical Information may be found in Annex 1 called NSR Updates
The Maltese public health care system provides a comprehensive basket of health services to all persons residing in Malta who are covered by the Maltese social security legislation and also provides for all necessary care to special groups such as irregular migrants. No user charges or co-payments apply but a few services including elective dental services, optical services and coverage of certain formulary medicines are means-tested. The private sector acts as a complementary mechanism for health care coverage. The state health service and private general practitioners comprise primary health care in Malta. However, the two systems of primary care practice function independently of one another.
The median cost of a GP visit is €12 and to a specialist €42 in the public sector, according to European Health Interview Survey 2008. Please refer to the Utilisation of Health Care report available on http://www.healthsurveys.gov.mt. Little if any inequalities in access to health care have been noted.
Equal access is granted to all persons residing in Malta and covered by the Maltese Social Security System.
Government is committed to bringing waiting time for interventions down to an acceptable level. The following are a number of initiatives taken:

- A central departmental unit has been set up within MDH to consolidate all existing waiting list data into a single updated list.

o The verification and 'clean-up' of waiting list data has resulted in a roughly 30% reduction in the length of waiting lists tackled so far.
o For this process to move faster, the unit needs to be better staffed.

- Bottlenecks along the care pathway that lead to increased waiting times have been identified in the Pathology and Medical Imaging Departments.

o Actions taken to reduce these bottlenecks, such as the non acceptance of non-symptomatic cases for mammography, are bearing fruit.

- Better guidelines for prioritising patients awaiting diagnostic procedures are now in force.
- Negotiations have started for more foreign nurses to be recruited.
- Afternoon clinics have been introduced in certain departments, like Paediatrics and Diabetes, as well as for surgical operations.

o The monthly number of operations performed at MDH has risen.

- €4 million have been allocated to reduce waiting times for surgical interventions within 3 years.

The health care budget was 8.3% of GDP in 2006, which was a similar rate to that of other European countries.

The Committee is asked to take note of the following figures related to the number of dentists in Malta:
2008 – Licensed to practice – 183
2009 – Licensed to practice – 200
Practicing – 183
Malta emphasizes that this is a wrong interpretation of the information submitted by Malta in the previous reports."

65. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC11§1 MOLDOVA

The Committee concludes that the situation in Moldova is not in conformity with Article 11§1 of the Revised Charter on the grounds of the prevailingly high infant and maternal mortality rates.

66. The representative of Moldova emphasised that infant and maternal mortality were very difficult problem areas which related not only to health information levels and the monitoring, screening, the behaviour and the medical treatment of the population, but also more generally to the level of poverty in the population, a problem that could not be solved on a very short notice.

67. While the maternal mortality rate had decreased in the period 2001-2007, it had increased sharply in 2008 (to 38.4 per 100,000 live births) before decreasing again in 2009, and the rate remained extremely high by international standards. The infant mortality on the other hand had been steadily reduced to a level in accordance with the Millennium Goals (12.1 per 1,000 live births).

68. The representative of Moldova summarised various measures taken by the Government to improve the situation, including a joint programme with the Swiss Government on "Modernizing the Moldovan perinatal system 2008-2011", improved access to primary medical care under the Government's 2010 Unified Programme and the creation of incentives for young medical doctors to take up practice in rural areas, which traditionally had difficulty attracting doctors in sufficient numbers.

69. The representative of the ETUC requested more information on the following points:

– measures taken to ensure the presence of doctors in the rural areas;
– monitoring visits to pregnant women; and
– equal treatment of pregnant non-nationals in Moldova.

70. The representative of Moldova explained that in 2009, about 256 doctors and 675 medical students benefited from financial incentives to take up employment in rural areas and the annual Employment Forum had also paid special attention to the issue of employment opportunities in rural areas for doctors. More systematic monitoring of pregnant women was indeed one of the elements that would be addressed in the framework of the above-mentioned joint Swiss-Moldovan project. Finally, she confirmed that lawfully resident foreign pregnant women enjoy full equality with nationals in this respect.

71. The Committee took note of the information provided and of the intention of the Government to address this situation of non-conformity with the Charter. It decided to await the next assessment of the ECSR.

RSC 11§1 ROMANIA

The Committee concludes that the situation in Romania is not in conformity with Article 11§1 of the Revised Charter on the following grounds:

- the measures that have been taken to reduce the infant and maternal mortality rates, which are clearly – too high, are inadequate;
- the conditions in certain psychiatric hospitals are manifestly inadequate;
- it has not been not established that there are reasonable health care waiting times and that the management of waiting lists is satisfactory.

First ground of non-conformity

72. The representative of Romania stated that both the infant mortality rate and the maternal mortality rate have decreased in recent years. In addition, she provided extensive information on mortality in connection with abortion. She also gave information on a World Bank project which includes a component on “Maternal and neonatal medical assistance.

73. The representative of the ETUC noted that most of the information provided concerned abortion and wondered about other factors in maternal mortality. He asked whether specialised pre- and post-natal care is accessible to all or whether special insurance had to be taken out.

74. Several representatives (Belgium, France, Lithuania, Poland, Norway, Sweden) did not see the relevance of the information on abortion, legal or illegal, provoked or unprovoked, and asked specific information about the measures taken to reduce infant and maternal mortality.

75. The representative of Romania said that detailed information on the questions raised would be included in the next report and referred to the Government’s National Health Programme, which among other measures sets out a subprogramme for increasing the access, quality and efficiency of specific medical services for the pregnant and confining woman, a subprogramme for the prevention of neonatal deceases by increasing access to adequate care in regional units and for the evaluation of neonatal mortality as well as a subprogramme for promoting breastfeeding.

76. The Committee took note of the information provided and urged the Government to take all necessary measures to bring the situation into conformity with the Charter.

Second ground of non-conformity

77. The representative of Romania outlined measures taken to improve mental health services. Law 95/2006 provide, inter alia, for the reform of the mental health system in Romania.. The Ministry of Health has started the reform in the mental health system and has made efforts to remedy the situation in this field. A number of measures have been adopted such as: increased funds, a National Strategy in the field of mental health was elaborated; as well as a national Action Plan in the field of mental health, a National Center for Mental Health was set up as a strategic unit in the field by the Ministry of Health, to inter alia improve the qualifications of those working in psychiatric hospitals.

78. The representative of the ETUC pointed out that the ground of non conformity related to the conditions in psychiatric hospitals.

79. The representative of Portugal asked whether the legislative and administrate measures implemented recently had an effect on the conditions in psychiatric hospitals?

80. Other representatives asked whether there existed standards on the conditions psychiatric hospitals must meet, and whether existed independent monitoring bodies.

81. The representative of Romania stated that there were standards and that there was a National Centre for Mental Health.

82. Several representatives expressed the view that the situation was a serious one.

83. The Committee took note of the information provided and urged the Government to take all necessary measures to guarantee that all patients in psychiatric hospitals live in conditions consistent with human dignity.

Third ground of non-conformity

84. The representative of Romania provided the following written information:

> "**Management of waiting lists and reasonable waiting periods of time**
> Normally, the access to health services in Romania does not mean a period of waiting, patients being able to address immediately to the network of family physicians, specialized ambulatory or emergency services. However, for the diseases which need treatment by organs or tissues transplant it is necessary to have waiting lists according to the number of requests and to the possibility to identify compatible donors for those respective cases.
> For the diseases where the treatment is made under therapeutic protocols issued by the specialized committees of the Health Ministry, with or without the approval of the committees at the level of health insurance houses, as the case may be, or with medicines imported with the Ministry's approval, it is necessary to set up waiting lists because the solution for those cases depends on the number of patients, on the possibilities to support the costs of the medicines from the Single National Fund of Health Insurance, and of the possibilities to acquire the medicines that are imported.
> **The state budget for health care**
> For the Government of Romania, health represents a major priority. Although it does not raise to the standards of many Member States of the European Union, which allot a greater amount of their Gross Domestic Product, Romania makes efforts to increase the sums allotted to health. Thus, the budget allotted to the health sector for 2010 is 6.6% greater than in 2009."

85. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§1 TURKEY

The Committee concludes that the situation in Turkey is not in conformity with Article 11§1 of the Revised Charter on the ground that the rates of infant and maternal mortality are still manifestly too high.

86. The representative of Turkey made the following statement:

> "As it was mentioned in the Government's last report on this Article, the Health Transformation Programme (HTP) launched in 2003 which is still ongoing made a major reform of the national health care system. The said programme was aimed at facilitating and improving access to health insurance system which is one of the main components of the social security reform under Law No:5502 through which all the existing social security institutions were restructured and gathered under one roof which is named as the Social Security Institution. The Universal Health Insurance Law No:5502 was acted in May 2008 is going to be fully effective on the 1st October 2010.
> This Act aims to eradicate the inequalities in the accession to health services through defining the rights and responsibilities, besides covering the entire population by social security. No payment will be required from the citizens for primary health care even if they do not have any social security. All public hospitals are gathered under a Single Roof (that is the Ministry of Health) Private hospitals will serve everybody. Other step was to include private sector investments in the system in order for patients to benefit from these facilities as enabled by their own insurance systems. Now all sources (both private and public) are open to public without discrimination.

The representative of Turkey also provided the following Health statistics pertaining to 2008, outside the reporting period:

- Life expectancy was 75.8 years for women and 71.4 for men
- Infant mortality rate was decreased from 20.7 in 2007 to 17 in 2008 which is still well above the EU 27 average.
- The decrease in infant mortality rate covering the period 2003 to 2008 was 38.7 percent
- Neonatal mortality rate slightly decreased from 13,9 percent in 2007 to 13 percent in 2008.
- The decrease in Neonatal Mortality rate was 24,7 percent covering the period 2003 to 2008
- Under -5 mortality rate dropped to 24 from 26.6 in 2007.
- Maternal Mortality ratio (in 100.000 birth) decreased from 21.2 in 2007 to 19.4 in 2008

Some indicators of Mother and Child Health Care and Family Planning pertaining to 2003 and 2008 respectively:

- Proportion of Health Personal Attended Births to All Births (%)

2003	2008
83.0	91.3

- Antenatal Care Coverage (Minimum 4 Vsits) (%)

2003	2008
53,9	73,7

- Proportion of Cesarean Sections in All Births (%)

2003	2008
21.2	36.7

- Percentage of Contraceptive Method Use Among Married Women between the ages of 15 to 49:

2003	2008
42.5	46,6

- Proportion of Health Personnel Attented Births Among All Births (%) in 2008
  Turkey average: 91,3

Immunization Coverage by Years (%)

DBT 1	97
DBT 2	96
BCG	96
Measles	97
HIB-3	96

Average Number of Follow-Ups per pregnant

2000	2008
1.7	3,3

Number of Obstetric and Child Hospitals

2001	2008
64	73

General Hospitals

2002	2008
986	1171

Number of Hospital Beds:
2003 2008
161.234 190.185

Number of Obstetric and Child Hospital Beds
2002 2008
8078 11492

Population per 112 Emergency Stations by Years
2000 2008
175.571 54.677

Number of Nurses and Midwifes was 99.910 and 47.673 in 2008 whereas these figures were 82.626 and 43.640 in 2006 (increased)

Public and Private Health Expenditure 2007
GDP: 947.391 million USA $ (approx. 1.000 Billion Dollars)
Current Health Expenditure: 52.242 million USA Dollars
Investment Expenditure: 4.954 million dollars
Proportion of Investments:
Proportion of Current Health Expenditure to the GDP 5.5%
Proportion of Total Health Expenditure to the GDP 6.0%

Proportion of the Ministry of Health Budget to the Consolidated Budget by Years (%)
1999 2008
2.87 5.28"

87. The representative of the ETUC noted that efforts were ongoing to improve access to healthcare, however he pointed out that the rates of infant and maternal mortality were still high; more information was needed on direct measures taken to reduce these rates.

88. The representative of France noted the positive developments but asked the Turkish authorities to supply more precise information next time.

89. The Committee took note of the positive developments in Turkey but urged the government of Turkey to continue to take all measures necessary to reduce the levels of infant and maternal mortality. Meanwhile, it decided to await the next assessment of the European Committee of Social Rights with Article 11§1 of the Revised Charter.

Article 11§2 – Advisory and educational facilities

RSC 11§2 ALBANIA

The Committee concludes that the situation in Albania is not in conformity with Article 11§2 of the Charter on the following grounds :

- it has not been demonstrated that other health issues than creating an environment conducive to promoting health are addressed at schools;
- it has not been demonstrated that pregnant women are entitled to free consultations and screenings; and

- it has not been demonstrated that medical examinations at schools are of sufficient frequency, the proportion of pupils covered is sufficient and that screening is free.

90. The representative of Albania provided the following written information:

First ground of non-conformity

Health Education Public information and awareness-raising;

Information activities in our country are provided and undertaken at national and local level by the structures of public health and by different NGOs.

Measures taken in the regulatory area, in the programs area and in the areas of various strategies have helped in the enhancement of information knowledge and development of health promotion activities concerning prevention of diseases. These measures include:

Law No. 10138 of 11 May 2009"On Public Health": Chapter XIII is dedicated to health education health promotion. Article 48 provides structures, which participate in and develop health promotion by means of strengthening partnership between public sector, private sector and civil society. Moreover, the Law prescribes that broadcast and print media shall participate in health education and promotion based on the effective legislation. Article 49 defines that primary healthcare workers shall participate in health promotion by means of implementing the health promotion package. Whereas, Article 50 of the Law provides that Public Health Institute and regional public health structures shall be responsible for systematically organizing special programs of health education and health promotion, especially with the focus groups with low access rate to health service.

At local level, preventive healthcare is provided by the public health directorates, education cabinets and by the health clinics, which provide health services according to the basic package of Primary Healthcare Service as adopted upon the Decision of the Council of Ministers No. 857 of 20 December 2006 "On financing of Primary Healthcare Service by the obligatory scheme of healthcare insurance". The basic package of Primary Healthcare Service contains for the first time also the health education package that the health clinic must offer to the individuals and to the community.

Law No. 9636 of 06 November 2006 "On protection of health against tobacco products". The purpose of this Law is to protect public health against using of tobacco products and involuntary exposure against their smoke. Advertising and promotion of tobacco products via print media, TV and radio broadcasting, information services societies, as well as, advertising, and promotion of tobacco products of any other form is forbidden. Cigarette packets contain warning about health hazards and nicotine concentration, etc.

Law No. 9518 of 18 April 2006"On protection of minors against alcohol use"; the purpose of this Law is to prevent health consequences of alcohol when used by minors (18 years and younger). **Advertising of alcoholic drinks by broadcast media** is prohibited. Entities, which trade alcoholic drinks, are obliged to post at the entrance of their premises warning signs such as "Selling of alcohol to persons younger than 18 is prohibited". Using of any kind of advertising of alcoholic drinks in the education institutions for minors is prohibited, too.

Meanwhile, the strategy of reducing damages resulting from alcohol consumption is in progress.

Law No. 9942 of 26 June 2008"On prevention of disorders resulting from iodine insufficiency": intervention to eradicate disorders resulting from iodine insufficiency. To this end, awareness campaigns concerning the importance of using iodized salt have been organized with pupils and students in different schools of the country.

Strategic Paper as drafted by the Ministry of Health and Public Health Institute; "The public health and health promotion strategy 2002-2010"; "Towards a healthy country with healthy people" adopted upon Minister of Health Order No. 178 of 05 May 2003. This strategic paper contains prioritized actions concerning fundamental problems, with which Albania is faced and, with the risk factors, which affect health, including: smoking, using of alcohol, abuse with drugs, malnutrition, physical activity, accidents, cancer, reproductive and sexual health problems (STD, HIV, AIDS), mental health, suicides, etc.

Protection of people's health and of consumers interests by means of food safety is regulated by the special **Law No. 9863 of 28 January 2008 "On food".** The purpose of the Law is to set the basis about ensuring a high level of protection for people's health and for consumers' interests; therefore it deals with food safety snd, with safe food for the population. Based on the aforementioned Law, the establishing of the National Authority of Food Safety is in progress in the Ministry of Agriculture, Food and Consumer Protection.

In addition, there is **Law No. 9902 of 17 April 2008 "On consumer protection**", and Article 4 of it defines the consumers' rights.

The **Strategy of Consumer Protection and Market Supervision** has been drafted and adopted. Ministry of Economy Trade and Energy in cooperation with the Ministry of Health and Ministry of Agriculture Food and Consumer Protection was the leader of the process.

Law N. 9952 of 14 July 2008 "On prevention and control of HIV/AIDS", has been adopted, while drafting of the new strategy on HIV/AIDS is in progress.

Concerning drug area, our country has ratified and it has adhered to three UN Conventions on drug control.

Law No. 8722 of 26 December 2000 "On the membership of Albania to the UN Convention against illegal trafficking of narcotic drugs and psychotropic substances".

Law No. 8723 of 26 December 2000 "On the membership of the Republic of Albania to the Single Convention on Narcotic Drugs, as amended by the Protocol of 1972 on the amendments to the Single Convention on Narcotic Drugs 1961"; Official Gazette No. 50 of 2000, published on 29 January 2001, page 2190.

Law No. 8965 of 07 November 2002 "On the membership of the Republic of Albania to the UN Convention on psychotropic substances".

Articles 283, 235 and 286 of the Criminal Code of the Republic of Albania (adopted upon Law No. 7895 of 27 January1 995, published in Official Gazette No. 2 of 1995) stipulates severe penal punishments against trafficking, manufacturing, processing, distribution, transportation, possession and trading of drugs and psychotropic substances.

National Strategy as adopted upon Council of Ministers Decision No. 292 of 07 May 2004 "On the adoption of anti-drug national strategy 2004-2010", along with the Action Plan concerning the enforcement of anti-drug national strategy 2004-2010.

The Guide on "Recommendations about healthy nutrition in Albania" was drafted by the Ministry of Health in the frame of the Stability Pact Project on "Enhancement of Food Safety Services and Nutrition in SEE Countries" in cooperation with the line ministries including the Ministry of Agriculture Food and Consumer Protection and the Ministry of Education and Science. The Guide was adopted upon the Minister of Health Order No. 141 of 02 March 2009.

Reproductive Health Strategy 2009: The purpose of the reproductive health strategy is to fulfill every individual's needs, especially the needs of women, children and youngsters by providing qualitative and financially affordable services, which include all reproductive health components to influence on the improvement of health situation and decreasing of illness and mortality rate. The strategy stipulates also informing activities down to community level concerning reproductive health problems.

Print and broadcast media provide contribution for all promotion and prevention activities of public heath. Media is a reliable and permanent collaborator of different awareness campaigns and of TV shows or printed articles.

Health Education in Schools;

The Public Health and Health Promotion Strategy emphasizes that children may receive in the preschool and school institutions the basic rules of a healthy lifestyle – good social interaction and teamwork – and they may learn about personal hygiene, accidents prevention, healthy nutrition and other substantial issues concerning health and safety. (www.moh.gov.al).

The 9-year and secondary education schools have health service provided by doctors or nurses and there is cooperation with promotion specialists at national and local level. The activity of this service is carried out based on the joint regulation of the Ministry of Education and Science and Ministry of Health of 1998 "On health service in preschool and school institutions". Provision of this service is carried out by doctors and nurses. The health service activity is biased towards preventive activity, as well as, it follows normal physical and psychomotor development of kindergarten and schoolchildren, enforcement of hygienic norms and health promotion by aiming at their health protection and strengthening.

Until 2006, health education was taught as a separate subject in the 8-year education school system and it was organized in 17 lessons. Education topics, which were covered, included the following:

Vth Grade: Viral diseases, General and Personal Hygiene.
VIth Grade: Nutrition and Smoking Prevention.
VIIth Grade: Environment Protection and Abusive Substances (Alcohol, Drugs).
VIIIth Grade: Sexual education and AIDS

School Psychological Service (SPS) is a new service that is provided in the pre-university education system since 2004. The main purpose of School Psychological Service is to promote mental and physical wellbeing of pupils and facilitation of the learning process.

Health service functions in pre-university education system, in kindergartens and schools.

A. Information about health education in the school curricula

Health education in pre-university education is considered important and a natural part of children and youngsters education and training at school. After 1990, when Albania embarked on the road of democratic processes, human safety faced with drug and HIV-AIDS phenomena in addition to the other existing health problems such as alcohol, smoking, or malnutrition. Under these conditions, it was considered that pre-university school education curricula had to largely and gradually address the system of necessary knowledge, skills, and style to be assimilated by pupils in the area of health. Curricula is based on the assumption that pupils must learn via education the necessary health information, develop vital skills, behaviors, attitudes and values to ensure a healthy and qualitative life for themselves and for the others.

The aim of school program about pupils health education is to inform and train the pupils about health issues and the consequences of reckless behaviors, to resist against pressures to take drugs and alcohol, to smoke, to have early and unprotected sex. In addition, its aim is to develop a constructive communication with the family about health-related issues, to have citizen accountability in terms of helping the others and to heave the personal responsibility to protect them vis-à-vis different health issues.

Curricular approaches, in which school has addressed and continues to address these issues, include the following:

- As a separate subject
- As a cross-curricula
- As an extra curricular activity

As separate subject:

Starting in 1994 and until 2005, a moment, which coincided with the transformation of the obligatory education system from 8 to 9 years of schooling, a special program of health education was applied. This program contained the definition of health, nutrition, smoking, alcohol and drugs, sexuality, STD and HIV-AIDS). After 2005, the content of health education was incorporated in the biology subject of 6th – 9th grades.

In the secondary school education up to the school year of 2009- 2010, issues of health were addressed only in a cross-curricular and extra-curricular form.

In the school year of 2009-2010, the substantial curricula of the general school contains the subject “Life skills”, the aim of which to help students develop life skills by relying on the health contents.

As cross-curricula:

By means of school subjects including nature knowledge and social ethics in the elementary education level, biology, citizen ethics in the second level of elementary education, biology, sociology, psychology in secondary education. Health issues in secondary education not only in the bio-medical aspect, but also in the social and legal aspects.

Extracurricular activities:

A considerable number of source materials for pupils and teachers have been drafted by organizations, which operate in this area and by the schools themselves. Several concrete activities about pupils’ health education have been prepared and conducted by the schools themselves supported by NGOs.

The curricular education reform has laid down enforcement of curricula on school basis up to 15%. In this manner, the opportunity has been provided for the schools themselves to address health problems of daily life.

The positive element concerning the accomplishment of pupils health education includes also drafting of health education standards for pre-university education, which serve as a framework for the development of health education curricula in education and, which will enable expected achievements in the area of health for all pre-university education students.

Health in ethics subject

In obligatory education: Health issues are addressed in different approaches almost throughout the “Social ethics” subject curricula for the 1st – 8th grade.

In secondary education: Health in the curricula of the subject “Citizen Ethics” for the 10th – 11th grade of the general school and for the 10th grade of all vocational secondary schools as follows:

In the subject “Citizen Ethics” in the 10th grade, health is addressed as a separate line under the same title. In this subject, health is addressed in the frame of a right and of a value that must be protected with due care. The objectives of the Health line in the subject of Citizen Ethics of 10th grade include the following:

- To provide a definition for health.
- To list main risks, which endanger health.
- To address a number of diseases that are linked with the social well-being and problems.
- To provide explanation why health is a right and a duty for every citizen.
- To provide explanation about the importance of information and prevention concerning health protection.
- To describe some of the activities or steps to be pursued to protect health in various environments.
- To disc tribe damages that are inflicted by some of the health enemies including drugs, alcohol, smoking, etc.
- To provide argumentation based on the Albanian legislation and knowledge as received from other subjects concerning the importance of the struggle against these enemies of health.
- To list and state clearly its position on the controversies that exist about drug and alcohol use and about smoking and their legal or illegal character.
- To apply health law to protect his health and the health of other people in the daily life.
- To apply gained knowledge to protect health against hazards and against a number of known diseases.
- To collect facts and data about health problems and to interpret them.
- To predict consequences of different behaviors and attitudes on health.

In the school subject "Citizen Ethics", in 11th grade, health issues are addressed in the frame of "Nutrition" line. In this line, food is regarded as main resource, which provides basic energy for the functioning of human organism. To properly achieve the goal, for which it is used, food must be qualitative and controlled. Every individual must be informed about foods that he must use, foods that he uses and foods that are harmful to his body. Objectives of this line include the following:
To describe what it means to be nourished.

- To apply, by relying also on the knowledge gained from other subjects (biology, chemistry), the main physiological concepts, which are linked with nutrition, to describe or justify different citizen positions.
- To list some of the healthiest foods based on scientific criteria.
- To explain the importance of balanced nutrition.
- To describe some of the diseases that are linked with the position vis-à-vis nutrition.
- To distinguish healthy natural foods from the modified ones.
- To state his position about issues that have to do with production of genetically modified foods.
- To apply Albanian law that protects individual's rights in the area of nutrition to protect him and the others against modified foods.
- To collect facts and data about food issues and to make their interpretation.

When shifting from 8-year to 9-year obligatory pre-university education system, major changes presumably affected health education subject. Therefore, it does not exist anymore as a separate subject, but it is taught as integrated into the subject of Biology over the 5 years of the higher cycle of 9-year education. This subject includes, apart from the aforementioned topics, also other topics such as mental health, human body anatomy and the functioning of the body organs.
A good part of these topics is provided as extra-curricular knowledge during free classes that each school has. However, all this is accompanied by some phenomena that we consider "harmful" for our sector. There is a decline of the volume of knowledge, which is conveyed to the pupils each year. In the subject of Biology, it is not more than 5-6 health education related teaching topics, which are carried out during the school year.
Health education in pre-school institutions and elementary schools functions based on a regulation adopted in 1998, which has led to improper functioning of this service.
Based on the Minister of Health Order No. 698 of 17 December 2009, an inter-institutional working group has been established (Ministry of Health, Ministry of Education and Science, Public Health Institute, National Center of Quality and Safety Accreditation, Regional Health Authority) in cooperation with WHO concerning reorganization of health education and service at schools. The purpose of this group is not only to review the regulation of this service in conformity with standards and capacity building, but also to define the basic service package, in which the 12 basic services to be provided are defined. This includes the following: prevention of contagious diseases, chronic diseases, smoking, alcohol and narcotic substances (drugs), mental health and psychological wellbeing, traumas and accidents, physical activity, healthy nutrition, development and healthy growth, moral health, environment, children with special needs, violence, sexual health, HIV and reproductive health.

Counseling and screening population at large

Public Health Institute has drafted a new model of services of the Family Doctor with the purpose of early screening of potential causes of cardiovascular diseases and their timely treatment (practically counseling and follow up). The goal of this program is to encourage early detection and proper treatment with counseling or treatment of risk factors of coronary and cerebrovascular diseases with a final goal to prevent the health consequences in the Albanian Population.

A guide prepared to assist doctors (but also nurses, if necessary) is at the center of the program). The guide schematically includes, *inter alia*, also the standards of classification and counseling of individuals for each of the variable, major and minor 8 factors of cardiovascular diseases. The program stipulates regular evaluation of a set of indicators about behavior, as well as, individual biological parameters for all family doctor service users. Each insured person has the right to benefit from new services.

Actually, screening model has been tried in most districts of the country and the relevant health authorities have become aware of it. Ten new Voluntary/Confidential Testing and Counseling Centers have been established at a national level with the support of the Global Fund. Voluntary Testing and Counseling Center have been established in the Public Health Directorates of Tirana, Durrës, Vlorë, Fier, Korçë, Lezhë, Shkodër, Gjirokastër, Berat and Elbasan Districts.

Reasons of establishing anonymous VCT services in our country; existing situation concerning HIV testing is not satisfactory and it is expected to improve with the enforcement of this strategy. Confidentiality of screened persons will be maintained without taking into consideration their serological status.

Counseling and Screening on HIV/AIDS plays two main roles in preventing and controlling HIV/AIDS.

1. Prevention through changing behavior by using risk assessment and planning of its diminishing.
2. Care via psychosocial support to help patients face their future and make plans about it.

VCT (Voluntary Counseling and Testing) Services must provide:

1. Anonymous testing
2. Confidentiality
3. Reliability
4. Financial exemption (Free of charge)
5. Professionalism.

Tasks of each VCT clinic include:

a. Each VCT center must have the client in its focus and it must make sure that no client shall be disillusioned by the provided services. Staff will provide immediate care to the clients. No client must wait for a long time. If the client must wait more that 10 minutes, he must be informed and another appointment must be organized for him (if the client can't wait).

b. Each center must strictly adhere to the standards and protocols and drafted for the VCT.

c. Staff of each VCT Center shall have primary responsibility for all agreements with VCT Centers by hereby incorporating the procedure of quality control, counseling and reliability vis-à-vis the rules that must be considered confidential.

d. Management staff of each VCT Center must convene each week to review functioning of the clinic.

e. VCT Centers must make sure that written outcomes of the HIV/AIDS test shall be directly conveyed to the patient and not via telephone. The outcomes must be shown only to the patient and to those, for which he has signed "The permit to issue confidential information".

f. VCT Centers must make sure that no client shall receive a cope of the outcomes, due to the possibility of misuse of the letter in question. If there is an application to use the copy as a reference, the Center must sign "The permit to issue confidential information".

g. Each VCT Center shall pursue confidential protocols.

h. If the person/patient is minor, he must be accompanied and the permit of the companion shall be taken for all procedures that will be carried out about him.

i. No minor younger than 16 years shall be tested without the permit of the companion.

j. Make sure that each patient is provided with the VCT Center card, with the file and the personal number.

Second ground of non-conformity

Pregnant woman, children and adolescents;

Follow up, checking and counselling of pregnant women.

Follow up, checking and counselling of pregnant women is defined in Minister of Health **Instruction No. 146 of 11 April 2003.** This instruction prescribes that:

- All pregnant women shall receive free of charge health care during pregnancy, during birth and after birth in the mother and child healthcare institutions.
- During antenatal period, at least, four necessary medical pre-birth (antenatal) checks shall be carried out when following up the pregnant woman in order to prevent, detect and manage potential complications and, when necessary, refer them in due time.
- In cases when a pregnant woman is identified as having different health problems (the instruction provides also the list of problems to be taken into account), she will be checked by the doctor upon faster intervals depending on the type of detected problem.

In addition, the Guide defines the time when the 4 medical checks must be carried out and the content of examinations and procedures to be provided by the doctor.

- The first check shall be carried out by the first three months of pregnancy.
- The second check shall be carried out by the 22^{nd} – 26^{th} week of pregnancy.
- Third week shall be carried out by the 30^{th} – 32^{nd} week of pregnancy.
- The fourth check shall be carried out over the 38^{th} week of pregnancy.

The required procedures and examinations are provided for each check.

The Guide prescribes that during pregnancy the woman will carry out three echographic examinations free of charge during the following periods: first examination by the 8^{th} -11^{th} week of amenorrhea; second examination by the 19^{th} – 22^{nd} week of amenorrhea; third examination by the 32^{nd} week of amenorrhea. The guide also provided the follow up protocol for the woman during the postnatal period and it defines that:

All women during postnatal puerperal period shall be necessarily checked by the health staff that covers woman care during the prenatal and postnatal period in the urban and rural areas according to the guidance provided by this guide.

a-Puerperal period includes a period from the first day of birth up to its 60^{th} day.

b-Woman check in the postnatal period shall be necessarily carried out on the 3^{rd}, 8^{th} and 40^{th} day after the birth.

c-Woman must be checked for the following:

- Pulse, TA
- Temperature
- Anemia
- Breast checking and lactation management, as well as, referral in case of problems.
- Pelvic examination, checking of the uterus involution – potential infections of the genital tract.
- Checking of the vulvo-vaginal condition
- Urination and defection
- Discussion after birth with the mother about contraception via appropriate methods.
- It delivery is performed via sectio cesarean, an additional check may be needed in 8 – 15 days.

In addition, the guide provides explanations, counseling and treatment of the nutritional condition of the pregnant woman, provision of iron and folic acid, treatment of anemia against insufficient iron by starting from the preconception period (adolescence and reproductive age period) by continuing also during pregnancy and after the birth.

Third ground of non-conformity

Referring to the question asked by the students concerning frequency of examination:
School doctors conduct throughout a year the following:

- All emergency cases free of charge for students at school.
- Screening free of charge of all pupils from the 1^{st} – 9^{th} grade for nosology. Screening starts in September, which coincides with the beginning of the school year and ends by the end of the school year.
- Anthropometric measurements are made in cooperation with the physical education teachers of the pupils from the 5^{th} to the 9^{th} grade.
- School doctors conduct also hygienic checking of the school.

Not all the schools are provided with the cabinet and the necessary equipments to carry out these examinations. Actually, 1 doctor covers a school with about 800 hundred pupils/students, but this is not standard in all schools across the country as it varies as per the number of students in schools and per the regional capacities to cover schools."

91. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§2 GEORGIA

The Committee concludes that the situation in Georgia is not in conformity with Article 11§2 of the Revised Charter on the ground that the measures for counselling and screening of pregnant women and children are not adequate.

92. The representative of Georgia provided the following written information:

"*Health education*

Health education

Informational campaigns to prevent and control chronic diseases are conducting by different agencies of healthcare system of Georgia. Those campaigns are targeted to accomplish objectives of whole thematic projects, such as Prevention and Control of HIV, Tuberculosis, Tobacco Consumption, Drug addiction etc. Accordingly campaigns are periodically done, have different coverage, channels and quality.

Health Education in schools

According to the national educational standards of secondary schools information and education against tobacco consumption, alcoholism, drug abuse and other components of healthy lifestyle are required by. Accordingly those issues are included in guides and textbooks for pupils and teachers. At that those issues needs to be strengthened.

Important projects to promote health education in schools are planned and implemented by different t agencies of Education and Health sectors. Project to implement whole school approaches and creating network of health promoting schools is ongoing by the Center for Diseases Control and Public Health and Ministry of Education and Science.

Counselling and screening

Essential data on antenatal care, Georgia, 2008

	Number of pregnancies taken out from the enrolled lists	Deliveries		pregnant women with 4 antenatal care visits	
		Number	%	Number	%
Georgia	54760	49508	90.4	35532	71.8

Source: Statistical yearbook Georgia, 2008. /www.ncdc.ge/

In 2008, 71.8 percent of women encountered the women consultancy centers for 4 full visits. During the visits 41001 pregnant women were examined by a therapist; 56.2 percent of total number of examinations was provided in the first trimester of the pregnancy. 47044, 42885, 41382 and 40129 pregnant women were tested for Rh factor, syphilis, AIDS and Hepatitis B respectively. 6248 pregnant women had been sent for Hepatitis C testing.

Since June 2007, with the assistance of the Rostropovich-Vishnevskaya Foundation (RVF), it became possible to start the screening programme of pregnant women to identify carriers of ***hepatitis B surface antigen (HBsAg)***. In 2007 from June to December, 31 a total of 26015 pregnant women have been screened, in 2008 – a total of 40129 women. Moreover, the passive immunisation program has started for newborns of carrier mothers, using hepatitis B immunoglobulin (HBIG), to enhance the protective efficacy of the extant neonatal hepatitis B. A total of 557 newborns have been vaccinated from June 2007 to 31 of December 2007, a total of 1316 newborns – in 2008."

93. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§2 MALTA

The Committee concludes that the situation in Malta is not in conformity with Article 11§2 of the Charter because it has not been shown that:

- public information and awareness-raising is a public health priority;
- prevention through screening is used as a contribution to the health of the population.

94. The representative of Malta provided the following written information:

First and second grounds of non-conformity

"Malta follows international screening guidelines. Scientific literature has not yet managed to establish cost-benefit for screening for any condition. That said, Malta has already invested in breast cancer screening. This service has started operating in 2009. Other cancer screening programmes are in progress, particularly cervical cancer and colorectal screening.
Even if other non communicable diseases are not screened for, epidemiological surveillance of this top drivers of morbidity and mortality is carried out regularly through a population helath interview survey. Malta is also one of the partners for a European Health Examination Survey that will get a more accurate picture, simply because the respondents will be screened for a battery of diseases rather than just relying on self-response.
This is definitely available for everyone through the Antenatal Clinic. A number of pregnant women seek antenatal care privately. All pregnant women are strongly encouraged to book early on with the Antenatal Clinic. A schedule of visits depending on the gestational stage is organized, including screening for TORCH infections, hypertension, weight management and gestational diabetes, among others.
One cannot draw such conclusions – probably 70% make use of the public sector clinic but that does not mean that the remaining 30% do not get a checkup postnatally in the private sector. No figures are available to document national (ie incl both private and public checkups). The point is that this service is offered to ALL mothers through the Well-Baby Clinic and also through MMDNA visits.

Screening schoolchildren – The objection was raised as children are not screened in schools above the age of 11 years. This service is not available in Malta at present due to lack of human resources. However, in the proposed Management Plan for the next 5 years it is clearly stated that the following activities regarding schoolchildren should be provided free of charge by the Maltese School Health Service, which now forms part of the Primary Child Health and Immunisation Unit.

(a) Implementing a Child Health Promotion Programme

- Information, advice and support both to the individual parent/child and to the school as a community within which the child should thrive
- Health promotion for all children (pre-school and throughout school age), their families and school staff
- Unhindered access to the school health service for all school age children
- programmes to support individuals and communities with specialised needs.
- Primary service provider and co-ordinator for other services

(b) Providing Health Surveillance and Education

- The provision of health surveillance and education throughout infancy, childhood and adolescence by the same service provider.
- This would improve continuity of care for all infants and schoolchildren as well as providing motivation for medical staff thus ensuring optimum involvement in the provision of an effective health care service.

Malta does not agree with the conclusion reached by the Committee. The main health policy objectives identified by Government are enhancing equity in accessibility to healthcare, promoting quality and excellence and safeguarding sustainability. A focus on health promotion and healthy lifestyle initiatives aimed at increasing life expectancy has been identified by Government as one of the methods for reaching such a policy goal. This is also a crucial part of the national strategy for sustainable development.
To this end Government's direction is that emphasis across all services shall be on a preventive approach to health care, with efforts focused on non-communicable diseases including cardiovascular disease, diabetes and cancer Such efforts necessitate reliable up-to-date information on both established disease and pre-disease states and levels of risk factors to enable proper planning of health promotion and health care service for the future. To this end, a Health Examination Survey will be carried out jointly with other European Union countries in 2010 with the necessary planning and contracting of resources occurring in 2009.
Attention will be paid to risk factors associated with cardiovascular disease and diabetes. An ongoing initiative to publish national guidelines on the treatment of hypertension, and eventual enforcement of the guidelines across primary and acute care settings will help prevent unnecessary complications. Similar initiatives to treat other risk factors will ensue.

A national strategy encompassing non-communicable diseases has just been published, with cardiovascular disease and diabetes forming the central challenge. Government will gradually continue to upgrade the range of medicines available for treating these common illnesses.
Obesity and smoking will be tackled more holistically. Obesity is to be addressed through a National Action Plan drawn up by the Inter-sectoral Committee to Combat Obesity (ICCO) that is due to be published. This plan will see *inter alia* the involvement of public and private stakeholders in an effort to reduce the obesogenic environment, and the implementation of compulsory minimum levels of physical activity in schools. As for smoking, the continuation of anti-smoking campaigns coupled with the introduction of mandatory pictorial warnings and the setting up of a tobacco control reporting unit, will help curb this important risk factor. Young women will be particularly targeted.
As far as the prevention of communicable diseases is concerned, a National Sexual Health Policy will be soon published to address rising rates of sexually transmitted diseases, such as gonorrhoea. The policy will provide a framework from which a strategic plan of action will be formulated."

95. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§2 ROMANIA

The Committee concludes that the situation in Romania is not in conformity with Article 11§2 of the Revised Charter on the following grounds:

- it has not been established that there are public awareness-raising and information campaigns on the subject of infant and maternal mortality;
- it has not been established that health education activities are organised on the harmful effects of smoking and alcoholism and the prevention of sexually transmitted diseases and Aids.

96. The representative of Romania provided the following written information:

First and second grounds of non-conformity

"Information and raising awareness campaigns on child and mother mortality
Health education activities regarding the harmful effects of smoking. Alcohol consumption and prevention of sexually transmitted diseases and AIDS.
Within the national Program for health promotion and health education of the **Ministry of Health**, the staff of the offices for health promotion inside the County and Bucharest Public Health Directions have organized and participated to the implementation of activities on information, education and communication (IEC), activities which in most cases are integrated in national or local campaigns, to which NGOs and other partners from the public and private system took part.

Thus, there were organized and carried on:

- For the *prevention of harmful consumption of alcohol* - a number of 2,568 activities (e.g. education classes, lectureships with parents), 165,570 beneficiaries attended (e.g. students, teachers, parents, medical staff, patients, persons in jails), to whom there were distributed 855,667 promotional materials and it was allotted an estimated budget of 91,807 RON. 876 schools were involved in these activities.
- For *smoke prevention* - a number of 3,789 activities (e.g. press conferences, articles in the local newspapers, campaigns to measure carbon monoxide (CO) from the exhaled air) with 278,289 beneficiaries (e.g. students, parents, general population, pre teenagers, medical staff, patients, persons from placement centers) to whom a number of 137,394 promotional materials were distributed, and it was allotted an estimated budget of 154,735 RON. 1,586 schools were involved in these activities. The programs "For a healthy home" (for pupils in 1st grade), the Program "I do not smoke" (pupils in 4th grade) and the Program "Teenagers give up smoking" (pupils in 9th to 12th grades), were very well received and enjoyed a real success among pupils and teachers.
- For the *prevention of sexually transmitted diseases* - a number of 1,631 activities, with 133,047 beneficiaries (e.g. students, teachers, parents, medical staff, patients, HIV positive, prostitutes) to whom a number of 76,338 promotional materials were distributed and it was allotted an estimated budget of 58,291 RON. 602 schools were involved in these activities.
- For *HIV/AIDS prevention* - a number of 2,385 activities, with 244,376 beneficiaries (e.g. students, parents, medical staff, HIV positive patients, prostitutes) to whom a number of 118,690 promotional materials were distributed and an estimated budget of 155,176 RON was allotted. 1,679

schools were involved in these activities. The national campaign on prevention was carried on under the slogan "Stop AIDS! Honor your promises" and included a mix of activities against the discrimination of people infected with HIV/AIDS, conducted in cooperation with local mass-media and counseling voluntary centers for HIV/AIDS testing, organizations of medicine and pharmacy students, information activities, psychological counseling carried in schools, condoms distribution etc.

The Romanian HIV/AIDS Center carried on the following activities in this field:

- Campaign against AIDS started on the 27th of January **2009** on Facebook
- Press conference and printed materials for all the counties
- Mini market for health
- Human ribbon

The Ministry of Education conducts education programmes for health achieved through:

a) **Biology** as a subject (where personal hygiene topics are taught, as well as sexual education or venereal diseases, food disorders etc.), or within Technological subjects: "Hygiene", "Work Security", "Nourishment" etc.

b) The "**National Education Programme for Health in Romanian Schools**" coordinated since 2001 by the Ministry of Education, Research, Youth and Sport, in partnership with the Ministry of Health. Within this programme, the following projects have been developed:

- National curricula for the Ist - XIIth grades, for the optinal course „Education for Health"; these curricula have been posted on the site www.edu.ro
- Training 400 national trainers
- Training 8700 teachers
- Course supports for training courses of teachers and national trainers
- Teachers' guides (informative and methodological)
- Students' notebooks
- Advertising campaigns "Discover a Healthy World", radio and Tv spots, the web site www.educatiepentrusanatate.ro
- Extracurricular and extra-class activities (activities included in the Calendar of Educational Activities at a national, regional, county, local level
- Enlarging partnerships with international, government and non-governmental institutions. working on problems belonging to the health domain (UNICEF, UNFPA, John Snow, USAID, the Ministry of Health, the National Authority for the Consumer's Protection, the National Guard for Environment, the Foundation "Youth for Youth", the organization „Save the Children").
- When developing this programme, the decision-making factors took into account the fact that education for health in schools represent one of the main ways of promoting a correct knowledge about different aspects of health and for the formation of the attitudes and habits that are essential to a responsible and healthy behaviour.
- The main themes of the programme „Education for Health" include:

- Elementary notions of anatomy and physiology;
- The stages of growth and body development;
- Personal hygiene (hands and nails, teeth, nose and mouth, hair, clothes);
- Physical activity and rest;
- Environmental health (housing, pollution etc.);
- Mental health (belonging to a group, politeness and its rules, social roles, interpersonal relations, stress etc.);
- Alimentary health (aliment classification, the pyramid of a balanced nourishment, the consumer's protection etc.);
- Reproduction and family health (conception, contraception, sexual transmissible infections);
- The consumption and the abuse of toxic substances, drugs, alcohol, tobacco and the consequences that derive from these problems such as absenteeism and school leave, juvenile delinquency;
- Accidents (including first aid rules), violence, physical abuse, domestic violence, violence in the family.

Within the education for health curricula, there are topics for every educational level and grade targeting, especially, issues of hygiene, prevention of alcohol, tobacco and drug consumption, for instance:

1. Substances noxious to health;
2. The use and abuse of medicine a/o;
3. How to say NO! to the urge of drug consumption;
4. The passage from accidental consuming to drug abuse (tolerance, dependence, disintoxication);

5. Dependence on other substances (alcoholism, smoking);
6. Myths, prejudices and stereotypes regarding the consumption of toxic substances;
7. The consequences of drug addiction for the individual and the society;
8. The legislation on the marketing, trading and consumption of toxic substances.

It worth mentioning the fact that the National Programme "Education for Health" is still ongoing in approx. 3,254 schools, involving over 1,000,000 pupils in curricular, extracurricular and extra-class activities, having a positive impact on shaping responsible behaviours among children and youths for their own health and for the health of those around them.

c) With a view to ensure **the sustainability of the national programme on health education**, the Ministry of Education is currently implementing the ESF project entitled: "Extra-curricular and extra-class inclusive educational offers on shaping a healthy life style and an active citizenship for the children in disadvantaged communities, especially in rural areas, in the pre-university education system"

The specific objectives of the project are:

- drafting the specific educational offers for promoting a healthy life style and an active citizenship for supporting a quality inclusive education for children from disadvantaged communities, especially rural communities, by training categories of decision-making factors in pre-university education;
- raising awareness among categories of local social actors on the necessity of promoting a healthy life style and an active citizenship for supporting an inclusive education for children from disadvantaged communities, especially from rural communities;
- the development and implementation of inclusive educational offers, extracurricular and non-formal ones, on learning a healthy life style and an active citizenship for children from disadvantaged communities, especially from rural communities.

The target group was represented by 2,100 teachers, decision-making factors from the pre-university educational system as well as 12,800 pupils, especially from disadvantaged communities.

d) Concerning the **prevention measures against smoking, alcoholism and drugs consumption**, the Ministry of Education, Research, Youth and Sports is a signatory part of the National Strategy Antidrug 2005 – 2012, assuming under this document a series of tasks in the fight for preventing drug consumption among pupils and students. In this respect, regular reports are submitted to the leading staff of the National Antidrug Agency, for completing the country reports referring to the progress made with a view to achieve the assumed objectives.

Besides the general objectives assumed under the National Antidrug Strategy, the Ministry of Education is involved in partnership with the National Antidrug Agency, in two projects with international funding: „Uncensored" (a project for preventing alcohol, tobacco and other drugs consumption by children, based on the comprehensive model of social influence) and „I and My child" (an integrated part of the project RO-0047 "Family Training in Educational Skills on the prevention of drug consumption"). In 2010, the 7th edition of the national contest on antidrug projects called „Together" will be also organized, where teams of students in 9th and 10th degrees who implemented projects on prevention campaigns on alcohol, tobacco and drugs consumption in their high-school will participate. In that respect, a page web is under construction where examples of children's activities will be posted, as well as other projects conducted in schools all over the country will be posted there.

Moreover, the Ministry of Education cooperates with numerous governmental and non-governmental organizations, in raising-awareness campaigns and other types of prevention activities. The most significant document in this respect is the Protocol of Cooperation concluded between the Ministry of Education, Research, Youth and Sports and the National Antidrug Agency (no. MEC 12454/03.10.2005).

The universal, selective and indicative prevention programmes, as reported by the county school inspectorates in 2009, are as follows:

Programmes of universal prevention:

- No: 709
- Direct beneficiaries: 288,231 students, teachers and parents
- Indirect beneficiaries: 224,676 students, teachers, parents, local community etc.

Selective prevention programmes:

- No: 168
- Direct beneficiaries: 40,813 students, teachers and parents
- Indirect beneficiaries: 24,700 students, teachers, parents, local community etc.

Indicative prevention programmes:

- No: 65
- Direct beneficiaries: 6757 students and parents

- Indirect beneficiaries: 5460 students, parents, local community etc.

Examples of universal prevention programmes:

- „VIP without alcohol" and „Classes without smoking", implemented at national level by the National Antidrug Agency in partnership with the Ministry of Education and Research;
- Debates with students and contests on antidrug projects entitled „Alcohol does not grow you up";
- Elaboration, launching and free delivery of the Guide „Health in Ten Steps for a Longer Life";
- Information campaigns and skills training: „Tobacco and alcohol: two vices − three solutions", "Drugs Temptation can be Beaten", „Be Informed, be Strong", „Join Us", "Step by Step Antidrug", "Life Habits", "Alcohol and Tobacco Are not a Children's Game", „Near You", „You Can Do Something, Too", „I Learn to Protect Myself", „Start for a Healthy Life!", „Be fair play with your Life! Say NO to Drugs!", „ Prevention Caravan", „Health March";
- „Security Marketing" – prevention of trading and drugs consumption in school areas, project initiated by Police of Bucharest Municipality, the Prevention and Analysis Department;
- „A New Beginning" – prevention of drug consumption in schools;
- Prevention of drugs consumption – informing course addressed to the community police for preventing drug consumption in schools;
- „Take care of your health!" – a project meant to prevent drug use;
- "Be informed, be strong!" – a project meant to provide information by displaying monthly panels on prevention of drug use in schools;
- "Option: access to success" – students information and raising awareness through stage performances and plays showing the risks of drug use;
- "High school – life's doorstep" – aims at reducing the rate of juvenile delinquency and criminality and at maintaining drug use at a low level in the educational environment in Bucharest;
- "Alternatives" – youth's information campaign on the existence of Antidrug Prevention, Evaluation and Counseling Centers;
- The inter-school seminar "The Fight against Tobacco Use", with the participation of various schools, which took place at the People's University in Cluj-Napoca;
- "Temptations", a campaign aiming at preventing the use of alcohol, tobacco and drug among teenagers, aged 11-13, that should develop personal and social skills as well as the involvement in extra-activities;
- "Efficient Ways of Prevention and Fight against Alcohol, Drugs and Tobacco Use among Teenagers" – debates, essays, Power Point presentations, posters contest;
- Open debate: "Certain plants (tobacco, poppies, lime tree flowers) – drugs or medicines?";
- "I give up" – psychological counseling, rational and emotional behaviorism education;
- Anti-drugs Clubs;
- The international project "Preventing drug addiction is everybody's problem" – informative and interactive activities, such as peer – education, spare-time activities, open debates, volunteer training;
- "Drugs – a dangerous game", methodological activities with teachers, activities with Students' Councils, activities with the Parents' Boards, management classes;
- Organizing sportive competitions that would persuade students to adopt a healthy life-style – football championships, bicycles competitions and roller competitions, handball and basket competitions;
- The stage performance of the play" Yes to Art – No to Drugs!" performed by students and followed by a debate moderated by teachers;
- The regional educational project "The Institutional Network Against Drugs";
- Anti Drugs radio broadcasting at press clubs and in schools;
- The national contest on anti-drug themes VIDEOART.

Examples of programmes of selective prevention:

- the project "Adolescence without addiction – 2008-2009" – workshops with students from special needs schools;
- watching the movie "Message from the Inner World", at Employment Centers;
- informative activities done during the extra-class activities organized by children's clubs;
- "Developing a healthy lifestyle" – a campaign dedicated to students who practice sports;

- informative sessions, drawing contests, training of sport teams in schools with rroma students;
- campaigns dedicated to children whose parents are working abroad.

e) Regarding **the road safety** it worth mentioning the following:
Road education enjoys a legal framework that regulates both the organization, the carrying out of class activities and the specific educational activities, as well as the traffic of vehicles whose drivers are adolescents. The legal framework consists of:
The **Decree no. 195/2002,** republished, with subsequent modifications and completions (Art. 49 – limiting the maximum speed admitted; Art. 36, paragraph (1) and (2) – regarding the obligation to fasten the safety belt and get the safety equipment for bicyclists, motorcyclists; Art. 87 and 88 on the prohibition to drive under the influence of drugs or alcohol; Art.6, par. (3), Art. 32, 33, 35 on the obligation to build road bumpers that limit the speed).
The **Common Order** of the Ministry of Education, Research, Youth and Sport and the Ministry of Interior Affairs and Administrative Reform **no. 1589/25.07.2007** on road education classes in preschool, primary and secondary education, the partnership between MERI – MAI on the national programmes on the prevention of traffic accidents and with a view to develop the responsible traffic behavior amongst children, adolescents and young people.
In the field of formal education, the classes on road education are organized in preschools in the form of distinctive activities, whereas in the primary and secondary school they are conceived as *counseling and guidance* disciplines, in line with the themes elaborated in the partnership between the Ministry of Education and the Ministry of Interior. Complementary to the formal education, the projects and the educational syllabus have as targets the same categories: children between 3 and 6 years old, children between 6 and 10 years old, and children between 10 and 14 years old.
Other road education programmes at national level:
- The national contest *Road Education – The Education for Life* (an annual manifestation): conducted by the Ministry of Education, in partnership with the Ministry of Administration, the General Inspectorate of the Romanian Police – the Traffic Police Department – which is addressed to students in secondary schools. Starting with 2007, the national contest *Road Education – The Education for Life* – was developed by adding a section dedicated to road educational projects, which allocated space also for a theme adequate to high school students: design a model that should increase the road safety, autonomy and the participation in traffic for children, adolescents, but also for pedestrians, the implementation of an advocacy project, that should help the community understand the importance of investing in traffic safety, the elaboration of portfolios that should contain promoting materials used in a prevention campaign of eccentricities among young drivers.
- The national programme "Traffic School Patrols" (2008 - up to present) – conducted by the Ministry of Education and the Ministry of Interior, through the General Inspectorate of the Romanian Police – the Department of Traffic Police – which is dedicated to students in secondary education.
- The campaign *Stop the accidents! Life has priority* (2006-2008) – conducted by the Ministry of Interior, in which the Ministry of Education participated as a partner, adapting the monthly themes of the campaign to the particularities of the pre-university educational system.
- Subordinated campaigns, added to the national campaigns that concern the prevention of traffic accidents (*The International Week of Traffic Safety* – 2008, *The National Week of Traffic Safety – 2009*), initiated by the Inter-ministerial Board for a Safe Traffic, where the Ministry of Education is a member.
- Projects initiated by each county – consisting of contests specific to various age groups, debates, campaigns.
- The campaign concerning the prevention of traffic accidents among young drivers of two wheeled vehicles – *Do not play with your life* (2009 – 2010) – initiated by the General Inspectorate of the Romanian Police, through the Department of the Traffic Police and run in partnership with the Ministry of Education and non-governmental organizations.
- The European Project AdRisk – that prevents the risk of injuries caused by traffic accidents to youngsters (2009-2010) – issuing educational materials (DVDs) that support traffic education, designed for high school students.

f) For the area that concerns the **prevention of disasters and training for the reduction of the negative effects in emergency situations**, *The Protocol on Training for Civil Protection of Children, Pupils and Students enrolled in the National Pre-university and University Educational System* was issued and approved (No. Ministry of Education, Research and Youth 13527/07.09.2007).
g) In the 2010 timetable of the Ministry's of Education activities there are listed various activities with an educational and preventive character, such as:

- The National Contest "The Skilled Hospital Attendants"
- The Contest "Traffic education – Education for Life"

- The National Contest “The Firemen’s Friends”
- The National Contest on environment projects
- The National Contest on education for health “Discover a Healthy World”
- The National Contest on themes regarding the consumers’ protection “Choose! It is your right”
- The National Contest on anti drugs projects “Together”
- The National Contest “Non-Violence in Schools”
- The National Contest on anti-earthquake education
- The National Contest on ecological education “Earth is Our Home”
- The National Contest “Delta’s Friends”
- The National Contest “Good Practices for Environmental Protection”
- The National Contest “Trees’ School”
- The National Contest for protecting the environment “Radu Surdoiu Memorial”
- The National Contest on ecological issues “Let’s Rediscover Nature”
- The National Festival “Wings”
- The National Contest on ecological issues “Let’s Take Attitude”
- The National Contest of essays and papers “The Administration of Natural and Manmade Risks”
- The National Contest on ecological issues “Ovidiu Bujor”
- The National Contest “SOS Nature”
- The National Contest on ecological issues “Waste a Threat for All”
- The National Contest “Together We Can Change the World”
- The National Contest “Nature’s Friends Can Protect Earth”
- The National Contest “Pro Sana”
- The National Contest “Life’s Secret - A Healthy Nourishment”
- The National Contest “Health through Education”
- The National Contest “More Beautiful and Healthier Youth”
- The National Contest “Moving About Correctly We Protect Ourselves”
- The National Contest antidrug “Say No!”
- The National Contest on ecological issues and informatics “Young Eco-Reporters”
- The National Contest “Eco Patrol”
- The National Contest “Protecting the Ecosystems of Banat Mountains”
- The National Contest of Ecology, Dendrology and Environment Protection
- The National Contest on ecological issues “Edelweiss”
- The National Contest on ecological issues “Keep the Earth Healthy”
- The National Contest on ecological issues “We are Part of Terra’s Future”
- The National Contest on ecological issues “Your Gesture Counts Too”
- The National Contest on ecological issues “EcoKids”
- The National Contest on environment education “David Against Goliath”
- The National Contest on ecological issues “The Child and Nature”
- The National Contest on ecological issues “We Care! Involve Yourself”
- The National Contest on ecological issues “The Precious Planet”
- The National Contest on ecological issues “Save a Tree! Plant a Tree!”
- The National Contest on ecological issues “The Green Olympiad”
- The National Contest on eco magazines
- The National Contest on ecological issues “Forest Month”
- The National Contest on ecological issues “Practical Activities for Protecting the Environment”
- The National Contest on ecological issues “Water for Future”
- The International Contest “Ecofest Junior”
- The National Contest “Water as a Possible Enemy”
- The National Contest on Photography and Drawings “World Water Day”
- The National Contest on ecological issues “Children, Save the Blue Planet”
- The International Contest on ecological issues “Ships on Black Sea”
- The National Contest on ecological issues “Nature and its Gifts”
- The National Contest on ecological issues “We Recycle, we Do Not Throw Away!”

Measures for the protection of population against the risks of ionizing radiation

The European legal framework applicable to the protection of population health, which includes Directive 96/29 Euratom laying down the basic safety standards for the protection of the health of workers and of the general public against the dangers arising from ionizing radiation – art. 45 (estimates of population doses), Recommendation 2004/473 Euratom regarding the monitoring the levels of radioactivity in the environment for the purpose of assessing the exposure of the population as a whole and Directive 97/43 on the protection of individuals against the dangers of ionizing radiation in relation to medical exposure were transposed, and the implementation is ensured by the following legal acts:

- Law no. 95 on the health reform, Title I, Public health, articles 5 and 6 which provide as essential function of the public health and priority field of intervention the protection of population's health against environmental risks;
- Order no. 381/2004 on the approval of the basic sanitary norms for carrying on safely nuclear activities - Chapter III - Radioact control of drinkable water, food and other consumer products;
- Order no. 1.539/2006 of the Minister of Health on the approval of the specific Regulations regarding medical exposure of persons to ionizing radiation in case of medical and legal expertise;
- Order no. 1.540/2006 of the Minister of Health on the approval of the specific Regulations concerning the medical exposure in pediatric radiology;
- Order no. 1.541 / 2006 of the Minister of Health on the approval of specific Regulations concerning medical exposure to ionizing radiation of pregnant women;
- Order no. 1542 / 2006 of the Minister of Health on the registration and report of dose to patients;
- Order no. 1003/2008 of the Minister of Health on the registration and report of dose to patients;

The implementation of the above-mentioned decrees is achieved through the activities of the National Program on Public Health (417/2009), the Sub-program no. 4, Target 2: The protection of population against ionizing radiation.

Legislation and measures taken for phonic pollution

- Order no. 536/1997 Minister of Health for the approval of the Norms on hygiene and of the recommendations on population's environment;
- Government Decision no. 321/2005 concerning the assessment and management of environment noise;
- The joint Order of the Ministry of Health, Ministry for Environment and Water Management, Ministry of Transports, Constructions and Tourism and Ministry of Interior and Administration no. 678/1344/915/1397/2006 for the approval of the Guide on interim methods for the calculation of noise produced by the activities in industrial areas, by road traffic, rail and air traffic in the vicinity of airports;
- Order no. 1.119/9.06.2008 of Minister of Health on the approval of the Guide on the adoption of limit values and the implementation methods when the action plans are elaborated, for Lzsn and Lnight indicators, in the case of noise produced by traffic on the main roads and in congestions, railroad traffic on the main railroads and congestions, air traffic on the big and/or urban airports and for the noise produced in crowded areas where industrial activities are carried on, as provided in annex no. 1 of the Government Emergency Ordinance no. 152/2005 on the integrated prevention and control of pollution, approved with amendments and completions by Law no. 84/2006.

Legislation and measures adopted for water pollution

- Government Decision no. 974 of 15th of June 2004 for the approval of Surveillance Norms, sanitary inspection and monitoring of drinkable water quality and of the Procedure for sanitary authorization of production and distribution of drinkable water, published in the Official Monitor no. 669 from the 26th of July 2004;
- Order no. 341 of Minister of Health of 20th of February 2007 for the approval of hygiene norms and of the procedure of notification for the bottled drinkable water, others than natural mineral waters or other than spring waters, traded with the name of table water, published in the Official Monitor no. 149 from the first of March 2007;
- Order no. 764 from the 15th of July 2005 of the Minister of Health for the approval of the registration procedure by the Health Ministry of the laboratories which monitor the quality of drinkable water during the official control of drinkable water, with the subsequent modifications and completions;
- Government Ordinance no. 11 of 29.01.2010 for the modification and completion of Law no. 458/2002 on drinkable water, published in the Official Monitor, Part I nr. 69 from 29.01.2010.

Measures taken to fight against smoking, alcohol consumption and drug addiction

> ➢ Alcohol consumption, fight against smoking and drug addiction prevention represented and represents a permanent priority for Romania's Govern. So, by Government Decision no. 1101/2008, the national interest Program for the prevention of alcohol, smoke and drug consumption was approved for the years 2009-2012."

97. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§2 TURKEY

The Committee concludes that the situation in Turkey is not in conformity with Article 11§2 of the Revised Charter on the grounds that:

- it has not been established that public information and awareness-raising on health matters (…) were adequate;
- it has not been established that counselling and screening of the population at large as well as of children and adolescents, through school medical check-ups, were adequate.

First ground of non-conformity

98. The representative of Turkey made the following statement:

> "As it is was mentioned in the last Government report a programme on sexual and reproductive Health was run in cooperation with the European Union to improve access to the relevant health services that can provide information on sexual health and family planning which covered some 3.2 million couples. In 2006 the number of couples reached up to 4.6 million.
>
> On the same subject, the Ministry of Health and the Turkish armed Forces initiated a project on educating men and trainer's training was given to some 3150 military health care personnel so that they give Reproductive Health and Family Planning Counseling Services to commissioned and non-commissioned officers in the Turkish Armed Forces. Since 2004 more than 1 million conscripts had received training. Every year 500.000 young men are enlightened on reproductive health during their military service.
>
> Public information and awareness raising on health matters is carried out through radio and TV programmes in cooperation with the Ministry of Health and the Ministry of National Education on unhealthy life styles, on diseases with high mortality rates such as cancer, lung and heart diseases.
>
> With the aim of reducing the harmful effects of tobacco products and their consumption, broadcasting various warning and educational programmes for at least 90 minutes monthly on the TV channels is mandatory. On the subject of tobacco control, the Ministry of Health conducts several public education activities via posters, brochures and leaflets; establishes quitting centers and supports the potential quitters.
>
> A working group including the NGO's, universities and relevant institutions prepared a National Tobacco Control Programme in 2006 in order to control the smoking epidemic. The aim of this Programme is to increase the rate of non-smokers over the age of 15 to 90 percent at the end of 2010."

99. Several representatives asked whether this information was new information.

100. The representative of Turkey stated that it was partly new.

101. The Committee took note of the information provided and urged the Turkish government of Turkey to provide all relevant information and reinforce their efforts to ensure adequate health education.

Second ground of non-conformity

102. The representative of Turkey provided the following written information:

"**Advisory and Educational Facilities**
As regards the health education programmes in schools the following information has been supplied by the Ministry of National Education with respect to the curriculum in the Primary and High School educational establishment:
PRIMARY EDUCATION (4TH TO 8TH CLASSES)
The compulsory primary education is eight years in Turkey. The health education starts from Grade 4 to Grade 8 in the primary education establishments.
The curriculum is summarized as follows:
Grade 4
Unit 1 Our Anatomy
This unit covers the relations between the development of muscles and bones by exercises. It explains the benefits gained from regular sports for a healthy life.
Grade 5 Let us solve the Puzzle of Our Body
This unit covers the importance of a healthy nutrition and the different functions of the contents of different nutrients. It also establishes the relations between main groups of nutrients.
The unit also covers the area by establishing an example meal in a balanced diet. In this unit the importance of dental health is emphasized. The functions of the digestion system are also explained.
In this unit an awareness of own responsibility is developed in order to establish a healthy environment.
Grade 6 Reproduction, Growth and Development
In this unit what the mother candidate should pay attention is taught in order for the embryo to develop in a healthy way.
Students are also taught the psychological and bodily changes occurring from the transformation from childhood to adult.
In this unit the effect of harmful substances in the body systems causing addiction to such substances are examined. The donation of organs is also emphasized.
Grade 8 Cell Division and Genetics
In this unit the negative effects and results arising from marriages between close relatives are dealt with. In Grade 4 and Grade 5, general health problems are dealt with in two parts in the English classes […]

SECONDARY EDUCATION (9th-12th CLASSES)
Secondary education programmes containing subjects and achievements concerning health (hygiene) education are as below:
1. Knowledge of Health (Hygiene) (compulsory for 1 hour in 9th classes)
2. Traffic and First Aid (compulsory for 1 hour in 12th classes)
3. Biology (takes place as a compulsory course for 2 hours in 9th classes, and it's among common and optional courses in 10th,11th,12th classes)
4. In Fine Arts and In The Field of Sports in Sport High Schools "Human Anatomy, Protecting from Sport Accidents and First Aid, Sports and Nutrition, Sports Massage" take place in training programmes.
Hygiene Knowledge course is taught in 9th classes as a compulsory course for 1 hour. The subject distribution of hygiene knowledge training programme and their percentages according to achievements are as follows:

UNITS OF HYGIENE KNOWLEDGE AND THEIR PERCENTAGE DISTRIBUTION
1. Health (hygiene) concept
2. The basis of a healthy life
3. Growing, ageing and mental health
4. Bad habits for health

5. Family life, family planning, maternal and infant health
6. Fundamental principles about infectious disease
7. Accidents and first aid

Unit	% distribution	Course Hour	Special Purpose	Behaviours (achievements)	Basic concepts
Health concept	5	4	6	31	9
Basis of a healthy life	10	7	13	100	5
Growing, ageing and mental health	15	11	11	62	8
Bad habits for health	15	10	5	46	5
Family life, family planning Maternal and infant health	18	14	13	87	12
Infectious disease	17	12	17	102	14
Accidents and first aid	20	14	33	102	16
TOTAL	100	72	98	530	69

In secondary education Biology course training programme which takes place in addition to hygiene knowledge course in 9th class as a compulsory course for 2 hours and as a common and optional course in 10th, 11th and 12th classes there are themes and achievements concerning Health Education.
Moreover, there are courses on sport education and programmes of these courses in Fine Arts and in The Field of Sports in Sport High Schools.

Pregnant women, children and adolescents
With respect to the programs carried out by the Directorate General of Mother-Child Health and Family Planning (the The Acronym is AÇSAP in Turkish) are summarized as below:

- **Prenatal Care (PC)**

The researches carried out by the Turkish Census Survey (TNSA) between 1993-2008 on prenatal care which is important for the mother and child care are indicated in the following Table:

TABLE I – PRENATAL CARE

	%
TNSA 2008	92
TNSA 2003	80,9
TNSA 1998	67,9
TNSA 1993	62,3

According to the data of TNSA 2008, the ratio of women receiving prenatal care for at least once from health personnel is 92. In this respect, the share of physician for service demand was increased where the share of midwives and nurses was decreased. The fact that the first control of pregnancy was realized in the first three months of pregnancy and that the care was received from health personnel helped towards this development. The ratio of pregnant women who had received the adequate care is 74 per cent.
In order to enable each pregnant woman to receive quality care, clinical protocols have been prepared by taking into consideration of the standards of the World Health Organization (WHO) and international standards. In these protocols provisions containing the follow up of each pregnant woman for at least 4 times, the follow-up times and what should be done during the follow-ups have been included. The care protocol was published by the Circular No: 2008/13

- **Iron Support for Pregnants**

The iron support program was started in Turkey on 1st November 2005 in order to prevent any complications that may arise from anemia constituting a serious threat from the point of mother and baby care. Now every pregnant woman determined as requiring Iron support receives iron without discrimination.

- **Birth-Cesarean Section Program**

According to TNSA 2008, 91 per cent of births are realized by the help of health personnel and 90 per cent of such births occur in the health institutions.
According to the results of Research on National Mother Deaths, 2005, the number of maternal mortality was 28,5 in 100.000. Two of every three mothers are lost during birth and after birth. In addition, 21% of maternal mortality happens at home.
By taking in to consideration this existing fact it has been an objective to:
- Determine all pregnancy on time and to carry out the necessary follow-ups
- Enable all pregnant women to give birth in hospital, and
- Enable the pregnant women to stay in the hospital for at least 24 hours after birth, if there exist no risks for the mother and the new-born.

36,7 per cent of births are made by the cesarean section method. The WHO recommends that the cesarean section ratio should be between 5 to 15 per cent.
The Birth Administration Guide developed in cooperation with the related expert associations and a circular have been published in line with this guide in which the decision for birth should be taken accordingly.

Post Natal Care Program

In order for the mother's all systems to recover to its prenatal state, an average of 6 weeks should elapse.
For mothers to stay from 2 to 4 days in hospital after birth causes great benefits from the point of mother and infant health. In general, the duration of stay in hospital is at least 48 hours after a vaginal birth in cases with no complications.
This period time is 96 hours after a cesarean section.
In Turkey a Post Natal Care Administration Guide was prepared and published in 2008 with a view to protect the puerperant and the newly born form complications fot a period of 42 days after birth. The objective is to increase the quality and accessibility of pregnancy, birth and post natal care services.

POSTNATAL MOTHER FOLLOW-UPS IN 2008

LOCATION	(%)
URAL	78,8
URBAN	75,2
WEST	90,6
SOUTH	80,1
CENTRAL	92,0
NORTH	84,3
EAST	67,4
TURKEY (AVERAGE)	84,5

Source: 2008 TNSA

Ensuring Participation of Men in ACSAP Services (Turkish Armed Forced US Program) :

The program which was launched in 2002 in collaboration with the Ministry of Health, TSK Health Commandership and UNFPA is being continued towards privates and non-commissioned officers in Reproductive Health (RH) Courses opened in all military troops overall the country. Number of privates and non-commissioned officers trained within the scope of program has reached to 2,5 million.

Reproductive Health Services Towards Youth

Reproductive health refers to human beings' state of complete well being in physical terms as well as having the capability to have a safe sexual life and reproduction and the freedom to be informed about and decide on this issue easily. People have the right to continue their own generations according to their own decisions.
Reproduction health should be considered so as to cover all stages of life, namely childhood, adolescence, adultness and old age periods, and to be dealt with for both genders so as to include the sexual health.
Studies about Sexual Health and Reproductive Health (SHRH) of adolescents / youth have a significant position in the international agenda since the World Conference on Population and Development held in Cairo in 1994. Within the scope of action plan of the conference, it was indicated that "there is a need to rearrange reproductive health programs so as to cover the needs of women and adolescents and to make reproductive health knowledge, counseling and reproductive health services accessible by adolescents and adult men."
In World Population and Development Conference in 1994 and Beijing Fourth World Women Conference in 1995, a comprehensive and integral approach has been developed against sexuality

and SHRH, as an integral part of basic human rights. Within this framework, the action plans of both conferences emphasized the requirement of including SHRH attitudes and requirements of adolescents / youth in programs planned for improving health.
In 2003 TNSA, it was determined that 15,5% of 15 – 19 age group and 60,7 % of 20- 24 age group have experienced sexual intercourse. In "Turkey Youth Sexual Health / Reproductive Health Research" carried out by UNFPA, whereas the rate of women aged 15 – 24 who have experienced sexual intercourse was 34,5 %, this rate was 51,1% in men and 42,8% in total. According to 2008 TNSA, 9,6% of 15 – 19 age group, and 45,5% of 20- 24 age group are married.
According to 2008 TNSA rate of those who start to give birth in 15 – 19 age group was 8,6% in rural areas, 5% in urban areas, and 5,9% in total.
Besides, it was determined that 8% of pregnancies under age 20 have not received any prenatal care, that 10,4% gave birth at home, 9,6% gave birth without any health professional assistance, and 20% did not received any postnatal care. Whereas the number of mothers among primary school graduate adolescents was 3,4%, this rate decreases to 0,7 among secondary school graduates. As it can be seen, percentage of giving birth and pregnancy rapidly decreases as the level of education increases in women in 15 -1 9 age group.
When we look at the family planning situation in adolescents, 17,6% of those in 15- 19 age group use modern family planning methods, whereas this number is 37,4% for those in 20- 24 age group. According to 2008 TNSA, percentage of miscarriage in 15 – 19 age group is 2,9%, and in 20 – 24 age group this rate is 3,6%. Researches demonstrate that media and friends are the most frequently referred sources of sexual information for adolescents. The fact that information received from these sources is not accurate and reliable may misdirect the adolescents.
At this point it should not be forgotten that Youth Counseling and Health Service Centers (GDSHM) are a big stage for many youngsters who visit there for service. Many young people do not know what is waiting for them and what they will face with since they do not request any service, and most of them refrain from asking some questions. For that reason, it is vital to make these service youth-friendly. Service providers could find what the obstacles are only if they work together with youngsters. Eventually those are the youngsters who are experts on their own needs. For that reason, "young-friendly" means not only working for youth, but also working together with youth.
In our country, the 10- 24 age group constitutes one fourth (1/4) of the population. There is a decreasing trend in the number of pre-marriage sexual intercourse and there is a need for increasing youth-friendly services which aim at changing risky behaviors, preventing unwanted pregnancies and Sexually Transmitted Infections (STIs), and adopting healthy life styles. The overall policy of our Ministry is in this direction and routine services are supported with special programs. It is planned to develop and disseminate counseling and SHRH service provision for youngsters starting from big cities which receive migration and where young people are under high risk.

MOTHER-FRIENDLY HOSPITAL PROGRAMME

Purpose: Providing the conditions for sufficient pregnant, following the confined and reducing infant mortality by realizing the birth in reliable conditions in all the hospitals.
The implementation will be realized In 5 pilot provinces chosen in 2010 within the scope of "Mother-Friendly Hospital Programme Criteria". The criteria are generated with the Science Commission of the programme by integrating WHO and the other international implementations to our country.

Consanguineous Marriage, Precarious Pregnancies, Extending the Pre-Marital Consultations and Screen Tests

Wider observation of Hb variant in Turkey is a result of people's from many cultures and variety of races living in Anatolia throughout the years and consanguineous marriage. In Turkey one in every five marriages is consanguineous. (21.4) Consanguineous marriage is most realized between next-of-kin. As is known, the consanguineous marriage increases the prevalence of rarely seen autosomal recessive disorder in society.
In our country The Law of Struggling with the Hereditary Blood Diseases No: 3960 was enacted on 30.12.1993.
Within the scope of this programme, The **regulation for diagnosis and treatment with control programme of a hereditary blood disease hemoglobinopathy** is prepared and issued in an effort to regulate the methods and principles of activities for diagnosis and treatment of hereditary blood diseases like thalassamia and cell anemia being in the first place which are frequently seen in our country also preventing and struggling with these diseases within the context of preventive health services.
This regulation contains: Devoted to the hereditary blood diseases of state institutions and organizations also natural and legal persons;

- Education

- Surveillance
- Genetic counseling
- Pre and Post-Natal Diagnosis
- All kinds of activities related to the treatment of patients
- Facilities of diagnosis and treatment
- Issues of registration, notice, inciting and permission

The Follow-Up Programme for Infants and Children

Many preventive and improving events are being carried out devoted to children in our country. Activities in the field of health are mainly realized within the body and coordination of the Ministry of Health. The common goal of many programmes and projects is the healthier generations for happier future. The large part of these programmes is being implemented in the first step institutions whose main aim is already preventive health services.

The 94.4% of new born infants are being determined in our country. These babies are being followed-up 7.4 times in a year on average.

The Follow-Up Programme for Infant Mortality

The treatment of child health is accepted as the indispensable indicator of development in development summits by the international community both because of the importance of indicator with high number of death all over the world and the fact that large part of the infant and child mortality can actually be prevented with low-cost intervention. Reducing the child mortality is accepted as one of the main themes of Millennium Development Goals by UNICEF in Convention on the Rights of the Children, UNFPA in the course of International Conference on Population and Development and many other international organizations like WHO.

More than the successful studies we carried out up until today to be able to reduce the infant mortality is needed. We need to follow-up each and every infant mortality, reveal the reasons and prevent its reiteration with the same reasons. This progress will be possible only with a well-functioning register and notice system. While some faults with the system of data gathering and death cases are being experienced in the current implementation, a new registration system is developed to determine all the infant mortality realized in between 0-365 days and take the necessary measures on this issue.

Our aim is to obtain information related with the each infant and prenatal period mortality rates, monitoring each and every infant mortality with the reasons and preventing reiteration.

Newborn Reanimation Programme

The rate of infant mortality which is an important indicator of health is 0.17% in our country.(TNSA 2008) With extending the implementations of immunization, oral fluid treatment and breast milk, the post neonatal infant mortality started to decrease and neonatal period mortalities came into prominence. The positive impacts of the programme can be followed in two indicators:

1-The rate of infant mortality which was more than 200% in 1963, is reduced to 17% in 2008.

2-Rate of neonatal infant mortality is 13% and rate of post neonatal infant mortality is 4%.

The Aims of Neonatal Resuscitation Programme

- All the medical staff who attend the childbirth should have the training of resuscitation and update at certain intervals.
- Training teams should be constituted in provinces, and training sets including the training models should be provided for each province.
- Resuscitation with same qualifications and quality should be provided for the children born in every part of Turkey.
- Informative-Training-Communication materials devoted to target group and service providers should be generated, copied and distributed. (video cassette, slide, brochure, book)

Programme of "Turkey Like Iron"

As it is known, iron deficiency anemia that is of vital importance for every age group in our country appears approximately in 50% of the children at the age of 0-5 and in pregnants. In order to solve this important public health problem, theMinistry of Health initiated **"Turkey Like Iron" Project** nation wide so as to raise awareness about iron deficiency, to breast feed the infants in the first 6 months and to continue breast feeding till the infant is 2 years old through nutritional supplements, to provide free iron supplement for prophylactic purposes for every infant between 4-12 months and to suggest iron deficiency treatment for the infants having anemia for 13-24 months.

Programme on Preventing Vitamin D Deficiency and Protecting Bone Health

It is reported that vitamin D deficiency is an important problem affecting infants and children in our country for a long time and that the frequency of the disease changes between 1.67-19%. Despite the progress of the society in health level and the efforts of healthcare personnel on vitamin D support, it is known that there are regions where rachitism (rachitis) among children at the age of 0-3 is still seen at the rate of 6%.

Purposes

The purpose is to prevent rachitism which is one of the health problems related to malnutrition. Therefore;

1) All newborn babies should start to be breast fed immediately after birth and continue to be breast fed for the first 6 months,

2) Continuing breast feeding together with appropriate and sufficient nutritional supplements after 6 months,

3) Pregnants should be informed about calcium deficiency,

4) Infants should be provided vitamin D supplement for prophylactic purposes,

5) Evaluations and follow-ups of the mother and the infant should be realized.

Programme on Preventing Iodine Deficiency and Iodising of Salt

The risk groups in which the most damaging effects of iodine deficiency observed are the women in reproductive age group, pregnants, infants and children. Growth and developmental delay, the lower intelligence level (iq) of at least 13,5 points when compared to their counterparts, learning skill and decrease in performance at school for infants and children, increase in abortion and the risk of stillbirth for pregnants and goitre in every age group are some of the important problems originating from iodine deficiency.

In order to prevent iodine deficiency which is an important public health problem also in our country, our Ministry in cooperation with UNICEF conducts

"**Programme on Preventing Iodine Deficiency and Iodising of Salt"** since 1994. According to TNSA, the rate of using iodized salt was determined as 85.4% in 2008.

Programme on Encouraging Breast Milk and Baby-Friendly Healthcare Organisations

Breast-feeding is quite a widespread practice in Turkey. According to 2008-TNSA, 97% of all the children were breast fed for a while. The information on breast-feeding starting time demonstrates that starting time to breast-feeding is quite late in our country. Only 39% of the breast-fed children started to be breast-fed within the first hour after birth.

According to the programme which the World Health Organization suggested "Having all newborn babies started breast fed immediately after birth and for the first 6 months, continuing breast feeding together with appropriate and sufficient nutritional supplements after 6 months till the age of 2" is the key message. The programme started with the concept of "Baby-Friendly Hospitals" and it made progress as "Baby-Friendly Healthcare Organisations" today. The term "Baby-Friendly Province" has been developed. Until today, 77 of our provinces has been awarded with a plaque through being given the title of "Baby-Friendly Province" (December 2009).

Neonatal Intensive care Programme

When only being looked at the rate of mother infant mortality which is a basic indicator, the infant mortality rate which was projected above 250 per thousand in 1920s' has been realized as 17 per thousand as of 2008. The neonatal deaths make up most of these deaths with a rate of 13 per thousand. The perinatal mortality rate was determined as 19 per thousand.

While the studies of planning and infrastructure on neonatal intensivecare are being carried out by the General Directorate of Treatment Services, training courses for the personnel in the chief office are controlled by us.

Neonatal Scanning Programme

Approximately 1.300.000 babies per year is expected to be born in our country and 17 per thousand of these babies die before the age of 1. As a result of the studies which are going on in various programmes in our country, the infant deaths are decreasing within years. However, other problems become prominent which threaten child health. Neonatal scanning programme is one of the preventive healthcare services within this scope. While the neonatal rate which phenylketonuria scanning made in 2002 was 59.2%, this rate reached to 70.3%, 81.3% and 85.6% in 2003, 2004 and 2005 respectively. This rate rose to 86.3% in 2006.

As of 25 December 2006, including Congenital Hypothyroidism in Phenylketonuria Scanning Programme, Neonatal Scanning Programme was initiated by the Ministry of Health. Neonatal Scanning Programme is conducted in cooperation with the General Directorate of Maternal and Infant Health at the Ministry of Health and Presidency of Refik Saydam Health Centre. Biotinidase Deficiency was added to scanning panel in October 2009. While the rate of bloodletting in 2006 was 86,3%, this rate in the following years was determined as 88% for 2007, 95.1% for 2008 and 95.3% for 2009 respectively.

Neonatal Auditory Scanning Programme

This programme was designed “to determine the hearing loss of the children having born with hearing loss or emerging of hearing loss after birth without affecting his/her speaking progress and to raise awareness of the healthcare personnel and the society about the importance of this issue.”
The establishment of Primary Step Neonatal Auditory Scanning in 133 institutions and Secondary Neonatal Auditory Scanning in 82 institutions affiliated to the Ministry of Health were completed and hearing scanning was started. There are 12 Third Step training centres (227 centres in total).

Diearrhea which is a frequent disease in childhood

While mortality due to diearrhea takes place on the top in Turkey, it went into a decline. The child mortality rate below the age of 5 depends on diearrhea.
There are training courses for the families about the prevention of diearrhea and treatment rules which can be practised at home.
Training and logistic support studies are made for increasing both the number and the functioning of Diearrhea Treatment and Training Centres.
In order to prevent mortality due to diearrhea which is one of the main reasons of child mortality in our country, “Programme of Controlling Diarrheal Disease” is being carried out since 1986.
This programme focuses on training of the healthcare personnel, and of people about prevention of diearrhea and fluid treatment in diearrhea and cooperation between sectors.

Family Planning Program

The preferences of women with respect to giving birth to a child are very important from the point of changing and developing the existing policies in relation with family planning. Unwanted and / or unplanned pregnancies and miscarriages carry important risk from the point of mother health.
According to the TNSA survey in 2008, 20,5 of each 100 pregnancy results in miscarriage, of which 10,5 is auto-miscarriage and 10,0 is miscarriage at will.
The total birth rate is 2,17 in Turkey. The tendency of behavior of birth in the Turkish society is decreasing.
According to the results of TNSA 2008, the ratio of using modern methods in Turkey is 46 % whereas the need for unmet family planning is 6 % which is targeted to be dropped to below 3 percent by the end of 2013.
Family planning counseling services are rendered by the trained personnel. The distribution of contraceptives is carried out in town centers and in provinces.
The Ministry of Health has established a “Maternal Mortality Data System” as a result of the lessons learned from the National Survey on Maternal Mortality. It has been stated to be implemented throughout the country as from 2007 by means of publishing two separate circulars to all providers. In addition, according to the results of researches carried out national and regional strategies have been determined. In 2009, the national mortality rate was 18,4 in 100.000.
In WHO trends in its 1990 – 2008 MM Report, this figure was published as 23 in 100.000 with respect to Turkey.

Family Physician Application in Turkey

The pilot application of family physician was first introduced in Turkey in the province of Düzce on 15 September 2005. Up to the end of 2009 52 per cent of the total population was planned to receive family medical service from this application.
Until the end of 2009 18,533.000 people (%26,2 of the total population) had received this service through some 5186 family physicians.
In 2008, 28 more provinces were included in this application.
In the 31 provinces a total of 370 Community Health Centers (CHC) have been established up to 2010.
99 per cent of the 5186 Family Physicians positions are filled with physicians on a contractual basis (%99). 52 positions are carried out by secondment.
Until the end of 2010, with the inclusion of Istanbul, all the 81 provinces will receive this service.
Currently, in order to evaluate the conclusions of the pilot applications in the Family Physicians Model, studies are being carried out in order to develop a system of follow-up and evaluation that may be utilized in the examination of short, medium and long term changes.

The Study on the Effect Evaluation of the Family Physician Application:

This study carried out in cooperation with the London Imperial College, Gazi and Hacettepe Universities and the Turkish Statistical Institute (TUIK).”

103. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

Article 11§3 - Prevention of diseases and accidents

RSC 11§3 AZERBAIJAN

The Committee concludes that the situation in Azerbaijan is not in conformity with Article 11§3 on the ground that legislation does not prohibit the sale and use of asbestos.

104. The representative of Azerbaijan provided the following written information:

> "Concerning the conclusion of the European Committee of Social Rights that the situation in Azerbaijan is not in conformity with Article 11§3 of the Revised Charter on the grounds that legislation does not prohibit the sale and use of asbestos, we would like to note that in 16th of August 2010 Cabinet of Ministers of the Republic of Azerbaijan ordered the relevant government institutions to elaborate proposals for changes in the national legislation regarding the prohibition of sale and use of asbestos."

105. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§3 BELGIUM

The Committee concludes that the situation in Belgium is not in conformity with Article 11§3 of the Revised Charter on the ground that that it had not been established that the right to protection of health is effectively guaranteed in all communities.

106. The representative of Belgium provided the following written information:

> "Belgium took note of the missing information; they will be provided in the next report."

107. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§3 BULGARIA

The Committee concludes that the situation is not in conformity with Article 11§3 on the grounds that it has not been established that adequate measures have been taken in controlling asbestos use and reducing domestic accidents.

108. The representative of Bulgaria provided the following written information:

> "**Asbestos**
> The potential risk of specific health impairments connected with the exposure to asbestos dust when working is a long-term labour and medical problem in Bulgaria that affects more then 25 000 persons that have worked in the production or usage (construction, repair, removal) of asbestos products during the second half of last century as well as the workers nowadays who secure or remove asbestos materials put inside of buildings, structures, plants, installations, etc.
> For prevention of the problem are taken systematic legislative and control measures on national level aimed at limiting the production and use of asbestos and reduction of professional exploitation of asbestos fibers. In 1993 Ordinance 12 of the minister of health for the order and manner of import of asbestos and materials containing asbestos on the territory of Republic of Bulgaria was adopted.
> In the period 1990-2000 the use of asbestos material in Bulgaria is limited from 40 000 tons to 5 000 tons a year and from 01.01.2005 the sale and use of these products was forbidden.
> For the period after 1st of January 2003 the national legislation for protection from occupational health risk when working with asbestos was actualized twice (in 2003 and in 2006).
> A full compliance of the current national legislation and practice with the legislation and practice of the European Union in the field of protection of the persons working in exposure of asbestos on the working place is ensured.
> Directive 91/382 of the Council from June 1991 for amendment of Directive 83/477 for protection of workers from risks connected with exposure to the effect of asbestos at work (second special directive in the sense of art. 8 of Directive 80/477) was introduced into the national legislation with Ordinance 1 from 2003 for protection of workers from risks connected to the exposure to asbestos at work, issued by the Minister of labour and social policy and the Minister of Health.

Directive 2003/18/EC of the European parliament and the Council from 2003 for the amendment of Directive 83/477 of the Council on the protection of workers at risk connected to the exposure of asbestos at work was transposed in the national legislation with the Amendment and supplement act of the Health act (2006) and Ordinance 9 (2006) for protection of the workers at risks connected to the exposure of asbestos at risk, issued by the minister of labour and social policy (2006).
It is forbidden the use of asbestos through injection as well as activities including the use of isolation and soundproofing materials containing asbestos with low density.
Activities in which workers are exposed to asbestos fibers, connected to yielding of asbestos, production and processing of asbestos products or production and processing of products containing asbestos with the exception of activities on treatment and disposal of products obtained as a result of demolition or removal of asbestos and/or products containing asbestos but by meeting the requirements of the legislation for marketing and use of asbestos.
The activity for the demolition and/or the removal of asbestos and products containing asbestos are done by legal entities or persons that have issued permits under the Health Act.
Art.7 of the Ordinance 9 obliges the employer before start of the activity on removal or repair of constructions under the Organization of the Territory Act to undertake all necessary measures for receiving information for the buildings from the owner of buildings, by the floor owners or the person executing the owners right, thus to determine the materials for which it is assumed that contain asbestos. When there is a doubt for the presence of asbestos in a material or construction, the requirements of the Ordinance are respected.
For each activity in which a risk of exposure to asbestos dust or materials containing asbestos may occur, the risk is evaluated by determining the type of the asbestos and the level of exposure of the workers. The employer is obliged to use all technological and technical opportunities for the change of the asbestos with safe and less dangerous replacements with view ensuring better protection of the workers.
Before start of work the employer is obliged to inform the Directorate “Municipal Labour Inspection” /MLI/ and the regional inspection for protection and control of community health (RIPCH) on the territory on which the company is located, for the activities in which the workers are or may be exposed to asbestos dust of materials containing asbestos.
The employer provides to the relevant directorate MLI and RIPCH information about: the place for execution of the activity; the type and quantity of the used or treated asbestos; execution of actions and processes; the number of employed; the starting date and the duration of work; the undertaken measures for limiting the exposure of the workers to asbestos. The employer is obliged to inform anew the relevant MLI and RIPCH in each case when there is a possibility of occurrence of significant increase of exposure of asbestos dust or materials containing asbestos due to change in the working conditions.
Executive Agency “General Labour Inspection” /GLI/ annually executes control over the use of asbestos by making inspections in companies and objects for compliance of the requirements of Ordinance 9 /2006/ for protection of the workers in risks connected to the exposure to asbestos in work.
The inspections show that the question for insuring the safety when demolishing of building constructions and isolations remains open. These processes are usually accompanied by dust emission that cannot be controlled effectively with usual technical means and methods.
During the inspections it was discovered that the employers undertake some organizational and technical measures for reduction of the accident at work with asbestos or products and materials containing asbestos:

- These activities are lead by persons that have specific qualification and practical experience on the safety methods and techniques for demolition and they are performed by a specially trained and instructed staff;
- On the basis of the present executive documentation and construction projects, the place, type and quantity of building constructions and material containing asbestos that are put in during the relevant construction or installation are identified;
- A working agenda for the organization and execution for demolition works is developed that shows technological sequence, the type of means for execution (including the means used for collective protection), the organization of labour and the specific for the case activities that ensure safety at work;
- The working places on which the demolition is executed are fenced and limitation of the access to non-related in the activity persons. On the exits of the working places cleaning cabins are build and close to them – bathrooms for cleaning the body and the places for keeping the clean clothes;

- The asbestos-cement and frictional products are removed without violation of their entirety. The dust asbestos waste are cleansed with vacuum cleaner and are put in polymer bags;
- When demolishing the asbestos coatings and isolations watering is used or cleansing with a detergent (watering or injection in dependence with the thickness of the isolation) unless this is not in against the requirements for electrical safety of the relevant construction site;
- When necessary for the demolition of big quantities of asbestos isolations "on ground", the working place is isolated from the neighboring space by an improvised cabin with walls from a polymer material and in the cabin it is ensured the necessary minimum pressure for preserving the neighbouring space from asbestos contamination;
- Specific means for personal protection of the respiratory organs are used and protection clothes for the ehad and body.

Domestic accidents:
No new information received."

109. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§3 CYPRUS

The Committee concludes that the situation in Cyprus is not in conformity with Article 11§3 of the Revised Charter on the grounds that it has not been demonstrated that adequate measures have been taken to reduce water and noise pollution, that there is adequate monitoring of food stuff, that the sale and distribution of alcohol is sufficiently regulated and that adequate measures have been taken to prevent and reduce accidents.

110. The representative of Cyprus provided the following written information:

"RESPONSE BY THE WATER DEVELOPMENT DEPARTMENT (MINISTRY OF AGRICULTURE, NATURAL RESOURCES AND ENVIRONMENT)
Addressing water pollution in Cyprus - Implementation of the Water Framework Directive
The Water Framework Directive (WFD), which was adopted in 2000, laid the foundation for a modern, holistic and ambitious water policy for the European Union and defined a clear implementation calendar to achieve its objectives, with intermediate deadlines for the achievement of specific tasks, among them:

- December 2003: transposition of the WFD into national law (article 24), identification of river basin districts and set up of administrative arrangements (article 3)
- December 2004: pressure and impact analysis of river basin districts and economic analysis of water uses (article 5)
- December 2006: establishment of the monitoring programmes for the assessment of water status (article 8)
- December 2008: publication of the draft River Basin Management Plans for consultation (article 14)
- December 2009: adoption of the River Basin Management Plans including Programme of Measures (articles 11&13)
- December 2010: introduce pricing policies (article 9)
- December 2012: Programme of Measures operational at the latest (article 11)
- December 2015: achievement of good status for surface and groundwater (article 4) and first update of the River Basin Management Plans

The environmental objectives laid down in article 4 require Member States to prevent deterioration of the status of all bodies of surface water and groundwater and to protect, enhance and restore all waters with the aim of achieving good ecological status or good ecological potential and good chemical status for surface water and good groundwater status by 2015. In addition, pollution from priority substances has to progressively be reduced and emissions of hazardous substances have to cease or be phased out. Any significant and sustained upward trend in the concentration of any pollutant in groundwater generated by human activity has to be reversed by appropriate measures.
The Republic of Cyprus is progressing towards full implementation of the Water Framework Directive and is totally committed to the efficient implementation of its principles and provisions.
Cyprus has fulfilled all its obligations up to the end of 2007 and is currently proceeding with the public consultations on the draft River Basin Management Plan and Programme of Measures.
Monitoring Programmes

In accordance with article 8(1) of the WFD, Cyprus established monitoring programmes for the assessment of the status of surface water and groundwater in order to establish a coherent and comprehensive overview of water status within the river basin district. These requirements include monitoring of protected areas as far as the status of surface water or groundwater is concerned.
Monitoring plays a key role in determining whether the water bodies are in good status and what measures need to be included in the river basin management plan in order to reach good status by 2015.

Draft River Basin Management Plan / Programme of Measures

Cyprus identified all its water bodies and used the results of monitoring to assess which bodies are at risk of not reaching good status by 2015. In particular, a pressures and impacts assessment was carried out by defining the "driving forces", identifying pressures with possible impacts on water bodies and on water uses, assessing the impacts resulting from the pressures and, evaluating the likelihood of failing to meet the WFD objectives.
The actions and activities that need to be carried out to further address the pressures in Cyprus and maintain or improve the quality of the water are proposed in the draft River Basin Management Plan and Programme of Measures, which are available on the WFD dedicated section of the Water Development Department website (www.wfd.wdd.moa.gov.cy).
The Programme of Measures in Cyprus includes basic measures, which are the minimum requirements that each member state needs to comply with and supplementary measures, which are designed in addition to the basic measures with the aim of achieving the WFD objectives.
Furthermore one of the key elements of the WFD is that it integrates the requirements of other key existing EU Directives for the protection of water as minimum basic measures.
Cyprus has included in the basic measures the following directives, which are already in good status of implementation:

- *The Nitrates Directive (91/676/EEC)*
- *The Integrated Pollution Prevention Control Directive (96/61/EC)*
- *The Drinking Water Directive (80/778/EEC) as amended by Directive (98/83/EC)*
- *The Urban Waste-water Treatment Directive (91/271/EEC)*
- *The Bathing Water Directive (76/160/EEC)*
- *The Birds Directive (79/409/EEC)*
- *The Major Accidents (Seveso) Directive (96/82/EC)*
- *The Environmental Impact Assessment Directive (85/337/EEC)*
- *The Sewage Sludge Directive (86/278/EEC)*
- *The Plant Protection Products Directive (91/414/EEC)*
- *The Habitats Directive (92/43/EEC)*
- *The Groundwater Directive (2006/118/EC)*
- *The Floods Directive (2007/60/EC)*

In conclusion, the WFD provides all the tools needed to achieve truly sustainable water management in the EU and Cyprus is making every effort to implement these tools in the best possible way and in accordance with the tight deadlines.

RESPONSE BY THE ENVIRONMENT SERVICE (MINISTRY OF AGRICULTURE, NATIONAL RESOURCES AND ENVIRONMENT)

Water Pollution Control

Cyprus has fully harmonized with the Directives related to the protection of water (Drinking Water Directive, Water Framework Directive, Ground Water Directive, Bathing Water Directive, Priority Substances Directive, Urban Waste Water Treatment Directive, Nitrates Directive, Integrated Prevention and Pollution Control Directive, etc) and is in good status regarding their implementation.
Regarding the Water Framework Directive (2000/60/EC), Cyprus is at the final stage of the implementation of Article 11 and supplementary measures are proposed with the aim of achieving good chemical and ecological status for surface and underground water bodies. The measures are expected to be in effect in 2012.
In relation to the protection of drinking waters, supplies the above mentioned measures include the establishment of protection zones for surface water sources and the completion of the task regarding the establishment of Protection Zones for drinking water boreholes, according to Act 45/1996.
As far as the protection of health of bathers, the provisions of Directive 2006/7/EC regarding monitoring of bathing waters has been implemented. Monitoring of the quality of bathing waters continues with the objective of protecting public health and the environment. For 2009 bathing season, the results from the monitoring of the water quality of bathing areas indicated the excellent quality of Cyprus bathing waters.
In addition, issues regarding the monitoring and control of water pollution are regulated under the

"Laws on the Control of Water Pollution of 2002 to 2009" and the "Laws on Integrated Prevention and Pollution Control of 2003 to 2008". Competent authority for the implementation of the above Laws is the Department of Environment of the Ministry of Agriculture, Natural Resources and Environment.

The Department of Environment has the responsibility for the control, reduction and prevention of water and soil pollution arising from the operation of industrial activities, animal husbandry activities, waste treatment plants and generally from any activity which may potentially pollute the waters and soil.

Under this scope, the above mentioned installations are required to operate under consent conditions specified in Waste Discharge Permits issued by the Minister of Agriculture, Natural Resources and Environment. The Permits impose conditions on the quantity and characteristics of wastes and method of waste disposal depending on the type of operation.

Furthermore, the Department of Environment carries-out inspections to these installations and, in case of non compliance, the operator of the facility is subject to penalties specified in Water Pollution Control Laws. Specifically, there is a provision for up to three years imprisonment or a fine up to 34172 Euro, or both, for every operator of a facility that fails to comply with any of the conditions set in Water Discharge Permits.

Environmental Noise

The Law on the Assessment and Management of Environmental Noise (No. 224(I)/2004) has been in force since 2004. The Law addresses the environmental noise to which people are exposed, particularly in densely built-up areas, public parks, or quiet residential areas, quiet countryside areas, as well as near schools, hospitals and other buildings and areas sensitive to noise.

The Department of the Environment, has completed the preparation of Strategic Noise Maps for the major road arteries of urban centres, with more than 6 million movements per year. The Strategic Noise Maps cover a large percentage of the cities of Nicosia, Limassol, Larnaca and Paphos. These maps provide a comprehensive picture of the noise levels in the areas surrounding the basic road network of towns, while special reference is made to sensitive areas, such as schools, hospitals and churches. The percentages of the population exposed to traffic noise are given in real numbers for the whole 24 hour period.

Following the completion of these maps, the Department of the Environment, in cooperation with the Public Works Department and other competent departments and bodies, has prepared measures for the mitigation of transport noise for the mapped areas, giving additional weight to the management of transport noise around the major road arteries of more than 6 million vehicle movements per year.

With the objective of combating transport noise through vehicle management, the Department of the Environment has suggested measures for traffic management, including prohibitions on the movement of heavy vehicles during the night period and through a pilot reduction in speed limits for 2 major road arteries. Additionally, noise barriers have been placed in several major roads during 2009, in order to minimize noise levels audible in neighbouring residential areas.

The second mapping stage is planned to be completed according to the requirement of the Directive, covering residential areas of more than 100,000 residents and road arteries with more than 3 million vehicle movements per year.

Noise Emissions by Outdoor Equipment

The Regulations on Noise Emissions in the Environment by Equipment for Use Outdoors (No. 535/2003) have been in force since 2004. Their main requirements are the measurement of the noise level than emanates from the equipment and the labelling of the equipment indicating the "guaranteed sound power level". The responsibility for compliance lies on the manufacturer or the authorised representative. Inspections are carried out in installations which handle equipment covered by the Regulations. At the same time, data are continually updated in the register created recently, to serve as a database for outdoor equipment exporters.

RESPONSE BY THE PUBLIC HEALTH SERVICES (MINISTRY OF HEALTH)

Public Health Services (PHS) of the Ministry of Health is the main competent authority responsible for official controls on general food hygiene, GMOs and pesticide residues in foodstuffs, and import controls of food of plant origin and non animal origin. PHS supervises the activities of the 5 Districts, and, for general food hygiene, of the 8 autonomous municipalities. PHS is also responsible for controls on food of animal origin in relation to honey and ice-cream.

In the Budget, there are 91 permanent posts of Public Health Inspectors.

PHS at central level has three different divisions: the Food Safety Division (responsible for the registration and control of food premises), the Food Safety and EU Division (responsible for transposition of EU legislation and for food control and implementation of legislation) and the Environmental Health Division.

The official controls are organised by PHS at central level and implemented at regional and local level. The PHS also issues operational instructions for the implementation of the Community and national legislation including the harmonised national Regulations. Seminars and workshops were also organised both for Health Inspectors of the Ministry of Health and the Municipalities.
The sampling plans are prepared by both the PHS and the SGL, based on risks associated with specific foods, consumption frequency, results from previous years, and RASFF information and the relevant legislation and Commission Recommendations, if any. These programmes are implemented by both the districts and the municipalities on an annual basis.
As far as the official control of foodstuffs is concerned, a manual was prepared by the PHS which includes a risk categorisation of food businesses and the frequency of the official controls to be performed in each food business.
A number of guides to good hygiene practice were developed, approved by the Minister of Health and disseminated to the relevant food businesses.
The Head of the PHS is the National Contact Point (NCP) for RASFF. Since May 2004 all information is received from the Commission and is handled accordingly. The NCP does the preliminary assessment and the notifications are forwarded accordingly to districts and municipalities, to Veterinary Services and, for feedstuffs, to Department of Agriculture of the Ministry of Agriculture, Natural Resources and Environment.
When unsafe foodstuffs are found at regional or local level, the information is notified to the Health Inspector in charge of the District who in turn notifies the NCP. The NCP notifies any other authorities concerned, and makes a risk assessment as to whether the information constitutes an alert notification to be sent to the EC. The information is communicated mainly by e-mail, fax or telephone.
The Central Competent Authority for import controls of food of plant origin is PHS. All Public Health Officers are involved in the implementation of controls regarding the imports of food of plant origin.
The responsibility for the planning and organisation of controls on imports of food of plant origin belongs to the central level of the PHS and therefore instructions, guidelines and other information are issued for that purpose and distributed to the districts and to the Municipalities. Reporting of all activities carried out by Public Health Inspectors is also forwarded from the districts to the headquarters on a monthly and annual basis.
Close cooperation exists between the two departments (Customs and PHS) either at the nominated entry points (Larnaka Airport and Limassol Port) or at importers warehouses.
The PHS is the competent authority for transposition of Community legislation regarding foodstuffs of non animal origin and of plant origin.
The Public Health Services implement several programmes which are related to environmental hygiene, control of communicable diseases, control of vectors of medical importance, health education etc.
The Public Health Services have the following main responsibilities in relation to environmental health:
a. Monitoring of drinking water for verification of compliance with the provisions of the Regulations which are harmonised with the EC Directives,
b. Monitoring of sea water especially for bathing areas is carried out in accordance with the relevant EC Directives,
c. Control of swimming pools particularly of the quality of water,
d. Investigation of communicable diseases,
e. Control of the detergents,
f. Implementation of the legislation in relation to tobacco control (The Protection of Health (Control of Smoking) Law and Regulations).

The work of the Public Health Officers is organised based on the relevant community and national legislation. Therefore, a number of guidelines were developed for giving guidance on how the official controls are carried out.

On the other hand, multiannual national control plans were developed as required by the Regulation (EC) 882/2004 for the years 2007-2010. These plans have already sent to the European Commission and are implemented by the Public Health Services.

RESPONSE BY THE VETERINARY SERVICES (MINISTRY OF AGRICULTURE, NATURAL RESOURCES AND ENVIRONMENT)
Monitoring of food products

The Veterinary Services(VS) have the overall responsibility for the organization and the co-ordination of controls for the production, handling, transport, storage and distribution of food of animal origin up to wholesale level. In the case of meat, the controls extent to retail level.
VS is the responsible authority for the controls, inspections and approvals of the establishments that produced food of animal origin (including butcheries), with the exception of the ice-cream and the honey, where the competence belongs in the Ministry of Health. Furthermore an important role of VS is to ensure public health through the production of safe food.
Equally vital is the role of VS in coordinating trade between Member States (Intra Community Trade) and third countries.
Analytically VS have the responsibility of:

- ✓ Organization and coordination of production, handling, transport, storage and distribution in the market up to the final consumer the red and white meats, mincemeat, wild and farm game products, snails, frog-legs, fishery products, milk and dairy products, meat products, meat preparations, edible by products and egg products.
- ✓ Preparation and update of the annual programs of inspections and samplings of establishments of food of animal origin in order to verify the compliance with the relevant food safety criteria.
- ✓ Preparation and implementation of National Control Program for Residues and Pharmaceutical Substances in live animals and their products(heavy metals, PCBs, antibiotics)
- ✓ Granting the establishments with conditional and final approvals in accordance the regulation 853/2004. The approval of establishments of food of animal origin is granted by evaluating and approving their HACCP manuals that are submitted and their application and by performing on-spot inspection in the establishments in order to verify that they produce safe food.
- ✓ Preparation and submission on the web site of Veterinary Services of the list of approved establishments of food of animal origin.
- ✓ Organization of educational seminars regarding food of animal origin. The VS organize seminars and educational meetings concerning food safety issues for educating both the employees of Veterinary Services and the Food Business Operators.
- ✓ Public information by interviews at media for informing both consumers and Food Business Operators on food safety issues.
- ✓ Management on daily base of all information regarding Rabid Alert System for Food and Feed (RASFF) for unsafe food.
- ✓ Preparation of all preliminary drafts of laws and regulations which are related with the approval and control of establishments of food of animal origin, as well as to the controls of establishments that produce, process, store and distribute food of animal origin up to the retail sale.

Additionally, when a food incident arises VS take all the necessary measures to safeguard public health (recall of product, announcement in media).

RESPONSE BY THE DEPARTMENT OF CUSTOMS AND EXCISE (MINISTRY OF FINANCE)
Alcohol

Excise goods are moved between authorized economic operators within the territory of the European Union under duty suspension arrangements (without the payment of excise duty).

These movements always take place between an authorised consignor and an authorised consignee.

Consequently, an authorized warehouse keeper can move excise goods under duty suspension from his tax warehouse under the cover of the AAD or e-AD:

- to another tax warehouse in another MS;
- to a registered consignee " ;
- to a temporary registered consignee;
- to exempted Organizations;
- to an assigned and an approved place of direct delivery at the Member State of destination;
- for export.

All the above parties e.g. the tax warehouse, the warehouse keeper, the registered consignor, the registered consignee, and the temporary registered consignee, must be registered in the System of Exchange of Excise Data (SEED file) database by their respective Member State Administration so as to be able to take part in this type of transaction within the member states. The Department of Customs & Excise keeps such a register.

Cap 144< the Sale of Intoxicating Liquors Law> regulates the sale of duty paid alcoholic beverages. Any sale of such products is prohibited, unless the seller has a license for this purpose and for the particular premises. The authorities issuing such permits are the various Municipalities or

the District Administrations, depending on where the premises for selling such products are situated. The license is validated annually.

The various competent authorities assist the Department of Customs and Excise and the Police in enforcing the Law by regularly informing about the permits that have been granted and by giving any information needed when there is a relevant ongoing investigation or campaign.>

RESPONSE BY ROAD SAFETY UNIT (MINISTRY OF COMMUNICATIONS AND WORKS)

Road accidents

Road accident fatalities and injuries in Cyprus have been recording significant downward trends, since 2005. (see Table 1)

Table 1

Injuries				
Year	Fatal	Serious	Slight	Total
2004	117	960	2216	3293
2005	102	741	1555	2398
2006	86	730	1859	2675
2007	89	717	1438	2244
2008	82	661	1292	2024
2009	71	647	1076	1794

A Strategic Road Safety Plan for the period 2005-2010 is being implemented with a target for a 50% reduction in the number of road victims by year 2010. The basis for comparison is the average of the five year period 1999-2003, before the implementation of the Plan.

By the end of 2009 a reduction of 31,1% in fatalities was achieved, instead of the 41,7% reduction which was the target for that year. The targeted reduction in injuries, however, was achieved, as it reached 51,5%.

A new Strategic Road Safety Plan for the period 2011-2015 will be drafted in the coming months and a new target will be set for year 2015.

A number of road safety public awareness campaigns are organized every year, on the main road safety issues, which are speeding, drink and drive, seat belts and safety helmets, but also on other specific topics, such as mobile phones, pedestrian safety and motorcyclists safety. A total of 8-9 campaigns are run every year, 3 of which are organized in cooperation with private entities. The awareness campaigns are coupled with parallel enforcement campaigns.

The messages are sent to the public mainly through TV and radio spots, the internet, leaflets, posters, discussions on the media and lectures to organized groups. The year 2010 has been declared by the President of the Republic of Cyprus as Road Safety Year for the young road users and road safety awareness activities have multiplied.

RESPONSE BY THE MINISTRY OF HEALTH

Childhood Injuries

Child health and safety are considered a priority for the government and the Ministry of Health of Cyprus since 2002. This commitment has been demonstrated by:

o The establishment of an Advisory Committee to the Minister of Health for the Prevention of Childhood Injuries, in 2002.

o The adoption by the Ministerial Council in September 2005 of a 5 year Strategic Plan for the prevention of unintentional childhood injuries (2006-2010), a Plan that was developed by the Advisory Committee.

o The allocation of human and financial resources specifically for unintentional Childhood Injuries at the level of the Ministry of Health".

111. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§3 GEORGIA

The Committee concludes that the situation in Georgia is not in conformity with Article 11§3 on the grounds that it has not been demonstrated that adequate measures have been adopted in the field of environmental health, on tobacco consumption, alcohol use, drug abuse, food safety or to prevent accidents.

112. The representative of Georgia provided the following written information:

"*Policies of the prevention of avoidable risks*

Measures to combat smoking, alcoholism and drug addiction

At the beginning of 2009 Georgian Parliament adopted changes in law concerning tobacco control in Georgia. By the new law smoking were completely banned in medical, educational and sportive facilities and public transport, partly restricted in other public and work places, size of health warnings were increased to 30%, prohibited "lights", decreased levels of nicotine, tar and CO and promoted methods of testing, restricted sales, established principles of tobacco control according to FCTC. Established "Outline" - free of charge phone consultation of smokers to help then in cessation. Started project to improve situation in medical facilities and secondary schools towards main problem of smoking bans – enforcement the law requirements. In 2010 Ministry of Health elaborated and in near future will present amendment in Administrative Code of Georgia. Those changes are crucial to improve implementation of above-mentioned requirements of law concerning tobacco control and FCTC.

Prophilactic measures

Certain infectious and parasitic diseases, incidence rate per 100000 population by the regions, Georgia, 2007-2008

	2007				2008			
	All ages		In children		All ages		In children	
	Number of cases	Incidence rate	Number of cases	Incidence rate	Number of cases	Incidence rate	Number of cases	Incidence rate
Georgia	50829	1158,3	25121	3274,4	47124	1075,0	25120	3339,5

Source: Statistical yearbook Georgia, 2008. /www.ncdc.ge/

HIV/AIDS morbidity rates, Georgia, 2000-2008

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total number of cases registered by the end of the year	**153**	**232**	**314**	**387**	**508**	**671**	**912**	**1179**	**1851**
Prevalence rate	*3.4*	*5.3*	*7.2*	*8.9*	*11.6*	*15.3*	*20.7*	*26.9*	*42.2*
Including new cases	**79**	**93**	**93**	**94**	**163**	**242**	**276**	**344**	**351**
Incidence rate	*1.8*	*2.1*	*2.1*	*2.2*	*3.7*	*5.5*	*6.3*	*7.8*	*8.0*

Source: Statistical yearbook Georgia, 2008. /www.ncdc.ge/

Timely vaccination and immunization, Georgia, 2008

Vaccine	Vaccination age according to the National vaccination calendar	Total number of vaccinations	Vaccination coverage(%)
BCG - 1 (timely)**	0-5 days	50199	89,6
BCG - 1	Under 1 years	53195	95,4
DPT - 1	2 months – 11 months 29 days	46648	--
DPT - 2	3 months – 11 months 29 days	44681	--
DPT - 3	4 months – 11 months 29 days	42881	92,1
DPT - 4	18 - 24 months	38199	84,0
Polio - 1	2 months – 11 months 29 days	42399	--
Polio - 2	3 months – 11 months 29 days	41468	--
Polio - 3	4 months – 11 months 29 days	41840	89,9
Polio - 4	18 - 24 months	35289	77,6
Polio - 5	5 years - 5 years - 11 months 29 days	32760	75,0

Hp B - 1 (timely)**	0 - 24 hours	52658	94,0
Hp B - 1 (total)	0 - 24 hours +25 hours - 11 months 29 days	54909	98,5
Hp B - 2	2 months – 11 months 29 days	44763	--
Hp B - 3	3 months – 11 months 29 days	41619	89,4
MMR - 1	12 - 24 months	44133	96,5
MMR - 2	5 years - 5 years 11 months 29 days	38006	87,0
MMR	13 years	1531	15,4
DT	5 years - 5 years 11 months 29 days	36931	84,5
TD	14 years	37792	66,5

Source: Statistical yearbook Georgia, 2008. /www.ncdc.ge/"

113. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§3 IRELAND

The Committee concludes that the situation is not in conformity with Article 11§3 on the grounds that:

– it has not been demonstrated that that adequate measures are in place to prevent the risks arising from asbestos;
– it has not been demonstrated that adequate measures are in place to prevent and reduce accidents.

First ground of non-conformity

114. The representative of Ireland described in detail the regulations on asbestos in Ireland. It is prohibited to buy use or re-use asbestos products in Ireland. Any building owner who is renovating or demolishing a building is required by law to identify any particular risks, such as asbestos or asbestos-containing materials at the design stage. If asbestos-containing materials are identified in a building a risk assessment evaluation must be carried out and should only be performed by a person competent to make such an assessment and ensuing recommendation(s).

115. Based on the risk assessment, the owner must make every effort to remove these materials or to make sure they do not pose a threat to the health of his workers or others who may be affected. Asbestos must be removed before a building is demolished to prevent the risk of the fibres spreading and contaminating the surrounding areas and those who may be in the vicinity.

116. If it is decided to repair and maintain the asbestos-containing material rather than remove then it must be maintained in a safe way. For this reason, any asbestos that remains in the premises should be labelled clearly for asbestos and also its location should be clearly marked on the plans of the building so that if in the future, maintenance or refurbishment work is performed or the building is sold onwards or goes for demolition, those involved will know that there are asbestos-containing materials present and so will be able to plan their work accordingly and avoid potential situations that could cause exposure to fibres.

117. The Health and Safety Authority (HSA) has legal powers under the European Communities (Protection of Workers) (Exposure to Asbestos) Regulations, 1989 (as amended) to ensure the protection of workers from the risks related to exposure to asbestos at work. The Authority is responsible for policing anyone engaged in work with asbestos, including professional asbestos removal, and surveying firms so as to ensure that the worker protection legislation is implemented.

118. The Office of Public Works is responsible for monitoring asbestos in all government buildings, including schools. At the moment, it is attempting to identify all asbestos in the

nation's schools. Based on risk assessment and the results of surveys done by asbestos professionals, it is making decisions on how and when the asbestos needs to be removed.

119. The Committee took note of the information and invited the government of Ireland to provide all relevant information in the next report. Meanwhile, it decided to await the next assessment of the European Committee of Social Rights on Article 11§3 of the Revised Charter.

Second ground of non-conformity

120. The representative of Ireland provided the following written information:

> "**1. Material from the Department of Health and Children - Safety and Older People**
> In relation to preventing injury to older people in the home, the Health Service Executive (HSE), through its Home Care Packages and Public Health Nurses, provides advice and support to older people to ensure a safe and independent living environment. This support can be provided through practical safety enhancements in the home, e.g., a hand rail in the shower etc., to the identification and resolution of safety issues e.g., overloaded electric plugs etc., advice. The non-statutory sector also provides support to older people through community supports, home visits, meals service etc.
> The Report of "The 2004 Healthy Ageing Conference – Safety and Older People" is available attached herewith:
> The Health Service Executive, Department of Health and Children and National Council on Ageing and Older people have jointly prepared a strategy to "Prevent Falls and Fractures in Ireland's Ageing Population".
> Falls in Older people can have life changing consequences, and older people are most likely to suffer serious injuries, disability, psychological consequences and death following a fall. The risk of falling increases with age - one in three older people fall every year and two-thirds of them fall again within six months. As our population ages the number of falls and injuries in this age group will increase.
> Today Ireland has 480,000 people over the age of 65, which will increase to one million in 25 years time. By that time, there could be a doubling in the number of falls and fractures that occur if today's rates do not improve.
> Falls and fractures in older people can be prevented and the strategy being published today outlines a range of measures that should assist older people to avoid falls, and to protect them from the more serious consequences of a fall or fracture.
> Since 2008, the "Falls Prevention Strategy" has been put in place.[1]
> The national health and lifestyle survey – SLAN 07 – looked at accidental injuries and reported on the incidence, location and prevalence of injuries.[2]
> **Briefing Note on Cardiovascular Disease, Diabetes, Chronic Disease management & Obesity**
> **Cardiovascular Health**
> The Government has committed over €60 million since 2000 towards the implementation of the Cardiovascular Health Strategy, 'Building Healthier Hearts'. This funding has supported a wide range of new services and initiatives. These have had a positive impact on the diagnosis and treatment of patients with heart disease.
> An audit of progress on the implementation of 'Building Healthier Hearts', was published in September 2007. The report, "Ireland: Take Heart", shows a continuing decline in cardiovascular disease, despite a rise in obesity and low levels of physical activity. The report also identifies where services fall short of what was recommended in 'Building Healthier Hearts'.
> Following on from the audit the Cardiovascular Health Policy Group was established in September 2007 to set out broad guidelines for development of policy on cardiovascular health, including stroke. The report of the Policy Group Changing Cardiovascular Health: Cardiovascular Health Policy 2010-2019 has recently been approved by the Government and will be published shortly. The policy report addresses the spectrum of cardiovascular disease, including prevention and management, and how these should be integrated to reduce the burden of these conditions.

[1] This document may be accessed at the following website:
http://www.hse.ie/eng/services/Publications/services/Older/Strategy_to_Prevent_Falls_and_Fractures_in_Ireland's_Ageing_Population.html
[2] The web address for the report is: http://www.dohc.ie/publications/slan_injury_report.html

Diabetes

The Department of Health and Children published a policy document "Diabetes: Prevention and Model for Patient Care" in 2006. Following that, an Expert Advisory Group on Diabetes was established to draw up standards of care for Diabetes. It published its report in November 2008. The Group's work represents the blueprint for the development of first class services for people with diabetes. It is practical and patient focused with a strong emphasis on prevention, service integration and community based management, supported by specialist services.

Management of Chronic Diseases

The general management of chronic diseases has been set out in the Department of Health and Children policy framework which was published in 2008. This describes an approach centred on disease management programmes to treat and delay the onset of complications and reduce emergency hospital admissions. It addresses the management of chronic diseases at different levels through a reorientation towards primary care and the provision of integrated health services that are focused on prevention and returning individuals to health and a better quality of life.

Obesity

In May 2005 the Report of the National Taskforce on Obesity – *'Obesity the Policy Challenges'* was published. The report aimed to provide the policy framework for addressing the high prevalence and rising levels of overweight and obesity, in particular childhood obesity, in Ireland. An Inter-sectoral Group on Obesity, comprising relevant Government Departments and key stakeholders was established early in 2009 to oversee and monitor implementation of the Taskforce recommendations. The Group published a report in April 2009, detailing progress on each of the recommendations. The examination by the Group has show that significant progress has been made in the case of 32% of the recommendations; action is progressing on a further 59%; while no progress is reported on just 9% of the recommendations.

The work of the Inter-sectoral Group on Obesity is currently being examined in the context of a wider review of policy in relation to lifestyle-related illnesses to which obesity is a major contributory factor.

Briefing Note on Alcohol Policy

1. Alcohol Consumption in Ireland

A comparison of consumption rates in 2006 in a number of OECD countries revealed that Ireland had the highest per adult consumption at 13.4 litres of pure alcohol. Consumption fell in 2008 by 7.6% to 12.4 litres. The provisional figure for 2009 is 11.3 litres. It is possible that some of the decrease observed in 2008 and 2009 may be explained by people travelling to Northern Ireland to buy alcohol there. It is also likely that the current recession which began in 2008 accounts for the decrease in per capita consumption. The reduction in off-sale hours provided for in the Intoxicating Liquor Act 2008 may also have contributed to this fall in consumption.

2. Code for the Sale and Display of Alcohol in Mixed-Trading Premises

A new Code has been agreed between the Minister for Justice, Equality and Law Reform and the main supermarkets and convenience stores on the sale and display of alcohol. Alcohol must be displayed in one area of the store, away from the entrance. Controls are also in place on advertising. An independent company has been established to oversee the implementation of the Code and general compliance with the code is being observed.

3. National Substance Misuse Strategy

On 31st March, 2009 the Government agreed to include alcohol in a National Substance Misuse Strategy that would be coordinated jointly by the Department of Community, Rural and Gaeltacht Affairs and the Department of Health and Children. A Steering Group has been established to develop the alcohol element of the National Substance Misuse Strategy. It will base its recommendations on effective evidence based measures to deal with the significant public health issue of alcohol in areas such as supply, pricing, prevention, treatment, awareness and education. The Steering Group is currently meeting on a monthly basis and it is expected that its Report will be submitted to Government by the end of this year.

Briefing Note on Tobacco Control

Background

1. Tobacco use is the leading cause of preventable death in Ireland. Each year over 6,500 people die prematurely from the effects of tobacco and thousands of others become ill because of tobacco-related diseases. In November 1999, the Oireachtas Joint Committee on Health and Children published ***"A National Anti-Smoking Strategy - A Report on Health and Smoking"*** which recommended that a national anti-tobacco strategy be adopted.

2. In response, the Tobacco Free Policy Review Group was set up to carry out a fundamental review of health and tobacco and to make recommendations to the Minister for Health and Children. Their report ***"Towards a Tobacco Free Society"*** was published in 2000 and was adopted as Government policy.

3. The Public Health (Tobacco) Acts 2002 and 2004 provided for a number of significant tobacco control measures, including the establishment of the Office of Tobacco Control and the ***Smoke Free at Work*** initiative.

4. Implementation of further provisions of the Public Health (Tobacco) Acts 2002 and 2004 was delayed due to a legal challenge to key provisions of the Acts by PJ Carroll & Others. However, in 2007 the plaintiffs discontinued their legal challenge and further provisions are to be commenced from 1/7/2009. The announcement of these changes was made on 1 July 2008 to give retailers a 12 month lead-in-time.

New Measures introduced 1 July 2009

5. The key provisions of the Public Health (Tobacco) Acts 2002 and 2004 commenced with effect from 1 July 2009 include:

- Ban on in-store advertisingof tobacco products
- Ban on display of tobacco products
- Requirement for all tobacco products to be out of view and stored within a closed container only accessible by the retailer
- Prohibition on self-service vending machines **except** in licensed premises or registered clubs.
- Requirement for all retailers of tobacco products to register with the Office of Tobacco Control.

The aim of these provisions is to further de-normalise tobacco and to protect children from the dangers of tobacco consumption. Research shows that tobacco advertising at the point of sale is a key factor in a young person starting and continuing to smoke. If young people can be prevented from purchasing tobacco products there is less chance they will become addicted and suffer a smoking related illness. Restricting advertising will also support adults who are trying to quit.

Price has also been identified as an effective tobacco control measure, particularly in preventing young people's initiation and subsequent addiction to tobacco. From May 2007, the sale of cigarettes in packs of less than 20 and sale of confectioneries that resemble cigarettes was banned.

2. Road Safety Information. Material compiled by the Road Safety Authority (RSA) and the National Roads Authority (NRA)[1]

Our strategy- Summary

Find out how we plan to reduce roads deaths and injuries, by our four central pillars: Education, Enforcement, Engineering and Evaluation

Better road safety is achieved by bringing about **a cultural change in driver behaviour** and ensuring that the factors that underpin road safety, such as vehicle and driver standards, are rigorously monitored and enforced.

Our strategy is to **deliver major improvements in road safety** by effectively mobilising our internal resources and working with external stakeholders.

The national Road Safety Strategy (2007-2012) aims to reduce collisions, deaths and injuries on Irish roads by 30%. This should bring Ireland in line with countries that are considered to have **the safest roads in the world** – countries such as the Netherlands, Sweden and the UK.

The 4 pillars of road safety

Education

- Targeted safety campaigns in schools
- Safety campaigns within wider society
- Training scheme for vocational drivers

Enforcement

- Driver testing and licensing
- Road haulage industry
- Testing regimes for motor vehicles

Engineering

- Contribute to EU rules on vehicle standards
- Assist National Roads Authority with road design

Evaluation

- Road safety research
- Measuring effectiveness of road safety initiatives

Ireland's third Road Safety Strategy seeks to build on the progress and understanding provided by the first two strategies (1998-2002 and 2004-2006), with the objective of radically - and sustainably - improving safety on Irish roads. It draws on the insight and experience of countries implementing

[1] Summary of Material taken from the RSA document Road Safety Strategy 2007-2012, available at website http://www.rsa.ie/Documents/Road%20Safety/RSA_Strategy_ENG_s.pdf

best practice in road safety, among
them The Netherlands, Sweden, United Kingdom, Norway and France. New Zealand, the states of Victoria and Queensland in Australia, and a number of states in the USA also provided valuable input.

Public Consultation Process

A public consultation process was conducted to inform this Road Safety Strategy. An invitation for submissions was issued through national and local media in late 2006. Approximately 500 valuable submissions were received from members of the public, the media, corporate agencies and other sources. The consultation process showed overwhelming support for continued actions to reduce the number of deaths and serious injuries from road collisions. Consultation and communication will continue throughout the implementation and evaluation of this Road Safety Strategy.

Road Fatalities in Ireland

During the 1970s, the worst period for road deaths in Ireland, road fatalities averaged 50 per month, although the country had, at that time, only 1⁄3 of the current number of vehicles on the road.

Fatalities per annum and Fatalities per million registered vehicles, 1970 - 2006[1]

Fatality numbers fell as a result of increased enforcement, improvement in the safety engineering of vehicles and roads, together with improvements in medical interventions. Road safety developed as a research topic with increasing focus on the avoidable social and economic costs.

1997 was the most recent peak year in road fatalities, averaging 39 deaths per month. This led to the introduction of the first Road Safety Strategy in 1998. Actions based on the Strategy brought deaths down to an average of 35 per month by December 2000. The introduction of penalty points in November 2002 helped achieve the primary target of a 20% reduction in fatalities by December 2002.

Looking at the year-on-year impact of policy on road deaths, it's evident that the most successful years were 2002 and 2003 following the introduction of penalty points in November 2002. The years 2004 to mid 2006 were disappointing as fatalities increased and the gains of the previous years were lost. This trend changed in
July 2006 with the introduction of Mandatory Alcohol Testing (MAT) supported by the visible and consistent enforcement programme of the Garda Traffic Corps.

333 people died on the roads in the twelve months from the end of June 2006 to June 2007 (the lowest twelve month number in 4 years since 335 fatalities in 2003). That is an average of 28 fatalities per month or 80 fatalities per million of population. This is a reduction of 19% when compared with 412 fatalities in the twelve month period from the end of June 2005 to June 2006 – an average of 34 deaths per month or 98 fatalities per million of population.

Throughout this document calculations are based on a population in Ireland of 4.2 million.

Ireland's Road Safety Performance in the EU

Best practice countries in the EU have achieved a reduction to 50 deaths per million and are already committed to improving this position by a further 20% (figure 3). The EU has set an overall target of a 50% reduction by 2010 from the base year of 2000. Ireland now ranks 14th out of 25 countries in the EU. To join best practice
countries in the next five years, this Strategy must reduce annual road deaths to between 50 to 60 deaths per million of population. This allows for the different characteristics of our road network and kilometres per annum travelled compared with the best practice countries.

The target is to reduce fatalities to no greater than 60 fatalities per million by the end of 2012 and 50 or fewer in the following years with demonstrable downward reductions in each year of this Strategy (see page 36 of the document Road Safety Strategy, 2007-2012).

Achieving 60 road deaths per million of the population is equal to 21 deaths per month or 252 deaths per annum. 18 deaths per month is the monthly average that would place Ireland alongside The Netherlands, Sweden, Norway and the United Kingdom. This is equivalent to 210 deaths per annum, 50 road fatalities per
million of our population.

Primary Causes

The primary causes of road collisions, deaths and injuries are:

Speed inappropriate for, or inconsistent with, the prevailing circumstances or driving conditions ;

Impaired driving through alcohol, drugs (prescription or non-prescription), or fatigue Failure to use or properly use seatbelts and child safety restraints

Unsafe behaviour towards / by vulnerable road users (pedestrians, motorcyclists, cyclists, young children and older people).

See Appendix II of the document Road Safety Strategy 2007-2012 (The High Risks – Who, Why,

[1] Source: NRA / RSA Fatalities Fatalities per million Registered Motor Vehicles
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When and Where?) for research on primary causes.
9 out of 10 fatal collisions are caused primarily by the behaviour of road users. This fact is consistent over time.
Research on fatal collisions indicates:
Excessive speed is a contributory factor in 1 in 3 fatal collisions 1
Alcohol is a contributory factor in 1 in 3 fatal collisions 2
Driver fatigue is estimated to be a factor in 1 in 5 fatal collisions 3
1 in 3 of those killed in cars in the last six years were not wearing a safety belt or child restraint 1
1 in every 3 children travel unrestrained in a car 1
3 out of 4 people killed on the roads are male 1
Young men aged 17 to 34 are consistently over- represented in death and serious injury statistics.1
Annual Monthly Average Road Collision fatalities, 1997 - 2006[1]
Annual Average Number of
Vulnerable Road Users 1
Vulnerable road users are pedestrians, motor cyclists, cyclists, young children and older people.
6 out of 10 of those who have died on our roads in the last six years are vulnerable road users
2 out of 10 are pedestrians
1 out of 10 is a motor cyclist
1 out of 30 is a cyclist
Vehicle speed is the primary contributor to these fatalities.
At 60 km/h 9 out of 10 pedestrians will be killed in an impact with a vehicle.
At 50 km/h 5 out of 10 pedestrians will be killed in an impact with a vehicle.
At 30 km/h 1 out of 10 pedestrians will be killed in an impact with a vehicle. 4
Contributory factors for Fatal Collisions 2000 - 2005
Drivers
81%
Road
4.2%
Environment
2.1%
Pedestrians
12%
Vehicle
0.7%
Source: Calculated from NRA / RSA Data (2063 Collisions 2000-2005)
Fatalities Classified by Road User and Age: 2000 - 2005
Source: NRA Road Accidents Facts 1997 - 2004 / RSA Road Collision facts 2005 (1,706 road deaths 2000 - 2006)
Road Deaths By Road User Type 2000 - 2005[2]
Source: Calculated from NRA / RSA Data (2,307 road deaths 2000-2005)
Car Users
56%
Pedestrians
20%
Motorcyclists
13%
Pedal Cyclists
3%
Other Road Users
8%
The Four Es
International consensus has built around the Four Es as the pivotal elements in reducing road deaths.
Education – raising awareness of road safety by imparting knowledge and developing an understanding of the risks with a view to changing attitudes and behaviour at individual, community

[1] Source: NRA / RSA
1 Road Accident Facts, NRA 2000-2005 & Road Collision Facts, RSA 2006.
4 Source: Rules of the Road RSA 2007
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[2] Road Safety Strategy 2007-2012 11
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and organizational levels.
Enforcement – visible and appropriate enforcement acting as a deterrent and increasing compliance with road traffic laws
Engineering – making the road network safer and more forgiving of inevitable errors by road users. Vehicle engineering to improve occupant and pedestrian / cyclist safety and minimise harm
Evaluation – ensuring sustainable reduction in road deaths and serious injury by constant research into the efficacy of actions undertaken.
Evaluation is now included as part of the strategy for the first time. Individual actions under these measures vary between countries in response to local conditions, culture, legislation, demographics and road infrastructure. In Ireland, the RSA will collaborate with stakeholders to implement a range of actions appropriate to local culture, laws, and infrastructure.[1]

3. Health and Safety:

Occupational Safety and Health Legislation in Ireland[2]

The Health and Safety Authority is required, under section 57 of the Safety, Health and Welfare at Work Act 2005 (No. 10 of 2005) to keep under review safety and health legislation (relevant statutory provisions) and other statutes (associated statutory provisions) that have a bearing on occupational safety and health. The Authority will submit such proposals to the Minister for Labour Affairs, as appropriate, from time to time.
A wide range of occupational safety and health and dangerous substances legislation and associated codes of practice are administered and enforced, in whole or part, by the Health and Safety Authority.

List of Occupational Safety and Health and Dangerous Substances Legislation and Associated Codes of Practice

Administered and Enforced, in whole or part, by the Health and Safety Authority (as at 1 October 2010)[3]

Acts

There are a number of Acts (Primary Legislation) administered and enforced , in whole or in part, by the Health and Safety Authority.[4]

Other Legislation

Besides Acts of the Oireachtas, a wide range of occupational safety and health and dangerous substances legislation and associated codes of practice are administered and enforced, in whole or part, by the Health and Safety Authority.
These include regulations made under the European Communities Act 1972, and Regulations and orders made under the Safety, Health and Welfare at Work Act 1989 (No. 7 of 1989)[5]

Regulatory Impact Analysis (RIA)

Regulatory Impact Analysis (RIA) is a tool for structured exploration of different options to address particular policy issues. The process was introduced by the Better Regulation Unit at the Department of the Taoiseach (Prime Minister) in 2005 to promote the active consideration of alternatives to regulation or lighter forms of regulation. RIA is also useful where legislation has already been committed to by Government, in which case the aim is to identify the appropriate implementation option.[6]".

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[1] Ireland's national Road Safety Strategy may be accessed at http://www.rsa.ie/Documents/Road%20Safety/RSA_Strategy_ENG_s.pdf
Information on Collisions may be accessed at http://www.rsa.ie/RSA/Road-Safety/Our-Research/Collision-Statistics/
High-profile, impactful TV campaigns are a key part of the RSA's strategy to educate road users about the perils of dangerous driving. Please see web site http://www.rsa.ie/RSA/Road-Safety/Campaigns/Current-road-safety-campaigns/
Random data and Irish Road Traffic Statistics may be accessed at http://273k.net/cycling/statistics.html
The map of Ireland showing the location of road accidents may be accessed at http://www.rsa.ie/RSA/Road-Safety/Our-Research/Ireland-Road-Collisions/

[2] http://www.hsa.ie/eng/Legislation/

[3] http://www.hsa.ie/eng/Legislation/List_of_Legislation/

[4] These are referenced on the left side navigation and our site offers a list of the Regulations and Orders made under each Act.
Click on the Act on the left hand navigation to view associated regulations.
http://www.hsa.ie/eng/Legislation/Acts/

[5] see http://www.hsa.ie/eng/Legislation/Other_Legislation/

[6] http://www.hsa.ie/eng/Legislation/Regulatory_Impact_Analysis/

121. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 11§3 MOLDOVA

The Committee concludes that the situation in Moldova is not in conformity with Article 11§3 of the Revised Charter on the grounds that it has not been established that there are adequate measures in force preventing accidents or protecting the population from the risks of ionising radiation and asbestos.

Fist and second ground of non-conformity

122. The representative of Moldova provided the following written information:

"Information from the Ministry of the Environment

To regulate nuclear and radiological activities in the Republic of Moldova, constant improvements are made to the national legislative and institutional framework. The Republic of Moldova has acceded to a series of international treaties on the subject:

- the Convention on Early Notification of a Nuclear Accident of 26 September 1986;
- the Convention on Physical Protection of Nuclear Material of 28 October 1979;
- the Convention on Assistance in the Case of a Nuclear Accident or Radiological Emergency of 26 September 1986;
- the Convention on Nuclear Safety of 17 June 1994;
- the Code of Conduct on the Safety and Security of Radioactive Sources.

To bring the legislative and institutional framework for the regulation of nuclear and radiological activities into line with international treaties and recommendations, the parliament adopted Act 111-XVI of 11 May 2006 on the Conduct of Nuclear and Radiological Activities (Monitorul Oficial No. 98-101/451 of 30 June 2006).

The implementation of this Act began with the approval of Government Decision 328 of 23 March 2007 endorsing the regulation, the organisational structure and the staffing of the National Agency for Regulation of Nuclear and Radiological Activities (ANRANR), which is a specialised central government agency, set up by the government under the auspices of the Ministry of the Environment with full legal status and powers to supervise nuclear and radiological activities.

With a view to carrying out the provisions of Act 111-XVI and the international treaties to which the Republic of Moldova is a party, the following decisions have been drawn up and approved by the Government in keeping with European Directives:

1. Government Decision 1220 of 30 October 2008 approving the Regulation on state monitoring and supervision of nuclear and radiological activities (Monitorul Oficial No. 198-200 of 7 November 2008);
2. Government Decision 1017 of 1 September 2008 on the National Register of sources of ionising radiation and authorised natural and legal persons (Monitorul Oficial No. 169-170/1025 of 9 September 2008);
3. Government Decision 212 of 13 March 2009 approving the Regulation on authorisation of nuclear and radiological activities (Monitorul Oficial No. 59-61 of 24 March 2009, Article 271);
4. Government Decision 388 of 26 Jun 2009 approving the Regulation on the management of radioactive waste (Monitorul Oficial No. 110-111 of 10 July 2009, Article N456);

A regulation on the procedure for imposing penalties for infringements of nuclear and radiological standards has also been drawn up and adopted.

An inventory has been prepared listing all the sources of ionising radiation in Moldova. On the basis of the inventory and state monitoring and supervision, the national register of sources of ionising radiation and authorised natural and legal persons is updated weekly.

In accordance with Article 385 of the Labour Code, state monitoring and supervision of nuclear and radiological activities is carried out by the ANRANR. The ANRANR employs state inspectors who monitor and supervise compliance with legislation on safety and security conditions for ionising radiation.

The rules on protection against radiation and nuclear security for persons engaged in activities involving ionising radiation sources and for the public are set out in the Basic Standards for Protection against Radiation (health standards and rules) of 27 February 2001 (NFRP-2000 *(Monitorul Oficial 40-41/111, 05.04.2001)),* which were based on the International Basic Safety Standards for Protection against Ionizing Radiation and for the Safety of Radiation Sources (BSS; IAEA Safety Series No. 115) and Council Directive 96/29/Euratom of 13 May 1996.

NFRP-2000 covers all situations involving exposure to natural or artificial ionising radiation and the risk of it affecting people, animals or the environment, both under normal operating conditions and in

cases of radiological emergencies or nuclear accidents (or incidents). NFRP-2000 establishes admissible radiation levels, which are checked when installations are registered and licensed and during state monitoring and supervision procedures.
During the process of state registration and authorisation of nuclear and radiological activities, the ANRANR assesses the compliance of these nuclear and radiological activities with the regulations in force, thus ensuring that these activities will be safe.
Information from the Ministry of Health
Act 111 of 11 May 2006 on the organisation of nuclear and radiological activities was adopted in order to harmonise the legislative and regulatory framework for the establishment of proper standards for protection from radiation and radiological and nuclear security, in accordance with the requirements and recommendations of the Council of Europe, the International Atomic Energy Agency (IAEA) and other international organisations.
Under the act, the central government authority responsible for heath issues must carry out the following tasks:
a)supervising and assessing the content of radionuclides in food products including drinking water, building materials and other products intended for public consumption, and issuing health certificates for both home-made and imported products;
b) monitoring the impact of nuclear and radiological activities on public health and issuing opinions under the current regulations;
c) setting health standards in the radiological field;
d)epidemiological monitoring of the targets achieved by nuclear and radiological activities in accordance with current legislation;
e)monitoring of the exposure to ionising radiation of staff working with ionising radiation sources, patients undergoing medical examinations and the entire public in the event of radiological or nuclear accidents;
f) organising scientific research on the medical and biological effects of ionising radiation.
g)Supervision of activities involving ionising radiation is conducted in accordance with Act 10-XVI of 3 February 2009 on state supervision of public health, which provides as follows:
(1) operations involving sources generating ionising radiation must be conducted in compliance with the legislation in force on nuclear and radiological activities and health regulations and standards in the sphere of protection from radiation;
(2) nuclear and radiological activities using radioactive substances and other sources of ionising radiation are subject to supervision and authorisation by the health authorities;
(3) staff exposed to ionising radiation in places where radioactive substances or sources of ionising radiation are used, patients exposed to radiation during medical examinations and members of the public affected by nuclear or radiological emergencies must be subject to permanent monitoring, including assessments of the doses of ionising radiation to which they have been exposed;
(4) natural and legal persons conducting nuclear or radiological activities have a duty to make the necessary arrangements to monitor exposure to ionising radiation, assess their employees' state of health and establish safe conditions for work with ionising radiation sources."

123. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

Article 12§1 – Existence of a social security system

Common concerns raised by representatives of States while discussing all situations below:

- Adequacy of benefits should not be assessed under Article 12§1 but under Article 12§2. Moreover, since several States do not have minimum benefits, it is not appropriate to assess a situation based on speculations.
- The adequacy of benefits should be linked to purchasing power rather than to 50% of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty threshold value.
- Need to clarify why, when the amount of a benefit is below the 40% of the poverty threshold as defined above, the ECSR considers that its aggregation with means-

tested kinds of benefits, including social assistance, does not bring the situation into conformity with Article 12§1.

124. The Committee decided that the above concerns should be raised during the next joint meeting of the Bureau. It also asked the Secretariat to enquire whether a member of the ECSR could come to one of its next meetings to explain its Article 12 case law in detail.

RSC 12§1 BULGARIA

The Committe concludes that the situation in Bulgaria is not in conformity with Article 12§1 of the Revised Charter on the grounds that:

– the minimum unemployment benefit is manifestly inadequate;
– the minimum old age benefit is manifestly inadequate;
– the minimum survivors' benefit is manifestly inadequate;
– the minimum employment injury benefit is inadequate;
– the minimum invalidity benefit is inadequate.

First, second, third, fourth and fifth grounds of non-conformity

125. The representative of Bulgaria stated that as regards unemployment benefits, in 2009, an amendment was made to the mechanism for their calculation. From the beginning of 2009, the benefits were calculated as 60% of the average daily remuneration or the average daily insurance income for the last nine months before the month of termination of the labour relations. The amount was determined for each and every month separately by multiplying the average daily income and the working days of the month. This made access to unemployment benefits easier. Also in 2009, an increase to the mandatory minimum and maximum amounts of the benefit set by law were made. This resulted in an increase of 40% in the amount of the minimum unemployment benefit as compared to the amount in 2007.

126. In 2010 an amending bill to the Social Security Code was prepared by the Ministry of Labour and Social Policy that eliminated the statutory maximum amount of the unemployment benefit. This bill was at present being discussed in the Council of Ministers. However, on this amendment there was a consensus in the National Council for Tripartite Cooperation.

127. The representative of Bulgaria stated that as to the situation regarding old age benefits, employment injury benefit, survivors' benefit and invalidity benefit, the amounts of the three last mentioned were directly linked to the amount of the old age benefit because they were calculated as a percentage from the minimum amount of the latter. When the amount of the minimum old age benefit was raised, the amounts of all the above-mentioned types of benefits were augmented respectively. Also, according to the Bulgarian Social Security Code, each year, all the pensions that were granted before the end of the previous year, were updated with a percentage equal to half the index of consumer prices and half the increase of the median insurance income for the previous years.

128. In 2009 all pensions were increased by 10% independently of the yearly update. From April 2009, an amendment to the method of calculation of the benefits was made and more importance was given to the years of work as their "weight" was increased from 1% to 1.1%. In July 2009, the pensions were increased by 9% as set in the Social Security

Code. These increases and recalculations had brought the minimum amount of the old age benefit for 2009 to a 40% increase for the last two years.

129. The representative of Bulgaria also informed about the creation of the Consultation Council on Pension Reform to the Minister of Labour and Social Policy in September 2009 the main aim of which was to provide a multilateral platform for discussion on pension reform and on the approach to be taken with a view to the development and modernisation of the pension system in Bulgaria. A decision had been taken that due to the ongoing heavy reforms in the healthcare system and economic problems, the next serious step and specific amendments, legislative and practical measures in the pension system would be made in or after 2011.

130. The Committee took note of the positive developments announced and decided to await the next assessment of the ECSR.

RSC 12§1 CYPRUS

The Committee concludes that the situation in Cyprus is not in conformity with Article 12§1 of the Revised Charter on the grounds that:

- the social pension is manifestly inadequate;
- the sickness, unemployment, work injury and maternity benefits are manifestly inadequate even if calculated on the basis of average basic insurable earnings.

131. The representative of Cyprus provided the following written information:

First and second grounds of non-conformity

> "The rate of the benefits provided by the Cyprus Social Insurance Scheme is above the minimum standards set by the European Code of Social Security and the Convention 102 of the International Labour Organization when compared against the weekly wage of the standard beneficiary. It should be noted that the social insurance contribution is determined as a percentage on the earnings (wage/salary or earnings) taken into consideration for social insurance purposes, known as "insurable earnings". Consequently, the level of the benefits covered by the Social Insurance Scheme depends to a great extent on the level of salary/wages of the insured person.
> The European Code of Social Security describes three methods by which periodic cash benefits may be evaluated and the minimum amounts that these benefits must provide. The Code aims to set equivalent standards for each type of social security system and does this by giving contracting parties a choice of three models by which benefits levels may be assessed. The models are so designed as to provide standards that are roughly equal. The minimum amounts of benefit are based on the concept of a standard beneficiary which varies from one contingency to another. As a consequence, the Code could not specify a minimum amount of benefit in terms of euros or dollars but had to establish evaluation tools that were relative to the standard of living.
> As it concerns the rate of the at-risk-poverty threshold set by the European Union, in Cyprus because the income tax is very low and the social insurance contributions are amongst the lowest in the EU it appears to be very high.
> Furthermore, the rate of the Social Pension is 81% of the minimum pension paid out of the Social Insurance Fund, it is therefore in conformity with the minimum standards set by the European Code of Social Security. Social Pension is paid only to persons who fulfill the necessary residence criteria and are not entitled to pension from any other source.
> Concerning the terms "suitable employment offer" and "a reasonable opportunity for suitable employment" for which the Committee needed clarification we wish to state the following:
> **"suitable employment offer"** means the offer of an employment which is in accordance with the unemployed person's qualifications, his last employment and his last salary,
> the term **"a reasonable opportunity for suitable employment"** means the case where the insured person used to work in a profession which was not in accordance with his qualifications and he rejected an employment offer which complied with his last employment and qualifications.
> In the case where an unemployed person is offered a job which is related to his qualifications and he repeatedly refuses to accept it, then the payment of unemployment benefit is terminated. The

decision of the Social Insurance Services may be appealed by the unemployed person, however he has to justify the reasons for not accepting the jobs previously offered to him.

132. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 12§1 ESTONIA

The Committee concludes that the situation in Estonia is in not in conformity with Article 12§1 of the Revised Charter on the ground that the unemployment benefit, the minimum unemployment insurance benefit, the national pension and the minimum old age and invalidity pensions are manifestly inadequate.

133. The representative of Estonia mede the following statement:

"Conclusions 2009 have been translated into Estonian and are available on the homepage of the Ministry of Social Affairs. Conclusions have been forwarded to the management of the Ministry of Social Affairs, to the social partners, the Social Committee of the parliament and the Prime Minister's Office. The discussion in the Social Committee of the parliament will take place right after the meeting of the Governmental Committee.

The ECSR concluded that the situation in Estonia is in not in conformity with the Article 12 paragraph 1 of the Charter on the ground that the unemployment benefit, the minimum unemployment insurance benefit, the national pension and the minimum old age and invalidity pensions are manifestly inadequate. A negative conclusion was made as regards unemployment allowance in 2004, as regards minimum pension levels in 2006 and as regards unemployment benefit in 2009 (and hence for the first time).

Based on the first negative conclusion (in 2004) the level of unemployment benefit was increased by more than twice. While the level was 400 kroons per month in 2004, it has been about 1000 kroons per month since 2007. By today we have reached an agreement between the social partners and the government to increase the level of unemployment benefit even more. The agreed amount is at least 50% of the minimum monthly wage. This means that based on current indicators, another 2-fold increase in the unemployment allowance has been agreed upon. Relevant amendment was made into the Labour Market Services and Benefits Act which has already been passed by the parliament and will enter into force in 2013.

As regards the minimum rate of unemployment insurance benefit (i.e. the negative conclusion made in 2009) we also have an agreement with the social partners that the minimum amount of unemployment insurance benefit is 50% of the minimum monthly wage. Based on this agreement an amendment was made to the Unemployment Insurance Act that entered into force on 1 July 2009. This amendment means that if a person works part time, his/her unemployment insurance benefit will also be at least 50% of the minimum wage, as already earlier the benefit could not have been smaller than that if the person worked full-time. We also note that as regards the amount of unemployment insurance benefit Estonia fulfils the standards of the European Code of Social Security.

As regards pensions Estonia also fulfils the standards prescribed in the European Code of Social Security. However, the Government has decided, that the pensions' growth rate must be increased. The respective amendments entered into force in the State Pension Insurance Act on 1 April 2008. Two substantial amendments were made.

– It was decided that the annual indexation of pensions must be more dependent on the income from social tax. According to the previous regulation, the index

depended 50% on the annual increase in the consumer price index and 50% on the annual increase in the income from the social tax. Based on the new regulation the growth rate of pensions is more proportionate to the income from social tax as from 1 April 2008 only 20% of the value of the index depends on the consumer price index and 80% of the value of the index depends on the annual growth of the of the income from social tax.

– It was decided that it is particularly important to increase the base amount of the pensions, as it has proportionally a greater effect on the amount of smaller pensions. From 1 April 2008 the base amount of the pension is increased with an index and additionally, the increasing part is multiplied with a coefficient of 1.1. In case of other components of pension formula (component calculated on the basis of years of pensionable service and the insurance component) the value of a year of pensionable service is increased with an index and additionally, the increasing part is multiplied with a coefficient of 0.9. The use of additional coefficients annually increases the proportion of the base amount of the pension. In 2 years, the base amount of pensions increased 30.6%.

The full amounts of the national pension, minimum old age pension and minimum invalidity pension was 2009 kroons (EUR 128.41) in 2009 – it means that the minimum rate of pensions increased by 27.7% in 2 years. Even in 2009 when the real growth of the gross domestic product of the country was negative and the budget for the state pension insurance was in deficit, the pensions, including the national pension, increased by 5%.

A more radical increase in the minimum rate of pensions would jeopardize the financial sustainability of state pension insurance.

We will present all relevant information in our next report."

134. The representative of the ETUC observed that developments had occurred in agreement with the social partners and these ought to be welcomed.

135. The Committee welcomed the progress made by the government of Estonia and decided to await the next assessment of the ECSR.

RSC 12§1 FINLAND

The Committee concludes that the situation in Finland is in not in conformity with Article 12§1 of the Revised Charter on the ground that the minimum sickness and maternity allowances and the minimum national pension for single persons are manifestly inadequate.

136. As to the minimum sickness and maternity allowances, The representative of Finland pointed out that all residents (working or not) are entitled to sickness and maternity benefits. She underlined that this circumstance was quite exceptional. She highlighted that the adequacy of the benefits in question should be assessed by taking into consideration not just their amount but also the extent of their coverage.

137. As to the national pension for single persons, she informed the Committee about the following changes:

- as of January 2008, the national pension was increased in practice by 20.50 Euros;
- pension rates were unified (abolishing the distinction of rate based on the place of residency) by raising the lower one to the higher one. This change affected 75% of the recipients of national pensions.

138. The Committee took note of the information provided and decided to await the next assessment of the ECSR on Article 12§1 of the Revised Charter.

RSC 12§1 FRANCE

The Committee concludes that the situation in France is not in conformity with Article 12§1 of the Revised Charter on the ground that the minimum invalidity and survivor's pensions are manifestly inadequate.

139. The representative of France provided the following written information:

> "As the minimum levels of old age and invalidity pensions of former employees in the private sector are not mentioned in the 8th report on application of the Social Charter by France, the European Committee of Social Rights sought this information in the Missoc tables (2007). On the basis of the figures found there, it concluded that the minimum levels of invalidity pensions (€ 255.30, or € 366 subject to means test) and survivor's pensions (€ 308) were not in conformity with the Charter because they stood below 40% of the median equivalised income calculated on the basis of the Eurostat at-risk-of-poverty threshold value, which was € 522 in 2007 for France.
>
> **1) In practice, the minimum levels of these two benefits were far higher than 40% of the median income in 2007 if one takes account of the personal income of the beneficiaries.**
>
> 1 a) The minimum level of the contributions-based survivor's pension, which is in practice € 258.58, can, depending on the individual's income, be as much as € 621 per month (for a single person) if supplemented by the non-contributions-based *solidarity allowance for old people* (supplementary compulsory old age pension included), i.e. approximately 44% of the median income.
>
> 1 b) The minimum level of the contributions-based invalidity pension was in fact € 225.30 in 2007. However, depending on personal income, this minimum amount may be supplemented by a non-contributions-based *supplementary invalidity allowance*, of a maximum of € 366, which brings the total payment to € 621, to which should be added, since 2007, further allowances in the form of either the *supplement for an autonomous life* (*€ 103.63),* or the *complementary resources* (€ 179.31), bringing the total to over 50% of the median income.
>
> **2) The minimum means-tested old age pensions should also be far higher than 50% of the median income in 2012.**
>
> In 2007 France undertook to gradually raise the level of a number of minimum benefits by 25% by 2012, i.e. to € 777 in 2012 compared to € 621 in 2007. This undertaking applies to the solidarity allowance for old people. It also applies to those beneficiaries of the supplementary invalidity allowance whose degree of disability is equal to or higher than 80% (amount of minimum benefit raised to the level of disabled adults' allowance).
>
> 3) Moreover, entitlement to a rented housing allowance brings (or will in 2012 bring) the level of minimum invalidity and old age pension benefits to 60% of the median income.
>
> Persons on low incomes, and in particular the recipients of ASI (supplementary invalidity benefit) and ASPA (solidarity allowance for old people), may have access to rented housing allowances subject to certain technical conditions and/or on a means-tested basis: *personalised housing assistance* paid to persons whose homes are being bought through a state-subsidised loan to encourage home ownership or have controlled rents, *social housing allowance* and *family housing allowance.* The average monthly amount of these different benefits is approximately € 200."

140. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 12§1 GEORGIA

The Committee concludes that the situation in Georgia is not in conformity with Article 12§1 of the Revised Charter on the ground that the minimum levels of old age, disability and survivors benefits are manifestly inadequate.

141. The representative of Georgia provided the following written information:

> "Government has taken important measures that resulted increasing of pensions and other social transfers. Old age, Survivors and Disability cash benefits in fact are increasing annually in parallel of budget growth. At present, amount of minimum old age cash benefit is 80 (GEL), amount of minimum disability cash benefit is 70 (GEL) and is increasing with the level of disability. Amount of survivor's benefit is 55 (GEL). Since 2004 average growth of social benefits is approximately 100%.
>
> Considering current social-economic situation of the country, "Social Assistance program" is one of the prioritized program, the aim of which is reduction of extreme poverty by providing assistance to

the families below the poverty line. In 2009, The targeted social assistance monthly benefit per additional family member was doubled from 12 GEL to 24 GEL, wich is in addition to a base benefit per household of 30 GEL. Targeted social assistance coverage expanded from about 131000 households in December 2008 to about 155000 households in April 2009, and to over 164 000 by April 2010. In terms of number of beneficiaries- increases from 400000 in July 2008 to 470000 in April 2010.
Social transfers share of GDP increased from 4,6 of GDP in 2007 to 6 percent in 2008 and an estimated 7 percent in 2009.
A welfare Monitoring Survey undertaken by UNICEF in June-July 2009 estimates a poverty headcount rate of 25.7 percent, and extreme poverty rate of 9,9 percent."

142. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 12§1 IRELAND

The Committee concludes that the situation in Ireland is not in conformity with Article 12§1 of the Revised Charter on the grounds that:

– the minimum sickness benefit is inadequate.
– the minimum unemployment benefit is inadequate.
– the minimum survivors' benefit is inadequate.
– the minimum employment injury benefit is inadequate.
– the minimum invalidity benefit is inadequate.

First, second, third, fourth and fifth grounds of non-conformity

143. The representative of Ireland stated that Ireland had undertaken to observe the standards explicitly set by Article 12§2 and did not accept to be bound by another standard which the Committee believed to be supported by Article 12§1. Ireland did not consider the median equivalised income to be a reliable benchmark, finding that the Consumer Price Index was a better tool, also in times of recession and that higher rates of benefit would increase the difficulty in activating people from benefit dependency to employment. The Irish representative stated that the next report would provide more information in this respect.

144. The representative of Hungary proposed that the method used by the ECSR to calculate the adequacy of minimum level of benefits should be discussed and possibly reviewed at the joint meeting of the Bureaux of the European Committee of Social Rights and the Governmental Committee.

145. The Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 12§1 ITALY

The Committee concludes that the situation in Italy is not in conformity with Article 12§1 of the Revised Charter on the grounds that:

- it has not been established that the amount of the minimum unemployment benefit is adequate;
- the minimum level of contributory old age pension is manifestly inadequate as is the survivor's pension calculated on the basis of the latter;
- the monthly allowance paid for a permanent disability assessed at 100% is manifestly inadequate;

First ground of non-conformity

146. The representative of Italy provided the following written information:

"*The European Committee has on several occasions asked the Italian government to indicate the minimum level of unemployment benefit, only the maximum amounts being set by Italian law.*

In the previous reports, it was pointed out that, unlike in the case of maximum amounts, Italian law-makers did not consider it necessary to set minimum levels of unemployment benefit. In view of all of the foregoing, it should be noted that the amounts indicated below are not of an official nature, having been compiled on an *ad hoc* basis by the INSP (National Institute of Social Security) based on the minimum gross monthly benefits, including the 13th monthly payment, of manual and non-manual workers in the private sector.

Anno	Minimale giornaliero lordo	Minimale mensile lordo con tredicesima
	(importi in euro)	
2005	39,94	1.125
2006	40,62	1.144
2007	41,43	1.167

Source : INPS – Coordinamento Generale Statitisco Attuariale
Year – Minimum amount per day – Gross amount per month with 13th monthly payment – Amounts in euros
Over the period from 1 April 2005 to 31 December 2007, ordinary unemployment benefits (excluding the farming sector) were paid at the following rates:
50% of pay for the first 6 months;
40% for the next 3 months;
30% in the tenth month

Trattamento minimo mensile indennità di disoccupazione – triennio 2005-2007 (Minimum monthly amount of unemployment benefit – 2005-2007)

Anno	2005	2006	2007
Periodi indennizzabili	*(importi in euro)*		
primi sei mesi	563	572	584
successivi tre mesi di disoccupazione	450	458	467
decimo mese di disoccupazione	338	343	350

Source: INPS – Coordinamento Generale Statistico Attuariale
Periods for which benefits are payable – amounts in euros
First 6 months
Next 3 months
tenth month

Second ground of non-conformity

The second ground for non-conformity concerns the minimum amount of old age pension, which the European Committee of Social Rights considered to be manifestly inadequate.

On this subject, we would submit the following. Under Italy's current social security legislation, which has been amply described in previous reports, persons are eligible for the old age pension if they fulfil the requisite conditions (age, contributions, number of years worked). The requirements differ depending on the system of calculation, which can be based on contributions or earnings, or a combination of the two. Whichever calculation system is used, the amount of the pension is determined by the number of years worked and by the contributions paid. In the event that the amount of the pension should be less than what is considered "subsistence level", it would be increased until it reaches the amount determined by law every year. Persons whose taxable annual income is greater than the amount of the "trattamento minimo**"** but less than twice that figure are entitled to a partial supplement. The supplement tops up the income to the amount of the annual

"trattamento" which is equal to twice the "trattamento minimo". In the VIII report on Article 12, the minimum amounts payable over the period 2005-2007 were indicated (€420.02 in 2005, €427.58 in 2006 and €436.14 in 2007). In the opinion of the European Committee of Social Rights, these amounts are less than 40% of the median equivalised income (the parameter used by Eurostat to calculate the at-risk-of-poverty threshold). The at-risk-of-poverty threshold was estimated by Eurostat at €500 per month in 2007. In Italy, however, the at-risk-of-poverty threshold is calculated by Istat on the basis of other indicators, such as households' monthly average expenditure. On the basis of these indicators, a household is considered "poor" if its level of expenditure is below a certain value. In 2007 the at-risk-of-poverty threshold for a 2-person household was €986.35 (€493.17 per head). The amount of the "trattamento minimo" being €436.14 in 2007, it follows that the latter was slightly less than the value used as an indicator of the at-risk-of-poverty threshold. In order to narrow the gap between the "trattamento minimo" amount and the at-risk-of-relative-poverty threshold, as determined by Istat, the Italian Government has gradually increased the amount of the "trattamento minimo" with the aim of helping families in relative or absolute poverty to improve their circumstances by increasing their purchasing power. In 2009, in fact, the "trattamento minimo" stood at €458.20, as against an at-risk-of-relative-poverty threshold estimated by Istat at €491.50 per month per head. Although the amount of the "trattamento minimo" , taken separately from the "social increase" which is paid on top of it, is less than the at-risk-of-poverty threshold estimated by Eurostat at €500 per month, the social allowance including the "social increase" was greater than the value which the Committee considered to be an income sufficient to provide a decent standard of living. We should further emphasise that in 2006 the amount of the "trattamento minimo" including the "social increase" stood at €551.35 and was therefore greater than the reference value mentioned by the Committee. For information, we would like to point out that the "social increase" has been extended to include recipients of direct pensions (old age, incapacity, ordinary incapacity allowance or disability) and **survivors**, in some cases in an amount greater than the "trattamento minimo", on condition that the income limits are not exceeded, so as to ensure pensioners receive an annual minimum income.

Third ground of non-conformity

With regard to the third ground for non-conformity concerning the amount of the monthly pension paid by INAIL (National Insurance Institute for Occupational Injuries) for 100% incapacity and which the European Committee of Social Rights considered to be inadequate, we would submit the following.

In the report on Article 12, it was pointed out that INAIL pays a *monthly pension* to insured workers who have a degree of incapacity for work of between 11% and 100%. In the case of absolute permanent incapacity as a result of infirmities requiring continuous assistance, the pension is topped up by a monthly allowance for personal, continuous assistance, as established by the Decreto del Presidente della Repubblica 30 aprile 1965, n. 1124, "*Testo Unico delle disposizioni per l'assicurazione contro gli infortuni sul lavoro e le malattie professionali*" (Decree of the President of the Republic No. 1124 of 30 April 1965 containing amalgamated provisions for the insurance of workers against occupational accidents and diseases) and subsequent amendments[1]. The figure of €415.13 cited in the 2009 Conclusions and deemed to be below the Eurostat at-risk-of-poverty threshold in actual fact refers to the above-mentioned allowance for personal, continuous assistance in force from 1 July 2006. In view of what has been stated above, we wish to confirm that the allowance in question is an integral part of the monthly pension paid to workers with 100% incapacity and not, therefore, a separate payment. In 2007 the amount of the monthly pension for 100% permanent incapacity, including the personal, continuous assistance allowance whose amount had been revised that same year, was €1,373.51 for the industrial sector and €1,429.88 for the farming sector. Over the same period, the amounts of the monthly continuous allowances in case of incapacity of between 90% and 100% for the industrial and agricultural sectors were €950.76 and €1,007.70 respectively."

147. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

[1] Legge 10 maggio 1982, n. 251 "Norme in materia di assicurazione contro gli infortuni sul lavoro e le malattie professionali" ("Standards relating to insurance against industrial accidents and occupational diseases")

RSC 12§1 LITHUANIA

The Committee concludes that the situation in Lithuania is not in conformity with Article 12§1 of the Revised Charter on the grounds that:

- the minimum level of the unemployment insurance benefit is manifestly inadequate;
- the level of the old age state social insurance basic pension is manifestly inadequate.

First and second grounds of non-conformity

148. After having supported the common concerns referred to above, the representative of Lithuania pointed out that measures were taken during the reference period to improve the situation but these has not been sufficiently emphasized in the report. The new Law on Social Insurance of Unemployment (came into force on 1 January 2005) completely reformed the unemployment allowance with the fix amount into unemployment social insurance benefit with amount depending on the former salary of the beneficiary. If the former allowance basically relied on the state supported income and varied from 135LTL as minimum to 250LTL as maximum, then the amount of new benefit comprises two elements: 40% of former insured income of beneficiary plus state supported income. The duration of payment of the new benefit is also longer than the old one, which was paid maximum 6 moths.
The full amount of new unemployment benefit (40% of former insured income of beneficiary plus state supported income) is paid for 3 months and for remaining 3 or 6 months period, which depends on the insurance record, the beneficiary gets 20% of former insured income plus state supported income.

The minimums amount of the new benefit increased from 140LTL in 2005 to 212,5LTL in 2007. It is almost 60 percents higher than minimum amount of the old allowance. While the average amount of this new benefit increased from 312,3LTL in 2005 to 464,6LTL in 2007. As we see the average amount of the new benefit in 2007 is nearly 90% higher than the maximum of the old one allowance.

149. It was stressed that minimum unemployment benefit is allocated only in the exceptional single cases when person has no required 18 months insurance record during last 3 years for getting normal unemployment benefit. Such exceptional unemployment benefit is very low as it comprises basically only of 1 part of unemployment benefit – state supported income.

150. Additionally the representative of Lithuania mentioned that in 2008, within the context of the European Code on Social Security, an expert of the Council of Europe preliminary concluded that Lithuanian unemployment benefit in 2007 complied with requirements of the Code.
Furthermore, she considered that there had been a misunderstanding on the basic pension as this was only one element of the pension together with the insured income, wage and insurance record. There is no statutory minimal amount of old age pension in Lithuania, but according to the pension formula old age pension will be at leased higher than basic pension as two more elements are involved.

151. The representative of Lithuania also mentioned the last report where it was highlighted that during reference period two main parts of pension (the basic pension and the insured income) were increased constantly, taking into account the financial abilities of the country. Therefore all pensions have increased constantly too. The old age state social insurance basic pension increased from approximately 172LTL (50EUR) in 1 January 2005, not from

58EUR (200LTL) as mentioned in the conclusions 2009, to approximately 266LTL (77EUR). The insured income of the current year increased from LTL990 to LTL1356.

152. The representative of the ETUC asked for further clarification, in particular figures concerning the percentage of pensioners living below the poverty threshold and whether such percentage was decreasing or increasing. These figures were not available during the meeting.

153. The Committee congratulated the reformation of unemployment benefit and noticed the State efforts increasing the amount of basic pension. It invited the government of Lithuania to provide in its next report the relevant information and figures enabling the ECSR to assess the situation properly. Meanwhile, it decided to await the next assessment of the ECSR.

RSC 12§1 MALTA

The Committee concludes that the situation in Malta is not in conformity with Article 12§1 of the Revised Charter on the grounds that:

– the rates of sickness benefits for a single person, of unemployment benefit as well as of special unemployment benefit for a single person are manifestly inadequate;
– the duration for which unemployment benefit is payable is too short.

First and second grounds of non-conformity

154. The representative of Malta stated that in 2007 a study group was set up to analyse all benefits and assess whether they were still valid in today's society. He also pointed out that the report of this group was due to be submitted to Cabinet in June 2010.

155. The Committee invited the government of Malta to provide the relevant information and figures enabling the ECSR to assess the situation properly in its next report. Meanwhile, it decided to await the next assessment of the ECSR on Article 12§1 of the Revised Charter.

RSC 12§1 MOLDOVA

The Committee concludes that the situation in Moldova is not in conformity with Article 12§1 of the Revised Charter on the grounds that:

- there is no evidence that the adequacy of social security benefits is secured;
- it has not been established that unemployment benefits are paid for a reasonable duration.

156. The representative of Moldova provided the following written information:

First and second grounds of non-conformity

"*Replacement rate*

Statistical data on the coverage of the population in all the branches of social security and amounts of benefits are set out in the appended tables.

Measures taken by the government where employers pay social insurance contributions late or refuse to pay them.

Act 129-XVIII of 23 December 2009 on the State Social Assurance Budget for 2010 sets out the penalties applied to persons owing social insurance contributions for failure to pay such contributions in time, failure to pay the full amount or reducing or concealing amounts on which the calculation of contributions is based.

In the event of failure to pay social insurance contributions within the established deadline, the national tax authorities may enforce payment in accordance with tax legislation.

To recover debts owed by persons to the state social insurance fund, local tax inspectorates are entitled to take the following enforcement measures:

- seizing any funds on the bank accounts of the person concerned (except for certain accounts set up to fund training or to increase a company's authorised capital);
- seizing the person's cash assets;
- attaching, selling or confiscating the person's property.

The tax authorities also attempt to ensure that unpaid contributions are collected by ordering the suspension of operations with debtors' banks.
To ensure that all social insurance contributions are collected, the national tax authorities draw up an annual plan for the collection of unpaid contributions to the national and social insurance budget, which enables them to estimate the amount of arrears to be recovered.
During the year, local tax inspectorates also hold working meetings attended by representatives of local government and local social insurance funds to audit employers who owe money to the state including social insurance contributions. At the same time, the local tax authorities hold on-site seminars with representatives of local social insurance funds to organise the work of collecting debts from the owners of agricultural land and farms.

Unemployment benefit and length of entitlement for persons who have been contributing for fewer than five years.

Entitlement of unemployed persons to unemployment benefit is governed by Act 102-XV of 13 March 2003 on the employment and social protection of jobseekers. Under section 33 of this Act, unemployed people are entitled to benefit if they meet all of the following conditions:
(a) they are registered with the employment office in the region in which their home is located;
(b) they have worked or contributed to the state social insurance scheme for at least six months out of the 24 preceding the date of their registration;
(c) they do not receive any taxable income under the law.

Length of entitlement to unemployment benefit for persons who have been contributing for fewer than five years.
Under section 33 of Act 102-XV of 13 March 2003, unemployed people are entitled to benefit for a period which differs according to how long they have been contributing:
(a) six calendar months for those who have been contributing for six months to five years;
(b) nine calendar months for those who have been contributing for five to ten years;
(c) twelve calendar months for those who have been contributing for over ten years.

Whether there is an initial period where jobseekers may refuse to take up an offer of a job on the grounds that it does not meet their occupational requirements or experience.
Jobseekers receiving unemployment benefit are only given job offers which match their professional qualifications and experience. Under Act 102/2003, a suitable job is defined as one which is in keeping with the jobseeker's professional qualifications, length of service and experience in the occupation concerned and his or her state of health. The job also needs to be located at an acceptable distance from the jobseeker's home and provide a monthly wage at least equal to the standard minimum wage. Under section 39 d) of the Act, payment of unemployment benefit ceases on the day that a jobseeker refuses a job offer from the employment office for no legitimate reason. If the employment office cannot offer a suitable job, the jobseeker will be awarded benefit for the entire period prescribed by the law.

Minimum pensions
Under Act 156-XIV of 14 October 1998 on pensions provided by the state social insurance scheme, the minimum pension is a monthly sum awarded to persons whose full monthly pension, calculated in accordance with the Act, amounts to a sum below the minimum.
In cases in which the calculated pension award for a person with 30 years' service is less than the minimum pension, the minimum pension is paid. In cases in which the calculated pension award for an incomplete contribution period is below the minimum pension level, the claimant receives a minimum pension adjusted proportionately to the length of the contribution period.
In accordance with Government Decision 202 of 19 March 2010 on the indexing of benefits under the state social insurance scheme, from 1 April 2010 onwards, the indexed minimum pension awards will be as follows:
529.37 lei – old-age pension for farmers;
594.62 lei – old-age pension for other beneficiaries;
423.02 lei – category I invalidity pension;
408.50 lei – category II invalidity pension;
287.64 lei – category III invalidity pension."

157. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 12§1 PORTUGAL

The Committee concludes that the situation in Portugal is in not conformity with Article 12§1 of the Revised Charter on the grounds that:

– the information provided on sickness benefits is insufficient to determine its adequacy;
– there is no evidence to determine the adequacy of the minimum monthly invalidity and old age pensions for persons who contributed more than 15 years and less than 30 years.

First ground of non conformity

158. The representative of Portugal highlighted that since 2005 changes had been introduced in Portugal with regard to the rules governing social protection in case of sickness. She acknowledged that the information contained in the report on such changes could have been clearer. She promised that efforts in this respect would be made in the next report. She underlined that the rules were very complex as depending on a series of factors, benefits would cover from 65% to 100% of the wage reference. She pointed out that the underlying principle of the system was that the more a person was sick, the higher the sickness benefit would be. She however also underlined that assessment of sickness had been made more strict to ensure that the system would not be abused.

159. As to the minimum sickness benefit, she explained that this corresponded to 30% of the social protection index system (not a given wage). She clarified that this index is based on minimum wage but not entirely as other criteria come into play such as economic development and sustainability. She pointed out that generally this minimum benefit (30% of the social protection index system) applies only to part time work.

160. At the request of the representative of the ETUC, it was recalled that the risk of poverty threshold in Portugal was 377 Euros. The representative of Portugal also underlined that the minimum wage in Portugal was very low and that efforts were underway to improve it.

161. The representative of Estonia suggested that the Committee take note that Portugal is aware that the situation needs to be improved and that the Government has taken measures to this effect. She also underlined that given the low minimum wages, it was understandable that time was required to raise the levels of benefits. The amount of these levels should be included in the next report.

162. The representative of Lithuania asked whether it would be possible to provide the minimum level of the sickness benefit. It was indicated that this was possible and that it would therefore be provided. The representative of ETUC asked whether it was possible to also indicate the level of daily sickness benefit. The representative of Portugal explained that this was instead much more complicated as the figure would depend on how much a person earned.

163. Pointing out that the situation of Portugal with regard to Article 12§2 was in conformity with the Revised Charter, the representative of the Czech Republic stated that she could not understand how the situation could be held not to be in conformity under Article 12§1. She considered these findings controversial and considered that a literal interpretation of the two different provisions clearly indicated what was required under

Article 12§2 (attainment of a satisfactory level) was a step more than what was required under Article 12§1 (mere existence of a system). The representatives of Lithuania and the Russian Federation shared the latter view concerning the literal interpretation of paragraphs 1 and 2 of Article 12.

164. The Secretariat pointed out that since quite some time the ECSR explains that the first three paragraphs of Article 12 should not be seen as subsequent progressive steps. Each provision has a different and separate objective. Thus:

- under paragraph 1, a social security system should exist and be maintained. A social security system is deemed to exist when: (i) a significant proportion of the population is covered by the system; (ii) the system is based on collective funding; (iii) the social risks which are considered essential are covered by the system; (iv) the benefits paid are effective (i.e. they guarantee a dignified living);
- under paragraph 2, the overall level of the social security system should be satisfactory (i.e. correspond at least to the level necessary for the ratification of the European Code of Social Security –level which is based on the average amount of the benefits);
- under paragraph 3, the social security system should be improved. In this regard, it was recalled that a situation of progress could be found even if the social security system in question did not attain the levels required under the first two paragraphs of Article 12. It was clarified that the existence of a social security system of a higher level than that required under Article 12§1 or 12§2 is not to be presupposed under Article 12§3.

165. As to the remarks concerning the literal interpretation of the Charter, the Secretariat pointed out that the interpretation of treaties cannot stop at their wording. Interpretation should take into account also the intention of the authors of the treaty.

166. As to the intention behind Article 12§1, the Secretariat asked who could state that a social security system exists when a worker is sick and receives a sickness benefit which does not enable him/her to live in a dignified manner. To guarantee such a living the ECSR considers that income replacement benefits should stand in a reasonable relation to the wage in question and should in any event never be below the minimum subsistence level. For the ECSR this level is assumed to exist when the level of the income replacement benefits is above 50 % of median equivalised income as calculated on the basis of the Eurostat at-risk-of poverty threshold. When the minimum level of an income replacement benefit falls below 40% of the above mentioned threshold, the ECSR holds that it is manifestly inadequate.

167. The representatives of Estonia and France acknowledged it could not be stated that living conditions are satisfactory below 40% of median equivalised income as calculated on the basis of the Eurostat at-risk-of poverty threshold.

168. The Committee invited Portugal to provide all the relevant information and figures enabling the ECSR to assess the situation properly in its next report. Meanwhile, it decided to await the next assessment of the ECSR on Article 12§1 of the Revised Charter.

169. The representative of Portugal provided the following written information:

Second and third grounds of non-conformity

"In the 4th national report it was mentioned the Decree-Law 146/2005 introduced some adjustments in the amount of sickness subsidy in order to make it more supportive of citizens that get sick.
According to this new law the amount that corresponds to sickness benefit are:

- 65% of the earnings in case of temporary sickness with a duration period equal or lower than 90 days;
- 70% of the earnings in case of temporary sickness for a duration period longer than 90 days and lower than 365 days;
- 75% of the earnings in case of temporary sickness for a duration period longer than 365 days;
- 80% or 100% of the earnings in case of sickness resulting from infectious diseases as tuberculose (depending of the number of the family members of the beneficiary: one or more members.

The amount of the benefit is calculated on the base of the abovementioned percentage to the index earnings according to the mathematic formula R/180, in which:
R = is equal to the total of earnings registered in the 6 months before the beginning of the sickness
180 = 30 days x 6 months
There are some limits to the amount of sickness benefit:

- Minimum limit: 30% of the reference value of the IAS or the reference remuneration if this one is lower than the IAS. The IAS is defined each year by a Governmental regulation.
- Maximum: the value of the reference remuneration.

According to the National Public Expenditure Account the media of the amount of the sickness benefit paid per day was 13,0€ in 2006; 13, 5€ in 2007 and 13,9€ in 2008.

1. Inadequate minimum monthly invalidity and old age for persons who contributed less than 15 years, the minimum monthly invalidity and old age persons for persons contributing to the Special Social Secure Scheme for Agricultural Activities (RESSAA).

Invalidity and old age benefits are low in Portugal for persons who contributed
less than 15 years and are included in the RESSAA system and in the non-contributory systems. In fact these benefits do not reach 350€ -the at-risk poverty threshold defined by EUROSTAT- but there has been an effort to raise the protection of these citizens through an annual raise of these benefits in a percentage that is higher than the inflation rate.
Between 2006 and 2008, the raise of the benefits were:

	2006	**2007**	**2008**
<15 anos	223,24 €	230,16 €	236,47 €
RESSAA	206,07 €	212,46 €	218,29 €
Non-contributory system	171,73 €	177,05 €	181,91 €
Percentage of raise			
	2007/2006	2008/2007	
<15 anos	3,1 %	2,7 %	
RESSAA	3,1 %	2,7 %	
Non-contributory system	3,1 %	2,7 %	

It is important to underline that in 2006 it was created the Solidarity Supplement for old people (CSI) by the Decree-Law nº 232/2005 and 151/2009 to combat poverty among elderly population.
The CSI is an additional benefit aimed to complement the amount of old age pension and to assure a minimum income to people with low income such as 4338,60€ per year in 2007 for a single person and 7592,50€ for couples. In 2008 the values were respectively, 5.022€ for single person and 8.788,50€ for couples.

2. No evidence to determine the adequacy of the minimum monthly invalidity and old age pensions for persons who contributed more than 15 years and less than 30 years.
Invalidity and old age benefits are also low for persons who contributed for more than 15 years and less than 30 and do not reach the at-risk-of poverty threshold defined by EUROSTAT. Nevertheless these benefits are higher than the non-contributory and RESSAA abovementioned.

Between 2006 and 2008 the raise of these benefits was higher than the inflation rate, namely:

	2006	**2007**	**2008**
15 – 20 years	249,00 €	256,72 €	263,76 €
21 – 30 years	274,76 €	283,28 €	291,05 €
Percentage of raises			
	2007/2006	2008/2007	
15 – 20 years	3,1 %	2,7 %	
21 – 30 years	3,1 %	2,7 %	

The next report will give a more detailed information about the invalidity and old age benefit."

170. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 12§1 ROMANIA

The Committee concludes that the situation in Romania is not in conformity with Article 12§1 of the Revised Charter on the ground that it has not been established that the adequacy of old age benefit, survivors' benefit and emplyoment injury benefit is secured.

171. The representative of Romania informed that during 2008 – 2009 changes were made to Law No. 19/2000 regarding the public pension system and other social insurance rights. Pursuant to Law No. 11/2008 the possibility for a person to benefit of an invalidity pension was introduced, irrespective of the fulfillment of the contributory period, in case of serious medical injuries, as neoplasia or AIDS.

172. Also, for persons who performed activities in special work conditions of groups of 1st and/or 2nd degree, according to the legislation in force before the 1 April 2001, the pension score payment was increased, these categories benefiting from a supplementary number of pension points. The increments were made in stages, step by step, considering the retirement year.

173. Since February 2009 and under Law No. 196 of 29 May 2009, Romanian authorities introduced the minimum guaranteed social pension. The setting up of this right represents a measure for improving the living standards of pensioners, in order to avoid social exclusion of part of the pensioners from the public pension system that represent a disadvantaged category of population in the context of the current economic crisis. The categories applicable and criteria to be fulfilled in order to benefit from the minimum guaranteed social pension were explained.

174. The representative of Romania provided information on the risks covered, financing of benefits and personal scope of coverage in the public pension system as well as the adequacy of the benefits.

175. The Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 12§1 SLOVENIA

The Committee concludes that the situation in Slovenia is not in conformity with Article 12§1 on the ground that:

- the rate of minimum sickness benefit is manifestly inadequate.

- the rate of minimum unemployment benefit is manifestly inadequate.
- the rate of minimum old age benefit is manifestly inadequate.
- the rate of minimum invalidity benefit is manifestly inadequate.
- the rate of minimum survivors' benefit is manifestly inadequate.

First, second, third, fourth and fifth grounds of non-conformity

176. The representative of Slovenia provided the following written information:

1. "The principles of reciprocity and solidarity

The system of pension and invalidity insurance is based on the principles of reciprocity and solidarity, on the basis of which the insured persons are ensured financial and social security by paying in contributions in accordance with their abilities and, subsequently, when they satisfy the requirements, they enforce their rights. By extending the period one spends in the compulsory insurance and with a higher age of the insured person at the time of the enforcing the right to pension, the old-age pension is adequately higher. A shorter period spent in the compulsory insurance consequently means a lower pension.

Financial and social security is thus also ensured to all those persons who, based on their contributions and conditions, cannot secure themselves a general level of social security for objective reasons. Social security is attained with social corrective measures within the compulsory insurance scheme, which enables such beneficiaries an income that is comparable to active insured persons, and prevents their social exclusion. In particular, these are "the right to pension assessment from the minimum pension rating base" and "the right to minimum pension support".

2. The right to pension assessment from the minimum pension rating base

The principles of reciprocity and solidarity are reflected in the minimum and the maximum pension rating bases, whose amount has been determined by the law. Persons who have been insured for the entire scope of rights are guaranteed by the law pension assessment from the minimum pension rating base, if the pension assessed on the basis of the completed pension qualifying period from the actual pension rating base, calculated on the basis of salaries or insurance base, does not reach the amount that the beneficiary would receive if his/her pension was assessed on the basis of the minimum pension rating base.

Irrespective of the scope of insurance and the length of the completed pension qualifying period, all pension recipients are guaranteed an old-age pension no less than in the amount of "35% of the minimum pension rating base (minimum pension)". The measuring percentage (35%) thus represents the initial percentage for assessing the first 15 years of insurance in establishing the amount of old-age pension, as each insured person must complete a minimum of 15 years of insurance period if he/she wants to receive an independent Slovenian pension. Afterwards, each subsequent year completed until 1 January, 2000 is assessed at 2%, while each subsequent year completed after 1 January, 2000, is assessed at 1.5%.

Nevertheless, it should be mentioned at this point that, on the other hand, if a pension assessed on the basis of the completed pension qualifying period from the actual pension rating base would exceed the amount which a beneficiary would be entitled to if his pension was assessed from the maximum pension rating base, the pension is assessed on the basis of the maximum pension rating base. This implies that contributions above this base are treated as a subject of taxation.

In 2007, the minimum pension rating base equalled approximately **57.1%** of an average net salary (average monthly salary in 2007 (net EUR 834.50, gross EUR 1,284.79), the minimum pension rating base in that year (EUR 476.54)). In accordance with the law, the maximum pension rating base is four times the minimum pension rating base.

3. Minimum pension support

Minimum pension support is a social corrective measure which aims to improve the financial security of recipients of minimum pensions (old-age, disability, survivor's, and widower's pensions) insured for the entire scope of rights from the compulsory insurance.

The right to minimum pension support is subject to the financial conditions of the pension recipient and family members living in the same household, and it is assessed in a certain percentage (from 60% to 100%) in accordance with the completed pension qualifying period (from 15 to 35 years) (with old-age and disability pension) and the number of family members (with widower's or survivor's pension) from the difference between the base for assessing minimum pension support and the beneficiary's pension.

This implies that all pensioners receiving minimum pensions have the right to minimum pension support. Minimum pension support is, therefore, not intended for those pension recipients whose

social security and the social security of his family members living in the same household is not endangered despite the evidenced low income!

In February 2008, the new Minimum Pension Support Act /ZVarDod/ came into force, which transferred the right to minimum pension support from the pension legislation and settled it separately in an independent law. On the basis of the Minimum Pension Support Act, a new (higher) base for assessing a minimum pension support has been determined (marginal amount), which equals 81.6% from the minimum pension rating base.

Since the introduction of the Minimum Pension Support Act, minimum pension support is again aligned in the same manner as pensions; in the intermediate period – in 2007 – due to the introduction of the Act regulating adjustments of transfers to individuals and households in the Republic of Slovenia (ZUTPG), minimum pension support was aligned with and in relation to inflation in accordance with the ZUTPG in 2007, which caused - due to the simultaneous increase of pensions, different alignment in accordance with the Pension and Disability Insurance Act (ZPIZ-1), the ways of calculating minimum pension support - the reduction or even loss of minimum pension support. Due to the effect of the ZUTPG, in 2007 1,775 people lost the right to minimum pension support. In December 2007, 43,658 people were entitled to minimum pension support, while in December 2008 there were 46,612 people.

Likewise, the Minimum Pension Support Act ensures social security to those beneficiaries who have, in addition to their own old-age or disability pension, acquired the right to widower's pension, and those beneficiaries who receive pension supplement to pensions granted from other Republics of ex-Yugoslavia. Beneficiaries who are entitled to their own pension and who, at the same time, fulfil the conditions to receive a widower's pension, and where both pensions are lower that the marginal amount, have the right to widower's pension assessment no less than in the level of the marginal amount. Such beneficiaries would be, in case they decide for their own pension (and widower's pension), entitled to minimum pension support. Therefore, in principle, they are granted the right to a pension at the level of the marginal amount, which is at the same time a census that suffices for living.

UNEMPLOYMENT BENEFIT

We consider that the methodology used by the committee is not appropriate (their calculation showed that workers with the minimum wage receive minimum benefit payment, which is not the case).

The calculation of benefit payments to beneficiaries with **the lowest income** (minimum wage guaranteed by the state in accordance with regulations to all workers for full-time work) is as follows:

· minimum wage (gross) in 2009 = 597 eur
· assessment basis = 597 eur

70% of the assessment basis = 70% of 597 eur = **417 eur** (minimum DN 272 EUR)

· minimum wage (gross) in 2007 = 521 eur
· assessment basis = 521 eur

70% of the assessment basis = 70% of 521 eur = **364 eur** (minimum DN 237 EUR)

The replacement rate amounts to 70%; to this amount must also be added family benefits (according to the income bracket) and the payment of cash social assistance balance (for persons below a set threshold); the level of social security of these categories is thus even higher and the finding of the European Committee for Social Rights is incorrect.

It should be emphasised that minimum benefit payments are only made to persons who did not work full-time (1.3% of all beneficiaries according to the Employment Service data).

SICKNESS BENEFIT

According to the Article 31 of the Health care and health insurance act the basis for compensation is the average monthly salary and compensations, or the average basis for the payment of contributions in the calendar year preceding the year during which the temporary absence from work occurred.

The compensation shall amount to:

- 100% of the basis if the absence from work occurred due to an occupational disease, occupational injury, transplantation of the living tissue and organ for the benefits of another person, the consequences of donating blood and isolation ordered by a doctor;
- 90% of the basis if the absence from work occurred due to a disease;
- 80% of the basis if the absence from work occurred due to injuries gained outside work, care for a family member or assistance ordered by a doctor.

War disabled servicemen and civilian war invalids are entitled to compensation in the amount of 100% of the basis, even in cases stipulated in the second and third indent of the previous paragraph.

The compensation cannot be smaller than the guaranteed salary and higher than the salary the insured would receive if he worked, or the basis for which this person is insured during his absence from work.

DATA OF THE HEALTH INSURANCE INSTITUTE OF SLOVENIA (ZZZS)

1) In 2009, 39 insured persons received monthly salary compensation for a period of absence from work, with the gross I equal to or lower than 237.73 EUR (for 160 hours or more). On average in 2009, the insured person (out of the above-mentioned 39) received such low compensation for 3.28 months.

2) According to all the reasons for absence from work, the Health Insurance Institute of Slovenia paid or refunded more than 209 mio. EUR to those entitled to absence from work in 2009 (thus for absence from work from 1 January - 31 December 2009), chargeable to compulsory health insurance. The compensation was calculated for 173,658 insured persons. On average, in 2009 the compensation per insured person was calculated for 27.27 working days, chargeable to the compulsory health insurance. The calculated average monthly compensation for the insured person would amount to 827.45 EUR (gross). The exact calculations, also according to the reasons for absence from work (as the differences in the amounts according to the reasons for absence are extremely substantial, mainly due to the percentage of the basis used in the calculation according to the Health Care and Health Insurance Act), are shown in the attachment:"

177. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 12§1 SWEDEN

The Committee concludes that the situation in Sweden is in not in conformity with Article 12§1 of the Revised Charter on the ground that the minimum level of the basic unemployment insurance benefit is manifestly inadequate.

178. The representative of Sweden provided the following written information:

"The Government believes that the Swedish social security system provides an adequate and sufficient financial support for unemployed and consequently fulfill and respects the requirements of Article 12§1 of the Charter and in this way guarantees the right to social security to workers and their dependants including the self-employed.

Argumentation

Based on the construction of the social security system, one individual benefit cannot be singled out and used as a sole ground for evaluation of the total support to unemployed. Different types of benefits are intertwined and should not be viewed as a number of individual benefits. The Swedish Unemployment Insurance Scheme does not for example prevent unemployed persons from getting social assistance or housing assistance combined with unemployment benefit. To the Government, the aspects which the Committee recalls and refers to indicates that the adequacy and sufficiency of a social security system firstly, should neither be evaluated nor judged only by looking at one aspect and secondly, that such a system must be reformed and adapted to the situation in each country seeking to guarantee the best support for its citizens and the most efficient system in relation to the country's financial situation and welfare system.

As the Charter seeks to lay down minimum common standards with a view to ensure the effective exercise of the right to social security and neither imposes a common model, nor seeks to harmonise social security legislation but rather to lay down minimum common standards and thereby leaves each country free to define its own social security system, the Government believes that it is important to take into account different labour market situations and different economic conditions in each country when evaluating the sufficiency of a financial benefit. The level of unemployment benefit is a delicate balance. On the one hand, unemployment benefits may serve as automatic stabilizers in a recession: the benefit reduces the loss of income, thereby smoothing the drop in tax revenues and consumption. On the other hand, generous benefits may lead to a lack of economic incentive to find employment, thereby leading to a poverty trap where benefit dependency takes precedence over an employment. The Government believes that the unemployment benefit should reflect the average pay before the onset of unemployment, but not to the point that it serves as a disincentive to take up work. During the reference period, a number of reforms have been made to the Swedish unemployment insurance. The aim is to strengthen the role of unemployment insurance by activating and helping people to readjust and quickly find new employment.

The Swedish Unemployment Insurance Scheme

The Swedish Unemployment Insurance Scheme is an important and integrated part of the Swedish labour market policy. The Swedish labour market policy aims to maintain a "work-for-all" strategy, i.e. work rather than allowance. Unemployed are given support to return to employment as soon as possible after being unemployed. Unemployment benefit is available when it is not possible to offer employment or when active labour market policy measures are not successful. In that sense, the rules of the unemployment insurance scheme are coherent with the goals of the Swedish labour market policy.

Entitlement to unemployment benefit

An unemployed who is entitled to unemployment benefit will receive the unemployment benefit for 300 days. An unemployed who by day 300 is a parent to a child under 18 years old will receive benefit for an additional 150 days, at most 450 days in total (22 § the Unemployment Insurance Act (SFS1997:238)). A jobseeker must be prepared to accept suitable work when so offered (9 § the Unemployment Insurance Act (SFS1997:238)). Any work or programme offered is considered suitable for the jobseeker if:

• reasonable consideration of the jobseeker's personal qualifications for the work and other personal circumstances has been taken,

• the employment conditions are equivalent to those for employees who are employed in accordance with collective agreements in the same sector,

• the work is not linked to a workplace where there is an ongoing a labour dispute or industrial action, and the working conditions in the workplace are in accordance with Swedish laws and government regulations, and 11 §§the Unemployment Insurance Act (SFS1997:238).

It should also be added that the Unemployment Insurance Board, in its regulations in detail regulates what is considered to be a suitable work. The regulations describe specific situations where appropriate consideration of the jobseeker's personal circumstances are observed when determining whether a work is suitable or not (see attached regulations). The regulations clarifies that the Unemployment Insurance Scheme is a readjustment insurance and that conversion to the labour market shall be started directly at the entrance of unemployment by determining whether a work or a program is suitable or not. In this regard, personal circumstances such as education and professional experience, skills, medical barriers, geographically limited search area on the grounds of family reasons, travel to and from work, earnings, industrial disputes and the promise of another work are taken into account.

This means that due consideration is given to jobseekers prerequisites for the work as well as other personal circumstances and that the jobseeker does not risk loosing their benefit if turning down a work offer not considered as suitable.

The information above is new and was not provided in the last Swedish national report on the implementation of the Charter (8th Report). As the Committee states in its conclusion this is an aspect to take into account when establishing the adequacy of a country's unemployment benefits inter alia.

Assignment of special investigator to Long-Term Survey 2011

As from the April 2010, the government assigned a special investigator to a survey, The Long-Term Survey 2011 (the Survey). The Survey will present a broad overview of the Swedish labour market and if needed propose measures aimed at the creation of a well-functioning labour market at long-term. Examples of areas that will be analyzed are:

- Employment policy formulation and development opportunities
- Unemployment insurance function
- The design of social security
- The education and work

Conclusion

With regard to the above, the Government believes that the Swedish social security system provides an adequate and sufficient financial support for unemployed and consequently that the system fulfill and respects the requirements of Article 12§1 of the Charter. The Government will in its next national report provide adequate and sufficient information and respond to the Committee's request of additional information in its Conclusions 2009."

179. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

Article 12§2 – Maintenance of a social security system at a satisfactory level at least equal to that required for ratification of the european code of social security

RSC 12§2 MOLDOVA

The Committee concludes that the situation in Moldova is not in conformity with Article 12§2 on the ground that it has not been established that Moldova maintains a social security system that meets the requirements of the European Code of Social Security.

180. The representative of Moldova provided the following written information:

> "*Amendments to maternity and family benefits*
> Under Act 68-XVIII of 23 April 2010, the monthly benefit for children under the age of three was raised from 25 to 30% of the reference sum and no less than 300 lei per child."

181. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 12§2 ROMANIA

The Committee concludes that the situation in Romania is not in conformity with Article 12§2 on the ground that due to consistent lack of information, it has not been established that Romania maintains a social security system that meets the requirements of the European Code of Social Security.

182. The representative of Romania provided the following written information:

> "Article 1 of the **Law no. 116 dated 24 April 2009** stipulates that Romania has to ratify the European Code of Social Security of the Council of Europe adopted in Strasbourg at 16 April 1964 and entered into force on 17 March 1968; This Code was signed by Romania on 22 May 2002, ratified on 9 October 2009, and entered into force on 10 October 2010.
> When depositing its instrument of ratification, the following statement is made: "In accordance with Art. 3 of the European Code of Social Security, Romania declares that it accepts the obligations under Parts I, II, III, V, VII, VIII, from the corresponding provisions of Part XI, XII and XIII and does not stand on the provisions of art. 2. 2."

183. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

Article 12§3 – Development of the social security system

RSC 12§3 ITALY

The Committee concludes that the situation in Italy is not in conformity with Article 12§3 of the Revised Charter on the ground that it has not been established that sufficient steps have been taken to raise progressively the system of social security to a higher level.

184. The representative of Italy provided the following written information:

> "It should be pointed out here that in the last report on Article 12, it was stated that under Law No. 247 of 24 December 2007, the so-called "windows" (*finestre*) system had been introduced, including even for old age pensions. Under this legislation, as from 2008, persons whose pensions were disbursed by provident funds for salaried workers and who qualified for the old age pension at 31 March, would be entitled to this type of retirement pension from 1 July the same year. Persons who qualified for the old age pension at 31 June would be entitled to this type of retirement pension from 1 October the same year; if they qualified for the old age pension at 31 September, they could begin drawing this type of retirement pension from 1 January the following year; if they qualified for the old age pension at 31 December, they could begin drawing this type of retirement pension from 1 April the following year.

Given that it was introduced only recently, we feel it is still too early to assess the measure's impact on the social security system and whether or not it has led to any improvements in the old age branch. Information on the monitoring of the social security reform will be provided in the next report on Article 12. "

185. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 12§3 MOLDOVA

The Committee concludes that the situation in Moldova is not in conformity with Article 12§3 of the Revised Charter on the ground that it has not been established that sufficient steps have been taken to raise progressively the system of social security to a higher level.

186. The representative of Moldova provided the following written information:

"*Amendments to maternity and family benefits*

Under Act 68-XVIII of 23 April 2010, the monthly benefit for children under the age of three was raised from 25 to 30% of the reference sum and no less than 300 lei per child."

187. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

Article 12§4 - Social security of persons moving between states

188. The situation are divided into three groups of reasons for non-conformity:

– **Group 1**: Right to retain accrued benefits of persons moving to a State Party not covered by Community regulations or bound by a bilateral agreement: Denmark, Iceland, Belgium, Cyprus, Estonia, Finland, Lithuania, Netherlands, Romania;

– **Group 2**: Nationals of States Parties not covered by Community regulations or bound by a bilateral agreement who cannot accumulate insurance or employment periods completed in other States: Denmark, Germany, Greece, Iceland, Poland, Belgium, Cyprus, Estonia, Finland, France, Ireland, Norway, Romania, Czech Republic;

– **Group 3**: Equal treatment not ensured during the period of residence: Denmark, Belgium, Cyprus, Lithuania, Moldova and Slovenia.

Group 1: Right to retain accrued benefits

189. States concerned: **Belgium, Cyprus, Estonia, Finland, Lithuania, Netherlands, Romania**.

RSC 12§4 BELGIUM

The Committee concludes that the situation in Belgium is not in conformity with Article 12§4 of the Revised Charter on the following grounds:

– …;

– the retention of accrued benefits for persons moving to a State Party which is not covered by Community regulations or not bound by an agreement with Belgium is not guaranteed. **[Group 1, second ground of non-conformity]**

RSC 12§4 CYPRUS

The Committee concludes that the situation in Cyprus is not in conformity with Article 12§4 of the Revised Charter on the following grounds:

– …;
– accumulation of insurance periods acquired under the legislation of a State Party which is not covered by Community regulations or not bound by an agreement with Cyprus is not guaranteed. **[Group 1, second ground of non-conformity]**

RSC 12§4 ESTONIA

The Committee concludes that the situation in Estonia is not in conformity with Article 12§4 of the revised Charter, for the following reasons :

– the retention of accrued benefits for persons moving to a State Party which is not covered by Community regulations or not bound by an agreement with Estonia is not guaranteed; **[Group 1, first ground of non-conformity]**
– …

RSC 12§4 FINLAND

The Committee concludes that the situation in Finland is not in conformity with Article 12§4 of the Revised Charter on the following grounds:

– …;
– nationals of States Parties not covered by Community regulations or bound by an agreement with Finland are not entitled to accumulate insurance or employment periods completed in other countries. **[Group 1, first ground of non-conformity]**
– …

RSC12§4 LITHUANIA

The Committee concludes that the situation in Lithuania is not in conformity with Article 12§4 of the Revised Charter on the following ground:

- …;
- the retention of accrued benefits related to work accidents, occupational disease or sickness for persons moving to a State Party which is not covered by Community regulations or not bound by an agreement with Lithuania is not guaranteed; **[Group 1, second ground of non-conformity]**
- …

Second ground of non-conformity

190. The representative of Lithuania provided the following written information:

> "Lithuania has chosen to regulate accumulation of insurance and employment periods by bilateral agreements concerning the nationals of the State Parties not covered by Community regulations as bilateral agreements are mentioned in the wording of paragraph 4 of Article 12 of revised European social charter as one of the means to ensure the implementation of the provisions of this paragraph.
> We have consulted secretarial couple times asking what could be other measures than bilateral and multilateral agreements that could be appropriate to remedy the situation under provisions of paragraph 4 of Article 12. Having the answer that it could be unilateral administrative measures, we analyzed the situation and concluded that according to Lithuanian legislation and interests there was no other better option than bilateral agreement.
> In 2008 we examined the migration flows of 2005-2007, which showed that migration of population within member states of Council of Europe where EU regulations are not applicable was very small in comparison to general immigration and emigration flows, for instance in 2005 the highest flow was concerning Moldova – 26 persons, the lowest concerning Albania, Croatia – 4 persons, while migration of majority of State Parties of Council of Europe was zero... The appropriate numbers were also represented in the last report.
> In order to make procedure of arrangement of bilateral agreements simpler and quicker and in the view of the conclusions of the European Committee of Social Rights and the encouragement of the Governmental Committee of the European Social Charter to take urgent measures to improve the situation, on 24 November 2008 the Government of the Republic of Lithuania approved the Draft Model Agreement (bilateral) between the Government of the Republic of Lithuania and Another State on Social Security. Such model agreement should shorten the procedures of arrangement of the bilateral agreements in the Lithuanian legal system, because main positions and provisions of this agreement are agreed and confirmed by appropriate Lithuanian authorities. This model agreement

was prepared according to the relevant model of bilateral agreement on social security of the Council of Europe."

191. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 12§4 NETHERLANDS

The Committee concludes that the situation in the Netherlands is not in conformity with Article 12§4 of the Charter on the ground that the legislation does not provide for the retention of supplementary benefits when persons move to a State Party not bound by Community regulations or by an agreement with the Netherlands. **[Group 1]**

192. The representative of the Netherlands thought that the situation in that state was different and that the Netherlands should be dealt with separately.

193. The Chair agreed, though the Netherlands did support the joint statement.

194. The representative of the Netherlands said that the benefits legislation (the Toeslagenwet law) provided for a supplement to the invalidity or unemployment benefits when one of them is below the statutory minimum wage in respect to reach this statutory minimum wage. This benefit was means tested and was linked to the Dutch cost of living index. This was a form of social assistance and benefits provided under the Toeslagenwet law could not be exported.

195. The representative of Estonia agreed. Social welfare benefits were not intended for export. They were a form of support that formed part of the social assistance system of the state of residence, which explained why they were non-exportable.

196. The representative of the Netherlands said that there was currently a case pending on this subject before the CJEC.

197. The Committee noted the information, invited the Government to supply detailed information in the next report and decided to await the ECSR's next assessment.

RSC 12§4 ROMANIA

The Committee concludes that the situation in Romania is not in conformity with Article 12§4 of the Revised Charter on the following grounds:

– the retention of accrued benefits for persons moving to a State Party which is not covered by Community regulations or not bound by an agreement with Romania is not guaranteed; **[Group 1, first ground of non-conformity]**
– …

198. The representative of the Netherlands said that Article 12§4 entailed the use of complex co-ordination arrangements for social security, but he expressed doubts about the value of these arrangements, since the EU provided for the free movement of workers. The legal situation differed according to whether or not the countries concerned were EU member states.

199. The Secretariat explained that the EU regulations met the conditions of Article 12§4. The problem was for countries that were not EU members.

200. The representative of Lithuania said that in the previous supervision cycle the Committee had invited the government of Lithuania to provide information on migration

levels. The figures showed that very few persons were concerned. She asked why there had been a conclusion of non-compliance for Lithuania when, for instance only twenty-ix (the largest immigration from Moldova in 2005) of so individuals were involved.

201. The Secretariat said that the ECSR understood that certain countries had difficulty negotiating bilateral agreements when the figures showed that only a limited number of persons were affected. However, it had to abide by the wording of Article 12§4 and states must find other means of satisfying these persons' rights, such as unilateral rules.

202. The representative of Germany did not consider it possible to comply with Article 12§4 in the case of Turkey until common measures had been adopted. No unilateral solution was possible.

203. The representative of France thought that bilateral agreements could be the answer, but only if the countries concerned asked for them. At all events there were always problems since there were EU member states on the one hand and non-EU Council of Europe member states on the other.

204. The representative of Estonia agreed with the representatives of Germany and the Netherlands. Freedom of movement meant that countries could export benefits and must provide information on how these benefits were used. The transmission of this information could not be based on unilateral measures. Unilateral measures would course administrative and budgetary problems as there would not be appropriate oversight of the situation. The ECSR said that states should ratify the European Convention on Social Security. Yet the Netherlands had ratified this Convention and was still deemed not to be in conformity.

205. The representative of Norway emphasised the importance of reciprocity. Article 12§4 called for the conclusion of bilateral or unilateral agreements but the latter option was a difficult one to follow. Reciprocity was the fundamental principle. There were also problems with bilateral agreements, but Norway had never refused to conclude such an agreement if another country requested it.

206. The representative of Belgium said that the problem was that the ECSR obliged states to take unilateral measures in the absence of an agreement.

207. The representative of the Czech Republic agreed. The unilateral approach was not possible. There had to be bilateral or even multilateral agreements.

208. The Chair proposed that a joint statement be issued on this specific ground of non-conformity.

209. The Committee agredd on the following joint statement for the nine States that were not in conformity because it could not be guaranteed that persons moving to another state party would retain their accrued rights:

> "The Committee considers that ratification of the European Convention on Social Security and the conclusion of bilateral agreements is a means of securing compliance with Article 12§4 of the Charter.

The retention of social security benefits, irrespective of the beneficiaries' movements between States Parties, calls for co-ordination of the administrative procedures of the states concerned. States should therefore consider the need for further bilateral agreements with non-member countries of the EU if they have a mutual interest in concluding such agreements and there is a significant movement of population between the two countries concerned."

Group 2: Accumulation of insurance or employment periods

210. States not covered by EU agreements cannot accumulate insurance or employment periods: **Cyprus, Estonia, Finland, France, Ireland, Lithuania, Norway and Romania**.

RSC 12§4 CYPRUS

The Committee concludes that the situation in Cyprus is not in conformity with Article 12§4 of the Revised Charter on the following grounds:

– the length of residence requirement for social pension for non-nationals not covered by Community regulation is excessive; **[Group 2, second ground of non-conformity]**
– …

RSC 12§4 ESTONIA

The Committee concludes that the situation in Estonia is not in conformity with Article 12§4 of the revised Charter, for the following reasons :

– …;
– nationals of States Parties which are not covered by Community regulations or not bound by an agreement with Estonia cannot accumulate periods of insurance or employment completed in other countries. **[Group 2, second ground of non-conformity]**

RSC 12§4 FINLAND

The Committee concludes that the situation in Finland is not in conformity with Article 12§4 of the Revised Charter on the following grounds:

– …;
– nationals of States Parties not covered by Community regulations or bound by an agreement with Finland are not entitled to accumulate insurance or employment periods completed in other countries. **[Group 2, second ground of non-conformity]**

RSC 12§4 FRANCE

The Committee concludes that the situation of France is not in conformity with Article 12§4 of the Revised Charter on the ground that nationals of States Parties not covered by Community regulations or not bound by an agreement concluded with France have no possibility of accumulating insurance or employment periods completed in other countries. **[Group 2]**

RSC 12§4 IRELAND

The Committee concludes that the situation in Ireland is not in conformity with Article 12§4 of the Revised Charter on the ground that nationals of States Parties not covered by Community regulations or not bound by an agreement concluded with Ireland have no possibility of accumulating insurance or employment periods completed in other countries. **[Group 2]**

RSC12§4 LITHUANIA

The Committee concludes that the situation in Lithuania is not in conformity with Article 12§4 of the Revised Charter on the following ground:

- …;
- …;
- it has not been established that nationals of States Parties not covered by Community regulations or bound by an agreement with Lithuania are entitled to accumulate insurance or employment periods completed in other countries. **[Group 2]**

Third ground of non-conformity

211. The representative of Lithuania provided the following written information:

> "Lithuania has chosen to regulate accumulation of insurance and employment periods by bilateral agreements concerning the nationals of the State Parties not covered by Community regulations as bilateral agreements are mentioned in the wording of paragraph 4 of Article 12 of revised European social charter as one of the means to ensure the implementation of the provisions of this paragraph.
> We have consulted secretarial couple times asking what could be other measures than bilateral and multilateral agreements that could be appropriate to remedy the situation under provisions of paragraph 4 of Article 12. Having the answer that it could be unilateral administrative measures, we analyzed the situation and concluded that according to Lithuanian legislation and interests there was no other better option than bilateral agreement.
> In 2008 we examined the migration flows of 2005-2007, which showed that migration of population within member states of Council of Europe where EU regulations are not applicable was very small in comparison to general immigration and emigration flows, for instance in 2005 the highest flow was concerning Moldova – 26 persons, the lowest concerning Albania, Croatia – 4 persons, while migration of majority of State Parties of Council of Europe was zero... The appropriate numbers were also represented in the last report.
> In order to make procedure of arrangement of bilateral agreements simpler and quicker and in the view of the conclusions of the European Committee of Social Rights and the encouragement of the Governmental Committee of the European Social Charter to take urgent measures to improve the situation, on 24 November 2008 the Government of the Republic of Lithuania approved the Draft Model Agreement (bilateral) between the Government of the Republic of Lithuania and Another State on Social Security. Such model agreement should shorten the procedures of arrangement of the bilateral agreements in the Lithuanian legal system, because main positions and provisions of this agreement are agreed and confirmed by appropriate Lithuanian authorities. This model agreement was prepared according to the relevant model of bilateral agreement on social security of the Council of Europe."

212. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 12§4 NORWAY

The Committee concludes that the situation in Norway is not in conformity with Article 12§4 of the Revised Charter on the ground that accumulation of insurance periods acquired under the legislation of a State Party which is not covered by Community regulations or not bound by an agreement with Norway is not guaranteed. **[Group 2]**

RSC 12§4 ROMANIA

The Committee concludes that the situation in Romania is not in conformity with Article 12§4 of the Revised Charter on the following grounds:

– …;
– nationals of States Parties not covered by Community regulations or not bound by an agreement concluded with Romania have no possibility of accumulating insurance or employment periods completed in other countries. **[Group 2, second ground of non-conformity]**

213. The Committee agreed on the following joint statement for the fourteen countries that were not in conformity because nationals of States Parties not covered by Community regulations and not bound by an agreement were not automatically entitled to the accumulation of insurance or employment periods:

> "The Committee considers that ratification of the European Convention on Social Security and the conclusion of bilateral agreements is a means of securing compliance with Article 12§4 of the Charter.
>
> The retention of social security benefits, irrespective of the beneficiaries' movements between States Parties, calls for co-ordination of the administrative

procedures of the countries concerned. Countries should therefore consider the need for further bilateral agreements with non-member countries of the EU if they have a mutual interest in concluding such agreements and there is a significant movement of population between the two States concerned."

Group 3: Equal treatment not ensured during the period of residence:

States concerned: **Belgium, Cyprus, Lithuania, Moldova and Slovenia**.

RSC 12§4 BELGIUM

The Committee concludes that the situation in Belgium is not in conformity with Article 12§4 of the Revised Charter on the following grounds:

– equal treatment as regards the payment of disability allowance is not guaranteed to nationals of States Parties not covered by Community regulations or bound by agreement with Belgium; **[Group 3, first ground of non-conformity]**

– …

First ground of non-conformity

214. The representative of Belgium said that the situation had not changed during the reference period, but after submission of the report on which the 2009 conclusions were based, a royal decree of 9 February 2009 had been adopted making persons shown as foreign nationals on the population register also eligible for disabled persons' allowances. There would be a detailed explanation in the next report.

215. The Committee noted these positive developments, welcomed the efforts of the government of Belgium and decided to await the ECSR's next assessment.

RSC 12§4 CYPRUS

The Committee concludes that the situation in Cyprus is not in conformity with Article 12§4 of the Revised Charter on the following grounds:

– the length of residence requirement for social pension for non-nationals not covered by Community regulation is excessive; **[Group 3, first ground of non-conformity]**

– …

First ground of non-conformity

216. The representative of Cyprus said that the social insurance section of the ministry of labour and social insurance was looking at several options for reducing the length of residence requirement for entitlement to social pensions. However, there were currently no changes to report.

217. The representative of the ETUC expressed surprise, since the situation had been incompatible with the Charter since 2000.

218. The representatives of Estonia and Lithuania thought that the twenty year period was too long and needed to be shortened.

219. The Chair said that the situation had not been in conformity for ten years and that the Committee should press for change and a reduction in this length of residence.

220. The representative of the ETUC said that the social pension was designed for those who were not entitled to a pension from any source. It was an element of social security

based on residence. The non-compliance situation has lasted for ten years. The government of Cyprus had to take action.

221. The representative of the Czech Republic said that the Cypriot Government seemed to be relying on a review of the situation regarding social pensions. The matter needed to be looked at again in the next cycle.

222. The representative of Georgia said that this was a long-standing issue and proposed that a warning be issued.

223. The representative of Cyprus acknowledged that this matter had gone on for ten years but there had been changes of Government. A little more time was needed.

224. The representative of the ETUC said that there were also regular changes of government in Belgium but that country was nevertheless continuing with its reforms.

225. The Chair called for a vote on the proposed warning to Cyprus.

226. The Committee adopted a warning to Cyprus (11 voices for, 5 against and 21 abstentions).

227. At the end of the meeting, the representative of Cyprus made the following statement in relation to the Committee's decision to adopt vote on a warning (11 for, 5 against and 21 abstentions):

> "Thank you, Madam Chair, for giving me the floor. With respect, Madam Chair, I believe that the voting procedure followed was very confusing and did not reflect the application of justice and equal treatment of States Parties to the Social Charter. I would like to suggest that adopting the warning against Cyprus (11 votes for, 5 votes against and 21 abstentions) was unfair for Cyprus since the members who abstained were not aware that their vote would not be counted at all.
>
> Specifically, I would like to draw your attention to the working document T-SG(2010)7, paragraph 158 of Art. 13§1 regarding Denmark, which states the following: "The Governmental Committee voted on a warning which was not adopted (11 votes for, 6 against and 15 abstentions")… I repeat NOT ADOPTED.
>
> The votes cast in the case of Denmark and in the case of Cyprus were marginal, yet a warning was adopted for Cyprus. I am wondering whether we are applying the same rules of procedures for all Member States.
>
> The United Kingdom representative stated that in such circumstances it would be advisable if the rules of procedure were announced prior to voting, and the reaction was "we will make a note".
>
> Having said that, I remind everyone that Cyprus is "examining various scenarios for the reduction of the length of residence requirement for entitlement to a social pension".
>
> Cyprus is working towards reducing the length of residence requirement (currently 20 years), not least because the same applies to Cypriot nationals who were for

years living in third countries with no social security system. On their return to Cyprus, these Cypriot Nationals do not qualify for social pension paid out of the Social Security Fund.

With respect, I would like the Committee to take note of the above and decide on whether (a) its decision is final, despite the confusion in applying the rules of procedure fairly or, (b) a further vote can be taken".

228. Mr Kristensen recalled the voting rules related to the examination of the non-conformity conclusions by the Committee.

229. The representative of Cyprus asked for a new vote in accordance with the voting rules.

230. The Committee decided that a new vote would be carried out at its October meeting concerning Article 12§4 Cyprus.".

231. The Chair pointed out that at its 121st meeting (May 2010), the Committee had voted to address a warning to Cyprus. Since the vote on the warning had given rise to discussions, certain persons having been unaware that abstentions did not count towards "votes cast", the matter had once again been placed on the agenda.

232. The representative of Cyprus said that the authorities had taken the repeated conclusion of non-conformity seriously and that they were determined to find a solution. A study was being carried out on this subject. The findings were expected to be released by the end of 2010 and to include practical suggestions for resolving the problem in question.

233. The representative of Cyprus provided the following information:

"The Social Pension is a non-contributory scheme for persons who have attained the age of 65 years and are not entitled to pension from any other source. To become beneficiary of social pension one needs to be legally residing in Cyprus and satisfy the length of residency requirements. The Social Pension scheme is financed through the Government Budget and not the Social Insurance Fund.

An actuarial study on pensioners living below the poverty line, including social pensioners is currently been conducted and expected to be completed by the end of 2010. The study will suggest an alternative long term and sustainable solution for the design of an income support scheme for the low income pensioners. This solution, amongst others, will examine the possibility of amending the existing framework on social pension and other public pension provisions or even replacing social pension with the new scheme.

Over the last 15 years, the vast majority of applicants who were not entitled to receive social pension at the age of 65 due to the fact that they were not satisfying the residency requirement were Cypriot repatriates from third countries. A scheme for this group of the population is under consideration.

It should be noted, however, that Public Assistance legislation ensures a socially acceptable minimum standard of living for all persons legally residing in the Republic of Cyprus. The legislation does not include a length of residency requirement and

makes no discrimination on the basis of nationality, race, religion, gender etc. Any person whose income and other economic resources are insufficient to cover his/her basic and special needs, as defined in the legislation, may apply for public assistance, which may be provided in the form of monetary support and/or services."

234. Further information would be provided in the next report, once an actuarial study had been completed.

235. In the light of the information furnished, the representative of Lithuania asked for clarification on this subject, given that the ground of non-conformity (length-of-residence requirement) was the same for everyone (i.e. EU nationals and third-country nationals).

236. The representative of the Czech Republic felt that the area of social pensions under review here was more a matter of social assistance than social security, and therefore came under Article 13 rather than Article 12§4.

237. The Secretariat said it was difficult to draw a precise line between social insurance and social security. The Government of Cyprus had always presented this as a social security benefit. The problem in this instance was the 20-year residence requirement and nothing else.

238. The representative of Cyprus reiterated that over the past 15 years, the majority of people who had been refused a social pension were Cypriot nationals who had lived abroad and come back to settle in Cyprus; for people in this position, a solution could be found.

239. The representative of Greece noted that the proposed study demonstrated the commitments entered into by Cyprus.

240. The representatives of the Netherlands, Estonia and France noted that the only new element was this study, but said that at the May 2010 session, the confusion had been about the procedures for voting on whether to address a warning, and not the warning itself. In their view, the length of residence required was excessive and a warning ought to be issued.

241. The representative of the ETUC felt that, since there had been no changes (apart from the study), there was no need to vote again on whether to issue a warning about what was a long-standing non-conformity. It would be dangerous to hold another vote in this instance. Were the vote to take place, this would create a very bad and dangerous precedent.

242. The Committee nevertheless decided to proceed with the vote.

243. In accordance with the rules of procedure, it voted first on a proposal for a recommendation to Cyprus (0 in favour, 20 against and 8 abstentions). The recommendation was not carried.

244. The Committee then voted on whether to address a warning to Cyprus (8 in favour, 14 against and 10 abstentions). The warning was not carried.

245. The representative of Belgium hoped that this double vote would not set a precedent and asked that fewer states abstain in order to clarify matters.

246. The representative of Norway proposed that, since the warning had not been adopted, a strong message be sent to the Government of Cyprus.

247. The Committee urged the government of Cyprus to provide detailed information about the planned study in its next report and decided to await the next assessment of the ECSR.

RSC12§4 LITHUANIA

The Committee concludes that the situation in Lithuania is not in conformity with Article 12§4 of the Revised Charter on the following grounds:

– entitlement to state social insurance pensions is subject to a residence requirement; **[Group 3, first ground of non-conformity]**
– …;
– …

First ground of non-conformity

248. Concerning the first ground, there were some considerations during the meeting. The Committee even congratulated Lithuanian affords concerning finding some solutions to improve the situation (speeding up the procedure of making the bilateral agreement).
Firstly, the representative of Lithuania presented some affords made by authorities of Lithuania to improve situation amending the Law on State Social Insurance Pensions. Secondly, in 2008 Lithuaninan authorities examined the migration flows of 2005-2007, which showed that migration of population within member states of Council of Europe where EU regulations are not applicable was very small in comparison to general immigration and emigration flows, for instance in 2005 the highest flow is concerning Moldova – 26 persons, the lowest – Albania, Croatia 4 persons. The appropriate numbers were also represented in the last report.
It was emphasized that in order to make procedure of arrangement of bilateral agreements simpler and quicker and in the view of the conclusions of the European Committee of Social Rights and the encouragement of the Governmental Committee of the European Social Charter to take urgent measures to improve the situation, on 24 November 2008 the Government of the Republic of Lithuania approved the Draft Model Agreement (bilateral) on Social Security. Such model agreement should shorten the procedures of arrangement of the bilateral agreements in the Lithuanian legal system, because main positions and provisions of this agreement are agreed and confirmed by appropriate Lithuanian authorities. This model agreement was prepared according to the relevant model of bilateral agreement on social security of the Council of Europe. Nevertheless, that this information about this Draft Model Agreement was provided in the last report, but the efforts of Lithuanian authorities were not noticed.

249. The Committee took note of these positive developments announced and decided to await the ECSR's next assessment.

RSC 12§4 MOLDOVA

The Committee concludes that the situation in Moldova is not in conformity with Article 12§4 of the Revised Charter on the ground that equal treatment of nationals of other States Parties is not guaranteed. **[Group 3]**

250. The representative of Moldova said that her Government was aware of the need to settle social security relations with other states. Moldova had made some progress since

the last report and had concluded several agreements. The social insurance agreement between Moldova and Bulgaria was signed on 5 December 2008 and came into force on 1 September 2009. On 11 February 2009, a social security agreement with Portugal was signed in Lisbon. A social security agreement between Moldova and Romania was signed in Bucharest on 27 April 2010, and Moldova was currently in negotiations with the Czech Republic and Luxembourg.

251. The representative of the Czech Republic said that the ground of non-conformity concerned equal treatment and no information had been provided on this.

252. The representative of Moldova said that not only had the Government concluded bilateral agreements, there was also new legislation to provide for equal treatment.

253. The representative of the Czech Republic noted that new legislation had been passed and proposed that the Moldovan Government be invited to include this information in the next report.

254. The Committee expressed satisfaction with Moldova's efforts to negotiate bilateral agreements and invited the government to supply information on the new legislation.

RSC 12§4 SLOVENIA

The Committee concludes that the situation in Slovenia is not in conformity with Article 12§4 of the Revised Charter on the ground that several benefits (pension and disability insurance, parental allowance and partial payment for lost income) are subject to a nationality condition and therefore not available for nationals of States Parties which are not covered by community regulations. **[Group 3]**

255. The representative of Slovenia said that certain benefits were subject to a nationality condition but these were non-contributory benefits. Entitlement to family allowances had already been extended to members of the EEA and countries with which there were bilateral agreements. There was a commitment to concluding bilateral agreements with non-EEA member states such as Bosnia and Herzegovina, Serbia and Montenegro.

256. The Committee took note of these positive developments and decided to await the ECSR's next assessment.

Article 13§1 – Adequate assistance for every person in need

RSC 13§1 ANDORRA

The Committee concludes that the situation in Andorra is not in conformity with Article 13§1 of the Charter on the ground that foreign nationals legally resident in Andorra are subject to an excessive length of residence requirement to be eligible for social assistance.

257. The representative of Andorra provided the following written information:

> "As we stated in our report, Article 30 of the Andorran Constitution grants people the right to health protection and to claim benefits to meet other personal needs.
> Furthermore, on 16 June 2008 Andorra adopted a decree approving the National Social Welfare Plan for 2008-2011, which divides welfare activities into four main areas:
> - Prevention
> - Proximity and community
> - Active society
> - The socio-health sphere

Among the issues addressed by the plan are the right to state benefits (Article 2, paragraph g) and the gender perspective (Article 2, paragraph h). In Article 3.3, paragraph b, financial benefits are defined as material support provided by the public services to individuals or families designed both to give them the economic means to cover their basic needs and overcome situations of marginalisation and social exclusion and to foster independence. The purpose of social benefits is to guarantee people access to social welfare activities and services. The plan is currently being revised.
The rules on benefits are set out in Decree 19/11/2008 approving the Regulation on social welfare benefits, which replaces the former regulation of 1996. The Regulation was amended on 16 September 2009 to include, for the very first time, a benefit for people who have lost their jobs. On 25 November 2009 a further amendment was made removing the six-month residence requirement for entitlement to welfare benefits for victims of gender-based violence and their children.
We would like to provide you with some data which proves that foreign residents in Andorra have access to welfare benefits without having to meet any residence requirements, pursuant to Article 23 on "special benefits" of the Regulation on social welfare benefits. On 27 September 2010, 106 of the welfare benefits granted for the year 2010 were such special benefits, accounting for 28% of the total.
Total number of benefits granted by 27 September 2010: 378
Total number of welfare benefit claimants by 27/09/10: 302
Number of special benefits granted by 27 September 2010: 106
To give the Committee a clearer view of the situation in Andorra, we enclose the following table listing types of benefit, their aims and periods of residence required for entitlement.

Art.	Para.	Type of benefit	Purpose	Residence requirement
		Emergency financial benefit	For housing	
		Emergency financial benefit	To return to one's country of origin	
		Emergency financial benefit	To deal with other emergency situations	
20	A)	**Financial benefits to cover basic needs**	To deal with situations of financial insecurity	7 years
	B)	Financial benefits to cover basic needs	For housing	5 years
21	A)	**Financial benefits to prevent situations of exclusion and marginalisation and to foster independence**	To promote socialisation and provide academic support for children	6 months
	B)	Financial benefits to prevent situations of exclusion and marginalisation and to foster independence	To enable elderly people and people with disabilities to continue living in their own homes	7 years
	C)	Financial benefits to prevent situations of exclusion and marginalisation and to foster independence	To improve access through the removal of architectural obstacles and through technical aids designed to enhance personal autonomy	3 years
	D)	Financial benefits to prevent situations of exclusion and marginalisation and to foster independence	To adapt vehicles for use by persons with reduced mobility	3 years
22	A)	**Financial benefits for access to social welfare programmes, activities and services**	To help pay for child care and child-minders	6 months
	B)	Financial benefits for access to social welfare programmes, activities and services	For children to be placed with foster families	
	C)	**23 | | Special benefits**	To help women who are victims of gender-based violence	**I**
		Financial benefits for access to social welfare programmes, activities and services		
	D)	Financial benefits for access to social welfare programmes, activities and services	To help women to recover from gender-based violence	
	E)	Financial benefits for access to social welfare programmes, activities and services	To help cover the cost of the welfare component of day-care services	7 years
	F)	Financial benefits for access to social welfare programmes, activities and services	To help cover the cost of the welfare component of residential health and social care	7 years

258. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 13§1 ARMENIA

The Committee concludes that the situation in Armenia is not in conformity with Article 13§1 of the Revised Charter on the ground that the level of social assistance paid to a single person without resources is manifestly inadequate.

259. The representative of Armenia provided the following written information:

"Pension Security

Social pension is paid to 65 years of age women and men, who have less than 5 years length of service. In accordance with the RA Government decree N1122 dated October 2, 2008 this pension amounts to 8000 AMD starting from January 1, 2009, furthermore for the first group of disability – 11200 AMD, for the second group – 9600 AMD, for the third group – 8000 AMD.

According to the RA Government decree N 275 dated March 25, 2010 the amount of social pension was established 10500 AMD starting from November 1, 2010: for the first group of disability 14700, for the second group – 12600, for the third group – 10500.

With the RA law "About Veterans of the Great Patriotic War" monthly monetary reward is given to veterans of the Great Patriotic War. In accordance with the RA Government decree N444 dated May 15, 2008 the amount of monthly reward from July 1, 2008 amounts to 20000 AMD.

According to the RA Government decree N 207 dated February 5, 2004 monetary support is provided to disabled veterans of the Great Patriotic War and persons equalized with them, parents, widows and from childhood disabled children of military deceased during the Great Patriotic War and during hostilities in other countries. The amount of the monetary support is 6800 AMD from January 1, 2009 and according to the same decree the amount of the monetary support provided to participant of the Great Patriotic War is 4500 AMD.

Right to appeal the decision on pension refusal is guaranteed by the RA law "About State Pensions" Article 69, moreover decisions of the department in charge of pension entitlement can be appealed in superiority or judicial order.

The RA law "About State Pensions" Article 10 states that a foreign citizen or a person without citizenship having resident right in the Republic of Armenia has equal right for pension as a citizen of the RA in case of satisfying conditions stipulated by law.

Social Assistance

Kinds of Benefits and Conditions for Benefit Entitlement

Taking into consideration drastic increases of pension from January 2008, with the RA Government decree N 1530 dated December 27, 2007 the mechanism of pension calculation while assessing family vulnerability has been changed (is established by the size of pension prior to the month of application instead of former average of 12 months). Simultaneously, frontier score of vulnerability assessment decreased by 3 points.

The decree envisages special provision for stipulation of family benefit right of families having a lonely unemployed pensioner without heirs, according to which starting from January 2008 family benefit right is provided to those families having the mentioned composition, whose pension amount for each member will not exceed 30 thousand AMD. Moreover in 2009 that size amounted to 36500 AMD.

And reduction of vulnerability score to 30.00 under the conditions of pension increase gave an opportunity to maintain in the system families having pensioners.

With the RA Government decree N39 dated January 15, 2009 basic amounts of family benefit and additional payment for each under 18 years of age member changed in 2009 depending on family vulnerability score, place of family residence and number of family members under 18 years of age. The minimum amount of family benefit given to lonely pensioner is equal to the basic amount of benefit, which in 2008 was 8000 AMD, in 2009 – 10000 AMD.

The amounts are presented in the table below:

			2008	2009
Frontier score			30.00	30.00
Basic part of benefit			8000	10000
Basic part of benefit for family not having under age children				
Additional payment given to each under 18 years of age member	Differentiation			
	30.01-35.00		5000	5500
		In case of 4 and more under age children (family with many children)	6000	6500
		High mountainous and bordering places of residence	5500	6000
		Family with many children in high mountainous and bordering places of residence	6500	7000

	35.01-39.00		5500	6000
		Family with many children	6500	7000
		High mountainous and bordering places of residence	6000	6500
		Family with many children in high mountainous and bordering places of residence	7000	7500
	39.01 and more		6000	6500
		Family with many children	7000	7500
		High mountainous and bordering places of residence	6500	7000
		Family with many children in high mountainous and bordering places of residence	7500	8000
Urgent support			8000	10000

During January – April 2010 vulnerability frontier score and sizes of benefits remained the same and from May determined by gas tariffs growth basic amount of family benefit increased by 3500 AMD amounting to 13500 AMD. Determined by the mentioned circumstances the average monthly amount of the family benefit also increased by 3500 AMD.

The RA law "About State Benefits" Article 18 stipulates right for urgent support, according to which the right for urgent support is issued by the social assistance council to a family, registered in the system of family vulnerability and not having the right for family benefit, in case of finding itself in a vulnerable situation (partial reimbursement of costs as regards attending school, in state of emergency and having temporary financial problems) which requires urgent solution. The amount of urgent support is equal to the basic part of family benefit – 13500 AMD from May 2010.

At the same time, in the circumstances of the global financial and economic crisis there was no reduction of social costs in 2009, all costs were fully financed, and in the RA law "About Republic of Armenia 2010 State Budget" there is 2 percent increase of social costs in comparison with 2009.

According to the RA Government decree, 36.00 vulnerability score in the system of family vulnerability assessment gives the right for free of charge medical assistance in the framework of state order.

Primary medical assistance in polyclinics is free of charge for all citizens.

All persons with disability have the right for free of charge medical treatment. Persons of the first and second groups of disability receive free of charge medicine, and persons of the third group of disability pay only 50 percent of medicine cost.

Right for appeal and legal assistance

The RA law "About Social Assistance" Article 10 establishes types of monetary support, particularly state benefits, and Article 25 of the same law establishes timeframes of decision making on providing social assistance in the framework of state programs and order of appealing them. Particularly, Point 5 of the Article establishes that a citizen can appeal actions or absence of actions of the territorial body delivering social services to the head of the territorial body, the RA Government authorized state body in the sphere of social assistance and/or court.

The RA Government decree N2337 dated December 29, 2005 Point 1 establishes that the RA Government authorized state body in the sphere of social assistance is the RA Ministry of Labour and Social Issues.

In February 18, 2004 the National Assembly adopted the RA law "About Administrative Bases and Administrative Process", which entered into force in January 1, 2005. This law regulates adoption of administrative acts, types of appealing those acts, as well as actions and absence of actions of administrative bodies, relations between administrative bodies and physical or legal entities as regards implementation of administrative acts, administrative expenses and reimbursement of administrative damage. The procedure of recognizing family benefit right as a procedure of adopting an administrative act is regulated by the RA law "About Administrative Bases and Administrative Process".

Individual Scope

Foreign citizens having corresponding stay permit in the Republic of Armenia, finding themselves in a vulnerable situation can apply to social assistance programs if they satisfy requirements for the given type of social assistance, stipulated by the RA laws, the RA Government decrees or other legal acts, which are obligatory also for the local population.

This provision is established in the RA law "About Social Assistance" Article 6 and the RA law "About State Benefits" Article 2."

260. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 13§1 BELGIUM

In The Committee concludes that the situation in Belgium is not in conformity with Article 13§1 of the Revised Charter on the ground that the guaranteed income for the elderly (GRAPA) is not granted to foreigners without resources unless they are covered by community law or are nationals of States which have concluded reciprocity agreements with Belgium.

261. The representative of Belgium indicated that the scope of the legislation on guaranteed income for the elderly had been extended to nationals of States Parties to the Charter by a law of 6 May 2009 (which amended the original Act of 2001). This amendment would enter into force on a date to be fixed in a Royal Decree which was currently under preparation.

262. The Committee took note of this positive development and congratulated the government of Belgium. It decided to await the next assessment of the ECSR.

RSC 13§1 BULGARIA

In The Committee concludes that the situation in Bulgaria is not in conformity with Article 13§1 of the Revised Charter on the ground that:

– it has not been established that persons in need, whose social assistance is interrupted after 12 months, can obtain adequate resources to meet the necessary costs of living in a manner consistent with human dignity;
– persons who lose entitlement to social assistance are not provided with medical assistance which they might require;
– the level of social assistance is manifestly inadequate;
– it has not been established that elderly persons without resources receive adequate social assistance;
– the granting of social assistance to foreigners is conditional on a continuous presence in Bulgarian territory that is excessively long.

First, second and fourth grounds of non-conformity

263. The representative of Bulgaria provided the following written information:

> "1. Collective complaint № 48/2008
> The collective complaint was filed before the Council of Europe on March 28th, 2008 and it contains allegations of non-compliance with the provisions of art. 13, para 1 and art. F of the / European Social Charter (revised) regulating the right to social assistance and non-discrimination principle. In particular, it is attacked the amendment to the Social Assistance Act of February 2006, which introduced a limitation of receiving monthly social assistance continuously for the period of 18 /subsequently reduced to 12 / months of unemployed persons of working age.
> As it has already been set out in the Collective Complaint No. 46 of 23.02.2010, the impugned provision 12 (c) was abolished by an amendment of the Social Assistance Act promulgated in State Gazette that shall take effective from 01.01.2011.
> The Social Assistance Agency carries out weekly monitoring of persons who drop out of social assistance and it takes measures together with the National Employment Agency to promote their professional realization, as a long term solution. There are specific measures that are aimed at unemployed Roma registered at the Bureaus of Labour - the National Programme From Social Assistance to Employment, the National Programme Activate the Inactive Persons, etc. As of January 2010 in 72 Bureau of Labour Directorate there are 103 Roma employed as mediators to assist the activation and integration of inactive and discouraged people to the labour market. For the period of 2006 to 2009 a total of 125 Roma have been trained to work as mediators.
> The National Employment Agency organized specialized job fairs aimed at Roma community. For the period of 2006 to 2009 there have been organized 20 jobs fairs for the Roma population, as the number of employed persons was 3 117.
>
> 2. Collective Complaint № 46/2008
> Please see information provided under article 11.1.

3. Elderly persons without resources receive adequate social assistance

The Bulgarian social assistance benefits are meant to be granted to people and families in greatest need and whose monthly income is lower than the differentiated minimum income. The differentiated minimum income is set individually for each person and is equal to the multiplication of a base line amount called Guaranteed Minimum Income /set by law and is the base for both determining the amount of the social assistance and the access to the social assistance system/ and an individual percent that is determined by factors like age, if the child goes to school, medical situation, how many people are there in the household, etc. The Differentiated minimum income for a family is formed by the sum of the differentiated minimum incomes for all family members. The Guaranteed minimum income which is the base for calculating the assistance is set in a Decision of the Council of Ministers. As it is mentioned in the working document, the Government of Bulgaria analyzed the possibility of raising the amount of the social assistance. I can announce now that in 2009 the amount of the Guaranteed minimum income was increased by 18,2% with a decision of the Council of Ministers which resulted in an augmentation of the amounts of the social assistance benefits.

What concerns the heating targeted assistance I can say that in the last 5 years the terms and conditions for granting the assistance were changed many times because of the need of update of the access boundary, newly occurring problems so it was up to date with the situation in the country. The result of these changes is that in 2009 the amount of this benefit was 55 leva per month which is more than a 100% increase from the amount stated in the working document.

In the last 5 years Bulgaria makes substantial efforts for the increase of the level of the system of social security and in particular the pensions.

The expenditure for pensions from 2005 to 2009 have increase with nearly 72%. Their part in the GDP has also increased from 8.8% to 9.78% from 2005 to 2009 (table 1).

Table 1:

Expenditure for pensions (2005-2009 г.)

Year / Indicator		2005 г.	2006 г.	2007 г.	2008 г.	2009 г.
Expenditure for pensions (millions of leva.)	(млн.лв.)	3 771.49	4 203.80	4 675.40	5 597.30	6 480.41
Expenditure for pensions as a % of the GDP	(%)	8.80	8.50	8.30	8.40	9.78

Source: National statistics institute, National Insurance institute.

The undertaken measures in the field of pension ensured the progressive increase of the benefits. Table 2 shows that increase for the last 5 years.

Table 2:

Year / indicator	leva	2005 г.	2006 г.	2007 г.	2008 г.	2009 г.
1. Median amount of the pension of one retired person	(лв.)	134.63	152.08	171.62	208.97	244.46
2.Minimum amount of the pension for insurance time and age (median for the year)	(лв.)	65.65	78.73	91.59	108.17	130.46
3. Old age social pension (median for the year)	(лв.)	**57.08**	**63.00**	**68.41**	**80.18**	**96.70**

Източник: National Insurance Institute

The amount of the old age social pension is determined by the Council of ministers after a proposal by the Minister of labour and social policy and the National Insurance institute. It is determined in an amount not less than 40% of the poverty line for the country.

It is also a very important concern to the Bulgarian government that the social assistance system has to have a precise balance between the needs of the people and the financial possibilities that would guarantee the trust and support of the Bulgarian citizens to the policies implemented."

264. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

Third ground of non-conformity

265. The representative of Bulgaria stated that social assístance benefits for people in need were fixed individually for each person. She mentioned that in 2009 the level of the basic benefit, the GMI, had been increased by 18.2%. Moreover, the amount of the average heating allowance (the main supplementary benefit) had been doubled.

266. The representative of the ETUC questioned whether the increases mentioned could have a real or positive impact on beneficiaries bearing in mind that the original amount of benefits was very low in relation to the poverty threshold.

267. The Committee took note of these developments and encouraged the Bulgarian government to continue increasing the level of social assistance benefits. It invited the Government to provide all relevant information in its next report and decided to await the next assessment of the ECSR.

Fifth ground of non-conformity

268. The representative of Bulgaria indicated that social assistance was granted to citizens of the EU, to persons with permanent residence (granted after 5 years of stay in Bulgaria), to those with refugee status or when this was foreseen in an international treaty. The social assistance system was still being structured, so it was impossible for the time being to broaden the personal scope of the system, as this would represent an immense burden on the social assistance budget which would collapse.

269. She also mentioned that a national strategy on migration and integration of foreign citizens had been adopted for the period 2008-2015. Proposals would be made with a view to fixing problems of access to the Bulgarian labour market of people that were needed on it.

270. The Committee took note of the information and invited the Government to provide all other relevant information in its next report. In the meantime, it decided to await the next assessment of the ECSR.

RSC 13§1 ESTONIA

The Committee concludes that the situation in Estonia is not in conformity with Article 13§1 of the Revised Charter on the ground that the amount of social assistance granted to a single person without resources is inadequate.

271. The representative of Estonia made the following statement:

> "The issues raised by the committee may be divided into three:
> (1) the extent of housing costs' compensation;
> (2) the matter of subsistence level and the amount of subsistence benefit;
> (3) the health care of persons not covered by health insurance.
> I will address these issues in the same order:
> (1) the extent of housing costs' compensation. The committee has understood correctly that the subsistence level (also referred as coping line) is established taking into account minimum expenditure on food, clothing, footwear and other goods and services to satisfy persons' basic needs. All persons whose income after the payment of housing costs falls below the coping line are eligible for subsistence benefit (that means social assistance). The amount of subsistence benefit is calculated on the basis of persons' income and housing costs. A

person with no income receives the sum equal to subsistence level and in addition, his housing costs are met as a part of subsistence benefit.

The housing costs are taken into account within certain surface limits established by law. These limits are referred as socially reasonable norm which is 15 m2 for household in general and in addition 18 m2 per each household member. There are no limits for housing costs established on the state level. Upon calculation of the subsistence benefit, the following expenses are taken into consideration:

1) the actual rent or maintenance fee of the apartment;
2) value of thermal energy or fuel consumed for heating or supply of hot water;
3) value of used water and sewerage services;
4) value of used electricity;
5) value of used household gas;
6) expenses made on land tax;
7) expenses made on building insurance, calculated for a used dwelling;
8) the actual carriage charge for municipal waste.

The debts in the payment of housing costs are not subject to coverage from subsistence benefits fund. This means that people have to pay for all their housing expenses regularly – in the same month they are given support for that purpose. If they do not, and debts occur, the local authorities provide them also with other social assistance (for example debt counselling) to assist them to draft the feasible debt payment schedules.

The law has given the local authorities (who grant and pay the subsistence benefit) the right to establish limits for housing costs bearing in mind that the decent subsistence for person has to be ensured. In practice there have been no cases in which people have had to lose their homes due to the low limits. But there may have been cases in which a person (living alone) has been given advice and help, if needed, to exchange his/her present residence for a more reasonable one. However, such cases are not very common – people usually continue to live in their former homes. Our understanding is that, such policy helps us avoid situations that would encourage the emergence of ghettos – we do not want people with low income to live together in certain areas, where the housing costs are cheaper. On the contrary – we want them to be as integrated as possible.

(2) the matter of subsistence level and the amount of subsistence benefit. We would like to note that the subsistence level is not equal to the subsistence benefit and enc eta amounts specified in the conclusion – 900 EEK (58€) and 2341 EEK (221€) are not comparable. The amount of 221€ is based on the median equivalent income, whereas to the amount of 58€ the actual housing costs can be added.

Since 2004, from our first negative conclusion, Estonia has gradually raised the subsistence level. In 2004, the subsistence level was 500 EEK (32€), in 2005 it was raised to 750 EEK (48€), in 2007 to 900 EEK (57,5€) and after the reference period, since 1 January 2008 the subsistence level is 1000 EEK (64€).

The subsistence level is established and revised each budgetary year by the Parliament taking into account minimum expenditure on food, clothing, footwear and other goods and services to satisfy persons' basic needs.

In 2007[1], the cost of the minimum food basket was 1031 EEK (66€). This means, that in reality the subsistence level covers the minimum costs on food and the housing costs (as explained in previous issue). In addition, compared to the consumer price

[1] Latest available data.

index, the real value of the subsistence level has increased. For example, when in 2007 the real value of the subsistence level (900 EEK, 57,5€) was 844 EEK (53,9€) then in 2009 the real value of subsistence level (1000 EEK, 64€) was equal to its constructed value.
The concept of subsistence level has to be distinguished from the subsistence benefit. As the subsistence level represents a certain fixed rate, the subsistence benefit is calculated separately for each family and the amount of subsistence benefit varies monthly, depending on the income of the family during particular month and housing expenses (incurred in given month). The average amount of subsistence benefit per application in 2007 was 1312 EEK (83,9€) and has increased to 1666 EEK (106,5€) in 2009. In 2007, the housing costs formed almost 45% of the total amount of subsistence benefit and in 2009, the housing costs formed 47%.
Although the subsistence benefit is paid by local authorities, the funds are provided by the state. Local governments may pay supplementary social benefits to persons in need of assistance. For example, local governments may, according to the incomes of the family, compensate the costs for pharmaceuticals, compensate the fee collected for social welfare services (incl daycares), support schoolchildren to compensate the costs occurred due to going to school etc. All schoolchildren are granted free meal at school. In addition to benefits, the local governments provide social welfare services to the families in need. According to the law, local governments shall provide social counselling services to the applicants of subsistence benefit and their family members. During the current crisis, social services are retained and new social welfare services and counselling centres offering social, psychological, debt and legal counselling are established. Considerable increase in the amount of active labour market measures has increased investments to the adult training, job clubs, training vouchers for micro-enterprises and self-employed etc.
The right to receive help from the state is basic constitutional right. The payment of the subsistence benefit is decided monthly and the number of times receiving the subsistence benefit is not limited. However, local governments have the right to refuse to grant a subsistence benefit to a person in a working age and able to work, but is not studying or working and has more than once without good reason refused from suitable work, to participate in the labour market and social welfare services or study organised by local government directed towards independent ability to cope. The principle is in accordance with the policy described above - to keep people active, promote their participation in the labour market and leave the subsistence benefit as the temporary and last resort.
We are also on the opinion that our measures are minimal and that we have to provide more financial resources to the people in need. This issue has become particularly relevant in connection with the economic crisis in the course of which the possibilities for receiving local or one-time additional payments have decreased. Currently we are working with several activities related to the subsistence benefit. Firstly, the calculations and are made and discussions are opened to increase the subsistence level. Secondly, we have started a survey on use of subsistence benefit and its impact on alleviating poverty. The practices of granting subsistence benefit, possible traps, incentives to work, case management, impact on peoples' socioeconomic situation are being analysed and suggestions for possible policy measures will be made.

(3) the health care of persons not covered by health insurance. Over 95% of Estonian population is covered with health insurance. Those approximately 4%

who are not covered with health insurance, are mainly not registered unemployed, people living from incomes that are not subject to social taxation (for example dividends) and people who receive their salary and/or are covered by health insurance abroad.

All persons who are not covered by health insurance are guaranteed emergency medical care. All people who stay in Estonia are entitled to care. If the person has no health insurance, the medical aid is organised by local government and paid from the state budget. The local government may organise for example access to a family practitioner, compensate medical treatment or medications and organise reception of the general practitioner. We do not in fact have problems as regards with subjects to the right of medical assistance. Recently the scope of persons covered with health insurance has been widened. Whereas before 1 May 2009 health insurance was guaranteed to unemployed persons who qualified at least for unemployment benefits, then now it is guaranteed to all persons who have registered themselves as unemployed. Discussions are in progress as to whether it is possible to increase the level of medical care provided to persons not covered by health insurance. For example, a suggestion was made to ensure the help on the level of family doctors to these persons".

272. Following her presentation, as a reply to questions put forward by the Chair and the representatives of Czech Republic, Poland, France and ETUC, the representative of Estonia pointed out that:

- most of the information provided is new;
- people excluded from the health insurance (5%) are, for example, those who are not registered as unemployed persons or who are covered by other insurance;
- when applicable, the housing costs are covered by the subsistence benefits (i.e. subsistence benefits consist of subsistence minimum and housing costs);
- there are very few cases of refusal regarding requests for subsistence benefits;
- when a person is not entitled to the subsistence benefits, he/she can in any event receive the emergency health care;
- single persons without resources are entitled to receive 1000 Estonian kroons = 64€ per month plus the housing costs' compensation.

273. The representative of Estonia also indicated that the Government is aware that the subsistence benefits are lower than the threshold of poverty, as established by Eurostat. However, given the difficult financial situation of the country, she confirmed that for the time being the Government is not in a position to increase the level.

274. The Committee welcomed the progress made by Estonia, encouraged the Government to continue its efforts aimed at increasing the assistance granted to single persons and decided to await the next assessment of the ECSR on Article 31§1 of the Revised Charter.

RSC13§1 FRANCE

The Committee concludes that the situation in France is not in conformity with Article 13§1 of the Revised Charter on the following ground:

- as young persons aged under 25 are not entitled to the adequate social assistance;
- non-EU nationals with temporary residence permit are only entitled to the RMI benefit after having resided in France for 5 years;
- it had not been established whether the right of appeal in social assistance matters was effective.

First ground of non-conformity

275. The representative of France made the following statement: "The RMI benefit no longer exists. An Act of 1 December 2008, which came into force on 1 June 2009, provides for the introduction of the active solidarity income (RSA). The RSA is designed to replace two existing social minima – the RMI and the single parent benefit (API) – and three measures to encourage people to return to work (the back-to-work lump-sum, the back-to-work bonus and temporary profit-sharing). The RSA can take two forms: basic RSA of €469.09 per month for a single person (which is the equivalent of RMI and awarded to people who do not work at all) and supplementary RSA, which is intended for people who do work but whose incomes fail to reach a certain level (for example, for a ¾-time job with an income of €771, the supplement is €111). Initially, persons under the age of 25 were not entitled to RSA. However, section 135 of the 2010 Finance Act1 has introduced the principle into French law that RSA may be extended to persons under the age of 25 if they have been engaged in a professional activity for two years out of the last three. From now on, workers under the age of 25 who meet this requirement are entitled to the same benefit as their elders. In addition, those that are unemployed may benefit from the guaranteed income provided by the RSA once their entitlement to unemployment benefit has lapsed. Implementation of this new measure began on 1 September 2010 with the result that persons under the age of 25 now have access to the RSA".

276. The Chair expressed satisfaction with the changes the representative had described. She noted, however, that the new Act did not grant assistance to all persons under the age of 25. The representative of the ETUC asked with what resources people under the age of 25 who no longer lived with their families and had never worked were supposed to live. He also asked what the poverty threshold was in France. The representative of France said that she could not provide up-to-date information on this point. In reply to the first question, she referred to additional benefits such as apprenticeship allowances (which came to about €1000 or the equivalent of the minimum wage, the SMIC), training courses and housing benefit. She also mentioned local support centres (missions locales), which had been set up at local authority level to enable young people to make contact with people and bodies capable of helping them (through one-off assistance, job offers, training courses, apprenticeship allowances, housing benefit, etc.). The French authorities' aim was to encourage people under the age of 25 to find work; given that the Act had only just come into force, it was difficult to know at this stage whether some young people were still excluded all the same from the new forms of assistance that had been set up.

277. The representatives of the Netherlands and Poland considered that the French authorities' approach was constructive.

278. The representative of the Czech Republic considered that young people without work could have problems and they should be supported.

279. The representative of Iceland said that there was a risk that people under the age of 25 who no longer lived with their families and were not given any particular kind of assistance would suffer from social exclusion; this was why, despite the progress that had been achieved, she proposed that a warning should be issued to the government of France.

280. The representative of the Czech Republic agreed.

[1] The Finance Act for 2010 (No. 2009-1673 of 30 December 2009).

281. In response to a question from the representative of Norway, the representative of France explained that the labour market in France followed the same trends as those in other European countries. It was possible that young people in France tended to stay with their families for longer than young people in Scandinavian countries.

282. The Committee decided to urge the government of France to provide proper protection for all unemployed people under the age of 25.

Second ground of non-conformity

283. The representative of France stated as follows: "the introduction of the RSA has not changed the rules on entitlement to benefits that applied under the RMI, as non-EU nationals are still required to have been resident in the country for five years or more and hold a residence permit entitling them to work in France".

284. The Chair noted that there had been no change in the situation. The representative of the Czech Republic felt that there should be a vote on a proposal for a recommendation or a warning.

285. The representative of Turkey considered the problem to be serious and referred to ILO Convention No. 118.

286. The representative of the ETUC argued that the residence requirement posed a problem of discrimination.

287. In view of the procedure adopted in similar cases, the Committee decided to hold a vote. The proposal for a recommendation was rejected (0 votes for, 20 against, 10 abstentions). The Committee then held a second vote on a proposal to issue a warning to the Government, which was approved (12 votes for, 6 against, 10 abstentions).

Third ground of non-conformity

288. The representative of France made the following statement: "in the last report, it was explained that the legislation and regulations in this area were being updated. This update forms part of an overall examination of 'the public policies and reforms launched to modernise the management of the French state', which has led in particular to an extension of the jurisdiction of the administrative courts in the social sphere at the expense of specialised social welfare courts and an improvement in procedures in welfare courts.

1. The jurisdiction of social welfare courts was reduced by the following measures:
- the abolition of *département* commissions for workers with disabilities and the transfer of disputes in this field to ordinary administrative courts (Act of 11 February 2005);
- disputes over the enforceable right to housing were transferred to the administrative courts (Act of 5 March 2007);
- through an amendment to Article L. 134.1 of the Social Welfare and Family Code, Act No. 2008-1249 of 1 December 2008 on the RSA transferred all related disputes to the administrative courts. In this way, the field of application of the powers of social welfare courts was reduced.

2. Changes in procedures in the social welfare courts:
Although the social dimension of these courts makes them a key institution, the desire to improve procedures has become a constant concern of the authorities, made all the more pressing by the fact that the *Conseil d'Etat*, which is the supreme arbiter in this field, has been setting aside more and more decisions in such cases (based, in particular on Article 6 of the European Convention on Human Rights on the right to a fair trial). The matter has been under consideration for some years but no solution has yet been found.
In the meantime, France has reminded its decentralised departments, which serve as the registries for social welfare courts, and their presidents, who are qualified judges, that justice should be administered and committees should be appointed in a manner that is consistent with the principles enshrined in Article 6 of the Convention. At the same time, it has been aware of the problems created for certain *département*-level social welfare courts by the fact that a great deal of the information required to investigate such cases has to be sought from a wide range of other investigators (such as social security bodies, local and regional authorities, unemployment benefit offices), which are not always able to gather together the requisite information within the appropriate timescale. These difficulties account in part for France's decision when setting up the RSA scheme to provide for persons with complaints to make them before the ordinary law courts."

289. The representative of the Czech Republic noted that major legislative changes had been made.

290. The representative of France confirmed that a whole series of laws had been adopted, not just in 2008 but also in 2005 and 2007.

291. The Chair said that these changes were a positive development and that they would probably help to make the system more efficient.

292. The Committee took note of the legislative changes described by the representative of France and decided to await the next assessment of the ECSR.

RSC 13§1 ITALY

The Committee concludes that the situation in Italy is not in conformity with Article 13§1 of the Revised Charter on the grounds that it has not been established that the level of social assistance is adequate.

293. The representative of Italy provided the following written information:

"Regarding the questions raised by the European Committee of Social Rights, we would refer you to what was said in the Italian government's last report in connection with this article and also to the reply given by the Italian representative on the Governmental Committee of the European Social Charter concerning the legal framework for the minimum income (RMI) (cf. Art. 3, paragraph 1) at the 113th and 114th sessions (which were held from 12 to 14 September 2006 and from 10 to 12 October 2006 respectively) for a better insight into the matter.
In view of what was said earlier, it is worth recalling Constitutional Court decision No. 423/2004 which found that the regions have exclusive competence in matters relating to welfare, with central government empowered only to set the levels of assistance as regards basic social benefits (LEPs), as provided for in Section V of the Constitution, notably in Article 117, paragraph II, point m) of the Constitution).
The central government, therefore, cannot step in to set the levels of social assistance, which vary from one part of the country to another, being determined by law at local level. The central government, in fact, cannot intervene in those parts of the country where the RMI (minimum income) still exists at local or regional level. The Italian government is unable, therefore, to respond to the

European Committee's request concerning the total average amount of supplementary benefits paid to a single person without resources.
We would point out, however, that in those parts of the country where a type of RMI exists, or where a similar incentive measure is available at local or regional level (cf. table below), the levels of social assistance are revised every year. Also, the data provided by the mutual information system on social protection in the member states of the EU and the EEA (MISSOC) which are cited in the Committee's conclusions date from 1 May 2004, whereas the maximum limits have increased in recent years, as the following table shows:

Table 1: SOCIAL ASSISTANCE SCHEMES AT LOCAL AND REGIONAL LEVEL

Region/Province	Scheme	Reference legislation	Monthly amount
Bolzano	RMI	Law No. 13/1991	559 euros per month and per person, subject to variations depending on the size of the household.
Trento	Minimum subsistence	Laws No.14/1991 and No.13/2007	Based on an assistance plan drawn up by a team of professionals.
Valle d'Aosta	Minimum subsistence	Law No. 19/1994	The difference between the monthly income threshold for receiving RMI and the actual available income.
Basilicata	Social citizenship	Law No. 3/2005	The difference between the monthly income threshold set for receiving RMI and the actual available income up to a maximum of €300 for single-person households and €250 for each member of larger households multiplied by an equivalised income scale.
Apulia	RMI	Law No. 19/2006	Determined according to economic hardship and incapacity (total or partial) to participate actively in social life and the labour market.
Lazio	RMI	Law No. 4/2009	Approximately 530 euros per month (with a maximum of €7,000 per year).

Supplementary benefits
The minimum income initiatives taken at local and regional level have characteristics which match those referred to in the European Commission Communication COM (2006) 44 on promoting active inclusion:
- 1. *they meet the basic needs for a minimum standard of living by providing assistance for individuals and their dependants, when no other source of financial support is available*;
- 2. *they are financed from general taxation (non-contributory schemes);*
- 3. *eligibility is based on a series of criteria (including age, family circumstances and length of residence in the province);*
- 4. *they are means-tested and subject to some degree of discretion from authorities*;
- 5. *they are subject to the recipients' capacity and availability for work;*
- 6. *they can be combined with other social benefits (housing, heating, child allowances).*

These characteristics can also be found in the national measures recorded in Italy in April 2009 and listed in Table No. 2.
As we have already said, to describe the wide range of measures that directly or indirectly provide financial support for low income individuals and families is an extremely complex task. For instance, the yearly taxation relief and increase in family allowances according to the number of dependants, along with other reductions or bonuses for expenditure incurred for basic services (e.g. health care, public transport, rent and education) have a considerable impact on income levels.

Table 2: MEASURES FOR PERSONS RECEIVING THE MINIMUM INCOME

Name of scheme	Key legislation
Social allowance: this has replaced the social pension since 1996	Laws Nos. 153/1969, 335/1995 and

	133/2008
Civil invalidity: invalidity pension, monthly allowance for partial invalidity, attendance allowance	Laws Nos. 118/1971, 18/1980, 508/1988, 289/1990 and 247/2007
War: pension and allowances for veterans/war widowers and widows	Decree No. 915/1978 of the President of the Republic
Terrorism: pension and benefit for victims of terrorism, including victims of crime	Laws Nos. 302/1990 and 206/2004
Housing: allowances	Law No. 431/1998
Health: defrayal of costs	Law No. 537/1993
Low income: temporary bonus for low income households	Law No. 2/2009
Electricity: bonus for low income citizens (preferential tariffs for electricity and gas)	Laws Nos. 266/2007 and 2/2009
Social card: prepaid card to enable persons on low incomes to purchase food, electricity and gas	Laws Nos. 133/2008 and 2/2009

Source : www. peer-review-social-inclusion.eu

Medical assistance:

As regards the European Committee of Social Rights' request for information concerning medical assistance for persons without resources, we wish to make the following points.

The different forms of exemption from health costs are governed by Law No. 537 of 24 December 1993 which includes *unemployed persons and persons on low incomes* among the beneficiaries.

A total exemption is available for, *inter alia,* children under the age of 6 years and elderly persons over the age of 65 years, on condition that the gross household income is less than €36,151.98. In addition, citizens who fall into the low income categories (*persons who retired at the minimum age and who are aged between 60 and 65 years, unemployed persons except for first-time job seekers, retirees in receipt of the social pension)* are exempt from the patient's contribution payable for specialist visits, diagnoses and laboratory analyses and also physiotherapy, provided that the total household income for the previous year was not more than €8,263.21, or €11,362.05 if there is a spouse, with a further €516.46 being allowed for each dependent child.

For further information on this subject, see the Italian government's last report on Article 11 of the European Social Charter. "

294. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 13§1 LITHUANIA

The Committee concludes that the situation in Lithuania is not in conformity with Article 13§1 of the Revised Charter on the ground that:

- the level of social assistance paid to single persons without resources, including the elderly, is manifestly inadequate;
- the granting of social assistance benefits to nationals of other States Parties is subject to an excessive length of residence requirement.

First ground of non-conformity

295. The representative of Lithuania referred to the figures on 2007 taken into consideration by the European Committee of Social Rights from the MISSOC database. She explained that data is entered into the MISSOC system in January and July. Apparently, because of this procedure, the further amendments made in October of the same year can't be seen in MISSOC. Therefore the data in the report, where average amounts of the whole year were provided, differs from the MISSOC ones of 2007. The data requested by the ECSR related to average amount of supplementary benefits paid to a single person was provided. There was an increase of these benefits, for example, the average monthly amount paid for single person for heating rose from LTL 41 in 2005 to

LTL 62 in 2007 while average amount for the hot water was increased from LTL 8,6 in 2005 to LTL 9,8 in 2007.
More generally, the Government proceeds with the improvements in the social assistance, this is also indicated in the measures of the Governmental program for 2008-2012. The next report would describe developments on this front.

296. Following a comment by the representative of the Czech Republic and a proposal by the Chair, the Committee noted the fact that progress had been made in relation to the first ground of non-conformity and decided to forward the new information that had been provided to the ECSR for its assessment.

Second ground of non-conformity

297. The representative of Lithuania said that welfare benefits had decreased in 2010 because of the economic crisis which had struck the country. Despite this, in 2010 the Government made the study of country's legal and financial situation examining the possibilities for granting social assistance benefits also to nationals of other States Parties residing in Lithuania temporary and find some recourses to grant this assistance to those foreign nationals in particularly difficult situations (such as refugees and victims of human trafficking). The necessary legal amendments have been prepared and presented to the Parliament this autumn. The Government realised that the situation was still unsatisfactory but it has made affords to remedy the situation for the most vulnerable foreigners and it was not able financially to do any more for the time being.

298. The representative of Iceland noted that residence requirements still applied to most foreign nationals in the country. She asked how long this situation was going to last for.

299. The representative of Lithuania explained that because of the economic crisis, it had only been possible to remove these requirements for the most vulnerable groups of foreigners. The Government was intending to reduce residence requirements, and examined the possibilities but it was seen from the mentioned study of 2010, that it is not able due to the financial reasons.

300. The representative of the Czech Republic considered the situation to be serious. Lithuania's social assistance system did not cover most of the foreigners who had settled in the country and the situation dated back to 2006. She proposed voting on a proposal for a recommendation, as had been done in relation to similar situations in other countries.

301. The representative of Lithuania pointed out that this was the first time the situation was being examined following a renewed finding of non-conformity. The number of foreigners to which the residence requirement applied was relatively low in absolute terms and the Government was determined to address the problem again as soon as the general economic situation would allow.

302. The representative of Iceland asked if other resources were available for foreigners excluded from social assistance measures. She also referred to the possibility of at least reducing residence requirements.

303. The representative of Lithuania said that foreign nationals excluded from social assistance were entitled to emergency medical assistance. The Government had

considered the possibility of reducing the length of the residence requirement but due to finance crisis, it can not afford more changes.

304. The representative of France proposed applying the Committee's working methods. The situation was serious and it was likely that one of the underlying factors, apart from economic problems, was the Government's political attitude. It was necessary to send a "strong message" to the Government.

305. The representatives of Iceland and the Netherlands agreed with the representative of France.

306. In contrast, the representative of Poland considered that in view of the economic crisis, the Committee should simply take note of the situation.

307. At the Chair's suggestion, the Committee took note of the information provided, noted that there had been positive developments with regard to the most vulnerable categories of foreign nationals and invited the government of Lithuania to remove length of residence requirements for all foreigners lawfully resident in the country. The Committee decided to await the next assessment of the ECSR.

RSC 13§1 MALTA

The Committee concludes that the situation in Malta is not in conformity with Article 13§1 of the Charter on the following ground:

- it has not been established that the equality of treatment of foreign nationals legally resident or regularly working in Malta for eligibility to social assistance, is guaranteed.
- it has not been established that the right to assistance is guaranteed for as long as there is a need for it;
- it has not been established that the right of appeal is effectively guaranteed

<u>First, second and third grounds of non-conformity</u>

308. The representative of Malta provided the following written information:

> "The right of appeal is effective guarantee by providing legal aid for persons with non-adequate means.
> Nationals of States Parties, legal residents or legally employed in Malta, enjoy a quality of treatment with nationals in the matters of Social Assistance without being subjected to the length the prior residence requirement.
> Social Assistance is not granted only to holders of long term residence permit but also to holders to ordinary residence permit.
> When a person is registering for work under Part I and finds employment, he is to fill an engagement form and stop registering for work. Assistance and benefits are paid only when a person is registering for work under Part I.
> If a person is registering for work under Part I and his wife starts employment, the Unemployment Benefit will not stop, but her income will be deducted gross from his entitlement of Unemployment Assistance. On the other hand, if his son or daughter starts employment, the entitlement of Unemployment Assistance will be deducted by 8.15 euro per week.
> A person who refuses employment, fails to attend interviews or courses or is found to be employed while registering for work is struck off the register for unemployed and benefits and assistance stopped. He can appeal decision before National Employment Authority and dependents can also apply for Social Assistance Board for assistance for period until NEA decision is taken.
> Persons in receipt of Social Assistance are people who suffer from a disease or condition that renders them unfit for employment. Persons on SA cannot work and the earnings from work of their spouses will be deducted at 100 % from his entitlement. People in receipt of Social Assistance appear regularly before a medical panel to establish if their condition has improved. If he is found fit for work he is sent to register under Part I for suitable employment.
> Single parents in receipt of assistance can earn up to 52.58 euro per week from employment until children are 16 years of age or attending full time education up to age 18.

Persons in receipt of Social Assistance Carers and Carer Pension are eligible to assistance as long as they care for their relative for 24/7. Therefore these persons cannot engage themselves in any kind of employment.
When assistance is stopped for any reason the individual has the right for appeal before the umpire (without any payment) and finally also before the Court of Appeal.
Apart from the right of EU nationals and their family members, who are third country nationals, to exercise any of their Treaty rights in Malta in accordance with the relevant Acquis and here I must also point out that the grant of social and medical assistance is also granted on the basis of such community legislation, other Third Country nationals are allowed to reside in Malta only if they have been authorized to do so for a purpose and the relative permits are issued annually. Third country nationals who are no longer authorized to reside in Malta are not allowed job-seeking facilities.
If third country nationals satisfy the provisions of legislation concerned long term residence they would be granted permanent residence and certain socio-economic rights, including the right to social assistance and goods and services available to Maltese nationals.
Malta authorizes Third Country Nationals to reside in Malta permanently, provided they satisfy certain property and income conditions. If such persons no longer meet the required criteria their residence permits would be cancelled and they would be requested to leave the Island. One cannot envisage a scenario of persons who have been granted authority to reside in Malta on the basis of economically sufficiency being allowed to claim health and social assistance benefits."

309. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 13§1 MOLDOVA

The Committee concludes that the situation in Moldova is not in conformity with Article 13§1 of the Revised Charter on the ground that the right to social and medical assistance is not guaranteed.

310. The representative of Moldova said that the economic situation in Moldova had been giving cause for concern and problems had been compounded by the recent world financial crisis. Given the situation, the government of Moldova had made every effort to support the poorest sections of the population, particularly in rural areas.

- A series of measures relating to medical assistance had been included in the documents drawn up by the Ministry of Health with reference to the Government's work programme for the years 2009-2011. Act No. 1585 of 27 February 1998 on compulsory medical insurance had been amended in this connection at the end of 2009. Under the new rules, emergency medical assistance for people without insurance would be financed by compulsory insurance funds in accordance with the lists drawn up by the Ministry of Health. These rules had also made it possible to reduce the cost of compulsory insurance for self-employed workers in the agricultural sector.

- A new Welfare Support Act had been adopted in June 2008. One of its aims was to provide a guaranteed monthly minimum income for Moldova's poorest families. The amount of the benefit was established every year by the Finance Act and in 2010 it was 530 lei, which corresponded to the poverty threshold. The new law also provided that all decisions to reject applications for welfare support or to change or suspend an existing benefit could be contested in the administrative courts.

311. In 2009 spending on social assistance had amounted to 114 million lei while in 2010 it totalled 270 million lei. The Government had adopted other social assistance measures in February 2010. One of the main ones had been a new form of income support for disadvantaged families in rural areas.

312. In response to questions from the representatives of Lithuania and France, the representative of Moldova stated that the ECSR had not yet been informed of the adoption of the Welfare Support Act and that it also applied to single persons.

313. The Chair considered that the Government's aim should be to establish a stable social assistance system which could be applied to the entire population, not just people in vulnerable situations, and requested the Committee to take the appropriate decisions.

314. The Committee took note of the information provided by the representative of Moldova and decided to await the next assessment of the ECSR.

RSC 13§1 NORWAY

The Committee concludes that the situation in Norway is not in conformity with Article 13§1 of the Revised Charter on the ground that the level of social assistance benefit that is paid to individuals in need who are not participants in the individual qualification programme is not adequate.

315. The representative of Norway provided the following written information:

> "The Committee concludes that the situation in Norway is not in conformity with Article 13§1 of the Revised Charter on the ground that the level of social assistance benefit that is paid to individuals in need who are not participants in the individual qualification programme is not adequate.
> The amount paid to participants in the Individual Qualification Programme cannot be regarded as the minimum level for adequate living. These participants have little or no entitlement to receive national insurance benefits and most of them are entirely dependent upon social assistance before they enter the programme. The amount paid to participants in the programme, is set to give them a better economic situation than they had when they were dependent on social assistance. There is an incitement to activity implemented in the amount, and people who have been dependant on social assistance shall experience an improved financial situation when taking part in the programme.
> The amount received under the programme is subject to taxation, which makes it difficult to compare the qualification-benefit with ordinary social assistance which is a net benefit.
> The Committee refers to the fact that the total average monthly amount of benefit that a typical all-year recipient of social assistance would receive, including both the recommended amount ('the uniform standard') and supplements such as for housing, housing insurance, prescription drugs, electricity, furniture and so on, stood at €913 for a single male and at €856 for a single female. The Committee assumes that all-year recipients of social assistance are largely dependent on social assistance alone. This is not correct. About 55 % of the recipients have social assistance as a supplement to other income. This must be taken into account when comparing the average level of social assistance with the EU poverty threshold.
> When the level of social assistance is seen in connection with the poverty threshold one must also take into consideration whether services like kindergartens, schools, health and other care services must be paid fully, partially or not at all by the individual. In Norway, these services are financed by public means, representing a substantial transfer of funds to the population groups using the services.
> According to the Social Security Act, the municipalities are obliged to consider each demand for social assistance individually. Some expenses vary throughout the country, especially housing. The amount of the benefit is calculated in accordance with the need of each individual, not as a standard sum.
> From 1 January 2010, a new Act regarding Social security in the Labour and Welfare administration (LOV 19.12.2009 nr. 131) has entered into force. The articles regarding economic social assistance have not been amended, but there has been introduced an authority, controlling, amongst others, systematically that the municipalities really do consider every demand individually and that the services provided are in accordance with the law, giving the right to an adequate standard of living."

316. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 13§1 PORTUGAL

The Committee concludes that the situation in Portugal is not in conformity with Article 13§1 of the Revised Charter on the ground that it has not been established that the level of social assistance paid to a single person without resources is adequate.

317. The representative of Portugal stated that the conclusion on this ground was based on lack of information. Portugal had a social assistance system, which consisted of basic benefit and supplementary benefits, such as invalidity benefit, child benefit, family/housing benefit, unemployment benefit, etc. Every person entitled to the benefit had to be included in the training programme/skills improvement programme. Public investment in this regard had been growing each year. Still, the level of the basic benefit was very low. The relevant information was missing from the report, because the competent service had not provided them, despite express demand from those responsible for the preparation of the report. The representative of Portugal agreed that the information should have been provided and requested the Committee's opinion as to what action should be appropriate.

318. Several representatives considered the situation to be a serious one and that a strong message should be sent to Portugal.

319. The Chair observed that the basic benefit was very low and even if supplementary benefits were taken into consideration, there could still be a conclusion of non-conformity on this ground. She agreed with the proposal of a strong message but reminded that the country should bring the situation into conformity.

320. The Committee urged the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 13§1 ROMANIA

The Committee concludes that the situation in Romania is not in conformity with Article 13§1 of the Revised charter on the ground that:

- it has not been established that the right of appeal is effectively guaranteed.
- it has not been established that the possibility of withdrawal of assistance in response to the failure to undertake community work does not amount to a complete deprivation of means of subsistence for the person concerned;
- it has not been established that the right of appeal is effectively guaranteed

321. The representative of Romania provided the following written information:

First second and third grounds of non-conformity

> ***"1. Types of benefits and eligibility criteria:***
> In 2006, Law no. 416/2001 was amended by Law nr.115/2006, some provisions being improved in order to ensure a better coverage of the beneficiaries and to focus the aid to the poorest families and single persons.
> The amendment of the previous law refered, among others, also to the application in a uniform way, at national level, of the criteria regarding minimum and maximum potential revenue resulting from turning account of the goods which overtake quantitatively the categories of basic necessities goods for family needs.
> For the amounts paid as social aid, **only one major person, of working age and capable to work from the beneficiary family** has the obligation to perform monthly actions or works of local interest, at the request of the Mayor, without exceeding the normal work time and in compliance with security and hygiene standards of work. Exceptions are families where the amount of the social aid resulted from calculation is up to 50 lei per month; for these beneficiaries the working hours are determined quarterly.
> The working hours are calculated in proportion to the amount of social aid received by family or single person, with an hourly rate adequate to the basic minimum gross salary per country guaranteed as payment, related to the average monthly working time.

The number of working days, limited to the monthly norm of 21.25, is calculated by dividing the number of working hours to 8 hours /day.
Mayors have to draw up an action plan for the works of local interest for the distribution of working hours, have to keep the evidence of performing these hours and also, have to ensure the briefing regarding the technical standards of labor safety rules for all persons who perform actions or works of local interest.
The person capable to work is the person who meets the following conditions:
a) has the age between 16 years old and the standard retirement age;
b) is not following a form of education, day courses, provided by law;
c) has the proper health and the physical and mental ability, which enable the person to perform those actions/works.
The physical and mental incapacity is proven with documents issued according to law.
Exception to the obligation to perform community working hours, is the person able to work who is in one of the following situations:
a) ensure the growth and care of one or more children aged under 7 years and up to 18 years in case of the child with severe, increased and medium disability, proved by certificate issued by the Commission for Child Welfare;
b) provide care of one or more persons with severe or increased disability, proved by certificate issued by the Evaluation Committee of disabled adults;
c) participate in a training program;
d) is employed.
In the case of temporary work incapacity or, if applicable, of total or partial loss of work capacity of the person nominated to carry out the actions or works of local interest, the obligation to perform the working hours may be transferred to other persons from the family receiving the social aid, with the mayor's approval. The documents for the evidence of temporary work incapacity or, of total or partial loss of work capacity are the following:
a) for infirmity pensioners - the decision issued by the physician expert in social insurance from the county house of pension and other rights of social insurance;
b) for persons with disabilities - the certificate issued by the Commission of medical expertise for people with disabilities;
c) for persons with disabling chronic diseases and who are not insured in the public pension system - the medical certificate establishing the ability to work, issued by the physician expert in social insurance from the county house of pension and other rights of social insurance;
d) for persons with diseases causing temporary work incapacity- medical certificate issued by the physician of the family or the specialist physician.
In 2009, in the context of the economic and financial crisis, reducing its negative impact particularly on vulnerable groups has enforced the need to modify the Law no.416/2001 by improving some provisions of the Law. Thus was approved the Government Emergency Ordinance no. 57/2009, which stipulated the following:
Increasing by 15% the minimum income guaranteed level up to which is granted the social assistance. Thus, the monthly minimum income guaranteed is currently:
• **125 lei** per person single;
• **225 lei** for families of 2 persons;
• **313 lei** for families of 3 persons;
• **390 lei** for families of 4 persons;
• **462 lei** for families of 5 persons;
• **31 lei** for each other person over the number of 5, which is part of the family, according to law.
Total sustaining of the social aid payment from the state budget.
Initially, the social aid was granted from the local budgets, mainly from amounts deducted from certain incomes of the state budget, but during the implementation of the Law was found that local budgets do not provide all the necessary amounts for the established rights. Thus, was considered necessary as all the payments to be ensured only from state budget sums. In this way, there are no situations when the request for social aid is rejected because of lack of financial resources at local level.
Meanwhile, there is a draft amendment of Law no. 416/2000 regarding the minimum income guaranteed in order to improve the current provisions about the payment of social aid. Thus it is envisaged that the funds necessary for paying the social aid to be supported from the state budget and allocated to this purpose to the Ministry of Labour, Family and Social Protection. The payment of social aid will be provided by county agencies for social benefits, and not by local councils.
Therefore, if until 2006 **each family member**, **able to work** should perform a number of (maximum) 72 hours of community work, **starting with 2006 a single representative of the family has this**

obligation. Also, if the person is unable to perform the activities for community, another family member who is able to work, can perform these actions of local interest, in agreement with the Mayor. Also, a number of people able to work, mentioned above, are absolved from the obligation to provide the working hours for the local interest. In this context, the persons receiving the social aid are not facing with the situation where the social aid is suspended because of the refusal to carry out the working hours for community. If a medical problem exists, which do not allow to the beneficiary to perform the working hours for community, then, based on medical certificate issued by the physician of the family, the persons is exempt from activities.

The employees of the City Hall have the responsibilities of monitoring the compliance with this obligation, the type of activities being established by the Mayor. But not always those who do not perform the working hours for community are suspended from receiving the social aid, being up to the mayor to assess the situation of difficulty occurred in each family. Also, during the cold season there is a certain understanding that the local authority show to beneficiaries and to the hours of community work.

Also, one aspect that was changed by the new provisions of Law no. 115/2006 is that the number of hours which has to be performed in the interest of the community are determined taking into account the level of benefit received and the number of hours which would be worked in order to receive that income if the person would be paid the minimum wage.

At the following changes that will be made to Law no. 416/2001 will be identified other possibilities to sanction the person beneficiating from social aid, able to work, who refuses to perform community work, so that the person without resources is not totally deprived of its means of subsistence for some time.

Another important aspect in granting the social aid, is that the amounts are fully supported from the state budget since 2009, according to Government Emergency Ordinance nr.57/2009.

Comparative situation regarding the average number of social aids during 2006 – 2009:

Year	2006	2007	2008	2009
The average number of social aids	359 340	301 348	276 702	281086
Total amounts paid (million lei)	449 233 027	396 615 888	366 540 421	414 584 280

2. The level of social assistance:

Families and single persons, beneficiaries of social aid, have the right to house heating benefits, during the cold season (November 1 to March 31), as follows:

- If they use **thermal energy** in centralized system for house heating, are entitled to a monthly aid for house heating. The benefit is established **by offsetting the value of thermal energy invoice with a percentage of 100%**.
- If they use **natural gases** for house heating, are entitled to a monthly aid for house heating in amount of **262 lei** if the monthly net income per family member, or the monthly net income of single person is up to 155 lei.
- If they use **woods, coals and oil gases** for house heating, have the right to a monthly aid for house heating in amount of **58 lei** which is paid once, aggregate for all winter season.

So, a single person, receives the monthly social aid and also, other monthly additional amounts, during the cold season, which are not conditioned by performing activities for community.

Also, persons receiving social aid have the right to free social services in the welfare canteens, according to Law no. 208/1997. According to this Law, the welfare canteens are public social assistance units with legal personality, subordinated to local councils.

For persons receiving social aid who have children, the amount of complementary family allowance and the allowance for single parent families is increased by 25%.

Also, the persons who temporarily do not have any income, can benefit by the services of welfare canteens, for maximum 90 days per year. The social services (preparation and serving two meals daily per person, lunch and dinner) are provided for free to people who have no income or whose income is below the net monthly income for an individual taken into account in establising the social aid.

According to the Government Program for the period 2009 - 2012, one of the main objectives in the field of family, child protection and equal opportunities is to review the conception of social assistance programs. In this regard, the Ministry of Labour, Family and Social Protection will evaluate and determine the principles for governing the new conception of social assistance programs and the elaboration of the normative acts. Therefore, it is envisaged to make efficient the national system of

social assistance by increasing the efficacy of social benefits and rationalization of the state budget spending, placing at the base of this system on the one hand, the individual responsibility towards his own social position and his activation and on the other hand the care of the state for preventing and combating any risks or situations that may lead to social exclusion. To ensure the sustainability of the system, the entire social benefit package will be reviewed in terms of using the best relation cost / benefit.

3. The right to medical assistance:

In accordance with Law no. 95/2006 on reform in the medical assistance field, all the persons who are from a family which has the right to the social aid, are assured during receiving this aid.
The contribution owned for the persons who benefit of social aid is supported from the local budgets, and contributions for these persons are established by applying the cote of 5,5% on the social aid which is granted.
So, all the beneficiaries of social aid are assured from the medical point of view, benefitting by all the rights for the assured persons and having access to the medical emergency care as well as special medical care.
Also, by the new changes that will be made to Law no. 416/2001 regarding the minimum income guaranteed, the health insurance contribution for single persons or families beneficiaries of social aid will be ensured from the state budget allocated for this purpose to the Ministry of Labor, Family and Social Protection. The payment of the contribution will be made by county agencies for social benefits and will be determined by applying the cote established by law on the amount of social aid.

4. The right of appeal and juridical assistance:

In accordance with art. 46 from Law no. 47/2006 on the national assistance system, any decision to establish one right of social services or social benefits can be disputed at the Social Mediation Commission. The Social Mediation Commission is organized and functioning in the de-concentrated structures of the Ministry of Labour, Family and Social Protection. Commission functioning for each county and sector of the Bucharest Municipality and has consultative role.
The Social Mediation Commission fulfills the following main attributions:
a) mediates the dialogue between the public services of social assistance and the persons asking for social assistance or the beneficiaries of social assistance rights;
b) analyses the discontented reason notified in written by the persons asking for social assistance or the beneficiaries of those social assistance rights;
c) analyses the discontents of the beneficiaries related of the measures comprised in the intervention plan or by the quality of the services granted on the basis of the individualized plan, plans scheduled at the granting of the social services;
d) clarifies by dialogue, different opinions between parties, the persons asking for social assistance or beneficiaries of the social assistance rights, on the one hand, and the representatives of the authorities or of the institutions which offered them, on the other hand;
e) granting free of charge the consultations in the field of the social assistance rights.
The Social Mediation Commission has to answer in a period of up to 30 days from the date of recording the request of mediation. Decisions of the social mediation commission can be attacked in a period of up to 30 days from the date of issue, in accordance with the provisions of Law no. 544/2004 regarding the administrative contentious. In the same time, the request addressed to the court in connection with solving conflict relating to social services and social benefits are exempted from the judiciary tax.
Before to address to the competent court of administrative contentious, the person who is considering himself/herself to be harmed in one of his/her right or in a legitimate interest through an individual administrative act has to request to the public authority or to the superior authority, if there is one, in a period of up to 30 days from the date of communication of the act, the revocation, in whole or in part, of this. In case of normative administrative act, the complaint can be formulated at anytime.
In the same time, the persons can address to the Labor Inspection, which has the main goal to control the implementation of the legislation in the field, as well as to inspect the activity of the public and private institutions, which are responsible with the granting of the benefits and social services. To fulfill its role, the Labour Inspection has the role to control, through which it is verifying the provisions of normative acts which are in force in the social assistance field. According to the provisions of Law 329/2009, the activity of Social Inspection has been undertaken by Labor Inspection."

322. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 13§1 TURKEY

The Committee concludes that the situation in Turkey is not in conformity with Article 13§1 of the Revised Charter on the ground that there is no legally established enforceable right to social and medical assistance.

323. The representative of Turkey made the following statement:

"As it was in the last Turkish report, the Social Security Reform in Turkey, which became effective as from January 2007, aims at establishing a system covering the entire population. The Reform has three pillars: the social security system, general health insurance and the system of social transfers that are not based on contributions (non-contributory system).

The social security system was reorganised in 2005 by means of which all the Social Insurance Institutions, namely the Civil Servant Fund, the Social Insurance Institution and the Self-Employed Persons' Social Insurance Institution were all gathered under one roof in order to enable standardisation of pensions, social insurance constitutions, replacement rates etc.

The second part of the reform was the institution of a general health insurance system under which persons who are not related to any social insurance programmes were made compulsorily insured under this system. This reform act. No. 5510 came into effect as from May 2008 and will be fully effective as from December 2010.

The last part of the Social Security Reform was the part of establishing a system where social benefits and services which are currently provided by several institutions are aimed to be provided by the Social Security Institute under the Ministry of Labour and Social Security by means of which the Ministry would be the sole government institution for combating poverty and social exclusion.

The draft text on social assistance and non-contributory benefits was submitted to the all related Ministries, universities, social partners, non-governmental institutions etc. in order to receive their views and opinions. In the said draft text, the following elements are included:

1. Under the old GREEN CARD system persons whose income did not exceed one third of the statutory minimum wage and who were not covered under the general social security schemes were entitled to receive this card entitling them to medical treatment. The draft law provides for termination of the GREEN CARD system and the State will pay general health insurance contributions for persons who now do not have any health insurance.

2. Monthly Payments: Each month the following persons will receive the following benefits:
   - Elderly persons over age 65: 200 TL.
   - Disabled persons: 275 TL.
   - Child below 7 years old: 17,5 TL.
   - Children attending school up to 18 years: Up to 40 TL.
   - Pregnant women: 52,5 TL. Monthly

3. Subsistence Payment: The amount will be calculated according to the value of the poverty threshold to be announced by the Turkish Statistics Institute each year, which is currently 1500 TL. for a family of 4 members.

4. Rental Assistance: A family in need and who does not have a house of its own will receive rent assistance amounting up to 50 per cent of the statutory minimum wage.

5. Loan to Establish One's Own Business in the draft text: An amount of loan up to 34 times of the minimum wage will be provided to a person wishing to establish his own business; similarly, a loan up to 750 times of the minimum wage will be provided under the assistance of acquisition of a profession. These loans will be repaid in four equal instalments with [no] any interest.

6. The definition of poverty will be made and assessed by the State so that any arbitrary decision making will be abolished; within this definition “a database on people in need" will be established.

7. A Social Development Fund shall be established. A General Directorate of Social Development within the Social Security Institute is to be established in order to carry out all the procedures in relation with the social assistance. A Social Development Fund shall be established which will be the solely authorised state institution responsible for all the social assistance benefits to be provided to those in need.

8. All the current social assistance institutions including the social assistance and solidarity funds shall be transferred to the said Fund in order to prevent the distribution of social aid which is made by the different social assistance institutions according to their individual criteria.”

324. Several representatives expressed their acknowledgment of the dimension of the reforms undertaken as well as their understanding of the fact that they were carried out in stages. They congratulated the government of Turkey on their efforts and encouraged them to speed up the process.

325. The representative of the ETUC reminded a warning issued in 2002 and expressed his reservations about evaluating the law that has not yet been adopted.

326. The representative of Estonia observed that the reform benefited from financial support of the EU, which also seemed to monitor closely the reform process. In her opinion, Turkey should be awarded more time in order to fully assess the developments and the effects of the reforms in practice. Representatives of Iceland, Lithuania, Azerbaijan, Finland, and Portugal shared this view.

327. The representative of Turkey expressed his gratitude for the words of encouragement. He reiterated that the reform process was very difficult and lengthy due to the very scattered structure of the social security system. He affirmed that the difficulties would be overcome with the help of EU and other international organisations. He observed that the most problematic stage of the reform process, which required several bodies to give up their prerogatives, had been accomplished.

328. The Committee took note of the developments announced and encouraged the government of Turkey to continue their efforts in order to bring the situation into conformity. It decided to await the next assessment of the ECSR.

Article 13§2 – Non-discrimination in the exercise of social and political rights

RSC 13§2 MOLDOVA

The Committee concludes that the situation in Moldova is not in conformity with Article 13§2 of the Revised Charter on the ground that due to lack of information it has not been established that persons receiving social and medical assistance do not, for that reason, suffer from a diminution of their political or social rights.

329. The representative of Moldova provided the following written information:

> "Fundamental rights such as the right to vote and freedom of opinion of all citizens of the Republic of Moldova are guaranteed first and foremost by the national constitution.
>
> **Article 4 Human rights and freedoms**
>
> (1) Constitutional provisions on human rights and freedoms shall be understood and implemented in accordance with the Universal Declaration of Human Rights, and with other international treaties and agreements to which the Republic of Moldova is a party.
>
> (2) Wherever there is disagreement between conventions and treaties on fundamental human rights to which the Republic of Moldova is a party and domestic laws, priority shall be given to international regulations.
>
> **Article 16 - Equality**
>
> (2) All citizens of the Republic of Moldova are equal before the law and the public authorities, without any discrimination on grounds of race, nationality, ethnic origin, language, religion, sex, opinion, political affiliation, personal property or social origin.
>
> **Article 20 – Free access to justice.**
>
> (1) All citizens have the right to protection from the courts against actions infringing their rights, freedoms and legitimate interests.
>
> **Article 38 – The right to vote and be elected**
>
> (2) Except for persons banned from voting by law, all citizens of the Republic of Moldova having attained the age of 18 on or by voting day have the right to vote.
>
> (3) The right to be elected is granted to all citizens of the Republic of Moldova who have the right to vote as prescribed by the law.
>
> **Article 54**
>
> **Restrictions on exercising certain rights and freedoms**
>
> (1) No law that would remove or restrict fundamental human and citizens' rights or freedoms may be adopted in the Republic of Moldova.
>
> (2) The exercise of rights and freedoms may only be restricted within limits prescribed by the law, in accordance with generally accepted international legal standards and what is necessary to protect national security, territorial integrity, the country's economic welfare or public order, prevent offences or unrest, protect the rights, freedoms and dignity of others, prevent the disclosure of confidential information or preserve the authority and impartiality of the judicial system."

330. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

Article 13§3 – Prevention, abolition or alleviation of need

RSC 13§3 MALTA

The Committee concludes that the situation in the Malta is not in conformity with Article 13§3 of the Charter on the ground that:

- it has not been established that help and advice services operate in accordance with this provision;
- it has not been established that foreign nationals legally resident or regularly working in the Malta are provided with equal access to advice and personal assistance services, without being subjected to an excessive residence requirement.

<u>First ground of non-conformity</u>

331. The representative of Malta made the following statement:

> "The Foundation for Social Welfare Services in Malta is responsible for the provision of social services to individuals residing in Malta. The Foundation comprises 3

agencies –Sedqa Agency – the national agency against drug and alcohol abuse, Appogg Agency - the national social welfare agency for children and families in need, and Sapport Agency – the national agency with the purpose of providing community and residential services to persons with a disability, and their families.

SEDQA:

The possibility of referring people to Sedqa Agency is not restricted only to professional persons but could be done by the general public. Besides offering help to persons who are experiencing addiction-related problems, our services are also open for relatives and significant others of such persons. Moreover, all our services are free of charge including the more intensive ones, such as our residential services. Due to the small physical size of our country, the (lack) of geographical distribution of Sedqa's services was never experienced as a limitation. Our community services are in locations that are conveniently reached by public transport. Besides this, our workers also visit their clients in other locations besides our offices, such as hospitals, the prison, shelters and also at their homes.

APPOGG:

APPOGG, like Sedqa, receives referrals from the general public, professional persons, individuals and families who are in need of services from the agency; In addition Support line 179 is a national helpline run by the service, through which anyone can get information about service or request assistance; Social work services offered by the agency are all free of charge, other than the Court reports which are against a fee (as explained in the other section), and Smart Kids which is means tested. With regards to Court reports the Agency has also waived payment in situations of persons who did not have the financial means to cover this cost.

Due to the small physical size of the country the entire agency's specialised services are centralised – the main offices are in a central part the island and can be conveniently reached by public transport. In addition most of the services also meet service users in their own residences. In addition to this the Agency also has various community child and family services in Cottonera and Valletta – harbour regions; B'Kara – central part of Malta and Qawra (northern part of Malta); Another centre will open by the end of the year in the southern part of the island, Other community services in other localities are required to cover other parts of the island.

These two agencies offer all services free of charge, to Maltese nationals, and residents of other countries who are legally resident or are regularly working in Malta irrespective of their length of their stay in Malta.

SAPPORT:

Agenzija Sapport as all the other agencies utilises the media to relay information about our services. The agency has established an effective contact with the National Commission Persons with Disability as the entity that is responsible for holding register of disabled persons in Malta, and for taking action in situations of reports of discrimination in relation to the Equal Opportunities Act (2000). It also ensures positive relations with local NGOs in the disability sector to guarantee open communication with grassroots.

The agency has in place a flexible referral system whereby anyone is free to refer a situation of a person requiring assistance, whether it is the person themselves, a relative, another professional, or any acquaintance who considers that the person may benefit through such assistance. The agency also ensures a prompt response to new referrals whereby first contact is established within one working day of receipt of referral.

Similarly to Appogg and Sedqa, the Social Work Offices of the Agency, which offices are considered to be the first line of contact with the Agency, are centrally located, as is the Head Office of the Agency. The Social Work and Community Services are provided wherever these are needed, irrespective of geographical location, and include visits to the clients' homes as well as accompanying clients to an array of appointments, at hospital, or wherever needed; The Agency's Day Centres and Residences are also easily reached by public transport.
It is also important to note that the services provided by SAPPORT are largely free of charge although persons who utilize Residential Services are expected to contribute 60% of their Disability Pension, or equivalent, for the running of the residence in which they reside.
These three agencies are fully funded by government funds and accessible to all Maltese Citizens that include all persons residing legally in Malta."

332. In reply to the question from the representative of Lithuania, the representative of Malta confirmed that part of the information provided in his statement had not been submitted in the report and confirmed that welfare services were provided for persons in need without discrimination.

333. The representative of Poland inquired about the residence requirement necessary to be eligible for the assistance. The representative of Malta replied that for a person legally residing in Malta there was no length of residence required to be eligible for the assistance in question.

334. The representative of the Czech Republic observed that the conclusion of non-conformity for Malta was due to lack of information and suggested to urge the Government to provide all the relevant information in its next report. The Chair and the representative of Lithuania agreed.

335. The Secretariat indicated that the information contained in the above statement of the representative of Malta concerns mainly Article 14 and not precisely Article 13§3.

336. The representative of Estonia requested a clarification as to whether there were different systems of social assistance existing in Malta and whether special advice was guaranteed to everyone in need. The representative of Malta replied that personalised help was given by one of the three social service agencies or by a professional social worker and that a net of social help and information services existed in Malta.

337. The Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

<u>Second ground of non-conformity</u>

338. The representative of Malta provided the following written information:

"The Foundation for Social Welfare Services in Malta is responsible for the provision of social assistance to individuals residing in Malta. The Foundation comprises 3 agencies – Agenzija Sedqa – the national agency against drug and alcohol abuse, Agenzija Appogg - the national social welfare agency for children and families in need, and Agenzija Sapport – the national agency with the purpose of providing community and residential services to persons with a disability, and their families.
SEDQA:
The possibility of referring people to Sedqa Agency is not restricted only to professional persons but could be done by the general public. Besides offering help to persons who are experiencing addiction-

related problems, our services are also open for relatives and significant others of such persons. Moreover, all our services are free of charge including the more intensive ones, such as our residential services.

APPOGG:

APPOGG, like Sedqa, receives referrals from the general public, professional persons, and persons (individuals and families) who are in need of services from the agency;

In addition Supportline 179 is a national helpline run by the service, through which anyone can get information about service or request assistance;

Social work services offered by the agency are all free of charge, other than the Court reports which are against a fee (as explained in the other section), and Smart Kids which is means tested. With regards to Court reports the Agency has also waived payment in situations of persons who did not have the financial means to cover this cost;

Sapport:

Agenzija Sapport as all the other agencies, utilises the media to relay information about our services. The agency has established an effective contact with the National Commission Persons with Disability as the entity that is responsible for holding register of disabled persons in Malta, and for taking action in situations of reports of discrimination in relation to the Equal Opportunities Act (2000). It also ensures positive relations with local NGOs in the disability sector to guarantee open communication with grassroots.

The agency has in place a flexible referral system whereby anyone is free to refer a situation of a person requiring assistance, whether it is the person themselves, a relative, another professional, or any acquaintance who considers that the person may benefit through such assistance. The agency also ensures a prompt response to new referrals whereby first contact is established within one working day of receipt of referral.

SEDQA:

Due to the small physical size of our country, the (lack) of geographical distribution of sedqa's services was never experienced as a limitation. Our community services are in locations that are conveniently reached by public transport. Besides this, our workers also visit their clients in other locations besides our offices, such as hospitals, the prison, shelters and also at their homes.

APPOGG:

Due to the small physical size of the country all the agency's specialised services are centralised – the main offices are in a central place of the island and can be conveniently reached by public transport. In addition most of the services also meet service users in their own residences. In addition to this the Agency also has various community child and family services in Cottonera and Valletta – harbour regions; B'Kara – central part of Malta and Qawra (northern part of Malta); Other community services in other localities are required to cover other parts of the island;

Sapport:

Similarly to Appogg and Sedqa, the Social Work Offices of the Agency, which offices are considered to be the first line of contact with the Agency, are centrally located, as is the Head Office of the Agency. The Social Work and Community Services are provided wherever these are needed, irrespective of geographical location, and include visits to the clients' homes as well as accompanying clients to an array of appointments, at hospital, or wherever needed; The Agency's Day Centres and Residences are also easily reached by public transport.

It is also important to note that the services provided by SAPPORT are largely free of charge although persons who utilize Residential Services are expected to contribute 60% of their Disability Pension, or equivalent, for the running of the residence in which they reside.

SEDQA:

Sedqa is fully funded by public funds. As demands for our services change and increase, we periodically submit requests to the central authorities for further funds to expand our services to meet such needs.

APPOGG:

Like Sedqa the agency is fully funded by public funds. A number of our services have a waiting list and therefore additional resources are required to be able to meet the demand for the current services;

Sapport

SAPPORT is fully funded by government funds; In services in the social sector, it is a reality that the demand always exceeds the supply and it is the responsibility of the Agency to forward the realities of new arising needs to the relevant authorities, who in turn show the disposition to assist the Agency in addressing these needs.

SEDQA:

EU citizens are offered all services free of charge, similar to Maltese nationals, irrespective of their length of their stay in Malta. Citizens of other countries who are legally resident or are regularly working in Malta also enjoy the same rights.
APPOGG:
The situation for Appogg is the same as Sedqa.
SAPPORT:
In the case of Sapport, the main criterion of eligibility for access to services is that the person has been assessed by a medical professional as having a disability given that the person is an EU national, or has the legal right to live in Malta. Moreover, persons who have an application for asylum which is being processed by the authorities are also eligible for services."

339. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 13§3 MOLDOVA

The Committee concludes that the situation in Moldova is not in conformity with Article 13§3 of the Revised Charter on the ground that social services do not operate in the meaning of this provision.

340. The representative of Moldova provided the following written information:

"**Social services**
The social services are a series of measures and activities carried out to meet the social needs of individuals and families, to deal with certain difficult situations and to prevent marginalisation and social exclusion.
The Republic of Moldova is fully committed to the process of harmonisation with European values and standards. Social services is one of the most important areas in which reform is required. In this connection, Government Decision 1512 of 31 December 2008 approved the National Programme for the establishment of an integrated social services system for the years 2008 to 2012.
The aim of the programme is to extend community and specialist social services rapidly and considerably improve the efficiency of highly specialised social services. By combining prevention and rehabilitation measures and dealing with cases at community level before they get worse (and more costly to resolve), the system will become more cost-efficient, cover all those who need social welfare support and have a positive impact on the quality of life of people at risk.
The main features of the integrated system are as follows:
(a) the individual needs of people in difficulty are identified and prioritised;
(b) problems are solved at community level and specialised social services are provided according to users' needs;
(c) social services are co-ordinated, and duplication, overlaps and gaps in services are avoided;
(d) the process of making efficient use of the human resources involved in the running of the social assistance system and providing them with training is properly co-ordinated;
(e) it is ensured that the social services reach a level of quality and efficiency in keeping with established quality standards and methods.
The establishment of an integrated social services system will create improved opportunities for the social integration of disadvantaged people while ensuring that their fundamental rights are respected.
To make social assistance more effective and establish an integrated social services system, Government Decision 216 of 23 March 2010 endorsed Social Assistance Act 547-XV of 25 December 2003. Following this, amendments to the Social Assistance Act filled in the gaps in the regulatory framework and fleshed out the institutional framework needed to provide social assistance at the various levels of government.
At the same time, Government Decision 149 of 1 March 2010, has endorsed the draft Social Services Act. This draft act sets out the general framework for the establishment and functioning of the integrated social services system by defining the tasks and responsibilities of central and local government authorities and other legal persons authorised to provide social services as well as protecting the rights of social service users.
The basic principles underlying the provision of social services laid down in this act are as follows:
- the principle of targeted social assistance, in which social services are directed first and foremost at the most vulnerable, disadvantaged people, based on an assessment of individual needs;
- the principle of making users the centre of attention, whereby social services are tailored to users' needs on the basis of systematic impact assessments;

- the principle of accessibility, whereby it is ensured that individuals and families have proper access to social services and that they are promoted and established in close proximity to users;
- the principle of equal opportunities, whereby the right to social services is exercised under conditions of equal treatment, without any discrimination;
- the principle of promptness, whereby decisions concerning people in difficult situations are taken as promptly as possible.

The aim of this act is to ensure the quality and efficiency of social services, to establish clearly what the powers and responsibilities of the public authorities are at all levels and to establish clear procedures for the provision of social services.

Categories of social services:
- primary social services – at community level;
- home-help services;
- catering services in subsidised canteens;
- community welfare services;
- specialised social services;
- short–term residential services for persons in various crisis situations and for periods of intense cold weather;
- residential services.

Detailed information will be given in the next report."

341. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

Article 13§4 – Specific emergency assistance for non-residents

RSC 13§4 ITALY

The Committee concludes that the situation in Italy is not in conformity with Article 13§4 of the Charter as it has not been established that all unlawfully present persons in need receive emergency social assistance.

342. The representative of Italy provided the following written information:

"As regards the Committee's conclusions to the effect that it has not been established that all unlawfully present persons in need receive emergency social assistance, we wish to make the following points.

First, under the terms of the recent Law No. 94 of 15 July 2009, which contains provisions on public security, the maximum period for which non-nationals can stay in temporary reception centres has been significantly increased, from 60 to 180 days from 8 August 2009.

In addition, account should be taken of the fact that in Italy, the temporary reception centres include not only the centres run by the Interior Ministry via the police and government territorial offices (UTG - Uffici Territoriali del Governo), but also those run by associations and other institutions acting either on their own initiative or in partnership with local authorities (regions, provinces and municipalities). Persons in distress, whether Italian or non-Italian (present in the country lawfully or unlawfully), can turn to these centres even after they leave the temporary reception centres run by the Interior Ministry.

Particular mention should be made here of the leading charity, Caritas italiana, which has centres in various locations across Italy and provides accommodation, food and clean clothing for anyone in need, be they Italian or non-Italian.

There are also associations and faith-based facilities dotted all over Italy. These structures provide a reference point for migrants, the poor and persons experiencing hardship by offering them a wide range of support in terms of welfare, promoting compliance with standards and ensuring the exercise of their rights but also their responsibilities.

Typical examples of these structures include:

Community of Sant'Egidio: a well-known institution whose reception centres form a network of initiatives designed to meet the needs of persons experiencing hardship. These centres distribute hot, plentiful meals in a warm, family atmosphere, groceries, clean linen and footwear. They also offer shower facilities with a full change of clothing and, in the Rome centre, a dispensary where individuals can obtain medicines free of charge and see a doctor.

The Community also has a shelter in Rome, as well as caravans located at various points around the city in an attempt to provide a temporary solution to the housing shortage.
Founded in 1981, Centro Astalli helps immigrants with all kinds of administrative procedures and the headquarters in Rome has a canteen serving 400 meals per day, a dispensary, three reception centres, an Italian school and many other primary and secondary reception services.
The Programma integra association operated by the mayor's office of Rome provides assistance to all those who run support activities for foreign asylum seekers, refugees and migrants. The association has reception centres and youth hostels in Rome that take in foreign nationals who are having difficulty finding accommodation.
Founded in 1959 by the Cappuccini brothers in Milan, the San Francesco mission for the poor provides free accommodation and assistance for those most in need. It provides free meals, clothing, personal hygiene products and medical care in an effort to restore people's dignity and hope through sharing and mutual support. As well as meeting the practical, primary needs of persons in particular need, the San Francesco mission also provides a sympathetic ear and protection.
The S. Maria Goretti reception centre was set up in 1999. Affiliated to the Migrants office so as to be as close to the immigrant community as possible, the centre was designed to facilitate the reception of immigrants whose numbers have been increasing over the years. From the time it opened, the centre has focused on immigrants present in Italy. The first services to be introduced were a *soup kitchen, shower facilities and clothing distribution.* Later on, other services were added: *night shelter, infirmary, Italian language classes and an information and support service for immigrants.*
We should emphasise, therefore, that all the reception centres, including those mentioned above, provide emergency services such as food, accommodation, clothing, etc. to all persons in need, regardless of whether they are **Italian** or **nationals of other EU or non-EU countries, present in the country lawfully or unlawfully.**
We would further point out that numerous collections are organised by parish institutions and municipal social services, giving rise to distribution operations all over the country."

343. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 13§4 NETHERLANDS

The Committee concludes that the situation in the Netherlands is not in conformity with Article 13§4 of the Revised Charter as it has not been established that all unlawfully present persons in need receive emergency social assistance.

344. The representative of the Netherlands provided the following written information:

"In the Netherlands, everyone is entitled to medically necessary treatment. There is no legislation in the Netherlands that prohibits the provision of medically necessary treatment to anyone. On the contrary, every health care provider has the professional responsibility to provide medically necessary treatment.
Where people have health care insurance, some or all of the costs of such treatment are met by that insurance. Illegal immigrants and failed asylum seekers do not have a right to health care under the social health insurances. Uninsured people must meet the costs themselves.
However, even if people cannot pay for the costs medically necessary treatment must be provided. Health care providers who are unable to collect payment for medically necessary treatment given to aliens with no legal right of abode in the Netherlands can apply for reimbursement. The entitlement to reimbursement is laid down in the Act concerning the amendment of the Health Insurance Act concerning the reimbursement to care providers who lose income as a result of given medically necessary treatment to certain groups of aliens and of Exceptional Medical Expenses Act with a view to insurance of certain groups minor aliens. This Act was adopted on 30 October 2008 and came into force on 1 January 2009.
Extensive information about the reimbursement possibility under the Act of 30 October 2008 is given by the Heath Insurance Board (College voor zorgverzekeringen), which implements the measure. The information is given to care providers (such as general practitioners, hospitals, pharmacists), the coordinating organisations of care providers and to the organisations representing undocumented immigrants and failed asylum seekers."

345. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

Article 14§1 – Promotion or provision of social services

RSC 14§1 BELGIUM

The Committee concludes that the situation in Belgium is not in conformity with Article 14§1 of the Revised Charter on the grounds that it has not been established that:

- services adapted to people's needs exist in the French and German-speaking Communities;
- nationals of other States Parties have access to social services on an equal footing with nationals in these two Communities;
- supervisory mechanisms have been set up to guarantee the quality of the social services provided by different agencies operating in the French and German-speaking Communities.

First, second and third grounds of non-conformity

346. The representative of Belgium provided the following written information:

"**Contribution by DG05 of the Walloon Public Service to the report presented in connection with the European Social Charter – Governmental Committee – Article 14**

Background

The Decree of the Walloon Regional Council of 22 July 1993 assigning certain powers to the French Community of the Walloon Region and the French Community Commission had the effect of transferring a whole series of powers to the Walloon Region from 1 January 1994 onwards.

This transfer, which enabled the Walloon Region to regulate transferred sectors of activity through instruments including decrees, made it possible for it to devise new policies or allocate increased resources to existing ones.

In the health field, all of the health policy powers formerly exercised by the Community were transferred to the Region apart from those relating to university hospitals, the University of Liège Hospital, the Belgian Royal Academy of Medicine, the Birth and Childhood Office, health education, preventive medicine activities and services and the school health inspectorate.

In practice, this means that the Region is now responsible for planning, authorising and subsidising care facilities and bodies providing extramural care such as hospitals, homes for the elderly with increased care facilities, psychiatric treatment centres, sheltered accommodation, integrated health clinics, mental health services and telephone advice services.

In all areas of health, therefore, apart from those linked to universities, there is now a clear delineation between the preventive sector, which has remained with the French Community, and the treatment sector, which has been handed over to the Walloon Region.

In the social welfare field, all powers relating to support for individuals were transferred away from the French Community apart from the rules determining which categories of persons with disabilities are entitled to assistance and activities connected with the work of the Birth and Childhood Office, youth protection and social assistance for prisoners. In practice this means that the Walloon Region is now responsible for family policy, in other words family and elderly assistance services, family planning centres and policies to promote various types of work, studies and publications in the family policy field.

It is also now in charge of social assistance policy, in other words decisions concerning public social assistance centres and social service centres and policies to promote various types of activity, research and publications in the social assistance field. Also transferred was the reception and integration of immigrants. As far as people with disabilities are concerned, the transfer applied to services covered by the medical, social and educational support fund for people with disabilities, services to support disabled persons in their daily activities and the Community fund for the social and occupational integration of people with disabilities.

Lastly, policy on the elderly was transferred, which mainly involves the certification of and financial support for homes and day centres for the elderly.

This may all seem somewhat complex, but nevertheless in all these areas of activity for which the French Community formerly had responsibility there has been a major transfer of powers to the Walloon Region in the case of the French language region and to the French Community Commission in the case of the Brussels-Capital Region.

The transfer decrees contained not only the list of areas of activity in which powers were to be transferred but also a whole series of other provisions.

From the outset, Walloon political leaders argued that the transfer would lead to greater consistency

between these policies and regional policies on issues such as local government, housing, employment and training, environment and energy.
They also referred to the benefits of increased proximity and consideration for specific Walloon concerns.
Lastly, they maintained that the transfer would allow an injection of funds into these sectors as it had been impossible to support them properly when they had been managed by the French Community. Accordingly, the transfer decrees provided for a 1% increase in funding per year between 1994 and 1999.
After fifteen years during which these powers have been exercised by the Walloon Region, it is of course tempting to make an appraisal which focuses on the many positive results in numerous spheres.
In the social welfare and health sectors, the period from 1994 to 2009 was marked by a whole series of legislative reforms aimed at restructuring, modernisation and innovation. This included decrees in the sectors of aid for families and the elderly, mental health, integration of people of foreign origin, debt mediation, public social assistance centres, homes for the elderly, sheltered housing and day-care centres, adult reception facilities, social co-ordination offices and integration services, family planning and marital advice centres, medical transport and meeting forums.
The Walloon Region has made a major contribution to the financing and, above all, development of the social welfare and health sectors, which could not have expanded as they have without the transfer of powers which occurred on 1 January 1994.
The proportionate increase in the budget of the social welfare and health department (+118%, from €401 855 230 in 1994 to €879 457 000 in 2010), including the grant to the Walloon Agency for the Integration of Persons with Disabilities (AWIPH), has been greater than the increase in the overall regional budget over the same period (+83%), showing that there has been a significant injection of funds into these sectors of activity.
Briefly, the Walloon Region has allocated significant new funding to the social welfare and health sectors since 1994 through additional resources decided on in connection with the Declaration on a Complementary Regional Policy (DPRC) of 1997, the regional non-commercial agreements negotiated in 2000 and 2006, the social inclusion plan, the refunding of hospital, medical and social facilities through the Regional Centre to Assist Municipalities (CRAC) and a loan from DEXIA, new projects such as social co-ordination offices, social integration services and meeting forums and increased funding in certain sectors of activity.
The cause and/or effect of this increased funding has been an extension of the range of services on offer to the public, the professionalisation of these services, higher pay for staff, more employment and an increase in certified services.
These regional policies have therefore gone well beyond a mere revamping of the powers received from the French Community.
Since 1996 the Walloon Region's social welfare and health policies have been the responsibility of two major institutions: the Directorate General of Local Government, Social Welfare and Health (DG05) of the Walloon Public Service (formerly a Ministry of the Walloon Region) and the Walloon Agency for the Integration of People with Disabilities (AWIPH).

2010 Budget

The 2010 budget for the Walloon Region's social welfare and health activities breaks down as follows:
The overall budget for social and health policies in 2010 was €852 080 000, 59% of which was given over to people with disabilities.
Under the heading of social policies, the family sector (the family assistance service) accounts for practically all of the funding allocated for families and the elderly (€192 220 000).
The social welfare and health activities financed by the Walloon Region are designed to support frontline services, which provide assistance, care and other services, including social assistance, victim support, hostel accommodation, debt mediation, family support or integration of people of foreign origin.
The Walloon Region also provides subsidies for the construction or development of infrastructure, such as hospitals, homes for the elderly and care homes.
The homes for the elderly sector is unusual, however, in that it is financed by the INAMI, a federal state institution which charges residents for its services, whereas the region establishes the relevant standards of accommodation, quality and staff and ensures that they are observed.
Hospitals and other curative services are financed by the INAMI through daily charges or flat-rate grants although certification is awarded by the region on the basis of federal rules.
On the other hand, the Region is responsible for arranging care outside health care institutions, such as mental health services, home help and care and non-emergency medical transport.

Quality of support, assistance and services

The first means of ensuring the quality of services are certification standards.
In addition, all support, assistance and other services are provided by qualified professionals (social workers, psychologists, educators, family helpers and so on).
In some sectors special standards, or so-called quality plans, have been introduced to ensure quality of care, as in the case of hospitals and homes for the elderly.
The quality of care provided is also guaranteed by compulsory or optional training for specialised workers.

Staff

In 2009, 20 399 people were employed by the Walloon Region's public social assistance centres (CPASs).
The number of people working for private social services certified and subsidised by the Walloon Public Service in 2009 was estimated at 6 150.
A survey is being conducted in 2010 to narrow down this figure.
Eight thousand people work for services subsidised by the AWIPH.
Social welfare and health activities and work with people with disabilities in connection with employment are supported by the Walloon Region and federal bodies such as the APE and the PTP set up to promote employment in the social sectors.
The total number of people working for CPASs in the public sector and certified and subsidised private social services is estimated at 34 549.
The staff of associations working with CPASs, hospitals, homes for the elderly including those with special care facilities and curative health services financed by the federal authorities are not included in these figures.

Figures for 2008-2009 concerning the activities of certified services

Homes

number of places provided in homes for the elderly: 45 353 including 17 885 places with increased care facilities.

Social work

- debt mediation cases: 19 480 (2008);
- number of homeless people provided with emergency accommodation in 2008: 4 175, for a total of 30 357 nights (information provided by social co-ordination offices).

Accommodation for the homeless including short and longer term accommodation, night shelters and family-type accommodation

7 388 people provided with accommodation for a total of 523 346 nights (2008).
Days provided for under Articles 60§7 and 61 and subsidised through the CPASs at a rate of 10 euros per day in the Walloon Region: 800 150 days, covering 6 606 people (2008).
Social integration allowances awarded by Walloon Region CPASs: 41 177 (or 1.2% of the population of the Region) (2009).
Social assistance service for litigants (SAJ): matters relating to offenders: 699 (2008) – matters relating to victims: 1 888 (2009).
Social service centres (CSS): 100 610 cases (2008)
Social integration service (2008):
Non-profit-making associations: 1 224 persons.
- CPASs: 1 330 persons.

Family and elderly assistance service – 5 987 223 hours worked in 2009.
Mental health services: 35 000 users and over 200 000 consultations per year.
Telephone advice service: 100 000 calls per year.
Integrated health associations: 45 000 registered patients.
Home help and care co-ordination centres: 11 000 recipients per year.
Addictions: Activities too varied to determine the rate and no reliable figures yet.

Right of access to social services

The Walloon Regional Decree of 6 November 2008 on the fight against certain forms of discrimination, pursuant to European directives implementing the principle of equal treatment, guarantees equal access for all European Union citizens to the social services run by the Walloon Region to which this decree is applicable.

Budgets allocated by the Walloon Region to social welfare and health policies for 2009-2010

				(in thousands of euros)				
Division.	Heading	Prog.	Heading	Allocated budget 2009	Allocated budget 2010	Expenditure 2009	Expenditure 2010	2010 %

17	Local government, social welfare and health	11	Cross-sectoral policies in the social and health field	33.665	30.000	33.665	30.000	3,4 %
		12	Health	81.270	88.866	78.620	86.524	10%
		13	Social welfare	63.454	63.183	63.404	62.914	7,1 %
		14	Families and the elderly	178.835	192.220	175.926	189.492	21%
		15	People with disabilities	503.706	507.811	503.706	507.811	57%

Summary of services certified by the Walloon Region (2009 - 2010)

	Private services	Public Social Assistance Centres and other local
Mental health services	38	25
Family planning and marital advice centres	70	1
Social service centres	32	-
Home help and care co-ordination centres	29	
Telephone information centres	5	-
Assistance service for litigants	13	-
Meeting forums	12	-
Integrated health associations	45	1
Associations specialising in addictions	15	-
Certified welfare services for families and the elderly –	32	58
Short and long-term accommodation for the homeless	62	8
Regional integration centres	7	-
Debt mediation	17	196
Social integration centres	32	42
Residential homes for the elderly, including homes with	505 (of which 268*)	141 (of which 123*)
Homes with care facilities in converted hospitals	1	9
Day centres, including day centres with care facilities*	24 (of which 14*)	20 (of which 15*)
Elderly persons flats with communal services	76	8
Hospitals	18	30
Psychiatric hospitals	6	14
Psychiatric residential establishments	5	8
Sheltered accommodation for psychiatric patients	-	27
Social co-ordination centres for the socially vulnerable	-	7

German-speaking Community – social services

Introductory remarks

The German-speaking Community has a population of about 74 500 in 9 municipalities .
Nine public social action centres – one per municipality .
The appended tables are taken from a booklet on the social action centres (*Öffentliche sozialhilfezentren*):

Appendix 1

table 1: social actions centres' areas of activity
tables 2, 3 and 4: centre staffing by municipality
table 6: institutions working in co-operation with the centres

Appendix 2

table 3: number of recipients of the minimum subsistence allowance
table 4: number of recipients by category (lone person, cohabitee, with family responsibilities)
table 6: number of recipients by nationality
Table 7: number of recipients of social assistance
Table 13: "article 60" job creation

Appendix 3
Table 1A: table of the various forms of financial assistance granted
Table 3: recipients of food aid
Observation
The minimum, or social integration, subsistence allowance is payable to any Belgian of foreign national recorded on the population register who does not have adequate resources and is not able to obtain them (Act of 26 May 2002 on the right to social integration)
Social assistance is paid by public social action centres. It may be material, social, medical, medical-social or psychological (Act of 8 July 1976 on public social action centres).
Section 60 § 7 of the Act of 8 July 1976 states that when a person requires a certain period of employment to qualify for the full payment of certain social benefits the public social action centre must take all possible steps to find him or her employment. Where appropriate, it shall provide this form of social assistance by itself acting as the employer for the period in question.
Monitoring the quality of services provided
Many organisations and institutions are active in the field of social action. Most of these activities are monitored by the employment, health and social affairs department of the Ministry of the German-speaking Community."

347. The representative of Belgium provided as well additional written information on the situation in their country relating to Article 14§1.

348. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 14§1 GEORGIA

The Committee concludes that the situation in Georgia is not in conformity with Article 14§1 of the Revised Charter because there is no general social services system.

349. The representative of Georgia provided the following written information:

"Social services at present are available for several vulnerable groups. Such as, children, people with disabilities, old aged persons, families living under the poverty line.
For orphans and children deprived of parental care prevention and deinstitutionalization services are under way implying material aid of families, reintegration cash benefits and also provided alternative services such as foster care and small group home services.
Social welfare services support day care services for children from vulnerable families, children with disabilities, so-called ''street children''. Day care centers provide homework support, educational programmes for children with special needs, meals and psychological support as well as organizing cultural activities.
State programs also cover prevention of different types of health disorders, early diagnosis and rehabilitation of children.
Community based services, rehabilitation services, wheelchairs, day-care services are available for persons with disabilities.
For aged persons exists residential institution care service.
Social welfare services are actively involved in all above mentioned programs. Nowadays there are two hundred social workers who are key decision makers of placement different groups in different services.
Families living under the poverty line (on basis of existing means tested system) receive cash benefits and medical insurance (793,557 person).
Cash benefits and medical insurance is available as well for IDP-s."

350. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

CSR 14§1 TURKEY

The Committee concludes that the situation in Turkey is not in conformity with Article 14§1 of the Charter on the ground that there is no general social services system.

351. The representative of Turkey stated that Turkey's social work structure was complex and varied .Social services were mostly provided by the Directorate General of Social Services and Child Protection (SHCEK). However there were other public and private agencies providing social services. There is however some disparity between urban and rural areas. Demand for social workers is high and more social workers are being trained to meet this demand.. Social welfare services continue to be developed under the 9th Development Plan 2007-2013.

352. Several representatives (Estonian, Lithuanian) noted that reform and development of social services in Turkey was ongoing and that there was already some progress.

353. The representative of Azerbaijan pointed out that social services in Turkey were also provided by NGOs.

354. The Committee took note of the positive developments and asked the government of Turkey to provide all the relevant information in the next report and decided to await the next assessment of the ECSR.

Article 14§2 – Public participation in the establishment and maintenance of social services

RSC 14§2 BELGIUM

The Committee concludes that the situation in Belgium is not in conformity with Article 14§2 of the Revised Charter because conditions imposed on non-public service providers to have access to the provision of social services are not clearly defined and it has not been established that control mechanisms have been set up to guarantee that these providers fulfil the conditions imposed on them.

355. The representative of Belgium provided the following written information:

> "See relevant information on Article 14§1."

356. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 14§2 GEORGIA

The Committee concludes that the situation in Georgia is not in conformity with Article 14§2 of the Revised Charter on the ground that it has not been established that measures are taken to encourage individuals and voluntary organisations to participate in the establishment and running of social welfare services.

357. The representative of Georgia provided the following written information:

> "All stakeholders are actively involved in process of development of social welfare service policies including non-governmental organizations. They are providers much of social services and are interested in designing of adequate policies.
> The good example how representatives of civil society are involved in designing policies is developing process of national action plan for disabled 2010-2012. Working group was established with representatives from local and international NGO-s, ministries for designing the action plan. The action plan was adopted and it reflects considerations all parties of stakeholders.
> NGO-s are as well involved in monitoring process of State social programs and social services. "

358. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC Article 23 – Right of the elderly to social protection

RSC 23 FINLAND

The Committee concludes that the situation in Finland is not in conformity with Article 23 of the Revised Charter on the ground that the level of the national pension for low income elderly persons is manifestly inadequate.

359. The representative of Finland provided the following written information:

> "Pension security is covered by a range of occupational pension legislation, in which separate laws cover pensions for employees, entrepreneurs, farmers, mariners, civil servants, municipal and church employees. In addition there is the national pension act. People in Finland are guaranteed the statutory **occupational earnings-related pension**, or the **national pension**, in the absence of an occupational pension or if it is minimal. The **old age pension** is an occupational pension and national pension benefit.
> Finland would like to recall that national pension is only a part of the minimum social security provided to elderly people. As stated in the report the social security system consists of several different measures targeted to elderly people. Besides low cost health care a pensioner is entitled to a housing allowance to compensate the cost of housing and a disability allowance for pension recipients to cover the extra costs arising from the need of help and assistance at home as well as from other special costs caused by the illness. All these benefits should be viewed as a whole. It is not the national pension alone which provides the total minimum coverage.
> The new law concerning the guarantee pension improves the income of people with the lowest pensions. If the national pension or the earnings-related pension a pensioner receives are below the minimum level of pension laid down by law, the difference is paid as guarantee pension. The guarantee pension applies to:
> - persons of 62 years of age or more who receive old-age pension or early old-age pension;
> - persons of 16 years of age or more who receive disability pension;
> - persons receiving unemployment pension;
> - persons receiving a benefit under the scheme for farmers' early retirement aid; and
> - persons who are incapable for work or immigrants who are 65 years of age or more if they have lived in Finland for at least three years.
>
> If a person receives old-age pension in the form of early old-age pension, a corresponding reduction applies also to the guarantee pension.
> Family relations have no impact on the level of guarantee pension: the level of full guarantee pension is the same for both single and married pensioners. Other income than pension income do not affect the level of guarantee pension. The President of the Republic confirmed the act on guarantee pension on 20 August 2010, and it enters into force on 1 March 2011.
> Taking into account the above said the Ministry of Social Affairs and Health is of the opinion that Finland is in conformity with Article 23."

360. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 23 ITALY

The Committee concludes that the situation in Italy is not in conformity with Article 23 of the Revised Charter on the ground that the level of the minimum contributory old age pension and the social allowance for low income elderly persons are manifestly inadequate

361. The representative of Italy provided the following written information:

> "The European Committee of Social Rights has found the situation in Italy to be non-compliant with Article 23 of the Revised European Social Charter on the ground that the level of the old age pension and the social pension for elderly persons are inadequate.
> In particular, the Committee states in its 2009 Conclusions that the amount of the minimum pension was €472 per month (€5,669.82 per year). In the reply to the finding of non-conformity under Article 12, we pointed out that this amount refers to the *"trattamento minimo"*, namely the supplement that the state pays to pensioners whose income is less than what is considered to be *"subsistence level"*. Referring back, therefore, to the reply in question, it should be noted that in 2007 the amount of the

minimum pension was €436.14 per month and not €472 since the annual amount of €5,669.82 must be divided into 13 monthly payments. This amount is then topped up by the "social increase"[1].
The Committee considered the amounts of the pension and the social allowance to be inadequate because they were below the EUROSTAT at-risk-of-poverty threshold estimated at 50% of the median income. Our response to this is as follows. Having estimated the at-risk-of-poverty threshold at €500 per month[2], the Committee observed that in Italy the amount of the old age pension was below this value. In its opinion, an allowance which in 2007 amounted to less than €500 per month stood below 40% of the median equivalised income and, hence, the at-risk-of-poverty threshold calculated by EUROSTAT. In its reply to the finding of non-conformity under Article 12, the Italian government cited either the parameter used by ISTAT or the value of the at-risk-of-individual-poverty threshold in 2007 (€493.17) estimated by the same institute. In the 2009 Conclusions on Article 23, however, the figure of €625 was given as the at-risk-of-poverty threshold in Italy. This value is significantly different both from the ISTAT at-risk-of-poverty threshold and from that indicated in the 2009 Conclusions on Article 12. It is clear that the amounts of the allowances in question may be judged adequate or inadequate depending on the parameters used to calculate the at-risk-of-poverty threshold. In the absence of a single, unambiguous parameter and given the patent lack of consistency between the two values taken as an example by the Committee, the Italian government plans to annually review the amounts of the pension and the social allowance according to the at-risk-of-poverty threshold calculated by ISTAT. Having gradually increased the amounts of the above-mentioned allowances from year to year, the Italian government has given growing attention to the income of elderly persons. For example, the individual amount of the minimum pension was €443.56 per month in 2008, rising to €458.20 per month in 2009. The amount of the minimum pension for elderly persons aged between 65 and 69 years, plus the "social increase", stood at €526.20 per month in 2008, rising to €540.84 in 2009. Persons aged 70 and over received a monthly minimum pension including the "social increase" of €559.91 in 2007, €580 in 2008 and €594.64 in 2009. Most of these amounts, moreover, are above 40% of the median equivalised income cited by the Committee as the at-risk-of-poverty threshold in the 2009 Conclusions on Article 12.
With regard to the amount of the pension and the social allowance, it should be pointed out that the figure cited in the 2009 Conclusions (€7,540 per year) referred to the social allowance paid to retirees aged 70 or more in 2008. The monthly amount of the social allowance including the "social increase" is €580, as stated before.
As far as the "social increase" is concerned, we have already explained in the reply to the finding of non-conformity under Article 12 that this "increase" is an integral part of the allowance itself and not, therefore, a separate benefit.
In conclusion, given the lack of a uniform criterion for assessing social allowances in Italy, we submit that consideration of the situation in Italy should be deferred."

362. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 23 PORTUGAL

The Committee concludes that the situation in Portugal is not in conformity with Article 23 of the Revised Charter on the ground that the level of minimum old-age pensions – both contributory and non-contributory – was manifestly inadequate for a large part of the elderly population during the reference period.

363. The representative of Portugal provided the following written information:

"Attending to the ECSR conclusion it is important to recognise that the situation in Portugal is not ideal bearing in mind that in this group of persons with old age the majority is **pensioners** with a low income and a non contributory career. Nevertheless there has been an effort to raise the quality of life of this population, namely in what the minimum value of the benefits is concerned.
One of the most important measure implemented in this field is the Social Support Reference Rate (IAS). The IAS replaced the Guaranteed Monthly Minimum remuneration **(RMMG)** as the indexation to calculate and actualise the social benefits, allowances and pensions. The IAS is actualise every year: 397, 86€ (2007); 407,41€ (2008) and 419,22€ (2009). IAS has been raise 2,9% each year .
The Solidarity Supplement for old people (CSI) is an important social measure adopted during this period. This benefit aims to reduce the worst situations of poverty among elderly and it took about 250,000 citizens from poverty. The public investment reached 430M€.

[1] see reply to the finding of non-conformity in respect of Article 12
[2] see 2009 Conclusions on Article 12

In order to enlarge the number of beneficiaries of the CSI, the social security services launched awareness actions intended to inform the population about this benefit and to help elderly to fulfil their application forms. As a result of these efforts the number of beneficiaries has been growing progressively from 56,700 in 2007 to 179,600 in 2008. Most of these citizens did not finance contributory schemes or had very low wages during their active life

It is also important to bear in mind that elderly without economic resources are entitled to benefit from CSI and social services such as home care services, Day and Night care, home assistance, elderly residences, recreation services and family care. The CSI beneficiaries can also benefit from supplementary l health benefits in order to assure a better access to health treatments and assistance devices.

Finally is important to underline that Portugal has been improving the social pensions and benefits through social expenditure in a recessive economic framework. The public investment made in improving the life conditions of the most vulnerable groups, namely elderly is an important effort to combat poverty."

364. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 23 SLOVENIA

The Committee concludes that the situation in Slovenia is not in conformity with Article 23 of the Revised Charter on the grounds that:

- the level of the minimum contributory old-age pension and the social pension for low-income elderly persons are manifestly inadequate;
- the length of residence requirement for entitlement to the social pension is excessive.

First and second grounds of non-conformity

365. The representative of Slovenia provided the following written information:

"Initially, it needs to be clarified that State pension is not a right that is ensured from the compulsory pension and invalidity insurance scheme, despite the fact that it contains the word "pension" in its name.

State pension is an income that is granted to people upon reaching a certain age (65 years) who have not fulfilled the minimum insurance period to be entitled to pension in accordance with the Slovenian rules on pension and invalidity insurance, other rules, or from foreign public pension schemes.

In addition, one must also fulfil other statutory requirements, such as: 1/ residence requirement (a minimum of 30 years of evidenced permanent residence in the RS between 15 and 65 years of age), and 2/ property census to obtain minimum pension support (however, unlike the minimum pension support, entitlement to State pension does not take into account other family members of the person who are, in accordance with the family legislation, obliged to maintain them, or their income and property!).

The right to State pension is thus not a right from the public pension scheme, as it not bound to the status that the insured person obtains on the basis of work and paid in contributions, but is financed from the State budget in order to provide funds for maintenance or social security to those who have not been granted a right to pension on the basis of their previous work.

For this reason, State pension is a right of social nature and must not be, despite the word "pension", equalled to a "minimum old-age pension". This also stems from state pension assessment, which equals 33.3% of the minimum pension rating base, while "minimum pension" for 15 years equals 35% of the minimum pension rating base.

With the pension reform and changes of the social assistance legislation the right to state pension will be newly regulated.

To ensure more transparency in the functioning of the retirement scheme and to regulate in one place all benefits related to the material status of an individual or a family, the pension and invalidity insurance shall no longer include social transfers paid to beneficiaries out of the national budget, which depend not on the contributions paid, but rather on the social status of the individual or the family instead. This will warrant a clear separation of social transfers and purely pension-related benefits (old-age pension, invalidity pension, widower's pension and survivor's pension) funded from contributions collected for the purpose of pension and invalidity insurance.

Rights to state pension and supplementary allowance depend on the material status of the individual and not on the contributions collected. The state pension is a benefit guaranteed to persons as provided by the law, who have attained the required age (65 years) and have not reached the pension

qualifying period, but do meet other statutory conditions (Republic of Slovenia was their declared country of residence for at least 30 years during their age between 15 and 65 years), provided that their personal income does not exceed the property census set for persons entitled to supplementary allowance under the Pension and Disability Insurance Act (Official Gazette of the Republic of Slovenia, No 109/06 – official consolidated text, 114/06 – ZUTPG, 10/08 – ZvarDod, and 98/09 – ZIUZGK; „ZPIZ-1“). The right to state pension provides social security to the beneficiaries, and is not dependent on the status acquired by the insured person based on their work and contributions paid. State pensions were intended for people who are not entitled to pensions neither from the Slovenian social insurance scheme nor from any foreign pension insurance system to be given financial means to survive. According to current legislation, the decision about a person's entitlement to this right does not take into account the dependents the beneficiary must support under family legislation, nor does it depend on the dependents' income and property. Persons entitled to state pension in the transitional period who shall lose this right upon the expiry of this transitional period will be guaranteed social security in the form of social-security benefits pursuant to this legislative proposal (national old-age pension and supplementary allowance as an independent right). Other current beneficiaries of state pensions who will not be entitled to social-security benefits under this law upon adoption of this legislative proposal shall be provided social-security benefits from other sources (persons obligated to support them, their property, savings etc.).

Supplementary allowance granted to beneficiaries under the Minimum Pension Support Act is a supplementary allowance intended to provide social security to persons receiving pensions below the minimal amount, provided that these persons and their family members have no other income and property that would guarantee them sufficient financial security. Under the Minimum Pension Support Act, supplementary allowance is not granted to a pension beneficiary if his social security, and the social security of the family members in the same household, is not threatened despite the low income. The Pension and Disability Insurance Institute of the Republic of Slovenia may examine ex officio if the conditions for a beneficiary's entitlement to supplementary allowance are still met.

Social work centres will have to determine ex officio, within three months upon entry into force of this act, whether recipients of supplementary allowance or state pension under the Pension and Disability Insurance Act (ZPIZ-1) or persons entitled to invalidity benefit or care and assistance allowance under the Act Concerning Social Care of Mentally and Physically Handicapped Persons, whether these persons fulfil the conditions to have their rights transformed into rights to social-security benefits under this act and issue a decision annulling the decision to grant the right to supplementary allowance under the Minimum Pension Support Act, to state pension under the Pension and Disability Support Act, or to invalidity benefit or care and assistance allowance under the Act Concerning Social Care of Mentally and Physically Handicapped Persons and decide that the right ceases on 31 December 2010. If the beneficiary fulfils the conditions for social-security benefits under this act, he is granted the appropriate right to social-security benefits since 1 January 2011 under the same decision; otherwise, the social security centre decides he does not meet the statutory conditions to be entitled to social-security benefits. All benefits – i.e. state pension under the Pension and Disability Insurance Act, supplementary allowance under the Minimum Pension Support Act, and the or to invalidity benefit or care and assistance allowance under the Act Concerning Social Care of Mentally and Physically Handicapped Persons – are to be transformed into social assistance in cash or supplementary allowance. Transfer of data on beneficiaries of supplementary allowance under the Minimum Pension Support Act and of state pension under the Pension and Disability Insurance Act, will be made from the Pension and Disability Insurance Institute of the Republic of Slovenia to the Ministry one month before the entry into force of this act, and the Institute will inform the beneficiaries of this transfer.

It is also provided that payments to beneficiaries entitled to state pension or supplementary allowance or to invalidity benefit or care and assistance allowance under the Act Concerning Social Care of Mentally and Physically Handicapped Persons on the day the new act enters into force, are made until a new decision on entitlement to or cessation of social-security benefits under this act is issued. Funds paid on this basis are considered advanced payments of social-security benefits under this act. If, based on the decision on cessation, the beneficiary is entitled to a higher monthly sum than was awarded to him in the form of advanced payment, this decision only provides for the difference between the advanced payments and the actual sum awarded to the beneficiary based on this decision to be paid to him for the time when he received advanced payments.

The rights to supplementary allowance under the Minimum Pension Support Act (Official gazette of the Republic of Slovenia, No 10/08, ZVarDod), to state pension under the Pension and Disability Insurance Act (Official gazette of the Republic of Slovenia, No 109/06 – official consolidated text, 114/06 – ZUTPG, 10/08 – ZvarDod, and 98/09 – ZIUZGK; „ZPIZ-1“) and to invalidity benefit or care and assistance allowance under the Act Concerning Social Care of Mentally and Physically Handicapped Persons are thus transferred into the social-security benefits scheme with this act, which

prejudices the acquired beneficiaries' rights. This affects the principle of legal certainty or the principle of legitimate expectations, but this intervention is necessary to uphold other principles and public interest, which must be given priority in this case, namely:

- the principle of equality of all citizens of the Republic of Slovenia before the law or this legislative proposal, aimed to provide means for basic needs and decent living, as well as
- the protection of another constitutional right, i.e. the right to social security of other citizens as guaranteed by the Republic of Slovenia. As a welfare state, Republic of Slovenia must guarantee social security to all citizens without unduly depleting the funds earmarked for this purpose and thereby jeopardizing this right. Different legislative measures currently regulate the rights to state pension, to supplementary allowance and to social assistance in cash, all of which represent corrective measures, and must therefore be regulated within a comprehensive social-security benefits system to lay down equal conditions for granting all of these benefits

Pension and Disability Insurance Institute of the Republic of Slovenia is responsible for the first-level procedures for determining entitlement to state pension based on applications submitted which have not yet been decided before entry into force of this act, whereby it shall apply the Pension and Disability Insurance Act (ZPIZ-1) when deciding on the entitlement for the period between the submission of the application and the entry into force of the new act.

This article provides that the Pension and Disability Insurance Institute of the Republic of Slovenia is responsible for the first-level procedures for determining entitlement to supplementary allowance based on applications submitted which have not yet been decided before entry into force of this act, whereby it shall apply the Minimum Pension Support Act when deciding on the entitlement for the period between the submission of the application and the entry into force of this act.

If the applicants for the right to state pension and supplementary allowance, whose applications have not yet been decided by the Pension and Disability Insurance Institute of the Republic of Slovenia before entry into force of this act, apply for social assistance in cash or supplementary allowance within two months after entry into force of this act, the right to supplementary allowance is granted to them as of the date this act enters into force. If they exercise this right after this deadline, the right to supplementary allowance is granted to them on the first day of the month following their application."

366. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 23 SWEDEN

The Committee concludes that the situation in Sweden is not in conformity with Article 23 of the Revised Charter on the ground that the scope of the legal framework to combat age discrimination outside employment is not sufficiently wide.

367. The representative of Sweden provided the following written information:

"In response to the Committee's conclusion 2009 the Swedish Government (the Government) would like to submit the following comments.

It is a high priority for the Government to promote equal rights and opportunities for all persons. Effective and comprehensive anti-discrimination legislation is necessary to combat actions that directly or indirectly violate the principle of the equal worth of all persons. Already today elderly are guaranteed a high level of protection of discrimination and have the right to a solid framework of social protection. The Government aims at guaranteeing a dignified ageing and to shift focus from professions and institutions to individual needs and wellbeing.

The Swedish Discrimination Act

As the Committee notes the Act protects individuals against discrimination on the grounds of age within the specific areas of working life, educational activities, labour market policy activities and employment services not under public contract, starting and running a business, professional recognition and membership of certain groups. The background for the limited protection on the ground of age can be found in the findings of the parliamentary committee which had the assignment to conduct a review of the Swedish discrimination legislation and to propose new legislation in this field. Regarding some and here relevant areas of society[1] the parliamentary committee concluded that further analysis was needed before the discrimination prohibition based on age could be formulated

[1] I.e. goods, services and housing, public meetings and public events, the social services, the social insurance system, unemployment insurance, health and medical care services, public study support, compulsory military and compulsory civilian service, public appointments and public assignments.

and defined in an effective way which permitted desirable and justifiable preferential treatment. In August 2009 the Government therefore appointed a one-man inquiry to look at a solution securing the same level of protection against discrimination regardless of grounds of discrimination. The inquiry will seek to propose a solution on how a protection against discrimination on the grounds of age can be formulated and defined for the areas which today are not covered by the Act. The investigator is to present a report during Autumn 2010. The Government will closely follow the development and result of the inquiry and will provide necessary information to the Committee.

Additional existing framework for the social protection of elderly

Legislative framework

The Social Services Act (socialtjänstlagen) states that the municipality has the responsibility to ensure that all persons residing in a municipality should have an adequate standard of living. The Act on Municipalities (kommunallagen) states that all residents in a municipality should be treated in the same way (likställighetsprincipen). In the Health Care Act (hälso- och sjukvårdslagen) it is stated that everyone should be treated according to their needs.

Adequate resources

Within the pension system an important tool to guarantee adequate resources for elderly is the housing supplement for pensioners. This means that almost no elderly in Sweden are depending on social assistance. Another important safeguard against poverty is the reserve sum that each person has the right to keep after fees for services are paid for. That means that a pensioner with low income and in need of extensive services are assured an adequate standard of living.

Prevention of Elder Abuse

The Government has the last years made an unprecedented effort on developing the competence of staff working within the elderly care. More than 1 billion SEK has been provided for this project (Steps for Skills). The most common theme for the competence development was ethical values and changing of attitudes towards the elderly. Also, a special law (Lex Sarah) makes it compulsory for all staff to report to the authorities, abuse and mal practice towards elderly. The municipalities are also encouraged to develop local dignity guarantees and develop systems for obtaining labeling certifying standards of dignity. Moreover, as from 2009 the social services have a legal responsibility to give support to persons who care for an dependent by giving for example practical help and nursing. The Government also provide economic resources to stimulate the municipalities to develop this kind of support to informal care givers. In order to protect the interests of persons who are not self-managed, a trustee can be assigned to take care of economic matters and to ensure that the person receive the support he or she is entitled to. The Trustee is appointed by the District court.

Housing

The Government has since 2007 provided 500 million SEK per year to stimulate construction and conversion to special housing for the elderly. Until now, this grant have financed over 6000 apartments for elderly. Moreover, the Government has recently launched a program to support innovation and development of housing for elderly. Focus is on improved accessibility in housing and physical environment, strategic physical planning to improve accessibility in society, better use of new technology and facilities and a good working environment for care givers. The aim is to improve the conditions for elderly and other groups with impaired mobility to be autonomous and take part in society.

Institutional Care

A legislation on freedom of choice makes it possible for elderly to choose among different providers of elderly care. This legislation also means that service providers are allowed to compete for customers and since everyone receives the same financial grant, the providers have to compete by showing good quality. The freedom of choice will stimulate services that better correspond to the needs and preferences of people with for example different ethnical backgrounds or different sexual orientation.

Conclusion

With regard to the above, The Government believes that the Swedish system provides an adequate support and protection of elderly which guarantees a right for elderly persons to social protection. The Government will continue to strive for an appropriate legal ground for the protection against discrimination of age. The Government will in its next national report provide adequate information to the Committee."

368. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

RSC 23 UKRAINE

The Committee concludes that the situation in Ukraine is not in conformity with Article 23 of the Revised Charter on the ground that the level of minimum old-age pensions – both contributory and social – are manifestly inadequate.

369. The representative of Ukraine provided the following written information:

> "In 2008 the value of 1 year of the covered service period was increased from 1% to 1,35%. After this increasing the ratio between average pension and average wage constituted 48.5%.
> As a result of actions taken in 2008-2009 the average size of pensions composed to 2007 increased by 64.5%. Effective from 1 April, 2008, the minimum pension benefit to all categories (without exception) including people who are not eligible for a pension (at age 63 (men) or age 58 (women)) and not eligible for a pension under the current legislation is fixed at a level not lower than the subsistence level for those who are not-able-to work.- 481 UAH; from 1 July, 2008 - 482 UAH; from 1 October, 2008 – 498 UAH.
> From 1 November, 2009 pensions were paid on the basis of the new subsistence level for those who are not-able-to work - 573 UAH.
> In addition, in October 2009 the Cabinet of Ministers approved the Concept of further implementation of the pension reform.
> The Concept provides for effective mechanism of protection of rights and interests of aged people and other categories of citizens who lost capacity for work, as well it ensures stable functioning and transparency of the pension system.
> The Concept will be implemented in 2010-17 in two stages.
> Specifically, from 2010 to 2013 the Government plans introducing an effective mechanism of raising pensions granted; ensuring differentiation of the size of minimum pension payment depending of acquired pensionable service; legalisation of salaries; ensuring protection for pension assets; promoting development of non-government pension security; and introduction of economical incentives for payment of pension contributions.
> At second stage, from 2014 to 2017, the Government will ensure equal rights for citizens in the pension system via introducing common for all rules of granting pensions; free the Pension Fund budget from non-characteristic payouts; and ensure development of financial defined contributions for the pension security.
> From 1 January, 2010 minimum pension for those who are not-able-to work is amounted to 630,4 UAH."

370. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

Article 30 – Right to be protected against poverty and social exclusion

RSC 30 ITALY

The Committee concludes that the situation in Italy is not in conformity with Article 30 of the Revised Charter on the ground that it has not been established that there is an overall and coordinated approach to combating poverty and social exclusion.

371. The representative of Italy provided the following written information:

> "With regard to the European Committee of Social Rights' conclusion concerning the absence of an "overall and coordinated approach to combat poverty and social exclusion", it is worth noting the following, given what has already been said in the Italian gvernment's previous reports.
> The pursuit of the objectives set out in the 2006-2008 National Strategy Report, some of whose initiatives were addressed in the last report (which dates back to 2008), was mainly accomplished through increased negotiations and the conclusion of pacts and agreements between the various tiers of government, i.e. central, regional and local. During the 3-year period under review, the latter concluded a series of "agreements" designed to set out, via a process based on the open co-ordination method, shared objectives, uniform guidelines and assessment and monitoring mechanisms with respect to actions and measures which, even though they fall within the exclusive remit of regional or local government, are nevertheless linked to anti-poverty and social exclusion policies.

Among the key measures adopted and which are currently being implemented in this area, we would mention the following, in addition to those mentioned earlier:

a) Early childhood services:

The development of care, social and educational services for early childhood (0-2 years) has received particular attention, in line with the 2006-2008 National Action Plan. The 2007 Finance Act marked the launch of a long-term, organic scheme totalling €340 million, with 250 million euros to be distributed among all the regions and the remaining 90 million used to harmonise the situation in the 11 regions which have a level of coverage below the national average, namely the southern regions, plus Venetia, Friuli-Venezia-Giulia and Lazio. The central and northern regions contribute to the scheme with 30% of the costs, equal to a further €53 million or so. The financial resources made available are being used to increase the level of coverage of demand for social and educational services for early childhood to 13% in the case of the national average, and no less than 6% in each region, thus creating more than 50,000 new places in the integrated social and educational services system for early childhood, on top of the 188,000 places that already exist.

b) Special sections for early childhood (sezioni primavera):

In accordance with the provisions of the 2007 Finance Act, the government has concluded an agreement with the regional and local governments under which 1,362 special sections for early childhood as well as an experimental educational programme involving crèches (0-3 years) and nurseries (3-5 years), targeting children aged between 2 and 3 years, have received funding for the 2007-2008 and 2008-2009 school years. In addition, this sector receives central government funds totalling €35 million per year.

c) Family support programme:

Following an agreement between the Ministry for Family and Children and the Unified Conference (consisting of the State-Regions Conference and the State-Cities and Autonomous Local Entities Conference) in September 2007, it was decided to plan and trial measures and actions aimed at:

- *abolishing utility charges for households with 4 or more children and reducing the tariffs for electricity and waste collection, as well as projects aimed at reducing the costs incurred by households for using or accessing other goods and services at local level;*
- *improving the social and care services provided by the family advice centres (ASL branch), especially with regard to the social, relational and psychological welfare of households, ensuring a multi-disciplinary approach (educational, legal and health promotion issues) through family mediation, with a view to providing support to couples and parents and encouraging good parenting.*

The scheme promotes “listening centres” for families, especially families where certain members are at risk. The scheme also identifies ways of facilitating the social integration of immigrants and providing better support for foster and adoptive families.

d) Non-self-sufficient persons:

The scheme that has been developed to help the most vulnerable members of society is aimed at delivering integrated social and health services for non-self-sufficient persons (whether elderly or disabled). The quality and quantity of these socio-health services is fairly even across the country. In order to ensure greater equality among citizens, a “non-self-sufficiency fund” has been set up, from which payments have been made to the regions and autonomous provinces. The fund will be used to provide and care for non-self-sufficient persons through tailored care programmes and to set up a one-stop-shop for services, with increased emphasis on home care. The fund spent an initial 100 million euros in 2007, followed by 300 million in 2008 and 400 million in 2009.

e) Measures for people with disabilities:

The “targeted employment” method has now been extended nationwide. The idea is to facilitate the integration of people with reduced mobility into the workplace, with the same level of productivity as other workers. Following confirmation of the effectiveness of the system of occupational integration applied under the so-called *welfare protocol*, the National Fund that provides economic assistance, technical support and counselling for employers of people with disabilities (by simplifying the procedure, i.e. the documents to be produced and the hire lists) was increased in July 2007.

f) Housing support: measures have been introduced to help certain social groups facing “expired lease” eviction orders, as follows:

a. *tenants with a gross annual income of less than* 27,000 *euros;*
b. *tenants with family members over the age of 65 years, family members suffering from a terminal illness or who have a degree of disability of 66% or more;*
c. *tenants who do not have access to other suitable housing.*

In 2007, measures were introduced which provided for urgent action to increase the amount of public housing available for rent, to enable people facing eviction to be rehoused. For this purpose, 550 million euros were earmarked for a special public housing construction programme, which funds were

used for the housing plan in question. These measures also helped to block eviction orders for 8 months.

The numerous initiatives mentioned here highlight the variety and complexity of the commitments undertaken. This is due to the way in which the institutions responsible for social welfare and, more specifically, integration policies between 2006 and 2008 were organised. Over this period, it was decided to assign the functions to separate bodies, with respect to both political responsibility and administrative management. This entailed (i) the definition of a varied set of measures and actions and (ii) considerable difficulty in framing integrated, sufficiently consistent policies.

In the light of this assessment, the newly composed government decided to place national welfare competencies under a single umbrella in terms of policy and management (Ministry of Labour and Ministry for the Family and Children), thus paving the way for closely co-ordinated activities in terms of national competencies but also with a view to promoting a similar integrated approach in Italy's other institutional spheres."

372. The Governmental Committee invited the Government to provide all the relevant information in its next report and decided to await the next assessment of the ECSR.

APPENDIX I / ANNEXE I
LIST OF PARTICIPANTS / LISTE DES PARTICIPANTS

(1) 121st meeting, 3-6 May 2010 / 121e réunion, 3-6 mai 2010
(2) 122nd meeting 11-14 October 2010 /122e réunion, 11-14 octobre 2010

STATES PARTIES / ETATS PARTIES

ALBANIA / ALBANIE
Mrs Albana SHTYLLA, Director of the Legal Department, Ministry of Labour, Social Affairs, and Equal Opportunities (1) (2)

ANDORRA / ANDORRE
Mme. Maria GELI, Directrice du Travail, Ministère de la Justice et de l'Intérieur (1)
Mme Magda MATA**,** Secrétaire d'Etat à l'Egalité et au Bien-être, Ministère de la Santé du Bien-être et du Travail (2)

ARMENIA / ARMENIE
Mrs. Anahit MARTIROSYAN, Head of Division of International Relations, Ministry of Labor and Social Affairs (1)
(Apologised/Excusé) (2)

AUSTRIA / AUTRICHE
Mrs Elisabeth FLORUS, Federal Ministry of Labour, Social Affairs and Consumer Protection (1) (2)

AZERBAIJAN / AZERBAÏDJAN
(Apologised/Excusé) (1)
Mr. Vugar SALMANOV, Senior Consultant of the International Cooperation Department, Ministry of Labour and Social Protection of Population (2)

BELGIUM / BELGIQUE
Mme Marie-Paule URBAIN, Conseillère, Service public fédéral Emploi, Travail et Concertation sociale, Services du Président, Division des Etudes juridiques (1) (2)
Mme Murielle FABROT, Attachée, Service public fédéral Emploi, Travail et Concertation sociale, Division des Etudes juridiques, de la documentation et du contentieux (1) (2)

BOSNIA AND HERZEGOVINA / BOSNIE-HERZEGOVINE
Ms Azra HADŽIBEGIĆ, Expert Adviser for Human Rights, Ministry for Human Rights and Refugees (1) (2)

BULGARIA / BULGARIE
Mme Yuliya ILCHEVA, Conseillère, Direction des Affaires européennes et coopération internationale, Ministère du travail et de la politique sociale (1) (2)

CROATIA / CROATIE
Mrs Gordana DRAGIČEVIĆ, Head of Department for European Integration and International Cooperation, Ministry of Economy, Labour and Entrepreneurship (1) (2)

CYPRUS / CHYPRE
Mrs Eleni PAROUTI, Chief Administrative Officer, Ministry of Labour and Social Insurance (1) (2)

CZECH REPUBLIC / REPUBLIQUE TCHEQUE
Ms Kateřina MACHOVÁ, Legal Official; Department for EU and International Cooperation, Ministry of Labour and Social Affairs (1) (2)

DENMARK / DANEMARK
Mr Kim TAASBY, Special Adviser, Danish Ministry of Employment (1) (2)
Mr Leo TORP, Head of Section, The national Directorate of Labour (1)
Ms Lis WITSO-LUND, Head of Section, Ministry of Employment (1)

ESTONIA / ESTONIE
Mrs Merle MALVET, Head of Social Security Department, Ministry of Social Affairs (1) (2)
Ms Seili SUDER, Chief Specialist of Working Life Development Department (1)
Ms Eha LANNES, Advisor to the Social Welfare Department, Ministry of Social Affairs (2)

FINLAND / FINLANDE
Mrs Riitta-Maija JOUTTIMÄKI, Ministerial Councellor, Ministry of Social Affairs and Health (1)
Mrs Liisa SAASTAMOINEN, Senior Officer Legal Affairs, Ministry of Employment and the Economy (1) (2)

FRANCE
Mme Jacqueline MARECHAL, Chargée de mission, Délégation aux affaires européennes et internationales, Ministère de la Santé et des Solidarités (1) (2)

GEORGIA / GEORGIE
Mr George KAKACHIA, Head of Social Protection Programmes Division, Social Protection Department, Ministry of Labour, Health and Social Affairs (1)
(Apologised/Excusé) (2)

GERMANY / ALLEMAGNE
Mr Udo PRETSCHKER, Federal Ministry of Labour and Social Affairs (1)
Mr Jürgen THOMAS, Deputy Head of Division VI b 4, "OECD, OSCE", Council of Europe, ESF-Certifying Authority, Federal Ministry of Labour and Social Affairs (2)

GREECE / GRECE
Ms Maria SPANOU, Official, Department of International Relations, Ministry of Labour and Social Security (1)
Ms Evanghelia ZERVA, Government Official, Ministry of Employment and Social Protection, International Relations Directorate (1) (2)

HUNGARY / HONGRIE
Dr. Ildikó BODGAL, Chief Councellor, Ministry of Social Affairs and Labour, Department for European Union and International Affairs (1)
(Apologised/Excusé) (2)

ICELAND / ISLANDE
(Apologised/Excusé) (1)
Mrs Hanna Sigrídur GUNNSTEINSDÓTTIR, Head of Department, Department of Equality and Labour, Ministry of Social Affairs and Social Security (2)

IRELAND / IRLANDE
Mr John Brendan McDONNELL, International Officer, International Desk, Employment Rights' Legislation Section, Department of Enterprise, Trade and Innovation (1) (2)

ITALY / ITALIE
Ms Carmen FERRAIOLO, Ministry of Labour, Health and Social Policies, Directorate General Working Conditions (1) (2)

LATVIA / LETTONIE
Ms Liene RAMANE, Insurance Department, Benefits Policy Unit, Ministry of Welfare Social (1)
Mrs Velga LAZDINA-ZAKA, Ministry of Welfare, Social Insurance Department, Benefits Policy Division (2)

LITHUANIA / LITUANIE
Ms Kristina VYSNIAUSKAITE-RADINSKIENE, Chief Specialist of International Law Division, Ministry of Social Security and Labour (1) (2)

LUXEMBOURG
M. Joseph FABER, Conseiller de direction première classe, Ministère du Travail et de l'Emploi (1) (2)

MALTA / MALTE
Mr Franck MICALLEF, Director (Benefits), Social Security Division (1) (2)

MOLDOVA
Mme Lilia CURAJOS, Chef de la Section des relations internationales et communication, Ministère de la Protection sociale, de la Famille et de l'Enfant (1) (2)

MONTENEGRO
Ms Vjera SOC, Senior Adviser for International Cooperation, Ministry of Health, Labour and Social Welfare (1) (2)

NETHERLANDS / PAYS-BAS
Mr Onno P. BRINKMAN, Policy Advisor, Ministry of Social Affairs and Employment (1) (2)
Mr Kees TERWAN, Ministry of Social Affairs and Employment, International Affairs Directorate (2)

NORWAY / NORVEGE
Ms Mona SANDERSEN, Senior Advicer, Ministry of Labour and Social Inclusion, Working Environment and Safety Departement (1) (2)

POLAND / POLOGNE
Mme Joanna MACIEJEWSKA, Conseillère du Ministre, Département des Analyses Economiques et Prévisions, Ministère du Travail et de la Politique Sociale (1)
M. Jerzy CIECHANSKI, Ministère du Travail et de la Politique Sociale (2)

PORTUGAL
Ms Maria Alexandra PIMENTA (**Chair/Présidente**), Directora do Instituto Nacional para a Reabilitação, I.P./MTSS (1) (2)

ROMANIA / ROUMANIE
Ms Cristina ZORLIN, Deputy Director, Directorate for External Relations and International Organisations, Ministry of Labour, Family and Social Protection (1)
Ms Roxana ILIESCU, Main Expert, Directorate for External Relations and International Organizations, Ministry of Labour, Family and Social Protection (2)

RUSSIAN FEDERATION / FEDERATION DE RUSSIE
Mme Elena VOKACH-BOLDYREVA, Conseillère, Département de la coopération internationale et des relations publiques, Ministère de la Santé et du Développement social (1) (2)
Mme Nadejda SAVOLAYNEN, Directrice du Département de Finance, Ministère de la Santé et du Développement social (2)

SERBIA / SERBIE
Ms Dragana RADOVANOVIC, Senior Adviser, Sector for International Cooperation and European Integration; Ministry of Labor and Social Policy (1) (2)

SLOVAK REPUBLIC / REPUBLIQUE SLOVAQUE
Mr Lukáš BERINEC, Director, Department of EU Affairs and International Cooperation, Ministry of Labour, Social Affairs and Family (1) (2)
Mr Juraj DŽUPA, Department of EU Affairs and International Cooperation, Ministry of Labour, Social Affairs and Family (1)

SLOVENIA / SLOVENIE
Mr Peter POGACAR, Director General - Directorate for Labour Relations and Labour Rights, Ministry of Labour, Family and Social Affairs (1)
Ms Janja GODINA, Senior Adviser, International Cooperation and European Affairs Service (1)
Ms. Katja RIHAR-BAJUK, International Cooperation and European Affairs Service, Ministry of Labour, Family and Social Affairs (2)

SPAIN / ESPAGNE
Ms. Adelaida BOSCH, Conseillère techique des Relations Sociales et Internationales, Ministère de Travail et d'Immigration (1) (2)

SWEDEN / SUEDE
Ms Lina FELTWALL, Deputy Director/Kansliråd, Ministry of Employment/Arbetsmarknadsdepartementet International Division/Internationella enheten (1)
Ms Anna-Lena HULTGARD SANCINI, Director, Kansliråd, Ministry of Employment/Arbetsmarknadsdepartementet, International Division/Internationella enheten (1)
(Apologised/Excusé) (2)

"the former Yugoslav Republic of Macedonia" /
« l'ex-République yougoslave de Macédoine »"
Mr Darko DOCINSKI, Head, Unit for EU Integration and Accession Negotiations, Department for European Integration, Ministry of Labour and Social Policy (1) (2)

TURKEY / TURQUIE
Mr. Halidun ERCAN, Expert, Ministry of Labour and Social Security (1) (2)

UKRAINE
Mrs Natalia POPOVA, Deputy Head of the International Relations Department, Ministry of Labour and Social Policy (1) (2)

UNITED KINGDOM / ROYAUME-UNI
Mr Stephen RICHARDS, Head of ILO, UN and CoE Team, Joint International Unit, Dept for Work and Pensions (1)
Mr Francis ROODT, Policy Adviser, ILO, UN and CoE (Employment)Team, Joint International Unit for Education, Employment and Social Affairs (1)
– (2)

SOCIAL PARTNERS / PARTENAIRES SOCIAUX

EUROPEAN TRADE UNION CONFEDERATION /
CONFEDERATION EUROPEENNE DES SYNDICATS
Mr Stefan CLAUWAERT, ETUC Advisor, ETUI Senior researcher, European Trade Union Institute (ETUI) (1) (2)
M. Henri LOURDELLE, Conseiller, Confédération Européenne des Syndicats (1) (2)

BUSINESSEUROPE
(former UNION OF INDUSTRIAL AND EMPLOYERS' CONFEDERATIONS OF EUROPE /
ex- UNION DES CONFEDERATIONS DE L'INDUSTRIE ET DES EMPLOYEURS D'EUROPE)
–

INTERNATIONAL ORGANISATION OF EMPLOYERS /
ORGANISATION INTERNATIONALE DES EMPLOYEURS
Ms. Maud MEGEVAND Legal adviser, International Organisation of Employers (1) (2)

SIGNATORIES STATES / ETATS SIGNATAIRES

LIECHTENSTEIN
(Apologised/Excusé) (1) (2)

MONACO
M. Stéphane PALMARI, Secrétaire, Département des Affaires Sociales et de la Santé, Ministère d'Etat (1) (2)

SAN MARINO / SAINT-MARIN
–

SWITZERLAND / SUISSE
(Apologised/Excusé) (1) (2)

INGO's DELEGATION / DELEGATION DES OING

M. Gabriel NISSIM, Président de la Commission Droits de l'Homme de la Conférence des OING du Conseil de l'Europe (1)

Mme Marie-José SCHMITT, Vice-Présidente de l'Action européenne des handicapés, Membre de la Commission «Droits de l'Homme » de la Conférence des OING du Conseil de l'Europe (1)

COUNCIL OF EUROPE DEVELOPMENT BANK / BANQUE DE DEVELOPPEMENT DU CONSEIL DE L'EUROPE

Mr. György BERGOU, Deputy Head of the Secretariat, Executive Secretary of the Partial Agreement on the Development Bank of the Council of Europe (2)

Appendix II
Chart of Signatures and Ratifications – Situation at 3 March 2010

MEMBER STATES	SIGNATURES	RATIFICATIONS	Acceptance of the collective complaints procedure
Albania	21/09/98	14/11/02	
Andorra	04/11/00	12/11/04	
Armenia	18/10/01	21/01/04	
Austria	07/05/99	**29/10/69**	
Azerbaijan	18/10/01	02/09/04	
Belgium	03/05/96	02/03/04	23/06/03
Bosnia and Herzegovina	11/05/04	07/10/08	
Bulgaria	21/09/98	07/06/00	07/06/00
Croatia	06/11/09	**26/02/03**	26/02/03
Cyprus	03/05/96	27/09/00	06/08/96
Czech Republic	04/11/00	**03/11/99**	
Denmark *	03/05/96	**03/03/65**	
Estonia	04/05/98	11/09/00	
Finland	03/05/96	21/06/02	17/07/98 **X**
France	03/05/96	07/05/99	07/05/99
Georgia	30/06/00	22/08/05	
Germany *	29/06/07	**27/01/65**	
Greece	03/05/96	**06/06/84**	18/06/98
Hungary	07/10/04	20/04/09	
Iceland	04/11/98	**15/01/76**	
Ireland	04/11/00	04/11/00	04/11/00
Italy	03/05/96	05/07/99	03/11/97
Latvia	29/05/07	**31/01/02**	
Liechtenstein	**09/10/91**		
Lithuania	08/09/97	29/06/01	
Luxembourg *	11/02/98	**10/10/91**	
Malta	27/07/05	27/07/05	
Moldova	03/11/98	08/11/01	
Monaco	05/10/04		
Montenegro	22/03/05	03/03/10	
Netherlands	23/01/04	03/05/06	03/05/06
Norway	07/05/01	07/05/01	20/03/97
Poland	25/10/05	**25/06/97**	
Portugal	03/05/96	30/05/02	20/03/98
Romania	14/05/97	07/05/99	
Russian Federation	14/09/00	16/10/09	
San Marino	18/10/01		
Serbia	22/03/05	14/09/09	
Slovak Republic	18/11/99	23/04/09	
Slovenia	11/10/97	07/05/99	07/05/99
Spain	23/10/00	**06/05/80**	
Sweden	03/05/96	29/05/98	29/05/98
Switzerland	**06/05/76**		
«the former Yugoslav Republic of Macedonia»	27/05/09	**31/03/05**	
Turkey	06/10/04	27/06/07	
Ukraine	07/05/99	21/12/06	
United Kingdom *	07/11/97	**11/07/62**	
Number of states 47	**2**+ 45 = 47	**13** + 30 = 43	14

The **dates in bold** on a grey background correspond to the dates of signature or ratification of the 1961 Charter; the other dates correspond to the signature or ratification of the 1996 revised Charter.

***** States whose ratification is necessary for the entry into force of the 1991 Amending Protocol. In practice, in accordance with a decision taken by the Committee of Ministers, this Protocol is already applied.

X State having recognised the right of national NGOs to lodge collective complaints against it.

Appendix III

List of Conclusions of non-conformity

A. Conclusions of non-conformity for the first time

ALBANIA	RSC 3§1, 3§2, 3§3, 11§1, 11§2
ANDORRE	RSC 13§1
ARMENIA	RSC 13§1
AZERBAIJAN	RSC 11§1, 11§3
BELGIUM	RSC 11§3, 14§1, 14§2
BULGARIA	RSC 3§3, 11§1, 11§3, 13§1
CYPRUS	RSC 11§3, 12§1
FINLAND	RSC 23
FRANCE	RSC 12§1
GEORGIA	SR 11§1, 11§2, 11§3, 12§1, 14§1, 14§2
IRELAND	SR 11§3
ITALY	RSC 3§1, 3§3, 11§1, 12§1, 12§3, 13§1, 13§4, 23, 30
LITHUANIA	RSC 11§1, 12§4
MALTA	RSC 3§3, 11§1, 11§2, 13§1, 13§3
MOLDOVA	RSC 3§2, 3§3, 11§3, 12§1, 12§2, 12§3, 13§2, 13§3
NETHERLANDS (Kingdom in Europe)	RSC 13§4
NORWAY	RSC 13§1
PORTUGAL	RSC 12§1, 23
ROUMANIA	RSC 3§1, 3§3, 11§1, 11§2, 12§2, 13§1

SLOVENIA	RSC 3§4, 12§1, 23
SWEDEN	RSC 12§1, 23
TURKEY	RSC 11§2
UKRAINE	RSC 23

B. Renewed Conclusions of non-conformity

BELGIUM	RSC 12§4, 13§1
BULGARIA	RSC 12§1, 13§1
CYPRUS	RSC 3§2, 12§4
ESTONIA	RSC 12§1, 12§4, 13§1
FINLAND	RSC 12§1, 12§4
FRANCE	RSC 3§2, 12§4, 13§1
IRELAND	RSC 11§3, 12§1, 12§4
LITHUANIA	RSC 12§1, 12§4, 13§1
MALTA	RSC 12§1, 13§3
MOLDOVA	RSC 11§1, 12§4, 13§1
NETHERLANDS (Kingdom in Europe)	RSC 12§4
NORWAY	RSC 12§4
PORTUGAL	RSC 3§3, 12§1, 13§1
ROUMANIA	RSC 3§2, 11§1, 12§1, 12§4
SLOVENIA	RSC 3§3, 12§4
TURKEY	RSC 11§1, 11§2, 13§1, 14§1

Appendix IV

List of deferred Conclusions

C. Conclusions deferred for lack of information for the second time

ALBANIA	RSC 3§4
ARMENIA	RSC 3§1
BELGIUM	RSC 3§1
CYPRUS	RSC 11§1
IRELAND	RSC 3§4, 14§1, 14§2
MALTA	RSC 14§1
NORWAY	RSC 14§2

D. Conclusions deferred because of questions asked for the first time or additional questions (first reports and others)

ALBANIA	RSC 11§3,
ANDORRA	RSC 3§1, 3§2, 3§3, 3§4, 11§1, 11§3, 12§1, 12§2, 12§3, 12§4, 13§4, 23
ARMENIA	RSC 12§1, 12§3, 13§2
AZERBAIJAN	RSC 11§2, 14§1
BELGIUM	RSC 11§2, 11§3, 12§1
ESTONIA	RSC 11§2
FINLAND	RSC 12§2, 13§2
FRANCE	RSC 3§3, 23

GEORGIA	RSC 11§3
ITALY	RSC 12§4
LITHUANIA	RSC 3§2, 3§3, 11§2,
MALTA	RSC 3§1, 3§2, 3§4, 12§4, 13§4
MOLDOVA	RSC 3§1
NETHERLANDS (Kingdom in Europe)	RSC 3§4, 12§1, 12§3, 23
NORWAY	RSC 12§1
PORTUGAL	RSC 3§1, 3§4, 11§2, 11§3, 13§2, 13§4
ROMANIA	RSC 11§3, 13§3
SLOVENIA	RSC 3§1, 3§2, 11§3
SWEDEN	RSC 12§3, 13§3, 14§1
TURKEY	RSC 3§1; 3§2, 3§3, 3§4, 11§3, 12§1, 13§3, 13§4, 23
UKRAINE	RSC 3§1, 3§2, 3§3, 3§4, 11§1, 11§2, 14§1

Appendix V

Warning(s) and Recommendation(s)

Warning(s)[1]

Article 13, paragraph 1
– France
(Non-EU nationals with temporary residence permit are only entitled to the RMI benefit after having resided in France for 5 years.)

Non-submission of report(s)
– Ireland
(4th warning for non-submission of the report for the Conclusions 2010)

[1] If a warning follows a notification of non-conformity ("negative conclusion"), it serves as an indication to the state that, unless it takes measures to comply with its obligations under the Charter, a recommendation will be proposed in the next part of a cycle where this provision is under examination.