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SOCIAL VULNERABILITY AND AGING THROUGH THE LENCE OF HUMAN RIGHTS OF ELDERLY POPULATION



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This report addresses matters related to human dignity (Article 1), a right to life (Article 2), a right to education (Article 14), equality before the law (Article 20), the principle of non-discrimination (Article 21), health care (Article 35) and a right to an effective remedy and to a fair trial (Article 47) falling under the Titles I 'Dignity', II 'Freedoms', III 'Equality', IV 'Solidarity' and VI 'Justice' of the Charter of Fundamental Rights of the European Union.

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1. KEY CONCEPTS AND TERMINOLOGY

The target group of the survey are elderly persons who self-identify as being gay, lesbian, bisexual or transgender, Roma and HIV positive persons respectively. The survey examines issues of equal treatment and discrimination on the ground of available/used social care services and offers recommendations to national/local stakeholders for future activities pointing at better and more proficient inclusion of needs of elderly vulnerable groups onto existing institutions of the system as well as immediate steps taken by civil society organizations.

The terms used are based on the Yogyakarta Principles on the application of international human rights law in relation to sexual orientation and gender identity.

Sexual orientation refers to “each person’s capacity for profound emotional, affection and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender”. Sexual orientation refers to identity (being), conduct (behavior) and relating to other persons (relationships). It is generally assumed that persons are heterosexual (orientation towards persons of a different gender), homosexual (gay, or lesbian, orientation towards persons of the same gender) or bisexual (oriented towards both genders).

Gender identity refers to “each person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms”. Those whose gender identity does not correspond with the sex assigned at birth are commonly referred to as transgender persons. This group includes persons who wish at some point in their life to undergo gender reassignment treatments (usually referred to as transsexual persons), as well as persons who ‘cross-dress’ or persons who do not, or do not want to, consider themselves as being ‘men’ or ‘women’. Some of them refer to themselves as ‘gender variant’.

Gender expression refers, then, to persons’ manifestation of their gender identity, for example through ‘masculine’, ‘feminine’ or ‘gender-variant’ behavior, clothing, haircut, voice or body characteristics. Since experiences of homophobia, transphobia and discrimination on the grounds of sexual orientation and gender identity often find their roots in social perceptions of gender roles, this survey has also included this element.

GAROP - Global Alliance for the Rights of Elderly Persons

HAART – Highly Active Antiretroviral Therapy

HIV – Human Immunodeficiency Virus

PLHIV – Persons Living With HIV/AIDS

SDGs – Sustainable Development Goals

VG – Vulnerable Group

2. FOREWORD/WHY IS THIS REPORT NEEDED

Defining old

“The ageing process is of course a biological reality which has its own dynamic, largely beyond human control. However, it is also subject to the constructions by which each society makes sense of old age. In the developed world, chronological time plays a paramount role. The age of 60 or 65, roughly equivalent to retirement ages in most developed countries, is said to be the beginning of old age. In many parts of the developing world, chronological time has little or no importance in the meaning of old age. Other socially constructed meanings of age are more significant such as the roles assigned to older people; in some cases it is the loss of roles accompanying physical decline which is significant in defining old age. Thus, in contrast to the chronological milestones which mark life stages in the developed world, old age in many developing countries is seen to begin at the point when active contribution is no longer possible.” (Gorman, 2000)

Life expectancies are increasing and with this the overall population structure is changing. Globally it is estimated that people aged 60 years or over will reach 2 billion by year 2050. This change is particularly apparent in the European regions where the ageing population has been identified as a priority issue. For example in 2012, 22% of the European population was over 60 meaning that Europe has the highest ageing society worldwide. However, it is estimated that the rate of increase of the ageing population will be faster in developing countries than in developed countries by 2050 so this will be ultimately a growing demand facing all regions. For example in 2002, four of the five BRICS countries: Brazil, Russia, India, China (and South-Africa) featured in the top 10 countries with the greatest number of their populations over 60 years of age; it is predicted that this trend will continue beyond 2025. According to the last census of the population of Serbia, the elderly population make up 16.8 percent of the total population. The percentage of people over 65 in Serbia will amount to at least 22 percent by 2030, which is almost every fifth resident.

It also needs to be recognized that there is a huge diversity within the older population group. Some of the people are dependent on provision of assistance to ensure quality of life on many levels (health wise, social services wise etc.) while others are still very active and autonomous and self-reliant. While there is diversity across income, often elderly women are poorer. Also the need for health services will vary significantly between a 60-year-old and a 90-year-old.

Even though human rights field has become increasingly specialized in the previous two decades, some of the disadvantaged groups - such as elderly persons with accent to those belonging to vulnerable categories still lack attention under human rights law.

There is a growing concern about respect of human rights in general, especially with sexual rights abuses when elderly people are dependent on institutional care or informal care. They may be refused the right to intimacy, the right to a fulfilling sexual life, the right to appropriate health care because of the lack of understanding that elderly people might still be sexually

active. Particular attention is needed for elderly LGBT and those who are HIV+, as well as elderly Roma population.

A contemporary understanding of culturally competent service delivery for seniors must be included in vulnerable populations' issues. LGBT, HIV positive and Roma elders face many of the same aging-related issues as their peers not belonging to vulnerable population, including challenges to their health, independence, and mobility. However, elderly LGBT, HIV + and Roma face special difficulties as well.

These seniors are "twice-hidden" due to social discrimination on two levels: ageism, social exclusion, homophobia or heterosexism.

LGBT seniors often face antigay or gender discrimination by mainstream elder care providers that renders them "invisible" and impedes their access to vitally important services. At the same time, LGBT elders frequently confront ageism within the LGBT community and the organizations created to serve the community's needs. Many older people respond to the pressures of discrimination by concealing their sexuality and/or health status in settings where being straight forward might hinder their access to quality care or even endanger their well-being. For many LGBT elders in their 60s and 70s, a lifelong survival strategy has been concealing their status or sexuality - one they are likely to carry with them when seeking long-term care, entering a nursing home, or speaking with a health care provider. This dynamic prevents many VG seniors from openly accessing the very social services that could be most beneficial to them - if only these programs were perceived as safe places to turn for help and if they were culturally responsive to VG elders' needs.

VG elders are vulnerable in another important area as well. Being closely linked with income, health status, and the availability of caregivers, living arrangements are an important indicator of well-being among older persons. LGBT elders are also less likely to have children than their heterosexual counterparts. Since life partners and children play an important role in caregiving, many LGBT elders become reliant on formal caregiving services sooner than other VG elders who eventually can turn to family members and partners for informal support.

Therefore, the paper aims at explaining how multiple forms of discrimination and living in social isolation can have devastating effects on the lives and well-being of several vulnerable groups such as LGBT, HIV positive older adults, including elderly Roma population, and how we need multiple responses to support this marginalized communities. Notable to mention is that these populations, especially elderly HIV positive haven't been recognized so far neither in research nor in policies that deal with a quality of life and support towards elderly. Namely, the first case of HIV was recorded in 1983, among younger members of prison population, and since that time, owing to medical progress and combination of available antiretroviral therapy, life expectancy of HIV positive people has multiplied thus nowadays creating a vast number of HIV positive persons above the age of 60 living in Serbia. Apparently this is the first generation of HIV positive persons in Serbia to experience senior age, which remain invisible in research community as well as in policies. Therefore, in the scope the preparation of the paper, we have conducted a small scale research that would provide an insight in general trends, their perception of the conditions and quality of life, as well as the level of discrimination and exclusion present among this particular type of vulnerable population.

As a result, the research aims at making a number of important recommendations, including promoting building of competences among elderly persons and service providers, taking

steps to improve personal security, increasing this population's access to health care, and producing more data and research on the lives of LGBT/HIV positive and Roma older adults. Its' final employment might best be seen in advanced advocacy efforts to integrate the needs of elderly vulnerable groups onto the Strategy for Elderly Population and coherent efforts seen by the Ministry for Social Affairs, Labor and Veterans to provide a variety of services based on stated needs, in line with Sustainable Development Goal 3 - **Ensure healthy lives and promote well-being for all at all ages.**

With regard to the need for more research, it is worth noting that while this report shall make a foundational contribution to building our knowledge of what happens at the intersections of the LGBT, Persons Living With HIV/Aids - PLWHA and aging experiences, much work remains to be done to deepen our understanding and to identify promising solutions. **It serves as well to provide necessary information which will enable designing comprehensive research and based on that the policy interventions, such as contribution to development of the Serbian National Strategy for Elderly People and particular service development.**

3. METHODOLOGY AND APPROACH

For the preparation of the paper combined research methodology has been developed. Namely, the research commenced with the identification and collection of key documents for the completion of the desk research phase and small scale qualitative research, which included realization of four focus groups – with Roma population and HIV positive, complemented with a number of in-depth interviews with LGBT male and female respondents. The mentioned approaches are described in more detail as follows.

Desk research – desk review of existing documentation, reports and available statistics data on key sectors, as well as national and international trends related to the position of elderly population, with particular focus on vulnerable groups, such as HIV positive, Roma population and LGBT elderly persons. The desk research has reviewed their position from perspective of different sectors/needs such as antidiscrimination/human rights perspective within the healthcare and social welfare system. Various local services provided by public or private service providers aimed at supporting quality of life of elderly persons, were also a subject of the research.

Focus groups and in-depth interviews – in order to provide better understanding of a position, particular needs and obstacles vulnerable elderly persons face in everyday life, four focus groups and several in – depth interviews were conducted in the scope of the research.

The qualitative component of the research has had for an *aim* to enable better understanding of needs and quality of life of elderly persons from vulnerable groups, the level of recognition of existing public services as well as the level of satisfaction with local services, which are provided to elderly population aimed at raising their quality of life.

Moreover, three specific objectives were set in order to meet the aim:

Specific objective 1. How do people in these three groups recognize the quality of life - what they see as the basic guidelines/conditions to be met in order to live a quality life (identify needs and opportunities for their achievement - what they have and what is still missing)

In this part of the research the focus was placed on how persons from different groups perceive a general quality of life, and how they evaluate their quality of life. It was significant to evaluate what they thought were the key needs, what are the constraints and how these aspects reflect on their feelings. Special attention was focused on the evaluation of: financial status, health, quality of social relationships that are established, the degree of autonomy (independence) they have, as well as involvement in community.

Specific objective 2. What services in the community are recognized as those that can meet the needs (as identified in the previous section) or can improve the quality of life, as well as assessment of the availability of services and satisfaction with the quality of services that they had the opportunity to use;

The second part focused on understanding of the visibility of specific services implemented in the community and identifying stakeholder's/service providers who offer services in/out of the system, recognized as significant and with quality. Special attention is paid to services within the health system and social security systems aimed at raising the quality of life of the elderly, as well as the services offered by other service providers - commercial and non-profit sector.

Specific objective 3. What are the key recommendations and in which domain the services need to be developed and how to make them more available and with higher quality; final part of the

discussion is focused on summarizing key issues and the creation of joint recommendations to the different actors - the state and service providers.

Sample. As it was explained above, the main focus was on elderly persons from vulnerable groups, more specific LGBT/HIV positive and elderly Roma population. Therefore, we have been recruited 48 persons from all three groups.

Due to the results of desk analyses, in developing sample profile we have put emphases on certain sub – groups recognized as more vulnerable within examined vulnerable population. This is specifically applied to the case of Roma population. Having in mind that there are different groups within the population depending on migrant status and level of integration within the society, we gave the attention to those subgroups which are living in more integrated suburban communities. We have chosen respondents from Obrenovac suburban community in order to better understand their position from antidiscrimination perspective, or level of inclusion and satisfaction with services provide in scope of health and welfare system. From perspective of a group we perceived on less demanding inclusion process as easier to get an idea for developing intervention which can serve to better involve more demanding subgroups. At the same time, having in mind that women are more vulnerable, we gave advantage to female respondents. The rest of the groups were gender balanced.

In terms of age structure of the sample, the age limit of respondents is somewhat below then what is consider elderly in general population, due to the fact that health status of Roma and HIV positive, indicate that they request earlier support, facing earlier limitations, than it is a case in general population.

Moreover, below tables give more information on profile of respondents cover by the research.

Table 1. Gender structure

Groups	Male	Female	Total
Roma	8	15	23
HIV positive	8	5	13
LGBT	5	7	12
Total	29	27	48

Table 2. Age structure

Groups	55 – 60	60 +	Total
Roma	6	17	23
HIV positive	10	3	13
LGBT	1	11	12
Total	17	31	48

The focus groups' discussion guide will be attach to the report.

The findings from the focus groups' discussions and in depth interviews will be integrated in the report and will serve to vividly describe and sustain the presented arguments.

4. OVERALL SITUATION IN SERBIA RELATED TO ELDERLY WITH FOCUS ON PARTICULAR VULNERABLE POPULATION

According to the quality of life of elderly population, the Republic of Serbia is on the 66th place on the list of Global Aging Indicators for 2015. Indicators show the economic and social well-being in the quality of life of elderly people, which in Serbia is not satisfactory.

Elderly people in Serbia belong to the group of vulnerable populations and are discriminated against not only on the basis of age, but also by other parameters that lead to acquiring poor health, social and economic status, causing complete invisibility and neglect of the rights of elderly persons, especially the rights of elderly people from marginalized groups. Multiple discrimination is not recognized as a dominant factor in the violation of human rights of the elderly population in the social, nor in the institutional system.

Elderly people in Serbia face numerous difficulties of economic, social, health and legal nature that are not adequately regulated and stipulated by existing national legislation.

The overall socio-economic status of the elderly, especially elderly people from marginalized social groups is unfavorable, and they are often threatened, discriminated against and less visible in the public eye. Many of them do not receive even the basic human rights guaranteed by the Charter of the United Nations such as the right to social security and adequate standard of living.

In order to better portray the current status of elderly persons in Serbia, it is important to perceive it from social – demographic and human right perspective. More in particular, the report will try to depict specifically elderly position in health care and social welfare system that are recognized as main layers of support sustain adequate level of the quality of life.

5. THE SOCIAL - DEMOGRAPHIC ASPECT OF AGING

Globally speaking, aging is highlighted demographic trend. Trend of extension of life expectancy, at birth and at the age of 60, as well as lowering fertility rates, changed the demographic structure of the population in countries around the world. Although we can speak of the success of the development, it brings with it the challenges we have to face (Age International, 2015).

Aging brings with it a range of socio-economic, health, cultural and scientific challenges and the need to turn challenges into opportunities. All countries of the world will have to adapt their political, economic, health and social service needs of the elderly, to enable them with quality of care, a secure income and access to goods, more flexible employment, greater inclusion and involvement of the elderly in all spheres of society. Among the major achievements in the last few decades, are the development of policies aimed at reducing inequality and improving social inclusion. Especially important fact is to ensure respect for the human rights of the elderly (UNFPA, 2014).

An important feature of demographic aging is the “feminization of aging”: women make up 54% of the population aged 60 years and 63% of the population elderly than 80 years. Predictions are that by 2050 elderly than 60 years will make up 22% of the world’s population. The oldest continent by 2050 will certainly be Europe with a total participation of population over 60 years of 33.6%. (UNFPA, HelpAge International, 2012). Serbia is also in the process of demographic aging and the average age of the population in Serbia in 2013 was 42.40 years. This process will be intensified, and according to projections of the Republic Institute for Statistics, the number of population over 65 years in Serbia until 2030 will amount to more than 21%. The number of “elderly elderly”, those over 80 years, will be rising to 5% (National Bureau of Statistics, 2014).

All of these data undisputedly show that efforts are necessary for more precise, age segregated data enabling us to follow demographic trends, which are the basis for creating all the more successful politics and approaches based on legal framework.

Socio-demographic characteristics of the elderly population in Serbia recognize standard-parameters characteristic of the elderly population, such as: the number, age and gender proportion in the population of the territory, life expectancy, the socioeconomic position, the quality of life in the community and the like. This parameter does not include features that are related to certain personality characteristics of members of certain marginalized groups whose health or social status (HIV status, belonging to the Roma national minority or affiliation LGBTI community) crucially affects the quality of life and especially the availability or lack thereof, of health care.

“Social aging” of the population as a product of isolation, loneliness and even rejection by the society and system performance, usually earlier than biological aging. Social decompensation leads to many health problems and even the inability to use health services. Social consequences of aging that are replicated through the inaccessibility of health services are particularly pronounced in elderly members of Roma population, among people living with HIV/AIDS, in adults with disabilities and elderly members of the LGBT population. Stigma and discrimination as well as self-stigmatization in the field of health care are present in society but also in health care facilities and institutions

Fear is the colour of Ageing

Characteristics of “social ageing”, such as isolation, loneliness and feeling of rejection by the society is dominant in perception and talks of the respondents from all subgroups – LGBT, HIV positive, Roma. In their talks and description of imaginary old person life stories, the sadness and fears are dominant. When they portrayed old persons, they describe them as lonely and isolated and furthermore reporting of those feelings as familiar, personally well known.

Speaking about fears, they perceived life in future as uncertain. The feelings of helplessness and powerless prevail. They already feel being more depending on others in everyday activities and recognize that they could be left alone with no family or societal support in future.

All of them reported that they do not have or cannot rely on daily support of family members. In respectful number of cases, they reported that they won't have anybody to rely on. This is mostly present in case of LGBT and HIV positive, which primary family, parents, are died or being old, so become more depending on their daily support. They usually are not in close relation with other member of the family. Sometimes they are rejected or they do not feel confident to share with family members their status.

Their social life is poor and therefore they have small social network that can be the base of support in future. The stigma makes them very cautious and distrustful and suspicious toward others, which keep them staying isolating in small social circle.

Although these findings are not surprising in case of HIV positive and LGBT, it was a bit unusual that similar situation can be perceived in Roma community as well. The significant number of the respondents who are 60+ reported that they are staying alone at one – person household due to migration of the their family in other parts of the country or abroad. Significant number of Roma elderly women reported feeling of being lost and desperate since they lost their husbands. They are overwhelmed by emotion of despair and depression showing high level of passivity and hopelessness.

The *quality of everyday life* is extremely low in case of all groups. The lack of structure and meaningful activities are obvious and this makes them feel useless and depressive. According to their daily diaries, the main activities are daily rituals around house and preparation of the food. Weekly, depending of the groups, they spend significant number of hours in healthcare system, mostly in queues waiting for intervention. Social contacts are reduced and modest, mostly based on spending time with neighbors or family members in short visit (“having coffee together”). The obstacles are numerous – from financial to health reasons (low mobility depending on health status). It is also obvious that expectations and perception of quality of life defer from group to group and significantly depends on level of education. For instance Roma elderly women couldn't easily notify activities what could make their quality of daily life wealthier unless improvement of material status, while other groups could list variety of activities easily – cultural, social, even sports. They show undoubted urge to make the change in this matter.

6. GENDER ASPECT OF AGING

Viewed through the eye of demographic statistics, aging is primarily a “female destiny.” Rare are the studies that show and explain the difference between elderly men and women including members of marginalized social groups. The quality of life in later years could be considered in the context of gender discourse as one of the dominant ones within the social sciences. While some believe that gender inequality and gender stereotypes are not visible in elderly population, age being in itself discriminatory and equalizing the genders, others feel that gender differences are particularly prominent in elderly age especially when talking about the elderly marginalized populations such as the Roma, the elderly with disabilities, elderly members of LGBTI population and HIV positive persons. Hand in hand with longer life expectancy of women and the goes the feminization of poverty associated with inferior status in terms of social, economic and health status. The “privilege” of having long life of elderly women is fully decompensated by the fact that many elderly women carry the weight of “age” associated with negative trends expressed through the adverse health, wealth and social status. In Serbia there are no statistics or records that discuss the gender aspect aging including segregation of data and individual affiliation of particular vulnerable group.

Gender inequality in old age is the result of accumulated disadvantages throughout the life of the individual. The needs of elderly women are not equal to the needs of elderly men. Diversity is especially recognizable in the field of the use of social services, where the social protection system has not been set, nor adapted to consider and take into account gender differences. Gender aspect of aging is visible in the field of health service in the form of non-recognition of the needs of elderly women from marginalized groups.

7. AGEING AND HUMAN RIGHTS

When it comes to human rights of elderly persons, we can state that their rights are often not recognized, and in some cases severely violated, there is age discrimination and prejudice against the elderly and there is a prominent need to speak, write and work more on promotion of rights of this age group. The elderly men and women have the same rights as everyone else, as stipulated in the Universal Declaration of Human Rights from 1948, which is related to all people and all age groups. We are all born with equal rights and this does not change as we age. What changes is the way in which we exercise these rights, which should be understood, but despite the above-mentioned, the rights of the elderly are mostly invisible from the standpoint of the international law (HelpAge International, 2009).

From the standpoint of the international law, there is no adequate protection of the elderly's human rights. Globally speaking, there is no distinction or emphasis on human rights of especially vulnerable groups of the elderly who are mostly incapable of exercising their own rights in comparison with the elderly who belong to the general population.

Most documents and agreements on human rights do not state age as the cause of discrimination or violation of human rights, and they are in most cases included in the term «others» or «other» (Mokhiber, 2011). For example, rights of women, children, disabled persons and other are protected by international conventions and standards, whereas there are no such standards for the elderly, especially bearing in mind their vulnerability when it comes to violation of human rights. Besides that, the elderly are under higher risk from abuse, violence and exclusion and they are often viewed from aspect of mercy and users of services, instead from aspect of development. Many states see ageing as a matter of social and health care, but not as a matter of society's development. This reduces the elderly to users of social care, instead of treating them as equal persons who should enjoy their human rights as everyone else. It should also never be disregarded that this is not a homogenous group and that the elderly within this group differ maybe even more than members of other age groups and they should not be artificially homogenized. The especially vulnerable groups of elderly persons, such as the Roma, members of LGBT population, HIV positive persons, should be particularly considered. Policy creators must not disregard the fact that the elderly are becoming a group with increasing power and a significant segment of electoral body, which means that they can achieve a significant political influence.

The rights of the elderly are, historically observed, at the level of the United Nations, have been largely invisible. Current national standards for rights of the elderly are not equal and they are inconsistent, so only a small number of countries today collect data on violation of the rights of the elderly. Due to the above-mentioned, this problem will remain unresolved as long as there is lack of information about nature, spread and cause of violation of the rights of elderly persons. This is also confirmed by the data from the period from 2000 until 2008, during which the Human Rights Council with the Office of the High Commissioner for Human Rights received reports from 124 countries and found specifically taken measures for decrease of age-based discrimination in only three of them, and only one report pointed out the risk from violence in adult foster care homes (United Nations Department of Economic and Social Affairs Division for Social Policy and Development Programme on Ageing, 2009).

The United Nations began dealing with the phenomenon of ageing in a more severe and systematic manner at the beginning of eighties. So far, several documents which exclusively deal with the elderly have been adopted and these documents also include human rights. Vienna

International Plan of Action on Aging from 1982 was adopted at the first Global Assembly on Ageing and it contains 62 recommendations for governments and civil society for more efficient resolution of problems related to ageing of the population. It was the first important step in turning attention to problems, needs and possibilities of the elderly to contribute to the society they live in. The Plan of Action reminds us that fundamental rights which are guaranteed by the Universal Declaration on Human Rights are inalienable in terms of age and invites to enable rights to family life, safety, health and participation in society to everyone, regardless of their age. The Vienna Plan especially emphasizes the significance of development impact on the elderly population and vice versa and provides a recommendation to develop an international action plan which will guarantee economic and social security of the elderly and give them a chance for better integration in the society and contribution to the development.

The United Nations Principles for Elderly Persons were adopted by Resolution A46/91, and they contain a recommendation to governments to build their national programs intended for the elderly through respect of independence, social participation, social care, self-containment and dignity of elderly persons. Madrid International Plan of Action on Ageing (MIPAA) was enacted in 2002 and it stands for building a society for all ages and also recognizes three priority directions of activity: elderly persons and development, improvement of health and promotion of welfare of elderly persons, as well as provision of encouraging environment. The same year, the United Nations Economic Commission for Europe (UNECE) reached the Regional Strategy for Implementation of the Madrid International Plan of Action on Ageing and this document includes ten obligations of the member states. So far, three regional minister conferences on ageing have been held in Berlin (2002), Leon (2007) and Vienna (2012), and the main conclusions from these conferences are related to inclusion of elderly persons in all areas, activities and policies, adaptation of social and health care system to elderly persons, promotion of positive image of the elderly, decrease of poverty and social inclusion, increase of quality of living and promotion of concept of active ageing and lifetime learning. These documents are important from the standpoint of development of international frameworks and change of opinion from the policy standpoint, they provide specific details and represent guides for creation of public policies. However, these documents have a major flaw – they are not legally obliging for governments around the world, they just represent a moral obligation. Implementation of these “soft laws”, including their financing, is largely dependent from the capacity of individual countries and their political will for implementation. Audit and analysis of implementation of MIPAA showed significant drawbacks because many obligations are accepted only on paper.

All of the above-mentioned three international documents do not provide a definition of an elderly person.

Only some of the United Nations conventions explicitly mention elderly persons in their text: The Convention on Protection of Rights of All Migrant Workers and Their Families mentions age-based discrimination; The Convention on Elimination of All Forms of Discrimination and Violence against Women mentions the right to social security of elderly women; The Conventions on the Rights of Persons with Disabilities mentions the elderly in the context of right to social security and access to health services. These documents represent a sufficient argument for some states that a convention on rights of elderly persons is not necessary and that these documents are sufficient for respecting human rights of elderly persons. They argue that the existing conventions do not cover all aspects of ageing, because reference to ageing in the above-mentioned conventions is insufficient because not all elderly people are migrant workers, women or persons with disabilities. We must point out once again that these documents are important because their enactment has improved the position of the above-mentioned

groups in practice and they also represent a direction in which efforts should be invested in order to improve the position of elderly people (Murphy, 2012).

After identification of the need to pay special attention to this problem, the United Nations General Assembly Resolution 65/182 from December 21, 2010 established Open **Work Group for Ageing**, for the purpose of better recognition and empowerment of struggle for protection of human rights of elderly persons. The basic role of this work group is the examination of the existing international framework of fight for protection of human rights of the elderly, identify their drawbacks and propose a solution for overcoming these drawbacks. For that purpose, it also considers the need to create new instruments for protection of human rights, such as a new convention of the United Nations on rights of elderly persons. The Council for Human Rights also appointed an independent expert for monitoring of reverence of human rights of elderly persons in May 2014. This is an honorary and volunteer position, so the independent expert is not employed by the United Nations, and he expresses his attitudes without bias and representation of his own state, which is especially important.

An important contribution to promotion of protection of the rights of the elderly is provided by the **Global Alliance for the Rights of Elderly Persons** (GAROP), which is comprised of a network with 115 civil society organizations and was created in 2011. The objective of the Alliance, which represents the voice of elderly women and men across the world, is empowerment and promotion of rights of elderly persons and advocacy of a new convention on rights of elderly persons. The Alliance contributes to enhancement of national capacities of civil society organizations through consultative processes and printing of guides and tools for representation at national and international level with the aim of protecting and improving human rights of elderly persons. The Global Alliance supports creation of international and regional instruments for human rights as powerful tools for empowerment of human rights of elderly persons. (GAROP, 2015). At the beginning of 2015, the Global Alliance executed a research named "In Our Own Words" in 50 countries. The objective of this research was that the elderly persons identify problems and solutions for fight against discrimination and violation of human rights of the elderly. The elderly answered the questions about whether they were deprived of some of human rights and, if yes, which rights. Their answers include not following general principles which represent the core of human rights, such as autonomy, respect and dignity, but also deprivation of numerous specific rights which influence different aspects of their lives, starting from the right to work to the right to health. The participants in the research identified principles and human rights which they consider significant and suggested an all-encompassing and systematic approach to better protection and promotion of human rights of elderly persons. The participants pointed out a special risk which exists with elderly people who are functionally dependent and live in institutions and their rights depend from other persons, especially problems of elderly inmates, including their right to appropriate accommodation in jails. The research also confirmed that elderly women are more exposed to risk from violation of human rights. The research pointed out the following principles and human rights of elderly people: fight against discrimination; respect; dignity; autonomy; equality; self-sufficiency and personal development; full and effective participation; social inclusion; intergeneration solidarity; recognition of essential value and value in the capacity of a human being. The answers provided by elderly persons pointed out to experience of multiplied *discrimination which, besides age, includes discrimination based on sex, disability, physical and mental health, economic status, cultural/linguistic diversity and access to technology*. The need to live life with self-sufficiency and personal development until the last day, be full of hope, have future and respond to new challenges and possibilities, pursuant to one's wishes and capacities, has also been identified

in this research. The same goes for the wish for full and efficient participation in all areas of life: public, political, cultural, economic; in development activities; in reaching decisions at the level of household, community and nation; as well as inclusion in recreational activities within family and the community (The Global Alliance for the Rights of Elderly People (GAROP), 2015).

Regional documents which were enacted at the level of the **European Union** also play a major role in protection of human rights of the elderly: the European Convention on Protection of Human Rights and Fundamental Freedoms from 1950, Revised European Social Charter from 1996, Revised Strategy for Social Cohesion from 2004. The preamble of Unique European Act from 1986 and Article 6 of the EU Contract from 1993 formally introduce obligation of the EU to respect the rights established in the European Convention for Protection of Human Rights. The Contract from Amsterdam from 1997 forbids all forms of discrimination, including age, and the Charter on Fundamental Rights in the EU from 2000 includes respect of rights to social insurance and social services which provide protection in case of old age. The Contract from Lisbon from 2007 marks the fight against exclusion and discrimination, promotion of intergeneration solidarity and equality. Anti-discrimination rules of the EU are also contained in several directives that were successively adopted. Progress was certainly made, so the Committee of Ministers adopted Recommendations for Promotion of Human Rights of Elderly Persons on February 19, 2014. The objective of this document is to promote and enable full protection of human rights and fundamental freedoms of the elderly, promote their dignity, autonomy, independence and participation in the society, inform them adequately, provide them with adequate health and social care and possibility of employment, and protect them from violence and abuse. This document names establishment of the position of the Commissioner for Protection of Equality in Serbia as a good example (Council of Europe Committee of Ministers, 2014).

The revised European Social Charter as a regional mechanism for protection of social and economic rights dedicates Article 23 to the right of the elderly to social care and obliges signatory states to take measures for enabling the elderly to have a freedom of choice in terms of lifestyle and possibility to equally participate in social life. The need to create an effective mechanism of the United Nations (UN) for human rights of elderly persons has been recognized by the Human Rights Committee of the United Nations and in the report which the Secretary-General submitted to the General Assembly in 2011.

The Constitution of the Republic of Serbia does not recognize elderly persons as one of social groups. Article 21 guarantees equality of all citizens and forbids discrimination against all bases, including age.

In terms of **Republic of Serbia**, we can single out several significant laws which explicitly mention the elderly. The Constitution of the Republic of Serbia from 2006 forbids all discrimination, including age-based discrimination. The Anti-Discrimination Law from 2009 also forbids age-based discrimination. The Government of the Republic of Serbia adopted the Strategy for Prevention and Protection against Discrimination for the period from 2013 to 2018, as well as the Law on Prevention of Discrimination against Persons with Disabilities. The laws that should secure the right to physical and mental health of the elderly are the following: the Law on Health Care, the Law on Health Insurance, the Law on Public Health, the Law on Patient's Rights and the Law on Protection of Persons with Mental Illness. *The public health strategy of Republic of Serbia has expired, and the necessity and the need to enact a new one is more than obvious.* The Law on Social Care should provide the right of elderly people to have adequate standards of living and social services, and the Law on Retirement and Disability Insurance should provide their social security. The right to dignified life and dignified death should be secured by the

Strategy for Hospice Care which expired in 2015, and the new one has still not been enacted. It is especially troublesome that the strategy was enacted as a response to growing ageing trend in Serbian population and increasing number of persons who suffer from diseases with progressive course (cardiovascular, malign, diabetes, neuromuscular, cerebrovascular), HIV/ AIDS and other diseases. This was especially connected with the epidemics of persons with HIV infection in Serbia and a trend in increase of number of persons living with HIV due to significantly reduced dying rate due to implementation of highly-effective antiretroviral therapy and increase of number of newly-diagnosed persons, which was partly a result of an increased number of persons who have risky behavior and who tested for HIV. At the beginning of 2016, there were 2120 persons in Serbia who were living with HIV, and it is evaluated that additional 1100 persons do not know that they have been infected with HIV, because very third person who is infected with HIV does not know its status.

The right to physical, mental and emotional integrity and dignified action should be provided by the Criminal Law and the Family Law, and the right to education and culture should be provided by the Law on Adult Education from 2013. When it comes to the rights of elderly women, there is the Law on Gender Equality from 2009, and *the following new strategic documents are supposed to be enacted: National Strategy for Improvement of the Position of Women and Promotion of Gender Equality and the National Strategy for Prevention and Suppression of Domestic and Partner Violence against Women, because these documents expired in 2015.*

The National Strategy on Ageing 2006 - 2015 is the first complete all-encompassing document which establishes state policy towards the elderly and creates key directions and field of action in order to improve position of elderly persons in Serbia, pursuant to recommendations from the MIPAA and the Regional strategy for its implementation. *After it was displayed, no steps for enactment of a new document have been taken.* Enactment of new strategic documents that will influence decrease of poverty is particularly important, because the population categories which are the most exposed to risk from poverty in Serbia are the elderly (65+), the Roma and other, among others.

Generally, we can name four types of drawbacks when it comes to protection of human rights of elderly people: normative, because there are no adequate laws that would protect human rights of elderly people; lack of implementation of the existing laws; lack of monitoring of violation of human rights of the elderly (the existing independent bodies do not have adequate capacities or there is a lack of political will for preservation of their independence and execution of enacted decisions), as well as the lack of adequate data classified pursuant to age that would enable precise insight into current situation and enable better insight into consequences of certain measures or policies. Collection and analysis of appropriate statistical data are absolutely necessary in order to monitor progress of society development, including human rights of elderly persons, in the context of UN Sustainable Development Goals after 2015 (SDGs).

The issue of population's ageing represents a challenge to states in terms of execution of multi-sectorial programs, where local self-governments are often placed in the foreground. Successful interventions include a series of partners – the state as the policy creator, institutions, private sector, civil sector, community groups, the media (Age International, 2015). All of the above-mentioned supports the fact that the evidence of discrimination of elderly persons are sufficiently convincing and they obviously require a more efficient manner to guarantee the rights of elderly persons on the one hand, and their implementation on the other hand, which is even more important. (The Global Alliance for the Rights of Elderly People (GAROP), 2015).

What is visible in the legislative framework in term of proclamation, guarantee and protection of human rights of the elderly, and especially the elderly who are members of marginalized groups is the lack of adequate normative and implementation framework, as well as the lack of a system for monitoring and evaluation of the existing legal instruments. As a result, the process of social marginalization of various groups within the population of elderly, turns to be concerning trend.

8. SOCIAL MARGINALIZATION

The phenomenon of social marginalization leaves a lot of marginalized groups out of numerous social systems, even out of health care system. This is a dynamic process in which marginalized persons have little or no control of their lives and available resources. In the process of social marginalization, the members of especially vulnerable population in which low social-economic status drastically affects their health status are particularly harmed. Living on the margin, poverty and disease occur jointly in this group. Social marginalization is sometimes forcedly “acquired” – by birth, as is the case with ethnic disqualification of the Roma population in this region, but it starting to be very affecting for old age groups within marginalized groups. Progressive dynamics of this process most severely affects elderly members of the Roma population, LGBT population and members of the elderly HIV positive population. Social and systematic unawareness, together with “selective approach to protection of human rights” shows that elderly members of vulnerable population are not recognized as a specific, multiply discriminated social group.

The dominant problems of the elderly in Serbia expressed through poverty and social exclusion, and often disregard and violation of human rights, which is manifested through exposure to discrimination, violence and abuse of elderly persons particularly visible among members of marginalized social groups, such as the elderly Roma ethnicity, elderly people living with HIV, elderly members of the LGBT population, elderly people living with disabilities, directly implying deterioration of general position and the lack of minimum standards that ensure a satisfactory quality of life.

However, the issue of human rights of elderly persons in Serbia are not recognized as matters of importance. There is neither a social nor institutional “awareness” of the existence of a very heterogeneous group within the category of elderly persons. Marginalized elderly people are not only systemic and socially isolated but can be subsumed under almost “invisible population groups”. Although possibly there is an awareness on the fact that in the population of elderly people, there are people whose marginalization and stigmatization aggravates otherwise already disadvantaged position of the elderly population in Serbia there is no segment of social, economic, social, health and political system, which in a comprehensive manner enables the use of legally guaranteed rights for all citizens.

Another indicator of its invisibility can be seen in lack of studies, reports, records or other relevant documents from which the quality of life of “the elderly on mainstream of society” can be determined. As a matter of fact, majority of parameters, indicators, methodologies and general established and accepted methods of quantitative and qualitative measurement of certain facts, phenomena and “experiences and practices,” of environment in which elderly people live in Serbia are made and are based on lifetime “ordinary” elderly man with periodic special emphasis on vulnerable groups of the elderly population. However, usually it not explicitly citing HIV status, sexual orientation or belonging to the Roma national minority as a crucial determinant of the impact to the general life process of the individual in the community and society. Human rights of elderly population and quality of life are usually observed through the lance of demographic aspect of aging as significant phenomenon, followed by social-economic and health characteristics of this large part of the population as well as through the national and international legal framework which at least on declarative level proclaims, guarantees and protects the rights of elderly population.

Discrimination as common experience

Respondents from all groups (LGBT, HIV positive and Roma) have the experience/feeling of being discriminated. Although they are aware of policies who guarantee the equal rights, they reported about various kind of violation which they witness on various levels – facing problems in accessibility and quality of public services, or in lack of social acceptance.

According to them, in the root of all problems they are facing with are strong stigma and prejudice of general population based on ignorance and intolerance, present in the society. While this is a common experience of all three groups, the manifestation of the problems and the level of accessibility of the services are differ.

Namely, Roma and HIV positive respondents reported about different experience which could be perceived as unequal treatment within the health care system. Both groups stated that majority of the problems lay in a fact that some of the medical stuff – doctors, nurses, behave very discriminatory towards these groups, treating them with disrespect – in case of Roma people, or with unreasonable fear-HIV positive. Very similar dynamics can be perceived in general population – high level of aggression and intolerance towards Roma and LGBT is present as well as unrealizable fear of transition of disease, in case of HIV positive. In order to avoid unnecessary inconvenience, LGBT and HIV positive persons choose to hide their orientation/status perceiving it as “personal right”, an intimate choice or personal characteristics which should be communicate with others as long as the person is responsible in her/his behavior.

9. ELDERLY IN HEALTH CARE SYSTEM

Institute of Public Health of Serbia "Dr Milan Jovanović Batut" performed the third national research of population's health in 2013 and the named research contains data about health status, use of health care and use of medicaments. According to the research which also includes information about health status of elderly people, 22,4% of the elderly in Serbia evaluated their health as very good and good, and 40,2% as bad or very bad. The largest number of persons who evaluated their health as bad or very bad are persons with the lowest degree of education and belong to the poorest category of population. As for the frequency of chronic non-communicable diseases in this population, the data is as follows: 65,6% of the elderly suffer from hypertension, 22% have high lipid levels in blood, 17,8% suffer from diabetes, 10,8% of the elderly show symptoms of depression, 8,4% suffer from chronic respiratory disease and 6,8% suffer from asthma. Three quarters of elder population, 75,8%, stated that they suffer from a long-term disease or a health problem. 33,6% experience severe problems in performing everyday chores, and 11,1% have problems with performing personal hygienic activities.

During the last years, frequent topic, besides ageing of population, is the "epidemiological transition" which is related to change in the structure of major causes of disease and death that included a range from decrease in acute communicable diseases to increase of chronic non-communicable diseases (cardiovascular diseases, various type of cancer, injuries) and degenerative diseases. Today, chronic non-communicable diseases represent the biggest encumbrance for global health, and the adults and the elderly are under much higher risk from these diseases in comparison with younger persons and such diseases result in poorer quality of life and increased costs of health care and long-term care. Namely, elderly persons most frequently suffer from heart and blood vessel disorders, cancer and diabetes and often suffer from several health conditions at the same time (Omran, 2005).

Primary health care is the protection that meets the basic needs of each community, through the established system of providing health services. When assessing the needs of elderly people in primary care, in order to provide a satisfactory quality of life it is necessary to take into account the inclusion of all categories of elderly people including elderly population that is socially in isolation and who live on the margins of society.

Although primary health care is legally available to all categories of the population, lack of information and inaccessibility of health care services is undeniably evident when it comes to the elderly population from marginalized groups. At the national level there is no comprehensive assessment of overall health needs of the elderly population including members of particularly vulnerable category, and there is a tendency for certain categories of the population when health status is determined as particularly vulnerable (people living with HIV / AIDS) were detected as high - percentage present in society to displaying their social and health problem has become more visible and higher priority in the field of planning more efficient health care system.

Health status of HIV positive

Life expectancy. A 25 year old HIV-infected person currently has an 80% chance of reaching the age of 50; before 1996 this was no more than 5%. Research in the Netherlands has shown that the survival rate in patients successfully treated with combination therapy is comparable

to that in patients with diabetes (van Sighem et al. 2005). Yet the life expectancy of hiv-infected patients is still lower than that of non-hiv-infected individuals. A large international cohort collaboration has shown that people who start combination therapy at the age of 20 have an average life expectancy of 69 years (The Antiretroviral Therapy Cohort Collaboration 2008). In comparison, the average life expectancy of a non-hiv-infected 20-year-old male is 78 years.

Age and HIV Diagnosis. A second cause of aging of the hiv population is the higher age at hiv diagnosis. The average age of individuals diagnosed in 1996 was 37 years compared to 39 years in 2008. Homosexual men are not only diagnosed at an elderly age, but are also elderly at the time of infection. Yet the moment of start of treatment is still late for a large number of patients.

Effects of HAART. Treatment with HAART, may cause changes in fat distribution (lipodystrophy) in both sexes which in many cases leads to negative changes in body image and self esteem that can contribute to sexual problems due to a feeling of diminished attractiveness [Guaraldi et al. 2007; Luzi et al. 2009; Corless et al. 2004].

Health status of LGBT

While solid public health data on elderly LGBT populations is quite limited, a number of health issues have been identified as areas in which LGBT individuals exhibit distinctive patterns of need. These issues include HIV/AIDS, other sexually transmitted diseases (STDs), breast cancer, substance abuse, mental health, hate violence and elder abuse, and (for many transgendered individuals) the long-term health impact of hormone replacement therapy.

10. THE ELDERLY AND THE RIGHT TO HEALTH CARE

The right to health care is guaranteed by the Constitution of the Republic of Serbia which stipulates the following: “**Everyone** is entitled to protection of physical and mental health.” Health care is provided **for everyone** under equal conditions, and especially for the citizens who are exposed to increased risk from diseases, who include the citizens who are elderly than 65 years.

Health care includes implementation of measures for citizen health preservation and promotion, prevention, suppression and early discovery of identification of diseases, injuries and other health disorders and timely treatment and rehabilitation. Persons who are covered by obligatory health insurance exercise the right to health care on the above-mentioned basis. **When it comes to the elderly (persons older than 65 years)**, the persons who are covered by health insurance are retired persons, persons who are insured through a family member, as well as the users of social protection, i.e. permanent financial social assistance. In case that they are not entitled to any of the above-mentioned bases for insurance, they have the right to free health care (from budget funds), because they belong to the population group which is exposed to increased risk from disease. In that case, they need to visit the branch office, subsidiary or service of the Health Insurance Fund in the territory of their municipality, take their ID cards with them and ask for issuance of health insurance card.

The right to obligatory health care based on obligatory insurance includes preventive measures and measures for early identification of disease; examination and treatment of women related to family planning, as well as during pregnancy, childbirth and maternity up to 12 months after birth giving; examinations and treatment in case of disease and injury; examination and treatment of mouth and teeth diseases; medical rehabilitation in case of a disease or injury; medicaments and medical assets; prosthesis, arthrosis and other support devices (hereinafter: medical-technical support devices). Diseased, i.e. injured elderly person is also approved patient transport vehicle in cases when it is justifiable and medically necessary. The elderly are also approved emergency dentist health care, as well as creation of total acrylate prosthesis and subtotal prosthesis for 5 years, i.e. prosthesis repair, as needed – after the guarantee period of 40 months has expired.

The users who use health care based on obligatory health insurance shall pay participation fee for examinations, diagnostic procedures, treatment and rehabilitation in the prescribed amounts which are audited each year. Medicament participation fee has been established in the Medicament list with the possibility of exemption of certain categories of the elderly which also include persons who are elderly than 65 years and who have acquired the right to health care based on their age (they do not have another insurance basis).

Health care is provided by health institutions, namely: health centers, their clinics and health stations; pharmacies; general and special hospitals; institutes for public health; clinics and institutes; clinical-hospital and clinical centers. Provision of health care is based on the following principles: physical, geographical and economic *availability* to all citizens of Republic of Serbia; *principle of equity* – discrimination against all bases is strictly forbidden, including age; and *the principle of highest level of health care with the lowest consumption of funds*, i.e. provision of services should achieve the best possible results in relation to the available financial funds.

For the purpose of protection of rights, the Law on Patient Rights was adopted in 2013 in the

area of health care. Pursuant to the Law, rights and obligations of the patients on the occasion of use of health care services have been identified, as well as manner of exercise and protection of the subject rights. The following rights are particularly important for exercise of protection of rights of the elderly: **right to information** – the patient is entitled to all types of information about his/her health status, health service and how he/she can use it, as well as the information about rights from health insurance and procedures for exercise of the subject rights (the information are provided to him/her by the competent health worker); **right to appropriate health services for preservation and promotion of health, prevention, suppression and early identification of diseases and other health disorders** (preventive measures); **right to timely and high-quality health service**, pursuant to the health status and established professional standards (it also implies humane relationship with the patient); **right to notification**, which implies doctor's obligation to inform the patient in an understandable manner about all details which will help him/her to reach a decision about whether he/she wants to continue the treatment or not (information about diagnosis and prognosis of the disease; description, goal and benefit from the proposed manner of treatment; type and probability of potential risks; alternate methods of treatment and action of medicaments); **right to freely choose a doctor**, medical doctor (selected doctor); i.e. dental practitioner (dentist), as well as free choice of the proposed medical measures; **right to privacy and confidentiality of data**, i.e. the examination and execution of treatment measures can be attended only by health workers and associates who directly participate in the above-mentioned, and, if the patient has given his/her consent – other persons may attend as well, and all personal information communicated to the competent health worker by the patient shall be confidential; **right to consent to, i.e. refuse treatment** which provides free, independent decision-making about everything related to the patient's life and health (even in case that the patient endangers his or her life and health through such decision, but only if that does not endanger other people; however, the doctor shall point out the consequences of such decision to the patient); **right to provision of emergency medical assistance** (and obligation of a health institution to provide such assistance to the patient); **right to the highest level of easement of suffering and pain**, which includes therapy against pain and humane hospice care; **right to immediate acceptance of patients in a health institute for the purpose of performing specialist-consultative examination** (and no later than 30 days), in case that a specialist examination is not on the waiting list – if opposite, the health worker is obliged to write the reasons because of which the patient was not admitted on the referral letter and certify it with a stamp, because a patient can be examined in a private practice or an additional institution with which a contract has been signed if he/she possesses such document, and the patient can refund costs of private examination in registration branch office with a referral letter, receipt, finding, photocopy of health insurance card and a filled in request.

The above-mentioned rights are also accompanied by obligations of each patient, primarily towards himself/herself, but also towards other people. Some of the obligations that are important for life of the elderly are as follows: provision of full and accurate information about his/her health status and following instructions obtained from the doctor regarding application of prescribed therapy and other advice about the patient's life activities and habits.

In case that the patient thinks that he has been deprived of some right in the area of health care or he/she is not satisfied with the manner in which his/her right was exercised, there is a possibility to lodge an appeal /objection to the person managing the work process, director of a health institution or advisor for protection of patient rights (protector of patient's rights) who is provided by the unit of local self-government, and the health institution shall display

the name and surname, working hours, address and telephone number of the protector of patient's rights in a visible place. If the patient is not satisfied with the work of the protector of patient's rights, he/she may contact Health Council (comprised of representatives of the local self-government, citizen association of patients, health institutes in the territory of the local self-government and the competent branch office of the Republic Health Insurance Fund), health inspection, i.e. the competent body of health insurance organization with which he/she has health insurance.

The regulations of Republic of Serbia in the area of health care classify persons who belong to the Roma ethnic group in particularly vulnerable population group and they have been singled out as a special category of insured persons. Despite the above-mentioned, a large number of elderly members of the Roma ethnic group face problems in their attempts to exercise the right to health insurance, as well as the right to use services in health institutions. The problems related to impossibility to obtain health services are numerous: discrimination performed by health institutions, i.e. employees in the health institutions, abusive language on national basis, impossibility to obtain the documents which are necessary for applying for health insurance and other.

Health care for elderly persons who have HIV also represents a significant challenge. There is a high level of stigmatization in society in relation to the persons from marginalized groups. There is no official statistics about number, sex and quality of life of the elderly who have HIV. The existing health care system does not provide adequate and complete health care to persons who live with HIV, which drastically reflects on their quality of living. Generally, health care for persons living with HIV is executed within a functionally centralized system which is focused on clinical practice and hospital care with use of insufficiently accessible antiretroviral therapy.

The international recommendations related to HIV/AIDS and human rights state that the states are obliged to change and reform the part of their legislation which deals with health care of persons living with HIV.

The objective of these recommendations is to enable resolution of issues related to HIV, as well as to secure that the provisions related to communicable diseases are not wrongly applied in case of HIV. The legislation that deals with health care should make it possible for health authorities to provide a wide range of services in terms of prevention and treatment of HIV/AIDS, including provision of necessary information and education, access to voluntary testing, condoms, addiction treatment and other.

The Law on Health Care and the Law on Health Insurance regulate health care for all citizens of Republic of Serbia, as well as other persons with residence or address in its territory. Increased social care is expressed through provision of health care to population groups which are exposed to higher risk from diseases, in sense of prevention, suppression, early discovery and treatment of diseases which have a more significant social-medical importance (to which HIV infection also belongs). Persons who are treated from HIV infection and other communicable diseases belong to a specially protected group of insured persons and have guaranteed health insurance and in case of debts based on contributions for health insurance. The costs of health care for obligatorily insured persons are covered from funds for obligatory health insurance, and for those persons who do not have obligatory health insurance these costs are covered from the budget of Republic of Serbia.

The next important law related to HIV is the Law on Protection of Population from contagious diseases. Pursuant to provisions of this Law, treatment of persons infected with HIV is perfor-

med in special health institutions for hospital treatment of persons who suffer from contagious diseases. The Law does not stipulate special isolation and quarantine measures for patients who have HIV. However, realization of health care in stationary health institutions for specialized rehabilitation (spas, rehabilitation centers) is difficult in practice for persons who live with HIV, because it is conditioned by tests for contagious diseases.

Treatment with combined antiretroviral therapy requires use of several groups of medicaments and frequent change of their combination, due to resistance or non-acceptance. As opposed to the EU countries, there is a limited number of such combinations in Serbia, so there is need for treatment abroad. The patient's position is also affected by regulations on import of drug, as well as general customs regulations which do not recognize specific provisions that would take care of persons infected with HIV. Besides the rights related to achievement of health care, persons who live with HIV also have certain obligations as the contagious disease carriers. Pursuant to the Law on Protection of Population from Contagious Diseases, infection carriers are obliged to follow doctor's orders, especially in terms of disease spread. Doctor's advice, especially advice related to further spread of disease (for example obligatory use of condoms) represents obligation of the patient. Pursuant to the Law on Health Protection, all patients, including persons with HIV, are obliged to follow general acts of health institutions about conditions related to stay and behavior in the relevant institution. On the occasion of exercising health care in a health institution or a private practice, the patient shall actively participate in preservation and promotion of his/her own health, fully inform the competent health worker about his/her health status and follow the instructions and measures of the prescribed therapy. If he/she wishes, the patient may stop the treatment, but he is obliged to give a written statement about the above-mentioned.

The exact data about the number of elderly persons living with HIV is not known, since the number of HIV positive persons is apparently larger than the number of tested persons.

Achieving satisfactory quality of living for elderly persons who have HIV will definitely represent a challenge, due to inadequate "social" treatment of this vulnerable group. The cases of the elderly HIV positive persons who are subject to multiple discrimination and their quality of living are difficult to measure in a systematic manner if we bear in mind the inadequate "social" treatment expressed through non-recognition and invisibility of this category of population which is frequently left out of the system in its state of social marginalization.

Health as most concern issue of elderly people

The health status turns to be the far most important topic for all respondents. Undoubtedly, all respondents perceive health as main determinant of level of independence and in line with it the general quality of life. Namely, their introductions are starting with their reports about personal health status, and continuing through discussion, majority of them relate any topic with prediction of their future health condition. It has been seen as the main factor that color and define what will be the future life, how independent they will be.

Health status is the critical especially for HIV positive and Roma population who face more challenges than an ordinary elderly person. Still, there are differences in the nature of the problems they are facing when they enter the health care system.

For Roma people the major concern is accessibility to health care system. Namely, there is still an open issue whether persons have obtained necessary documents in order to be able to use services covered by Health Care Fund. Even though when they have all papers, there is an issue of limitation of services which can be obtained for free. For instance, majority of the respondents reported that more often it is necessary to seek health assistance outside of Obrenovac, which immediately means that they need an additional financial means to be able to go and use services. Very often they are in situation to be sent to private hospitals/ centers in order to do necessary examination in diagnostics purposes, or to wait for months in line. For majority of them it is financially unattainable, which make them feel powerless and scared. Moreover, they reported that even when they manage to get necessary health assistant, some of the medicals which are used in everyday practice – i. e. pain killers, antipyretics, are too expensive for them. In addition, as we have already mentioned above, they feel that when they are in the system, they are not treated fairly and with respect. All of these aspects makes the feel discriminated and with less opportunities then general population.

For HIV positive persons has more specific position then other groups due to their medical status. Therefore, their position within the system and needs require multi -sectorial approach. They demonstrate significant level of knowledge of health care system, rights and their own health position. Namely, what they recognized as most urgent issue which can systematically improve their position is necessity to change the recognition of HIV positive status as infective illnesses to chronic condition/disease. That way many of the service, not only in health care system then social services as well, will be more accessible. By that they specifically recognized services such as using SPA and rehabilitation programs, etc. When it comes to the specificity of their own treatments, they report on lack of tests which will enable doctors to improve treatments by selecting new combination of drugs more effective and appropriate not only in relation to HIV then to be in line with other health treatments related to preservation of general health condition. They recognize lack of multi – disciplinary approach in treating HIV positive persons and report on lack of education of other doctors about HIV infection.

LGBT persons do not have specifically different position than any other elderly person, since their health issues are not necessarily related to sexual orientation and therefore there is no need to be shared with medical staff.

11. THE ELDERLY AND SOCIAL CARE SERVICES IN GENERAL

In terms of needs of the elderly related to rights, measures and social care services, we need to have in mind the combination of universal and specific characteristics of ageing. All people age and it is a universal characteristic, but each person ages authentically in his/her own specific manner under specific living conditions. Ageing is not a single, homogenous phenomenon, it includes a set of different individual characteristics. Specific characteristics of ageing are especially visible in marginalized members of the elderly population, and especially if the marginalization is joined by HIV status, LGBT status or membership in the Roma minority. The position of marginalized categories of the elderly population is significantly different from the position of the elderly who come from the general population, which is also reflected on approach and use of social care services. Generally, the need of the elderly to use social care services is much more frequent than with the average population because they often do not have income or have small income, frequently live in single elderly households or elderly households and due to health problems, often encounter problems in performing everyday chores in the area of self-care. In terms of members of marginalized categories of the elderly population, the negative effects of social exclusion are even more emphasized when it comes to approach to social care service.

The elderly users of social care are, pursuant to records of Social Care Center in Serbia until April 2011, were defined pursuant to the criteria from the Law on Retirement and Disability Insurance, i.e. pursuant to the age which is defined by the Law as one of the criteria for retirement of women and men. The social care records showed that the elderly users were women aged 60 or above and men aged 65 or above. Obtainment of the status of elderly persons automatically meant change of their work capacity, i.e. they obtained status of persons incapable of work. The new Law on Social Care from 2011 cancelled this difference which was based on gender. Pursuant to the above-mentioned, according to the new Law on Social Care, potential users of social care are defined as the elderly who ask for "social help and support with the aim of securing existential minimum and/or support to social inclusion".

Article 41 of the Law on Social Care defines elderly users of social care as the persons of age who are elderly than 65 years and endangered by risks due to old age, disability, disease, family and other life circumstances, and especially if they have bodily, intellectual, sensor or mental problems or problems in communication, as follows:

- if there is danger that they will become victims or if they are victims of self-neglect, neglect, abuse, exploitation and domestic violence, addiction from alcohol, drugs and other addictive substances or due to other forms of socially unacceptable behavior
- if they encounter problems due to disturbed family relationships
- if they are victims of human trafficking, foreign citizens or persons without citizenship who need social care
- if they have any other needs for social care.

The Law on Social Care defines user groups pursuant to characteristics of users which are relevant for use of social care services. Such characteristics, pursuant to the Law, do not include HIV status, membership in the Roma minority or sexual orientation. In sense of this Law, there is no clear statement of individual categories of population who exercise rights in the area of

social care. This, however, does not mean that members of marginalized groups cannot exercise social care rights. These categories can also use social care if they fulfill any of the conditions prescribed by the Law.

In 2011, the data about gender of all elderly users of social care have been collected for the first time pursuant to the Law on Gender Equality. According to the records, it has been established that with the increase of age in users of social care, the number, i.e. share of women who are elderly users of social care also increases. At the Social Care Center, the women comprised 2/3 of elderly users or 63%. Researches show that elderly women, as opposed to elderly men, are in a more severe material position and have more health problems.

More than half of the registered elderly users of Social Care Center or 54,44% did not enter composition of any of the offered user groups defined in the Law on Social Care. All of them were classified into group "Others". Elderly persons who use social care rights and services are classified in this group as the response to their specific needs related to old age. There is no available information that persons with HIV status are also classified in this group of the elderly.

Most capacities of social care system are engaged in function of exercise of rights, such as addition for custodial care and provision of services such as accommodation in adult foster care home, house assistance service, day-care centers, protected housing and other.

The Law on Social Care also mentions especially vulnerable user groups which are derived from legal provisions. Especially vulnerable user groups that can include the elderly have been defined pursuant to the Law on Social Care. Some vulnerable groups are also user groups. Vulnerable groups are the following:

1. persons who live in socially and materially vulnerable families
2. disabled persons
3. persons who are victims of violence and human trafficking
4. persons who come from families with disturbed relationships
5. members of the Roma community
6. homeless persons
7. others

Elderly users use social care services in three priority areas:

1. poverty and social exclusion
2. disease and disability
3. violence and discrimination

The most difficult problem which is the reason why the elderly content Centers for Social Work is related to lack of material funds. Elderly women are more often than men encumbered with various types of deprivation. Members of the Roma population are frequent users of material funds at the Centers for Social Work, but there is no data about the percentage of the elderly who use the right to material financial assistance.

Disability, together with ageing, represents one of major challenges as it accompanies ageing in poverty.

The social care system does not have available data on percentage in which multiply vulnerable representatives of the elderly population use social care services. Social care system does not show relevant sensitivity to various user problems.

Existence of a diagnosed disease in old age is also one of the challenges in terms of exercise of the right to social care, especially when it comes to marginalized members of the elderly, such as HIV positive persons.

Flat monetary assistance provided by local self-government is also one of frequently used social care services which is, in comparison with the other user age groups, very often used by the elderly population, which supports the fact that a large number of elderly population, including the elderly who belong to marginalized groups, lives near poverty threshold in Serbia.

Disabled persons represent one of especially vulnerable groups that mostly includes elderly persons and twice the number of women in comparison with men.

The elderly are often exposed to violence and discrimination. These are the main five categories of violence over the elderly that are the most talked about categories:

1. physical violence
2. mental violence
3. abuse
4. economic negligence
5. sexual violence (harassment or abuse of an elderly person)

“Ageism” or discrimination based on age is a widely spread phenomenon that especially affects the elderly who belong to marginalized categories. Although the discrimination of marginalized population is omnipresent, there are no adequate and efficient social and legal measures for systematic suppression of discrimination that would significantly affect the increase of quality of living of the elderly marginalized population.

Specific social services intended for the vulnerable elderly population

According to the report of the Republic Bureau of Statistics, in the period of 2011-2014. 99.913 elderly people in Serbia used the services of social protection. There are statistics in relation to the gender (categorization of women / men), but no statistics based on other parameters such as HIV status or belonging to the Roma population.

The term “long term care” as the concept of the provision of services to the elderly as well as people who need daily support for a longer period is a novelty in our system of social protection. House assistance (care) services and day-care centers are two services which are most relevant for long-term care of the elderly in Serbia.

This type of support includes:

- Help in performing basic daily activities
- Help with housework, cooking, shopping etc.
- Nursing and palliative care

In Serbia, elderly persons traditionally rely on family assistance and support, but that assistance can often be absent, therefore it is necessary to include institutional system for Long-term care.

In Serbia, there are elements of the national system of long-term care, in the form of cash and non-financial benefits that are provided through institutional services and accommodation services in the community. The cash benefits are in the mandate of the Republic Government and funded from the national budget and the Fund for Pension and Disability Insurance. The service of institutional accommodation is also in the mandate of the Government, while the community services are provided by local governments. Long-term care health services are financed by the Health Insurance Fund.

In Serbia, the right to assistance and care of another person as a cash benefit, realized in the framework of the system of pension and disability insurance and social protection system. This service is exclusively determined by condition of the beneficiary in both systems. Addition for assistance and care of another person and increased addition for assistance and care of another person are regulated by the Law on Social Protection and funded from the national budget. This right can be exercised by the person who is in need of necessary assistance and care of another person to satisfy their basic needs due to physical or sensory impairment, intellectual disability, or changes in health needs.

The house assistance service has been recognized as one of the key daily services for the elderly persons. The purpose of this service is support in meeting the everyday needs of beneficiaries in their own homes, with the aim of retention of beneficiaries in its natural environment and prevention of accommodation of beneficiaries in institutions. This service is available when family support is insufficient or unavailable in accordance with established individual characteristics of the beneficiaries. This service is available to elderly people irrespective of financial status, or financial status is taken as a criterion of which may depend financial participation of beneficiaries.

Daily-care centers for elderly (and adults) is a service that aims to contribute to the care and social inclusion of elderly people who are in status of highly dependence from support and help. This service in our system of social protection is primarily created to support elderly people with disabilities, then developed in the sphere of support for children, and only in recent times as a service for the elderly.

Clubs for the elderly people aim to prevent social exclusion of elderly people and to develop their capacities in order to prevent dependence on institutional forms of care. Clubs for the elderly function on the principle of visiting the clubs by beneficiaries, according to their own time and interests, where they are encouraged to get involved in various activities within the club. In Serbia, there are a lot of clubs for the elderly.

The least used services for elderly people are accommodation in shelters and reception station, as well as hangout for adults and elderly people due to the fact that they are primarily developed for children and young people.

Assistance services, clubs for the elderly and daily-care centers are provided primary within the gerontology centers, social work centers and non-governmental organizations.

Business Unit Day-care centers and clubs provide only home assistance services and clubs for the elderly. This unit is part of the Gerontology Center of City of Belgrade and is financed from the budget of the City of Belgrade. Law on Social Protection widely define target groups that

are intended to house assistance services and daily care services. The right to house assistance service have elderly, chronically ill and other persons who are unable to take care of themselves. One of the criteria for entitlement to home assistance service is whether a person has or does not have relatives who are able to help him. About this service in the first instance decide the Center for Social Work.

Institute for Gerontology and Palliative Care, Belgrade is a specialized medical institution referent for extra-institutional (community based) health care of the elderly. The Institute is conceived as a health care establishment for the older adults and implementation of measures for health improvement and prevention of diseases characteristic for this population, including home treatment and nursing, palliative care and rehabilitation of the old people (Law on Health Care of the Republic of Serbia, Article 106). The Institute performs its activities in accordance with the legislation and the National Strategy on Aging, as well as with all other relevant internationally accepted principles and strategies in care of the older adults.

Social services of home care and help include only social services or medical and social services. In the first case, it is called home help service, and in other, if it includes medical care too, it is called home care and help. On the territory of Belgrade, home help includes seven groups of services:

1. The help in food provision
2. The help in maintaining personal hygiene
3. The help in cleaning clothes and bed sheets
4. The help in heating rooms
5. The help in maintaining apartment hygiene
6. The help in fulfillment of the basic human needs
7. The help in ensuring the services (repairs, installations, etc.)

On the territory of Belgrade, in age structure of beneficiaries of these services, most of them are persons older than 70 years (80%). 78% of them are women, mostly with pension gained on various basis (disability, family pension, etc.).

On the basis of the Decision on the Rights from Social Protection of the City of Belgrade, day care is provided in clubs and day care centers for adult and elderly persons. In clubs, day care is provided 12 hours every day except on Sunday. Stay in day care centers can lasts 10 hours per day, except on Sunday.

The Rules of Procedure of the Business Unit Day Care Centers and Clubs for Elderly determined people older than 55 years as the target group for the club services.

By the Law on Social Protection, clubs for elderly and adult persons are intended for socializing, social integration and rehabilitation, development of solidarity or self-help, cultural-entertaining, recreational, spiritual and other needs. Legislator leaves the possibility of other services provision by the clubs (food, bath, laundry and ironing), in accordance with the capacities and identified needs.

The National Strategy on Ageing 2006-2015 as the first strategic document in which the ageing is recognized as a phenomenon of importance to the entire social development in all aspects and through all the sectorial policies of the Government as a relevant factor for future activi-

ties, has expired in 2015. The same situation is with the National Strategy for the fight against HIV/AIDS. New strategies are still not created and adopted, even though there is a need for engagement of society in work on improvement of the quality of life of elderly people, including elderly people from marginalized groups.

Dependence on others as a destiny

The lack of personal capabilities and strength to take care of itself is unquestionably the future for the majority of respondents. This makes them unsecure and frighten. There is a limited support around them due to isolation from/ lost of family members and poor social life. Therefore, social services can be the crucial support for those people in coming days. However, the respondents show low level of recognition of social services as well as benefits that those services can provide for them.

There is a difference in level of knowledge of services depending on different group of respondents. For instance, the Roma respondents recognize mostly financial measures as important and those perceived as inaccessible to reach. Other services such as daily support (help with housework, cooking, etc.) including gerontology home assistance or daycare centers, they have recognize very general – reporting of hearing of some of them. There is clear message that they are motivated and highly evaluated only financial support. There is an impression that there is a hesitation to take other services unless it is inevitable. The same is with services aimed at supporting socializing – Clubs for elderly. Although, especially old Roma women, reporting of being lonely and isolating, they refuse to think that those programs that are offered within the Clubs have some benefits for them. It is not surprising findings, having in mind their very difficult and challenging financial status. Their major attention is on issue how to get additional income, for essential needs (food, life expenses, and medicaments and treatments). Testing different options, it seems that a combination of the programs which connect socializing and work as an opportunity to get smaller allowance could make difference for them.

On the other hand, LGBT/HIV positive shows significant higher level of knowledge of available social services and more motivation to use it. Apart from needed financial measures, they do recognize a scale of different social services such as help in households, gerontology and nursery support services, day – care centers, etc. It is acceptable for them to be the beneficiary of those services. However, they report that there is a limitation to use some of them due to their health status. For instance the Residential accommodation for elderly is not available for HIV positive persons, since this is recognized as infective disease (as in the case of using SPA and rehabilitation programs). They find themselves limited as well in situations when they become users of pensions based on disability, since they are not allowed to work anymore. It is important to recognize that their health status makes them incapable to work solely from time to time, and therefore it would be very important to enable freezing the status of invalid pensioner and to continue working when their condition allowed.

They highly evaluated social services provided by various service providers – public, OCD, business initiatives, that provide space and support for socialization. Programs of non – formal education, support groups, psycho – social counseling, socializing, etc., are highly evaluated based on experiences. They do recognize importance and benefits of Clubs for elderly, showing readiness to join the Clubs. However, they would do so if their sexual orientation and health status remains unknown. Necessity to increase the number of services and its availabilities for the community is highly recommended.

12. INSTEAD OF A CONCLUSION

Reverence of all human rights, including the right to health care of the elderly, represents a benefit to the society as a whole. Special attention must be paid to protection of multiply endangered population categories, such as elderly women, persons with disabilities, the Roma, members of LGBT population, persons living with HIV/AIDS, members of population with different sexual orientation, the poor, rural population. The report clearly indicate that these persons often encounter multiple discrimination, especially in the area of health care. As well as that multiple discrimination exists in cases when a person is discriminated based on several personal characteristics, for example a woman with disability may be discriminated based on gender, different sexual orientation and disability. This issue receives insufficient attention in Europe, as well as in Serbia.

Maltreatment of elderly persons, and especially those who are discriminated on multiple bases, leads to abuse and violation of their human rights, exclusion from the society, poverty, discrimination and violence against elderly persons. By understanding the severity of this global problem and the effects it could cause to our communities, societies and economies, they need to be enabled to have the right to safety, social care and health, freedom from discrimination and violence, as the most severe form of discriminatory action, the right to work and lifetime learning, personal property and inheritance right. Better protection of rights of the elderly enables the society to use the potential these persons have in a better manner by using their experience, knowledge and wisdom, and its general progress.

Therefore, the report, based on desk analyses and qualitative research offered several key recommendations and based on that, interventions:

- **There is necessity to recognize sub – groups within the general population of elderly who are more vulnerable than others from perspective of poverty and human rights violation.**

As report show, the special attention should be given to LGBT/HIV positive and Roma elderly, which special position, needs and limitation have to be taken in consideration within public policies, such as National strategy for Elderly, but also in other policies within health care and social welfare system. The inter – sectorial approach in dealing with these particular vulnerable population is crucial assumption that lead to success of improving the quality of life of those groups.

Therefore, it is necessary to build network among those stakeholders who recognize necessity in improving position of LGBT/HIV positive and Roma elderly and creating wide national campaign aimed at making those groups visible to the public audience. It is of crucial importance to educate and make general population more aware of the particular problems and obstacles this people face with in everyday life. This wide national campaign could have multi benefits in fighting prejudice and promoting tolerance and openness of the population towards those groups. The campaign should also serve as support for advocacy activities aimed at making those groups visible in inter – sectorial public policies. Main aim of advocacy intervention should be recognition in National Strategy for Elderly, which would lead to creation of particular services and support programs directed not only to members of these groups then to building capacities of public servants within different sectors (sector of health, social welfare, local self – governments, etc.).

- **It is of crucial importance to get familiar with actual position of those groups, their specific needs and other relevant factors which should have in mind while developing policies and interventions.**

This report undoubtedly shows a lack of data and knowledge on the position of LGBT/HIV positive and Roma elderly persons. There is a lack of research as well as a lack of really understanding what are the position and perception of the quality of life and what it means improving it. The small scale qualitative research clearly indicates that those groups offer important information that is essential for the development of any intervention, especially for the development of the policies. It is of great importance to develop research based on similar international research initiatives conducted with an aim to understand what are the right approaches in terms of developing policies and/ or interventions. Creation of an inter – sectorial research team which consists of experts from various fields – health care and welfare system, etc. is necessary and crucial in order to enable applicable findings, guidelines and recommendations for any of the planned interventions.

- **It is important to be proactive in terms of developing, piloting and testing various services so as to be able to develop most effective support to LGBT/HIV positive and Roma elderly people and sustainable from an economical perspective.**

It is of extreme importance to contribute to the policy development by developing, adapting, testing services aimed at improving the quality of life of those particular vulnerable groups, which could be introduced and incorporated in policy documents as a model of best practices. Therefore, it is important to start developing a model of services by using a client – centered approach, where representatives of those groups are actively participating in all phases of the creation of services. This way it will be secured to develop the most efficient and effective services which best answer the needs of beneficiaries. It is also important to choose those services which turn out to be the most cost – efficient. In terms of securing sustainability, cost – benefit analyses should be applied and all services tested, helping these ways decision makers to choose the best models of services and the modality of implementation.

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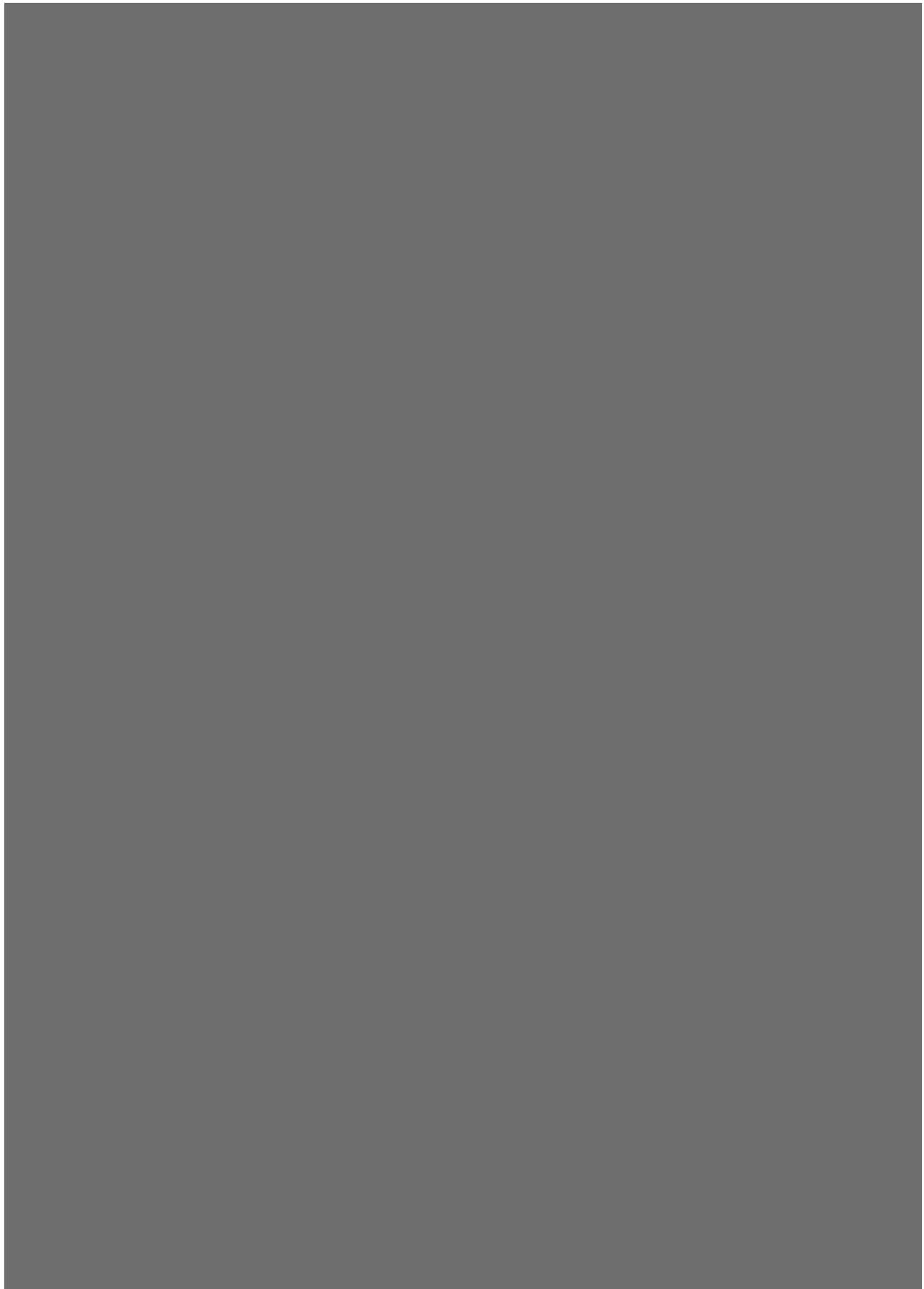
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