European Social Charter | Charte Sociale Européenne

COUNCIL OF EUROPE CONSEIL DE L'EUROPE

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EUROPEAN SOCIAL CHARTER

6th National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF MALTA

(Articles 3, 11, 12, 13, 14, 23 and 30 for the period 01/01/2008 – 31/12/2011)

Report registered by the Secretariat on 15 April 2013

CYCLE 2013

SEVENTH REPORT ON THE

EUROPEAN SOCIAL CHARTER (REVISED)

submitted by the

Government of Malta

(1 January 2008 – 31 December 2011)

2012

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Group 2 – Health, Social Security and Social Protection

Report made by the Government of Malta in accordance with Article 21 of the European Social Charter, on the measures taken to give effect to the following accepted provisions of the European Social Charter, the instrument of ratification of which was deposited on the 4th October, 1989:-

Articles 3,11,12,13,14,23 and 30 for the period 1 January 2008 to 31 December 2011.

No observations have been received from the organisations of workers and employers regarding the practical application of the provisions of the Charter, of the application of legislation, or other measures for implementing the Charter.

I. INTRODUCTION

This Report by Malta is drafted within the context of the form for submission as adopted by the Committee of Ministers on the 26th March 2008.

The following information is to supplement previous information submitted by Malta with respect to the same provision under the European Social Charter and should be taken as additional information. Where a new provision of the Revised Charter has not been reported upon in previous Reports from Malta, full details of the situation of the respective Article in Malta will be provided.

II. PROVISIONS OF THE EUROPEAN SOCIAL CHARTER (revised)

Article 3 – The right to safe and healthy working conditions

Replies from OHSA

The State recognizes the major contribution that adequate levels of health and safety can have in ensuring quality and productivity at work and in promoting economic growth and employment. As a result, OHS is given due consideration in the formation of public policies concerning all fields of activity including but not limited to those concerning public procurement, education, social inclusion, employment and gender equality. To mention a few, following OHSA's insistence, the Government has introduced a number of measures to mainstream OHS into its operations, such as:

(a) the inclusion of specific provision on OHS in public procurement particularly public tenders and safeguarding the OHS levels of workers employed on public tenders;
(b) the setting up of an OHS unit within the Education Division to assist in the carrying out of risk assessments in Government Schools and to teach the subject to school children;
(c) through the inclusion of OHS in the conditions of provision for government employees enshrined in all public service / sector collective agreements.

As regards to the evaluation of national policies, Government has set up the Management Efficiency Unit within the Office of the Prime Minister and has been tasked with the development of management strategies, systems and structures. In collaboration with OHSA MEU recently embarked on the evaluation of the potential burdens of OHS regulations on employers and coming with measures to mitigate such adverse measures.

Role of Labour inspectors:

During visits at places of work by the OHSA, its Officers request to be accompanied by both the employer and the Workers' Health and Safety Representatives, with whom all findings, shortcomings and action that need to be taken are amply discussed. In addition all orders issued by OHS officers are given to the employer in the presence of the Workers' Health and Safety Representatives. Where written orders are issued, a copy is also given to the Workers' Health and Safety Representatives.

In addition, the main outcome of its investigations, campaigns etc are reported on an annual basis in its activity report, which is made a public document and is also presented to the House of Representatives. No specific employers are mentioned in the annual report due to confidentiality matters.

OHSA report on the "establishment and further development of programmes":

- training (qualified staff);

Upon recruitment all new employees are assigned to work with a more experienced colleague during their probationary period, and in the case of Officers, are not appointed as OHS Officers in terms of the Act automatically upon recruitment. They therefore have no powers of entry or any other power given by virtue of the Act with regards to places of work.

Employees also undergo an induction phase, where they are made familiar with all internal rules and regulations and administrative procedures in place. New OHS officers are also required to attend any training programmes that are held by the Authority.

Specialist support is obtained either from within the Authority, a process that is greatly facilitated by the small size of the entity, or where this is unavailable, the Authority sources out externally – support is usually obtained from academia who are all well-known to the Authority. OHS Officers have also received training on technical matters through a number of Twinning Agreements with foreign Labour Inspectorates and also participated in a number of e*xchanges of Labour Inspectors*, both initiatives being financed by the EU.

- information (statistical systems and dissemination of knowledge);

This is mainly done through the publication of periodical press releases by the OHSA to address topical subject which may be of certain importance at that moment, such as to address common misconceptions or following certain accidents / incidents at work. In the latter cases, OHSA disseminates the causes of the accident / incident, as well as the preventive and protective measures that should have been taken with a scope of avoiding similar occurrences.

- quality assurance (professional qualifications, certification systems for facilities and equipment);

OHSA is not involved in the issuing of certification of facilities or equipment, as this matter does not fall within its remit.

Regarding assurance of competence of third part OHS practitioners, recently OHSA has drawn up the requirements for a certification and accreditation system for third party OHS practitioners who tender advice to employers as part of the protective and preventive services established by Article 7 of Directive 89/391/EEC (as transposed locally through LN 36 of 2003). This activity formed part of a larger project which was partly financed by the European Union under Operational Programme II – Cohesion Policy 2007-2013 (European Social Fund (ESF)).

The contractor awarded the contract for drawing up these requirements recommended to OHSA that certification of third party OHS practitioners will depend on:

- A basic education level (diploma or equivalent);
- Proof of completion of training in occupational safety and health;
- Experience in industry & occupational health and safety;
- Continuing Professional Development (CPD) and,
- Signing of a code of conduct governing the independence, trustworthiness and professionalism of practitioners.

In addition, the system as proposed would concentrate on improving the current voluntary system registration while making it compulsory for all those practising their profession as third party consultants and not to those workers who are in employment and who tender OHS advice to their own employers.

The contractor recommended a system that in future may be able to register specialized advice. In addition it was proposed to OHSA that accreditation of the whole system would follow once the certification system is mature enough to be accredited. OHSA was proposed as the best option for being the certification body, which will then need to establish a system of receipt and review of complaints as well as a system to cover appeals from decisions taken.

This system will be launched once adequate resources for its implementation are made available to OHSA.

- where appropriate, research (scientific and technical expertise).

With the limited resources available to OHSA very little research has been conducted by the OHSA. However having tapped EU funded for this purpose the OHSA during the period 2008 – 2011, embarked on an extensive research initiative aimed at assisting policy makers to make more targeted interventions so as to improve the overall levels of OHS in Malta.

The main deliverables of this research were as follows:

I. The delivery of statistics on:
   (a) occupational injuries,
   (b) physical ill-health and
   (c) occupational psychological ill-health, while determining the root causes of such injuries and ill-health at a macro level;
II. The generation of data regarding level of access of workers to internal and external OHS services and,
III. The calculation of costs of the prevailing risk levels of OHS to the nation.

In a nutshell, the key findings were as follows:

• Statistics on OHS show that the number of workers who were injured or fell ill while at work was significant, with a large amount of such cases being unreported to local authorities (Department of Social Security or OHSA);

• A number of employers do not provide adequate OHS service to their workers. The research shows that a number of workers are still not being provide OHS training as required by law, are not covered by a medical examination and do not have access to a Workers" Health and Safety Representative. Furthermore a number of employers do not carry out risk assessments and have not drawn up an OHS policy;

• The cost of poor OHS to the nation is significant and, despite many of the costs being hidden or undetermined due to lack of data, it amounts to nearly 33 million Euros each year.

The full findings of this research may be accessed from OHSA's website (http://www.ohsa.org.mt/docs/RSFR.pdf).

Yes – all amendments to the EU Directive on the protection of workers form risks associated with asbestos exposure have been through the publication of LN 323 of 2003.

Inventory of contaminated buildings and materials has not been drawn up by the OHSA as there is no obligation of such a requirement under Act XXVII of 2000 (OHS Authority Act (2000)).

In the case of places of work and other places to which workers have access during the course of their duties, it is the ultimate duty of their employer to ascertain the quality and integrity of any asbestos in that place of work and to ascertain the level of airborne fibres and as a result to assess the level of risk to workers. Based on this assessment, the employer shall decide whether to remove the asbestos, (taking into consideration the protective and preventive measures established by OHS legislation) or other measures to render this asbestos safe.

Regarding asbestos in public buildings, OHSA suggests that this matter is raised with the Department of Public Health as this is a public health concern.

Reg. 22 of LN 44 of 2003 lays down maximum doses of exposure to ionising radiation in the workplace as well as in respect of the general public (vide schedule III of same regulations).

The levels of protective and preventative measures afforded by OHS legislation to workers in long term employment also cover temporary workers (vide reg. 18 of LN 36 of 2003).

Full statistics about occupational injuries and diseases, including rates and sectors of activity may be obtained from the Department of Social Security.

However the OHSA has prepared the following data which may be useful for the purpose of this report:

Table 1: occupational injuries for the period 2005 - 2011

	Gainfully Occupied[1]	**Injuries at work[2]**	**Injuries per 100,000 workers**	**Fatalities at work[3]**
2005	138,166	3978	2879	6
2006	138,880	4,366	3,144	7
2007	142,179	4,328	3,044	7
2008	145,100	4,023	2,773	3
2009	144,661	3,366	2,327	9
2010	145,000[4]	3,314	2,286	4
2011	145,000[4]	3,024	2,085	1

Sources: (1) NSO, (2) DSS / NSO, (3) OHSA, (4) Estimate

Table 2: Trends in occupational injuries and fatalities

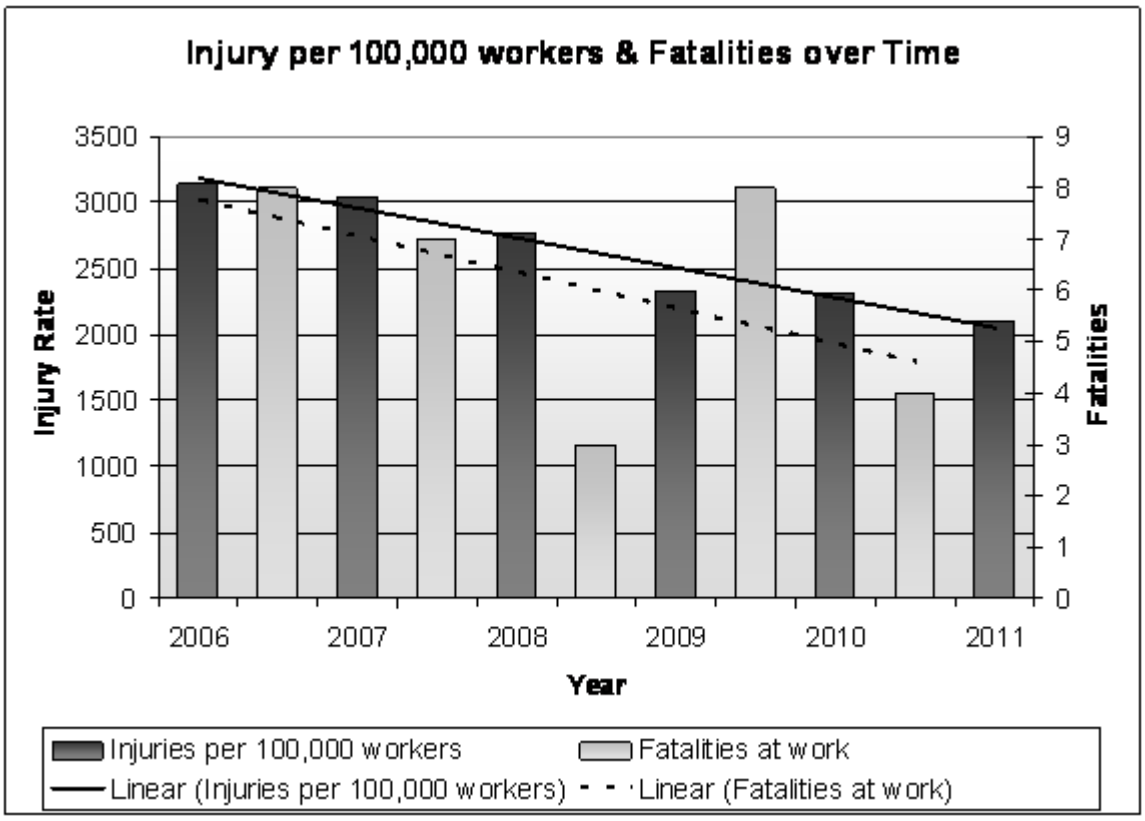

Table 3: Fatal accidents at work (2005 – 2011) (Source (OHSA))

	No. of Fatalities at work (cases)	Sectors (as per NACE codes Rev. 2)
2005	6	3 construction; 1 wholesale / retail; 1 manufacturing (ship repair); 1 hotels & restaurants.
2006	7	3 construction; 2 Manufacturing (1 wine making), (1 ship repair); 1 Crop and animal production (raising of animals); 1 Wholesale / Retail.
2007	7	5 Construction; 1 Manufacturing (glass / aluminium); 1 Electricity, gas and water supply.
2008	3	1 Mining and quarrying; 1 Construction; 1 Retail / wholesale.
2009	9	2 Transportation and Storage; 2 Construction; 1 Crop and animal production (agriculture); 1 Public administration and defence; 1 Waste collection / management; 1 Manufacturing (ship repair); 1 Mining and quarrying.
2010	4	3 Construction; 1 Professional activities (Photographic activities).
2011	1	1 Wholesale and retail trade

By the powers conferred under Article 17 of 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…" (Art. 17 (1)), including if required, by barring a work place (or part of a work place) - vide Art. 17 (2).

No records are kept on the number of workers covered by OHSA interventions at places of work. Visits by OHSA are determined according to the occupational risk of the activity involved or in connection with an EU campaign.

Table 4: Breakdown of OHSA activities for the years 2005 – 2011

	Workplace visits	**Improvement notices**	**Cessation of work**	**Prosecutions**
2005	1364	289	45	74
2006	1115	220	38	102
2007	1274	240	53	118
2008	2022	64	105	128
2009	2022	274	84	124
2010	2663	289	70	144

During the period 2005 – 20011 the OHSA employed an average of 15 inspectors in various grades.

Therefore, if occupational health services are not established for all enterprises, the authorities must develop a strategy, in consultation with employers' and employees' organisations, for that purpose. The Committee therefore asks that the next report focuses on these issues.

Various other specific OHS Regulations further reinforce this obligation for specific risks such as through the publication of:

Under the provision of LN 36 of 2003 workers are entitled to undergo health surveillance at regular intervals and it is the legal duty of an employer to ensure that workers are provided with health surveillance appropriate to the health and safety risks at work, and shall make all arrangements as are required.

In addition, without prejudice to the generality of the preceding requirements, health surveillance shall be carried out whenever the risk assessments required to be performed by an employer reveal (i) an identifiable disease or adverse health condition related to the work involved or that (ii) the likelihood that the disease or condition may occur under the particular conditions of work.

Arrangements at enterprise level on which type of health surveillance is appropriate are decided by the employer in consolation with the workers and / or Workers' Health and Safety Representatives. Some employers decide to enlist third party medical practitioners, others opt in favour of in-house expertise, such as through the employment of full or part time occupational practitioners / occupational nurse, while other employers may utilise the public health services.

One has to note that by virtue of reg. 8 of LN 36 of 2003, an employer shall not levy or permit to be levied on any worker, any charge or deduction in wages in respect of anything done or provided in the interests of occupational health, safety, hygiene or welfare in pursuance of any provisions of OHS

laws.

Ionizing radiation - The Committee takes note of the information provided in the report on radiation safety. However it seeks confirmation that the dose limits laid down by law are in accordance with the recommendations established by the International Commission for Radiation Protection (it refers in this respect to its conclusion under Article 3§2).

Asbestos - The importation, manufacture and use of asbestos is prohibited under Maltese legislation however the Committee wishes the next report to provide further information on the rules concerning the removal of asbestos from buildings including domestic dwellings(it refers in this respect to its conclusion under Article 3§2.

See earlier OHSA replies to these two matters.

Article 11 – The right to protection of health

Replies from MHEC

Paragraph 1 – Removal of the causes of ill-health

A. State of health of the population – General indicators

i. Life expectancy and principal causes of death

(Information on health care professionals and facilities updated to 2010)

Average life expectancy at birth in 2010 was 79.2 for men and 83.6 for women[1] (the EU 27 average in 2009 was 76.7 for men and 82.6 for women[2]). The crude mortality rate in 2010 was 7.24 per 1 000 inhabitants[3] (the EU 27 average was 9.7 per 1 000 inhabitants in the same year[4]). The main cause of death in 2009 was cardiovascular disease (38% of all deaths), followed by cancer (29% of all deaths).

The Maltese Government is tackling the causes of cardiovascular disease and cancer as well as the treatment of patients that have these conditions in a holistic way by launching and implementing strategies that include measures with an impact on the whole preventive and care pathways concerned (prevention and protection, screening and early diagnosis, definitive diagnosis and treatment, palliative and end-of-life care). These strategies include the Non-Communicable Disease Strategy[5], the National Cancer Plan 2011-2015[6] and the strategy to combat obesity: Healthy weight for life.

ii. Infant and maternal mortality

(Information on health care professionals and facilities updated to 2010)

[1] Directorate Health Information & Research, National Mortality Register, Annual Report – 2010: https://ehealth.gov.mt/download.aspx?id=6292.
[2] Eurostat: http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home/
[3] Directorate Health Information & Research, National Mortality Register, Annual Report – 2010.
[4] Eurostat: http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home/
[5] The Non-Communicable Disease Strategy and the Healthy weight for life: https://ehealth.gov.mt/HealthPortal/public_health/non_comm_disease_prev_unit/library/ncd_publications.aspx
[6] The National Cancer Plan 2011-2015: https://ehealth.gov.mt/HealthPortal/chief_medical_officer/overview.aspx

The infant mortality rate in 2010 was 5.48 per 1000 live births[7] (the EU 27 average was 4.2 per 1000 in 2009[8]).The main causes of death were either conditions originating in the perinatal period (ICD-10 Chapter XVI) or congenital malformations, deformations and chromosomal abnormalities (ICD-10 Chapter XVII).

It is important to note that in Malta termination of pregnancy is illegal. A foetus diagnosed with potentially fatal congenital anomalies is often born alive but pass away after birth. This greatly influences the infant and childhood mortality rates in Malta especially when compared to other countries where screening for congenital anomalies is practiced routinely and termination of pregnancy offered. Conversely, live birth prevalence rates of certain congenital anomalies in Malta are far higher than those of other countries where termination of pregnancy is practiced.

There were no cases of maternal mortality in 2010[9].

Malta has practiced a long-standing, strong and ongoing policy committed towards reducing preventable maternal mortality and morbidity, while respecting the dignity and rights of both the mother and the unborn child. Its policy involves maintaining a high and professional level of obstetric and paediatric/ neonatal care to all mothers on the Islands, making high quality health care before, during and after childbirth are freely accessible to all mothers and their infants. Malta has well established and advanced data systems in place routinely registering all births and mortality on a national level. These systems and indicators are compliant with those required on an International and European level.

Maternal mortality in Malta is very low. Total fertility rates have seen a steady decrease over the past ten years through the use of culturally acceptable methods of family planning. Fertility rates have in fact decreased from 2.1 in 1989 to 1.7 in 1999 and 1.4 in 2009 (WHO HFA-DB[10] and Demographic Review 2009[11]). Peri-natal mortality in babies delivered over 28 weeks of gestation (>=1000g birth weight) has, over the past years, seen an overall decline from 9.92/1000 births in 1999 to 6.02/1000 births in 2009 (WHO HFA-DB).

Maternal mortality and morbidity and infant mortality are closely monitored on a national level and all initiatives to improve these are considered for implementation, so long as they do not imply or lead to induced abortion which is illegal in Malta.

B. Health care system

i. Access to health care

- 'new health care bill': the Act has not yet been issued. The delay is a result of the fact that this Act needs to include the national legislation to transpose the European Union Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare. This Directive will come into force in the EU Member States in October 2013. The transposition of the Directive into the Maltese national legislation is in progress.

- 'health care system fully accessible to the entire population': the National Health Interview Survey of 2008 confirmed that an individual in Malta was three times more likely to attend a consultation with a private than with a public GP. However, this is not translating into unmet need or non-access to the health care system. The self-reported unmet needs for medical examination is low for Malta. Eurostat[12] published statistics for 2010 showed that the total self-

[7] Directorate Health Information & Research, National Mortality Register, Annual Report – 2010.
[8] Eurostat: http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home/
[9] Directorate Health Information & Research, National Mortality Register, Annual Report – 2010.
[10] WHO – Health for all database (HFA-DB): http://data.euro.who.int/hfadb/
[11] Demographic Review 2009: http://www.nso.gov.mt/statdoc/document_view.aspx?id=2776
[12] Eurostat: Self-reported unmet needs for medical examination by sex, age, reason and income quintile (%) - The European Statistics of Income and Living Condition

reported unmet need was 1.3 (EU average 2.0). Moreover, the self-reported unmet need for the first quintile of equivalised income 1.9 (EU average 5.2) while the same statistic for the fifth quintile was 0.3 (EU average 0.3). Total unmet need and the difference between the first and fifth quintile is lower than is several other EU Member States.

- 'health care is guaranteed equally to Maltese citizens and to foreign nationals residing and working lawfully in Malta': The public health care system provides a comprehensive basket of health services free at the point of delivery to all persons residing in Malta who are covered by the social security legislation of Malta and the other EU and EEA Member States and to several groups of third country nationals and also provides for all necessary care to irregular immigrants. The Healthcare (Fees) Regulations, Legal Notice 201 of 2004, as amended by Legal Notice 407 of 2007 provides for the entitlement for free health care to several categories of third country nationals and their dependents including those holding a licence to work issued under Article 11 of the Immigration Act, and who are paying the prescribed contribution under the Social Security Act; citizens of any country which has a reciprocal health care agreement in force with Malta; persons who enjoy freedom of movement in terms of Article 44 of the Constitution of Malta (i.e. refugees and asylum seekers) and persons who are undertaking a course of studies at a number of educational institutions in Malta.
- 'hormone therapy and sex change surgery': hormone therapy[13] and sex change surgery are not yet included in the national health care package. The Maltese Government abides with the principle of not tolerating any discrimination for the access of services on any basis including sexual orientation. A recent example of action to boost the implementation of this principle can be found in the National Sexual Health Strategy[14] launched in 2011. In a section titled Sexual Orientation and Diversity (pg: 26) the strategy includes the following measure:

"The health services will also be undertaking initiatives to sensitise service providers with regard to the negative impact of stereotype assumptions. This should continue to ensure that the dignity and rights of all patients and their carers are upheld at all times".

- 'information about waiting list management and health care waiting times':

Waiting-lists have been a feature of Malta's publicly funded health services for a long time. The need of a fair and transparent system for the management of waiting-lists across state hospitals in Malta was a recommendation of both the EU document: Joint Report on Social Protection and Inclusion in 2009 and the Ombudsman in December 2008. The elective waiting-list situation in Malta is the result of a complex set of factors. It is the result of demand exceeding supply but also of operational dynamics such as changes in the number of admissions from waiting-lists; and changes in the number of additions to these lists related to the actual length of the list and associated waiting times. Furthermore, external variables such as (i) resource-allocation (ii) timely availability of facilities (iii) harmonised shift-patterns, rosters/rotas and methods of working (iv) staff motivation and (v) apposite job-planning processes and (vi) longer life expectancy, collectively impact upon waiting list longevity and associated waiting times.

Since 2009 it has been Government's publicly stated objective that waiting-times for interventions across all clinical specialties needed to be gradually reduced to acceptable levels. This needed to be done equitably; through the adoption of a patient-centric approaches; and with the input and co-operation of professionals across the public health continuum. Since mid-2010, waiting time for certain

(EU-SILC) survey. Last update: 01-06-2012 http://appsso.eurostat.ec.europa.eu/nui/setupModifyTableLayout.do

[13] Hormone therapy for several medical conditions such as in the treatment for several types of cancer is included in the national health care package. The text above refers to hormone therapy related to demands arising directly from transgender issues.
[14] National Sexual Health Strategy 2011: https://ehealth.gov.mt/HealthPortal/chief_medical_officer/overview.aspx

elective interventions has been reduced quite significantly. The process leading to the better management of waiting lists for elective interventions included the assessment; cleansing; validation; and consolidation of elective waiting list information into single homogeneous data-sets such that a solid information base with standardised data-structures was implemented. Mater Dei Hospital now maintains a *Centralised Waiting List Management System* (CWLMS) that to-date includes orthopaedics; ophthalmology; and cardiology elective data. The process of populating the system with surgical and other specialty data is currently ongoing. The CWLMS is providing a transparent system for the management of elective waiting list data; and provides a verifiable and transparent representation of the waiting list situation at any one time. The system supports *end-to-end* traceability of interventions and associated data-subjects.

In order to supplement elective throughput at Mater Dei Hospital such that waiting time for certain elective interventions is further reduced, the Government has since 2011 embarked on an outsourcing programme. Several outsourcing contracts are currently maintained by Government with private sector operators. Amongst others these include the outsourcing of cataract removal surgery and arthroscopic interventions.

- Health care budget as a % of the GDP: The health care budget was 8.63% of GDP in 2010 (Total health expenditure as % of gross domestic product)[15].

C. Health care professionals and facilities:

(Information on health care professionals and facilities updated to 2010)

There were 4.51 hospital beds per 1000 inhabitants in 2010[16] (the EU 27 average in 2010 was 5.4 beds per 1000 inhabitants). Statistics show a large decline in the number of hospital beds from 2006 to 2010. This is due to the decision taken in 2009 to classify SVPR (St Vincent de Paule Residence for the Elderly[17]) as a residential home rather than a hospital.

There were 1.44 psychiatric hospital beds per 1000 inhabitants in 2010[18] (the EU 27 average in 2010 was 0.6 beds per 1000 inhabitants).

In 2010 there were 1602 doctors or 39 for every 10000 inhabitants[19].

In 2010, there were 207 dentists (or 5 per 10000 inhabitants) and 925 pharmacists (or 22 per 10000 inhabitants), while in 2010 there were 2838 nurses and midwives (68 per 10 000 inhabitants)[20].

Paragraph 2 – Advisory and educational facilities

A. Health education

i. Public information and awareness-raising

The Health Promotion and Disease Prevention Directorate (DHPDP) is one of the Directorates within the Office of the Superintendent of Public Health[21] (SOPH). The SOPH also incorporates the Directorates for Environmental Health and the Health Care Services Standards.

A major aim of the Health Promotion and Disease Prevention Directorate is to constantly create and collate information aimed at the general public covering all aspects of Health well-being and the

[15] WHO – Health for all database (HFA-DB): http://data.euro.who.int/hfadb/
[16] Eurostat: http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home/
[17] St Vincent de Paule Residence https://ehealth.gov.mt/HealthPortal/health_institutions/hospital_services/stvincentdepaul/introduction.aspx
[18] Eurostat: http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home/
[19] Eurostat: http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home/
[20] Eurostat: http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home/
[21] Superintendence of Public Health https://ehealth.gov.mt/HealthPortal/public_health/publichealthregulation/introduction.aspx

prevention of illness. This information is an essential part of the campaigns and initiatives that the Directorate holds based on national priority areas and uses information generated from research based on the local context. The aim of the resources is two-fold, primarily to raise public awareness of the health issue and secondly, to provide support material for the public, health and other professionals and other stakeholders.

The Directorate publishes material of information both in the paper format and on the online media. The publications are promoted in the media, and sent out on request. They are also distributed in hospitals and primary health centres, doctors' clinics, Local Councils, workplaces, schools and other public entities. All the information is also available on the Ministry of Health website (www.ehealth.gov.mt).

The Directorate utilizes a variety of the media to relentlessly communicate its messages to the general public. Press conferences are held regularly particularly on the launch of new or updated initiatives[22]. These events are organised with the participation of the Minister of Health and these press conferences are widely reported on all local television stations, radios, published and online media.

The Directorate also prepares and funds adverts for television and radio, and these are constantly being aired on most stations and at different times of the day, depending on and tailored for the audiences being targeted. Furthermore, the Directorate organises outreach programmes to target specific audiences targeting places where they learn, live, work and play. During these events, the public are offered information, counselling services are made available and interested individuals can be referred to services according to their individual needs. These events are generally very welcome by the public and are normally very much sought.

Apart from the work of the DHPDP other entities within the Ministry of Health are also constantly engaged in providing information on health to the public with the aim of increasing public awareness on a number of health issues. These include the issue of information by the Directorate for Health Information and Research, the Directorate for Primary Health Care and the individual health provider entities including hospitals and community-based services.

ii. Health education in schools

Malta is a member of the SHE Network (previously the European Network of Health Promoting Schools). Maltese schools participate in initiatives that take the whole school approach to encourage children to adopt healthy lifestyles. Initiatives take into consideration the ethos of the school, as well as the taught and hidden curriculum.

The Ministry of Health works in close collaboration with the Education Directorates in joint initiatives to implement health strategies. A recent example is the launch of the National Sexual Health Strategy[23] in November 2011. A whole chapter of this strategy is dedicated to sexual health education and promotion and a substantial part includes measures to augment sexuality and relationships education in schools in collaboration with the Education Directorates, the University of Malta and the national Youth Agency. Research: Malta participates in the Health Behaviour of School-aged Children Study24 (HBSC). This is a study conducted by the World Health Organization and takes place every four years. Through this study, the health behaviour and trends of adolescents are identified and their needs are studied. The data from the HBSC provides an understanding of young people's health, informs local

[22] 2012 campaigns: https://ehealth.gov.mt/HealthPortal/health_promotion/campaigns/world_cancer_day.aspx

[23] National Sexual Health Strategy 2011: https://ehealth.gov.mt/HealthPortal/chief_medical_officer/overview.aspx

[24] Health Behaviour of School-aged Children Study (HBSC), World Health Organization collaborative cross-national survey: http://www.hbsc.org/

policies and identifies needs in the local context. The study gathers data on:

- The psychosocial aspects of health, psychosomatic complaints and subjective health
- Health related behaviours such as tobacco use and alcohol consumption, medication use, exercise patterns, leisure-time activities, eating patterns and dental hygiene
- Perceptions of personal health and well-being, physical ailments, personal capacity (psycho-social adjustment) including mental health, self-concept, and body image
- Perceptions of family and peer relationships and support, and bullying
- Perceptions of the school and its influence, objective and perceived wealth, and parental occupation
- Sexual health knowledge and behaviour

The latest study was carried out in 2010. The preliminary results of the Maltese data were published in May 2010. The final report will be published later in 2012.

Health Education Committee: a Health Education Committee was established in 2009 with the aim of identifying issues that are common to both stakeholders (Education and Health) in promoting the health of schoolchildren. The committee proposes actions to be taken and coordinates activities between the two Ministries.

Advocating for Health Promoting Schools: DHPDP provided expertise in both the drafting and revision of the Healthy Eating Policy for Schools for Malta. The policy sets standards in nutrition policy for schools by addressing the sale of foods from school tuck shops, the foods allowed in schools as well as presenting healthy options for children. Additionally, DHPDP is also consulted on the National Curriculum for Schools, tobacco policies, changing the school environment to offer protection from the sun, and increase in the number of hours of Physical Education in schools.

Initiatives: DHPDP in collaboration with the Ministry of Education has set up various initiatives that address the health of children. These include: the Walking Bus, the Healthy Breakfast in Schools, Shape Up project which tackled obesity through physical activity and an Alcohol Peer Education project for students in higher education.

Training: training is offered throughout the scholastic year in all areas of Health Promotion and at all levels. This includes training of teachers at both pre- and in-service training levels, talks delivered to parents and sessions delivered directly to pupils.

European Union Initiatives - School Fruit Scheme: as of 2009, the Ministry for Resources and Rural Affairs' Paying Agency, announced an EU-funded initiative designed to increase the fruit and vegetable intake in children by providing every child in all primary schools with a free portion of fruit or vegetables once a week. The programme is being implemented in schools in Malta and Gozo. DHPDP is an active member of the Committee running the scheme and has carried out a preliminary evaluation of the scheme.

B. Counselling and screening

i. Population at large:

Several screening activities are ongoing in Malta and are funded and organised by the public national health system. These include screening programmes for communicable diseases, non-communicable diseases and risk factors and for cancer. The following text describes examples of these screening programmes.

The screening for SAI (Sexually Acquired Infections) is carried out primarily by the GU clinic (Genitourinary clinic). Such a service is strictly confidential. Patients who are referred to the GU clinic on the suspicion that they are suffering from an SAI such as syphilis due to typical presenting symptoms are given a priority.

In the community serological testing such as HIV and Hepatitis Screening are carried out by the community doctors at the governmental health centre. HIV patients who attend the HIV clinic have their bloods checked not only for HIV monitoring only but also for syphilis and Hepatitis Screen. Prenatally every woman that presents at the obstetrics department has serological testing for HIV, syphilis and Hepatitis Screen.

Pre-test counselling is carried out by the GU physician prior to the GU screen. Post-test counselling is carried out when the tests are positive. The nurses both at the GU and the HIV clinic provide advice to patients that call by phone or attend the clinic.

In the community Caritas (which is non-governmental agency) also provides pre- and post-screening counselling service called Xefaq. Xefaq services are confidential. A counsellor responds to the persons who need information about SAI s and others who suspect they may be infected. The conversation could be carried out on the phone. Face to face counselling is also offered. When the person needs to proceed to have a blood test, the Caritas Xefaq Counsellor makes the contact with the GU Clinic. The blood test result, which is strictly confidential, reaches the Caritas Xefaq Counsellor who transmits it to the client at a subsequent session. Counselling gives information, clarifies doubts, enables clients to see the benefits of testing and empowers clients to make a conscious, responsible choice of a lifestyle.

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At the primary health care centres, clients can request screening for non-communicable diseases and associated risk factors such as hypertension, diabetes mellitus and blood lipid levels. A number of services to combat these risk factors are also being implemented through the Non-Communicable Diseases Strategy and the Healthy Weight for Life strategy launched in 2010 and 2012 respectively.

National organised cancer screening programmes have been started in 2009. The first programme to be initiated was for breast cancer screening. This programme invites women between the 50 to 60 year age group for a mammography screening every 3 years. An organised colorectal cancer screening programme for persons aged 60 to 64 years will be launched in late 2012 while a national screening programme for cervical cancer is planned to start in 2014. A vaccination programme with the HPV vaccine for 12 year old girls was launched in 2012. All these programmes are in line with the National Cancer Plan 2011-2015 that was launched in February 2011.

ii. Pregnant women, children and adolescents
(updated information: in blue text)

- the free check-ups offered to babies at the ages of 6 weeks, 8 months and 18 months were availed of by 87% of babies born in Malta in 2011.
- A free supervisory and monitoring programme for pupils is run by the school health service. All pupils must attend a check-up prior to admission to Kindergarten at the age of 3 years, then at 4-5 years, at 6-7 and at 10-11 years old. Screening is carried out to detect anomalies or shortfalls in physical, social or psychological development, learning difficulties, visual and hearing impairments or curvature of the spine. The service is provided by nine teams of nine nurses and six doctors. A total of 28,700 children aged between 3 and 11 take advantage of it every year. The Committee asks what the situation is as regards free medical checks at school for children over the age of 11.

Services for young people beyond 11 years of age:

Beyond the age of 11 years, the Maltese School Health Service has introduced scoliosis screening for all 12-13 year olds in secondary schools. Furthermore, in the coming months Malta shall be introducing universal vaccination against HPV for all girls born in 2000 and later on reaching their 12th birthday. This is one of the measures of the National Cancer Plan 2011-2015.

Plans are in hand to introduce a nurse led drop-in clinic in all secondary schools in order to provide individual consultations and intervention for youths with health and social problems including smoking, alcohol intake, sexual health issues, weight problems, eating disorders and other chronic health problems. The main deterrent to this endeavour is the lack of human resources, as nurses tend to be employed more readily in secondary and tertiary care rather than primary health care settings.

Paragraph 3 - Prevention of diseases

A. Policies on the prevention of avoidable risks

i. Reduction of environmental risks

Air:

- Real time monitoring: (updating information). There are currently five air monitoring stations in operation. The Air quality plan is underway.

Noise: (updating information). In 2011, the Malta Environment and Planning Authority (MEPA) published a draft Noise Action Plan, which seeks to identify measures aimed at avoiding, preventing or reducing where necessary, the harmful exposure and effects of environmental noise on human health, resulting from major road traffic. This was prepared in accordance with the requirements of the EU Environmental Noise Directive (Directive 2002/49/EC) covering a five year period, and also provides an overview of the requirements and obligations of the Environment Noise Regulations and presents a summary of the results of the strategic noise mapping within Malta. The Noise Action Plan proposes a long-term strategy regarding the management of noise and will apply to the identified major roads. It also sets out a proposed approach to undertake a study for any necessary noise reduction measures.

Noise presently is locally regulated through various laws. The Ministry for Tourism, Culture and the Environment will be launching a White Paper on the Prevention, Abatement and Control of Neighbourhood Noise for public consultation in 2012. The White Paper aims to stimulate public debate to assist the government in formulating, and eventually implementing measures to improve the present legal and institutional framework for the control of various forms of excessive noise. The White Paper will propose new legislation for the control of neighbourhood noise, as well as the introduction of objective noise level thresholds based on international guidelines.

As required by the Environmental Impact Assessment Regulations (2001) related noise impacts of major developments must be assessed prior to any decisions to approve.

Ionizing radiation: Malta confirms that with regards to ionizing radiation the dose limits are in accordance with recommendation of current EU regulations[25].

B. Food safety: The following text includes amendments (in blue text) of the text in the Committee's report. Most of these changes reflect updating of the names of local structure and job positions.

[25] COUNCIL DIRECTIVE of 13 May 1996 laying down basic safety standards for the protection of the health of workers and the general public against the dangers arising from ionizing radiation (96/29/EURATOM)

The Food Safety Commission (FSC) is an independent statutory body, set up under the Food Safety Act 2002 to co-ordinate the functions of all Competent Authorities responsible for food safety in Malta. Technical and scientific advice is provided by the Technical Regulatory Division of the Malta Competition and Consumer Affairs Authority.

The Infectious Disease Prevention and Control Unit of the Ministry for Health Elderly and Community Care investigate notifications of food borne disease. For outbreaks which involve a significant number of persons, an epidemiological analysis is performed to help in identifying the source of food borne illness.

The Ministry for Health Elderly and Community Care, through the Environmental Health Directorate (EHD) has responsibility for secondary production and processing of food, for all retail sale of food and for all catering outlets including accommodation outlets.

The EHD prepares an overall annual sampling plan in conjunction with the Senior Principal Environmental Health Officers, the regional principal Environmental Health Officers, the FSC and the Public Health Laboratory (PHL). The regional offices are responsible for performing sampling activities on a weekly basis as directed. Results of the analysis are sent by the laboratory directly to the environmental health officers (EHO) working within the Health Inspectorate Services, who take the necessary follow-up actions. The Health Inspectorate Services are responsible for a wide range of control activities and provide a control framework covering all stages of food production, processing and distribution. The Health Inspectorate Services has responsibility for the monitoring and verification of compliance with and enforcing the requirements of EU food hygiene legislation especially EU Food Hygiene Package. They are also responsible for the monitoring and enforcing of food safety legislation including the enforcing the Labelling, Presentation and Advertising of Foodstuffs Regulations.

C. Measures to combat smoking, alcoholism and drug addiction

i. Regarding the combat to reduce tobacco smoking:

Malta is implementing all policies to ensure smoke-free public places in accordance with the WHO Framework Convention on Tobacco Control (FCTC). In fact, Malta was the second country of the 195 eligible parties to ratify the WHO FCTC (24 September 2003) and entered into force on the 27th February 2005. Regulations introduced in Malta in 2004 ban smoking in any enclosed private or public premises that are open to the public except in designated smoking rooms approved by the Superintendent of Public Health. Under new regulations that will come into force in January 2013 these designated smoking rooms will not be allowed any more. This was a firm step forward towards providing cleaner indoor air; however, it is recognised that this does not affect exposure to environmental tobacco smoke in private homes.

Pictorial warnings of the health consequences of smoking on the packaging of tobacco products sold in Malta have been introduced by the EHD through a legal notice which was issued in 2009 and come into force in 2011 in line with EU regulations. Shocking images showing the effects of smoking were printed on cigarette packets sold in local shops. These warnings underline the increased risks of cardiovascular disease, cancer, infertility and impotence among smokers, and the harmful effects on unborn babies and children.

Another legal notice published in 2010 established that e-cigarette devices will fall under the smoking ban. The legal notice states that any "device which is intended as a substitute to a conventional tobacco product" shall fall under the Tobacco (Smoking Control) Act. According to this legal notice, any device bearing the word 'cigarette' or 'tobacco' which is intended as a substitute to a conventional tobacco product shall be deemed as a tobacco device.

The Ministry for Health Elderly and Community Care, through the EHD, is a partner in the PITOC (Public Information Tobacco Control Project), an EU funded project which commenced in 2009. The aim of this project is to contribute to the reduction of smoking-related morbidity and mortality by

supporting tobacco product regulation and to inform the public on different tobacco ingredients. One of the obligations lay out by Directive 2001/37/EC is that that part of the data on tobacco ingredients, submitted by manufacturers, must be disseminated to the consumers. To inform the public well, authorities are obliged to make an understandable description of the different tobacco ingredients. During 2011 the PITOC factsheets were almost completed and a dissemination plan drafted. The fact sheets are to be translated into Maltese and English during 2012.

All forms of tobacco advertising have been banned in terms of a new legal notice which came into force in 2011. No person may advertise any cigarettes, cigars, tobacco or tobacco products. Adverts are no longer permissible anywhere, not even at the point of sale, including vending machines. With regards to the sale of tobacco from automatic vending machines, no person may sell or permit the sale of any other product except cigarettes and tobacco products from automatic sales machines which are used to dispense cigarettes and tobacco products. Sales from such machines are permitted only when these are continually supervised. By adopting the WHO directive on a total ban on tobacco advertising Malta has shown it is willing to be among the first to endorse best practice to protect the health of its people.

The EHD also introduced smoking bans in children's playgrounds, sports facilities and mass leisure events states that smoking is not allowed in a playground or in any public garden which hosts playing equipment for children. In 2010, over 30,000 Skolasajf (summer school) students took part in the EU anti-smoking campaign: "Help, for a life without tobacco"*.*
The campaign, held in all EU member states, was geared at tobacco prevention and awareness about the dangers of passive smoking as tobacco-related deaths were the single largest cause of death in Europe. The 32,000 pupils enrolled in Skolasajf were given an information pack about the negative effects of smoking and attended interactive fun sessions about health issues

EMTOC **(**Electronic Model Tobacco Control System). The Ministry for Health Elderly and Community Care, through the EHD is working on the introduction of the Electronic Model Tobacco Control System for the electronic reporting of tobacco product ingredients. This is a European web application which enables safe submission of the lists of tobacco ingredients by importers and manufacturers to the concerned authorities in accordance with the EU practical guide and the European Directive 2001/37. The data submitted to EMTOC is only accessible to national authorities (regulators) and the European Commission. The national authorities of a Member State have only access to data submitted to their corresponding Member State.

Actions in Tobacco: The Health Promotion and Disease Prevention Directorate (DHPDP) strives primarily to help smokers to quit smoking. It does this through reaching smokers in the places where they work and live; namely through initiatives in workplace and the Community. Workplace initiatives included training in smoking cessation, one to one counselling and advocating for the implementation of smoke-free workplaces. Various initiatives were aimed at the community. These included outreach programmes in places where people gather, use of all media communication channels to portray the message of the harm caused by Tobacco and initiatives for young people.

DHPDP also offers Smoking Cessation clinics where smokers are helped to quit and are followed for a period of eight weeks. Another initiative organised by DHPDP is Quitline. This is a service offered to the general public through which smokers are encouraged to call when they need help especially to quit smoking.

Training of health care professionals on tobacco cessation is also organised by DHPDP. The aim of the training is two-fold; a number of health care professionals lead the smoking cessation classes whilst all health care professionals are encouraged to be informed to be able to help their patients when needed.

The Directorate was instrumental in the development and implementation of a Smoke-free policy for Mater Dei Hospital (the main public acute general and teaching hospital in Malta). A tool-kit for doctors was designed, produced and disseminated during 2012. It is aimed that general practitioners in

particular use the tool-kit in their daily work in order to help and refer smokers to services to help them to stop smoking.

The Health Interview Survey (HIS) of 2008 showed that between 2002 (26.1%) and 2008 (25.2%) there were no marked differences in the total number of smokers including those who smoke daily and those who smoke occasionally. There is however a shift in the distribution of daily smokers and occasional smokers in 2008 with more occasional smokers and less daily smokers being reported when compared to 2002[26]. The percentage of regular daily smokers in the male population (15 years and older) has dropped from 29.9% (2002) to 25.6% (2009)[27]. On the other hand, the percentage of regular daily smokers in the female population (15 years and older) has dropped from 17.6% (2002) to 15.8% (2009).

When compared to EU member states the rate of daily smoking in Malta is comparatively low with Malta having the 5th lowest rate after Portugal, Sweden, Finland and Slovakia respectively[25].

The European School Survey Project on Alcohol and other Drugs (ESPAD) is a survey which aims to collect comparable data on alcohol, tobacco and drug use among 15 to 16 year old students in European countries. Data from the latest survey conducted in 2007 shows that 26% of students participating in the study had smoked during the 30 days before the survey[28]. This result compares well with the data from HIS 2008 which show that smoking habits seem to develop amongst youth and are maintained through adulthood.

ii. Regarding harmful consumption of alcohol and drug abuse:

Services to combat harmful consumption of alcohol and drug abuse are delivered and coordinated by the Foundation for Social Welfare Services (FSWS)[29], within the Ministry for Justice, Dialogue & Family, incorporates Aġenzija Appoġġ, Aġenzija Sapport, Aġenzija Sedqa. The Foundation offers prevention and treatment services, both on community and residential settings within the fields of substance abuse; children, families and communities; and disability. The main body offering these services is the Aġenzija Sedqa. Set up in June 1994, Sedqa, the national agency against dependencies, offers health promotion, prevention, treatment, and rehabilitation services to persons with drug, alcohol, and/or compulsive gambling problems, and to their families. Sedqa is made up of two divisions, namely Care and Prevention. Each of the said divisions contributes in a specific manner to the issue of dependencies.

The prevention services focus on education and the provision of accurate information as these are believed to be fundamental in the primary prevention process. The work of the Prevention Services aims to avert the incidence of addictive behaviours. This is mainly achieved by working with the educational system, the place of work and the community at large. Through interventions in these various areas, the Prevention Services endeavour to reach a wide audience within society.

The care services support persons with drug and/or alcohol problems or compulsive gambling, their families and others to help them live a stable life and to integrate better in society. The services provided include a:

a. detoxification service - this programme aims to engage individuals with a substance misuse problem in low threshold interventions whereby basic medical, social and psychological needs are assessed and the necessary assistance provided. An integral part of this service is harm minimization and methadone maintenance to individuals with a substance misuse problem. Prior referral by the Drugs Community Team or Caritas is necessary.

b. Residential Drug Rehabilitation Programme (Komunità Santa Marija) – this is an intensive, long-term residential programme offering a highly-structured communal living environment, whereby

[26] European Health Interview Survey 2008: https://ehealth.gov.mt/HealthPortal/chief_medical_officer/healthinfor_research/surveys/european_health_interview_survey_2008.aspx
[27] WHO – Health for all database (HFA-DB): http://data.euro.who.int/hfadb/
[28] The 2007 ESPAD Report, Substance Use Among Students in 35 European Countries, www.espad.org
[29] Foundation for Social Welfare Services (FSWS): https://secure3.gov.mt/socialpolicy/SocProt/family/fsws/sedqa/sedqa_fsws/sedqa_fsws.aspx

persons desiring to stop abusing drugs can discover their true selves, modify their behaviour, learn how to adopt a drug-free lifestyle and re-integrate in society. Individual psychotherapy and family therapy is an integral part of the programme. Admissions require referral and preparation by the key-worker from the Drugs Community Team.

c. The Alcohol Day/Residential Rehabilitation Programme – provide personalised services to individuals and their significant others who are experiencing some form of alcohol-related problems. The programme caters for the socio-psychological needs of clients by providing assessments, behaviour modification, individual counselling, group psychotherapy and group work, adult education, occupational activities, and support to families and significant others, all on both day and residential basis.

d. Alcohol and Gambling Community Services - provide personalised services to individuals and their significant others who are experiencing some form of alcohol and gambling related problems. Services offered by this Team consist of information and advice, intake and assessment of new clients with an alcohol-related problem, crisis intervention, support counselling to clients and family members, advocacy, referral to Sedqa's Psychological Service, Family Therapy Service or Psychiatrists when indicated, and the provision of an aftercare service, and social re-integration to clients who have successfully undergone a residential treatment programme. Such services are delivered both through home visits and office-based intervention. This Team also provides addiction counselling support to individuals and their families experiencing a problem with gambling. It offers a wide range of services, including crisis interventions and planning one's finances, employment and housing arrangements.

e. Drugs Community Services – provide individualised support to drug users and their significant others with the aim of motivating individuals to commit themselves to major lifestyle changes and assisting them in achieving and maintaining healthier lifestyles, ideally including abstinence from drugs. This is mainly done through one-to-one counselling sessions. Other services offered by this Team include assessment, harm reduction, crisis intervention, support to families and significant others, assistance at the Law Courts, advocacy, aftercare and social re-integration, social work interventions and preparation of those individuals who choose to do a residential rehabilitation programme.

f. Family Services - provide family assessments, family therapy, couple therapy and support to families with addiction-related difficulties. The interventions aim to strengthen and teach communication skills to the families of substance abusers. This service can be accessed following referral by a Drugs or Alcohol Community Team worker

g. Psychological Services - this team is responsible for conducting psychological assessments of the Agency's clients and is also an integral part of the drug residential rehabilitation programme. The Team also provides psychotherapy and group-psychotherapy to clients and supervision to care services staff. The Psychology Services are also concerned with child welfare issues and they offer parenting management sessions and individual psychotherapy and support group sessions to children. These interventions aim to facilitate the development of further skills that will protect or reduce the risk of harm these children face as a result of the parents drug and/or alcohol related problems.

In 2012, the Directorate for Health Promotion and Disease Prevention (DHPDP) in collaboration with Aġenzija Sedqa launched a programme to educate prospective parents about the harm that can be caused to the developing foetus when the mother consumes alcohol during pregnancy[30]. DHPDP also supports Sedqa in its promotion and education campaigns such as with regards to alcohol consumption and driving during the festive season.

[30] Celebrating pregnancy without alcohol, Directorate Health Promotion and Disease Prevention (2012): https://ehealth.gov.mt/healthportal/health_promotion/campaigns/2012_campaigns/pregnancy_alcohol.aspx

The Health Interview Survey (HIS)[24] of 2008 showed that more than half of respondents reported rarely or never having alcoholic drinks in the previous 12 months with 15.3% drinking alcohol at least once a week. When looking at data from ESPAD[26] one finds that 87% of 15 and 16 year olds report consuming alcohol in the previous 12 months which is double the proportion of adults consuming alcohol in the same time period. An emerging trend is the increase in the rates of binge drinking from 2002.

Other HIS findings showed that there are marked differences in the consumption of alcohol by gender. Weekly consumption amongst men is three times that of women. Weekly alcohol consumption is highest amongst those having a tertiary level of education while daily consumption is highest amongst those with a primary level of education.

HIS (2008) also tackled drug consumption and abuse. Measuring the extent of drug abuse through the use of surveys is difficult because of the unwillingness to disclose such sensitive information. The substance with the highest life time consumption rate is tranquilisers prescribed by at doctor at 18.7%. Of illicit drugs the highest reported life time rate is for cannabis with 4.7% of the surveyed population having used this substance at some point in their life. Other drugs such as cocaine and ecstasy have a 1% reported life time rate of use.

ESPAD (2007) the lifetime prevalence rate of cannabis reported by the students aged 15 to 16 was 13% which is over 3 times greater than the lifetime prevalence rate reported by the population aged 15 and over in the EHIS. Still in Malta the lifetime use of Cannabis amongst 15 to 16 year olds is lower than the ESPAD average where some countries such as the Czech Republic have a lifetime prevalence rate of 45%. The use of inhalants on the other hand is more frequent in Malta when compared to other European countries where on average 16% of the 15 to 16 year old age group make use of inhalants. As with alcohol consumption these figures may be indicating that the younger generations are increasing their usage and tolerance of these substances when compared to the usage and tolerance of the older generations.

D. Accidents

The rate of road traffic accidents with injury per 10000 population was 299.67 in 2006 and has dropped to 153.53 in 2009 and 199.52 in 2010[31]. The mortality rate per 100000 population (all ages) from external causes of injury and poisoning was 24.82 in 2006, 27.8 in 2009 and 24.92 in 2010. There is a marked gender difference (four-fold); in 2009 the rate for males was 41.08 and the rate for females 10.31. The rate for children below the age of 4 was 4.97 and for the age group 5-19 years 7.14 in 2009.

Through the Directorate of Health Information and Research, since 2005 Malta is a participant in the EU-based Injuries Database[32].

Campaigns to increase awareness to prevent accidents and promote a lifestyle that avoids the risks for accidents are organised by various agencies and organisations in Malta. These include several Ministries (responsible for Health, Police, Transport, Education), the Occupational Health and Safety Authority (OHSA), the Medicines Authority, and a number of NGOs such as the Sense Group[33] which promotes control in alcohol consumption and responsible driving. Examples of activities in this sector include the publication and implementation by of the strategic plan for 2007-2012 titled Occupational Health and Safety: Consolidating achievements and engaging further commitment and other ongoing activities by OHSA[34], the annual summer campaign to promote safe swimmers' zones by Transport

[31] WHO – Health for all database (HFA-DB): http://data.euro.who.int/hfadb/
[32] Injuries in the European Union, Statistics Summary 2005-2007 (2009 report): http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/0/2DD3B414D49544AEC1257686004E6EBC/$file/2009-IDB-Report.pdf
[33] The Sense Group (TSG): http://www.drinkawaremalta.com/thesensegroup/html/Default.aspx
[34] Occupational Health and Safety Authority: http://www.ohsa.org.mt/

Malta[35] and the extensive website of the Medicines Authority that promotes the safe use of drugs[36].

E. Immunisation

Reporting of the uptake of on the National Immunisation Database has considerably improved since 2008. Malta has now surpassed the 95% target coverage rates for diphtheria, tetanus, polio, Hib meningitis and pertussis vaccination. As regards Measles, Mumps and Rubella vaccination, Malta can confirm that the coverage rate for the second dose of this vaccine is now officially over 85% (97.2% uptake of MMR2 in 2010)[37].

The improvement in coverage rates since 2008 can be attributed to a number of initiatives. These include:

- more accurate reporting, especially for vaccines given in the private sector,
- the modernisation of the National Immunisation Schedule in 2010 which saw the switch to *acellular pertussis* component in the combination pentavalent vaccine given to all infants free of charge,
- the upgrading of the electronic National Immunisation Database,
- better and more efficient immunisation awareness campaigns and
- pre-school assessments for all children identifying those children with missing vaccinations and encouraging completion of vaccination schedules prior to school entry

Article 12 – The right to social security

Article 12.1

General Legal Framework

The Maltese social security scheme is governed by the Social Security Act (Cap. 318 of the Laws of Malta. This Act is available through the following link: http://docs.justice.gov.mt/lom/Legislation/English/Leg/vol_7/chapt318.pdf#

The Social Security benefits may be classified as follows: -

Contributory Benefits: There are two categories of contributory benefits short-term and long-term.
• **Short Term Benefits** cover: Marriage, Unemployment, Sickness, Injury at Work and Maternity.
• **Long Term Benefits** cover: Disablement, Invalidity, Old Age, Widowhood and Death (covers only Orphan's and Parent's of Deceased)

Non-Contributory Benefits: These are intended to cover persons who will not qualify for contributory benefits or as an addition to contributory benefits when these do not reach a minimum amount of income. These benefits cover disability, old age, carer's pension, social assistance, medical assistance, and family benefits. All these benefits are means tested. There are two specific non-contributory benefits, which are not means tested namely tuberculosis assistance and leprosy assistance.

[35] Transport Malta; Act responsibly let us all enjoy the sea safely: http://www.transport.gov.mt/ports-marinas/maritime-leisure-activities/safety-at-sea
[36] Medicines Authority: http://www.medicinesauthority.gov.mt/
[37] Source: Department of Primary Healthcare; The Primary Child & Youth Health & Immunisation Unit: https://ehealth.gov.mt/HealthPortal/health_institutions/primary_healthcare/the_primary_child_health_and_immunisation_unit/introduction.aspx

Benefits in kind: The benefits in kind provided for by the Act cover amongst others, free medical aid and health care. In the case of Health care, the Health Division is responsible to provide health care services and the necessary monitoring and control mechanism. A synopsis of the Social Security Act is available through the following link: http://www.msp.gov.mt/documents/dss/synopsis_dss.pdf. This document provides practical and detailed information of the Maltese social security scheme. It also provides information regarding the Social Security Division and its administration.

Legislative measures taken during the reference period, in line with the provisions of Article 12 § 1.

During the reference period 2008-2011 the Maltese Social Security Act experienced numerous amendments which varied from routine amendments such as increases in the rates of the Social Security Benefits to other major ones.

Legal Notice 149 of 2008 provided for the increases in the rates of Social Security benefits and contributions as previously announced in the Budget Speech for 2008. These increases are proportionately tied to the €3.49 cost of living increase rise in wages as awarded by Government. The mentioned Legal Notice is available through the following link: http://justiceservices.gov.mt/DownloadDocument.aspx?app=lp&itemid=20598&l=1.

Other amendments to the Social Security Act provided for the award of the full cost of living instead of the usual 2/3s increase for pensioners and that person in receipt of a contributory retirement pension may continue with their employment or self-employment irrespective of their earnings from said employment without forfeiting their right to a contributory pension. Another amendment also for persons in receipt of a contributory pension provided that the first €466 of a Service Pension should be ignored for the assessment of a pension where claimant is also in receipt of a Service Pension.

With effect from January 2008 a Children Allowance flat rate amounting to €250 per eligible child per year for households with an income that exceeds €23,923. Other amendments provided that a refund of the share of the Social Security Contribution paid by an employer on behalf of an employee who is certified as a severely disabled person or a visually impaired person for the first 156 weeks and also a refund of the share of Social Security Contributions paid by a disabled person who employs a carer. Also entitled to a refund of 52 weeks of SSC are those persons who were on the unemployment register for more than five years and who acquire a trading licence and become self-employed persons.

Legal Notice 143 of 2009 provided for the increases in the rates of Social Security benefits and contributions as previously announced in the Budget Speech for 2009. These increases are proportionately tied to the €4.08 cost of living increase rise in wages as awarded by Government. The mentioned Legal Notice is available through the following link: http://justiceservices.gov.mt/DownloadDocument.aspx?app=lp&itemid=20087&l=1.

Act 2 of 2009 also provided for amendments to the Social Security Act that increased the amount to be ignored for pension purposes assessment to €666 from a Service Pension of a person claiming a contributory retirement pension. Another amendment provided that where a person who is registering for work as an unemployed person and who is in receipt of a non-contributory unemployment assistance partakes of a scheme that enables him to provide work in the community has his unemployment assistance rate increased to 75% of the national minimum wage for the period said beneficiary remains in such scheme.

Legal Notice 437 of 2010 provided for the increases in the rates of Social Security benefits and

contributions as previously announced in the Budget Speech for 2010. These increases are proportionately tied to the €5.82 cost of living increase rise in wages as awarded by Government. The mentioned Legal Notice is available through the following link: http://justiceservices.gov.mt/DownloadDocument.aspx?app=lp&itemid=21481&l=1.

With effect from January 2010 the Child in Care Allowance was increased to €70 per week per eligible child and the ceiling for Supplementary Allowance purposes was increased to €10,269 for married persons and to €8,102 for single persons.

Legal Notice 330 of 2011 provided for the increases in the rates of Social Security benefits and contributions as previously announced in the Budget Speech for 2011. These increases are proportionately tied to the €1.16 cost of living increase rise in wages as awarded by Government. The mentioned Legal Notice is available through the following link: http://justiceservices.gov.mt/DownloadDocument.aspx?app=lp&itemid=22469&l=1.

The ceiling for Supplementary Allowance purposes was increased to €10,330 for married persons and to €8,162 for single persons and the maximum weekly rate also increased to €8.13 for married persons and to €4.57 for single persons.

Other changes provided for an increase in the highest rate of social security contribution paid by persons born on or after 1st January 1962 as a result of the pension reform enactments of 2006. Through this amendment this cohort will benefit from a higher pensionable income for pension purposes in order to maintain the adequacy of pensions for future generations.

Another amendment increased the amount to be ignored for pension purposes assessment from a Service Pension of a person claiming a contributory retirement pension from €666 to €866.

A new introduction related to social security contributions was that for part-time self-employed women who with effect from January 2011 now have the option to pay a pro-rata social security contribution of 15% of their actual earnings from a gainful occupation instead of the minimum flat rate which in most cases works out to be higher than the 15% given that it the lowest rate applicable for a self-employed person who earns less than the minimum ceiling taken. The social security contribution for full-time self-employed farmers and breeders was also reduced to 12% from January 2011.

Another important amendment provided that the first €52.98 from the earnings from employment of the spouse of a person who is registering for work as an unemployed person who applies for a non-contributory unemployment assistance are ignored in the incomes means assessment used for the entitlement of said assistance.

Pertinent figures, statistics and other relevant information.

The Social Security Department's annual reports for the years under review which provide the pertinent figures, statistics and other related information on Malta's Social Security Schemes is available through the following link https://secure3.gov.mt/socialpolicy/SocProt/social_benefits/publications/annual_reports.aspx

Article 12§ 3

New measures in Family Benefits.

Children Allowance

As stated in the introduction to this report, the beginning of 2008 saw the Social Security Division reforming its Family Benefits Schemes. In fact the Children Allowance was extended to all households and payable for every child. This measure was twofold. First an annual flat rate of € 250 per child was paid, as from 5th January 2008 those households whose income exceeded the amount of €23,923. The second group whose income is less than €23,923 had their allowance increased substantially as the percentage mechanism used to establish the rate of allowance due was reviewed upwards as follows:

Children Allowance %

2007 rates	**2008 rates**
6% for the first child	6% for the first child
9% for the second child	12% for the second child
12% for the second child	18% for the third child
3% increase for each other child	6% increase for each other child

The major elements of the reform can be described as follows: -

i. The percentage rate utilized to establish the rate of means-tested benefit increased from 3% for the second and subsequent child to 6% for each child (see table above). As a result the means-tested benefit payable to each child in the household is now the same;

ii. At the same time the minimum means-tested child allowance applicable to all households increased from €121.12 per annum irrespective of the number of children in the household, to €250 per year for each child in the household.

iii. A new flat rate allowance was introduced and payable to households who do not qualify for a means-tested Child Allowance. The Flat Rate Child Allowance has been established as €250 per year per child. As a result of this new measure 16,969 households (with approximately 26,692 children) started to receive this allowance during 2008.

The reform of the child allowance benefit required an overhaul of the software governing this benefit and also the manual input from the personnel of the section concerned.

Disability Child Allowance

A measure introduced in 2008 was vis-à-vis the Disability Child Allowance which ceased to be means tested. Moreover, as from January 2008 the flat rate of €11.65 was increased to €16.31 per week and paid to each child irrespective of the income of the head of household, once the child is confirmed by a medical panel to qualify medically to such allowance.

Foster Child Allowance

The Foster Child Allowance or child in care allowance was also increased from €27.95 to €39.60 effective from January 2008.

Maternity Benefit

The number of weeks that Maternity Benefit is paid has been increased from 13 to 14 weeks with effect from January 2008.

Article 13 - The right to social and medical assistance

Paragraph 1 - Adequate assistance for every person in need

Types of benefits and eligibility criteria

Malta provides for various benefits under the non-contributory scheme. Such benefits include social assistance, unemployment assistance, social assistance for carers, carer's pension and medical assistances.

Social assistance

A head of household (H/H) who is not fit for employment due to sickness, physical or mental illness; or persons who according to ETC cannot be employed, single parents (SUP) or separated persons (SA) who cannot engage in full-time employment due to family responsibilities and single persons (SA) who are over 18 years of age and live either alone or with someone else (excluding their parents), and cannot engage in gainful occupation or register for employment due to illness are all entitled to social assistance.

Social Assistance is means tested and before awarding the benefit a capital test and a weekly means test are carried out. The capital means for a household consisting of one family member or a number of persons who's head of household is either an unmarried person, a separated person or a single parent must not exceed €14,000. The capital means for a household consisting of at least the head of the household and partner/wife must not to exceed €23,300.

Social assistance for carers

A single or widow male or female, whether registered or not as an unemployed person and who is taking care of a sick or an elderly relative all by him/herself and on a fulltime basis are entitled to this assistance. It is important that no other unemployed person is in the same household unless said other unemployed person is not medically fit to take care of the sick or elderly relative. Relatives must be the parents, grand-parents, brothers, sisters, uncles, aunts, brothers or sisters' in-laws and father/mother in laws. Claimants and patients are to give proof that they are residing in the same residence.

The patient for whom applicants are claiming SA Carers are medically examined by the Medical Board of the Department of Social Security. Other members of the household may also be requested to attend for the Medical Board. A maximum rate of assistance payable is 75% of the Social Assistance rate plus bonuses.

Carer's Pension

Persons who are single or widow (male or female), who are taking care by themselves on a full time basis of a sick relative who is either wheelchair bound or bedridden are entitled to this pension. Relatives must be the parents, grand-parents, brothers, sisters, uncles, aunts, brothers or sisters' in-laws and father/mother in laws. Claimants and patients are to give proof that they are residing in the same residence.

A Carers Pension is means tested and before awarding the benefit a capital test and a weekly means test are carried out. A medical test on the patients for whom applicants are claiming Carers Pension is

also carried out by the Medical Board of the Department of Social Security. Other members of the household may also be requested to attend for the Medical Board.

Medical Assistance

Medical assistance is payable to persons suffering from a chronic disease or condition that could only be cured or alleviated by a special diet or regimen which incurs an exceptional expenditure.

This assistance means tested and before awarding the benefit a Capital Test and a Weekly Means Test are carried out. A household consisting of one family member or a number of persons who's head of household is either an unmarried person, a separated person, a single parent should not have a capital that exceeds €14,000 while a household consisting of at least the h/h and partner/wife are not to exceed €23,300. The patients are medically examined by the Medical Board of the Department of Social Security.

The capital assets taken for the capital means test for social and unemployment assistance, for carers and medical assistance are as follows:

- Financial resources both deposits and cash in hand (bonds, stocks etc.)
- Half bank deposits in children's name who are unemployed
- Unoccupied properties/land for development
- More than one/two vehicles depending on the case
- Agricultural land
- Income derived from sale of property or other valuables.

The weekly means taken into consideration are:

- Interests/dividends
- Bank accounts in claimant's name
- Rents
- Any other income derived.

All persons in receipt of the above are assistances are automatically entitled to the maximum rate of child allowance where the household contains children under the age of sixteen and to the maximum rate of supplementary allowance where no children allowance is due. Such households are also automatically eligible to energy benefits.

Level of assistance

The four weekly social and/or unemployment assistance benefit in 2011 amounted to € 381.76 for single persons, € 414.36 to a couple without children and to € 446.96 to a couple with one child. The four weekly benefits for social assistance carers in 2011 was €289.44 and the carers' pension rate was €394.80. All the mentioned rates include €12.48 as a supplementary bonus given to all beneficiaries of main benefits.

The medical assistance rate was €89.44 for one person and €158.36 for two persons. The maximum rate for supplementary allowance in 2011 was €8.13 per week for a married household and €4.57 for a single person household. The maximum rate of energy benefit per person per year in 2011 was €75.

Right of appeal and legal aid

Head of households who, while in receipt of unemployment assistance are struck off the unemployment register have the right to appeal with the National Employment Authority and until the

case is decided, the spouse of the head of household is eligible to apply for social assistance for herself and any other eligible members of the household. The award or not of such assistance is decided by a Social Assistance Board within the Department of Social Security.

Head of households while in receipt of social assistance are periodically referred to a medical panel who confirms that their medical condition still precludes them from employment. Where a person is found to be in good health, he is referred to start registering for work and subsequently awarded unemployment assistance. The beneficiary has the right to request a reconsideration of the decision by a different medical panel or to be seen by the Multi Disciplinary Board.

Article 13 - The right to social and medical assistance

Paragraph 2 - Non-discrimination in the exercise of social and political rights

Malta has no additions to make to the previous report.

Article 14 – The right to benefit from social welfare services

Organisation of the social services

The re-organisation of the social services, to which the Committee has previously referred (Conclusions XVII-2) is now completed. The Department for Social Welfare Standards (DSWS), within the Ministry responsible for Social Policy, is the responsible authority for establishing and monitoring the various social welfare services. Agenzija Appogg and Agenzija Sapport within the Foundation for Social Welfare Services– are responsible for the implementation of the operations. In both cases, social workers reassess individual needs with their clients on an ongoing basis. Formal case reviews, in particular for cases regarding minors are held every six months by Agenzija APPOGG, and on yearly basis in the case of every client within Agenzija SAPPORT.

Sapport offers four types of services for disabled persons and their families: Social Work Services that assist in any form of social problems encountered by persons with disability; Community Services that provide personal assistance and/or intervention to allow persons with disability retain their independence in their normal environment; Day Services that offer therapeutic programmes, training in life skills and employability and community integration; and, Residential Services, that provide a home to those persons with disability where their home of origin is no longer in a position to support them.

Appogg also provides various types of services: services for adults and families, including child care, psychological-therapeutic services, through psychological and family therapy services, reception facilities for the victims of family violence and care in hospitals and clinics, services for children, including, child protection services, the provision of out of home care services, in particular foster care and specialized foster care, monitoring of all looked after children, psychological support and visiting rights in the case of divorce, and initial legal assistance. There is an emergency telephone service. Certain specific projects have been launched during the reference period to train and find work for refugees.

Effective and equal access

In the case of Sapport, any person with disability, irrespective of severity and/or challenging behavior that develops as a consequence, is eligible to access the Services provided by the Agency. Priority is given however to persons with disability who have either challenging behavior and/or who are at risk of being institutionalised, or have already been institutionalised. In cases where the person institutionalised is still of young age, every effort is made to provide that individual with the opportunity to be integrated back into the community. Service provision by Sapport is free of charge.

Each of the different services of APPOGG, has its eligibility criteria, however due to insufficient human resources, case allocation is based on a prioritization system. The three types of service it provides are free, including psychological assessments, in the case of separating couples, when requested to do so by the Courts.

Legal advice services were restructured during the reference period, involving the preparation of reports by experts, the use of court-appointed staff to supervise the application of visiting rights ordered by the courts and the introduction of payment procedures for the court monitoring service, when payment is ordered by the Court. Children being followed by the Agency receive individual medical supervision. The Committee asks for further information on the payment procedures referred to. The Agency has an agreement with the Health Authorities, whereby a Consultant Community Paediatrician holds a weekly visit at the Agency clinic. Children are referred to the clinic by the Agency's social workers, and the service is offered free of charge.

FSWS does not clearly specify this however in its Clients' Rights Charter it clearly states that clients have a right to receive quality services in a respectful manner without any discrimination; in the light of this all services provided by FSWS are open to all persons requiring them, irrespective of their nationality.

In addition the FSWS has an equal opportunity policy for employment purposes which clearly states that: "Employment decisions are based on personal merit of the individuals applying for a post within the Foundations and on the needs of the organization, and not on race, colour, national origin, gender, gender re-assignment, sexual orientation, age, religion, creed, disability, marital/parental status, political affiliation, or any other factor protected by law."

Quality of services

Employees of Appogg and Sapport must as a minimum have a university qualification in social work,(psychology, social policy, youth work) apart from Support Workers who have a minimum qualification in Care Work or who have ordinary level of education. The two agencies also organise continuing training sessions. This is the focus of the ESF project, which started during the reference period. In addition other training courses were organised by FSWS, including training on Child Protection, and Children and the Courts, funded through a Commonwealth Project;

According to the report, state support for social services provided by Appogg fell from MTL 1.098 million (about € 2.6 million) in 2005 to MTL 1.057 million (about € 2.5 million) in 2007, whereas state support for Sapport's service rose from LTM 507 000 (about € 1.2 million) in 2005 to LTM 2.070 million (about €

4.8 million) in 2007

Budget Allocations 2008-2011

APPOGG

The budget allocated for APPOGG has increased since 2008. In the table below there is also included the budgets for High Support Services (HSS), through which APPOGG employees support workers to work in Residential Homes, as well as ACCESS Centres budget vote, since a substantial amount of this budget goes towards covering staff salaries of APPOGG community teams.

	2008	2009	2010	2011
Appogg	2,718,00	2,850,000	3,250,000	3,450,000
High Support Services (HSS)	303,000	629,000	629,000	703,000
ACCESS Centres	533,000	533,000	533,000	550,000

SAPPORT

SAPPORT Agency's budget vote continued to increase over the years 2008-2011 as follows:

	2008	2009	2010	2011
SAPPORT	5,467,000	5,750,000	6,250,000	6,590,000

This upward trend in the Agency's budget can be attributed to various reasons. Notably since it started operating from zero in 2001 the agency has continued to develop and increase services to meet the demand created by the same services. It is worth noting that in spite of all the development and increase in budget the agency is still finding it hard to cope with the heavy demand thus an unfortunate waiting list has been created which continues to rise.

It is worth noting that during 2008, new services in the form of a new residential unit at Bormla and a new Day Centre in Paola were launched which also had a major impact on the agency's finances.

There is a legal protection of personal data, particularly with regard to access to services provided by Sapport. It asks whether the same applies to services supplied by Appogg. Re Monitoring of Services: Services Users are informed of their rights, through the Charter (we can quote the section re complaints). In addition FSWS also has a service user satisfaction Policy. With regards to APPOGG, the Fostering and Adoption Services are accredited by Law through the Central Authority and such accreditation is issued following an assessment of the service being provided. In the light of this the Central Authority also has the function on monitoring and assessing Fostering and Adoption Services

provided by the Agency. With regard to monitoring, yearly reviews or more frequently if need be, are held in order to ascertain client satisfaction, attainment of client goals and wishes. Furthermore, regular staff supervision and team meetings are held at the various levels, in order to review service provision, ensure quality of service, and professional standards.

The Act resulted, in particular, in the establishment of a Commissioner for Voluntary Organisations, appointed by the Minister for Social Policy for a renewable three-year term. The Commissioner's role is to foster and facilitate voluntary work in the social services field and to supervise the provision of social services by non-profit-making organisations in accordance with the 2007 Act. He or she submits an annual report to the Minister of Social Policy on all these organisations' activities.

According to the report state subsidies for the work of the Commissioner amounted to MTL 16 000 (about € 37 000) in 2007 and total subsidies for non-profit- making organisations rose during the reference period from MTL 719 939 (about € 1.7 million) to about MTL 730 000 (over € 1.7 million). Voluntary organisations may also obtain state funding through a special fund set up by the 2007 Act. The Committee asks how much funding of this sort is provided and if the fund offers training for voluntary organisations.

Voluntary organisations must be entered in a special register before being able to engage in their activities. All applications for registration must be accompanied by a registration fee and after registration, a registration certificate is issued. Outsourcing of social service provision to private contractors is not very widespread in Malta. The Committee asks if voluntary organisations and associations can provide social welfare services on an equal footing as private bodies.

The new Act of 2007 also established a Council for the Voluntary Sector, which is charged with helping the Commissioner in his or her work and serving as a forum through which co-operation can be organised with the government and between voluntary organisations. It is composed of a chairperson and ten other members appointed by the Ministry on the basis of proposals made by the voluntary organisations themselves.

The Commissioner for Voluntary Organisations shares the authority to supervise voluntary organisations' activities with the Department for Social Welfare Standards, which was also set up during the reference period. The Commissioner is also entitled to investigate the activities of non-profit-making organisations. In the event of an infringement of the 2007 Act or a financial problem, the Commissioner may apply for the suspension of the organisation's activities to a Board of Appeal, which is also appointed by the Ministry for Social Policy and whose members are appointed for a three-year term under the Code of Civil Procedure. Individuals are also entitled to appeal to the same appeal

board against decisions by the Commissioner. Under the Criminal Code, penalties ranging from a fine of about € 116, to a prison sentence may also be imposed in the event of an infringement of the law.

Article 23 - The right of elderly persons to social protection

Replies still waited from appropriate entities