Hamburg University of Applied Sciences
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Access to pre- and postnatal care and social inequality – three case-studies of a German family-midwife

- Thesis -

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by

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Contents

Introduction

The health of mothers and their infants are sensitive markers for the quality and immanent equity of a health care system. Access to maternity services and infant screening programs is a precondition for the reduction of maternal and infant morbidity-, respectively mortality rates.

Very good outcomes in maternal and infant health can only be attained by granting equal accessibility to pre- and postnatal care to all women regardless of their social, economic, cultural or religious origin. The German government has ratified various human rights treaties which demand among other human rights the right to health. Access to health care services is mentioned as an indispensable step to create equal health chances for all and to overcome health inequality.

Thus, the term 'reproductive health' was defined in the Programme of Action developed at the International Conference on Population and Development (ICPD) held in Cairo in 1994, and at the International Conference on Women held in Beijing in 1995 as:

> *Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chances of having a healthy infant. (quoted in: Cook, R.J./ Dickens, B.M./ Fathalla, M.F., 2003; p.12)*

The topic of this thesis deals with the correlation of social inequality and access to pre- and postnatal care in Germany; it describes the impact of family midwifery on the access to pre- and postnatal care for underprivileged women. The first part describes the theoretical foundations of the research issue. The first chapter contains the legal principles which are documented in human rights treaties and ratified by many states including Germany. The legal perspective serves as the argumentation frame of the field described in this thesis.

The second chapter formulates definitions and concepts of social inequality and the third chapter gives an overview of the supply of pre- and postnatal services in Germany.

In part two the author shifts the perspective from theory to practice. Chapter one explains the concept of family-midwifes as health care professionals with a low-threshold outreach

approach. Chapter two defines the area of data collection and its demographic specificity; it comments on the qualitative research method of presenting case-studies.

Chapter three contains selected case-studies which serve the purpose to measure how the health care systems could be improved better to resolve individual health care problems and prevent their recurrence, and to develop their social conscience.

Chapter four derives recommendations of policy adjustments concerning integrated care, implementation of outreach health care services in the community setting and the reform of curricula in the health care professions.

Last not least, the author would like to express her gratitude and appreciation to all those friends, family members and colleagues who supported the process of this thesis by their critical advice and strengthening encouragement.

I would like to grant special appreciation to Dr. Anna Würth from the German institute for human rights. The dialogue with her and her fruitful critique were an essential help in grasping the legal context of the human rights discourse. Her profound knowledge and critical mind were and remain an inspiration and contributed to the completion of this thesis to a great extent.

I would like to give special acknowledgement to Christiane Deneke from the Hamburg university of Applied Sciences. Her deep theoretical knowledge and practical field experience in the topic ‘social inequality’ were a steady source of support in developing the contents of this thesis. Her critical remarks helped me to structure and conceptualise the phenomena and associations reflected in this work.

Those whose contribution to this thesis was absolutely essential cannot be mentioned by name; I am deeply indebted to them and remember them with gratitude. The women who offered the presentation of their case studies in this context have proven courage and put trust in the research project. I admire their personal strength and will to cope with burdened living conditions; their intention is to create a better life for their children. The work with them allowed me complex insights into social reality and a growth of understanding.

Without the sharing on the part of these brave women and their families this thesis could not have been written.

Part I Legal, social-scientific and Health Care Principles

1. Equity and Human Rights Principles

This chapter identifies the guiding values which form the inner core of 'health equity' as the goal of health outcomes. These values have been formulated in international human rights law, issued as Human Rights Treaties of the United Nations. The human rights approach may function as a tool for analysing the effectiveness of the health care system in regard to public health priorities like for example improving the accessibility to health care services for marginalized groups of the population.

> *[…] the language of human rights is extremely useful for expressing, considering and incorporating values into public health analysis and response.*
> *Thus, public health work requires both ethics applicable to the individual public health practitioner and a human rights framework to guide public health in its societal analysis and response. […] (Cook, J. R./ Dickens, B. M./ Fathalla, M. F., 2003, p. 91)*

Equity, on the other hand, has been aptly defined by Braveman and Gruskin (2003, p.254):

> *Equity in health is the absence of systematic disparities in health (or in major social determinants of health, including access to healthcare) between groups with different levels of underlying social advantage/ disadvantage.*
> *(quoted in: UN Millenium Project, 2005 , p. 29)*

Access to health can therefore be seen as an expression and issue of social justice: every human being should have the same health chances without being discriminated because of his/ her social status, income level, religion, nationality, sexual orientation, gender or age. But as it is formulated by the United Nations

> *The right to health is often misunderstood as the right to be healthy. Given the multiple determinants of health, including genetics, this would make little sense as a legal standard. No one can guarantee good health. Rather, the right to health encompasses both freedoms, such as the right to be free from torture or to have control over one's reproductive capacity, and entitlements, such as access to healthcare or to the social and environmental conditions that make good health possible (CESCR 2000, General Comment No. 14/…).*
> *Key human rights principles include the following:*
>
> - *Entitlement and obligation. […]*
>
> *Accountability. The concept of "constructive accountability" is useful here to make clear that human rights work is not only or always about identifying violations, finding blame, and imposing punishment (Freedman 2003). Fulfilment of the right to health will mean building responsive, equitable health systems. Positive relationships of accountability – including transparency and answerability (Brinkerhoff*

> *2004) – will be an important dynamic in making such systems function (World Bank 2003b). When properly grounded in a broader social and political framework, these ideas, together with the more conventional understanding of accountability as including mechanisms that provide recourse for violations suffered, become key parts of a rights-based approach. […](UN Millenium Project, 2005, p.34)*

The human rights framework allows us to understand what values and legal obligations should guide a national health policy. A human rights approach might also be useful as an instrument to improve the health chances for all members of society by raising consciousness for the hidden pitfalls and blank spots within the topography of the health care system.

> *[…] The health care system has obligations to people's right to health. It has the obligations to respect, to protect the 'freedoms' and to fulfil the right to health. […]The health care system can be held in violation of the right to health through acts of commission and through acts of omission. The obligation to respect requires the system to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires the system to prevent third parties from interfering with the freedom of people to enjoy their right to health. The obligation to fulfil requires the system to ensure that people have access to a system of health care that provides equal opportunities for everyone. […] (Cook, J. R./ Dickens, B. M./ Fathalla, M. F., 2003, p. 37)*

Lie (2004) argues that key to a human rights approach is the definition of non-discrimination. Should non-discrimination mean that all have equal access to the same health services? Or does non-discrimination imply that all have basically the same guaranteed access to health services, but can opt for additional services if they can pay them? He concludes that if one focuses:

> *[…] only on how government resources are spent [it] is at best only one component of government obligations to fulfil the right to health of their population. Persistent inequalities of access to health care, whether they are caused by income between population groups, should therefore be regarded as an essential concern of equity and rights oriented policies. […] (Lie, R. K., 2004)*

Apart from being formulated in the WHO Constitution of 1946, the right to health has been regulated in some detail in several human rights treaties, detailed below[1]. These treaties reflect the purpose of the international community to strive for the improvement of living conditions which make a life in dignity for even the weak members of societies possible. Like

[1] See also „Universal Declaration of Human Rights" and "International Convention on the Elimination of All Forms of Racial Discrimination" (CERD)

many other countries, Germany has ratified all of the respective treaties, and is thus obliged to respect, protect, and fulfil the right to health.

1.1. International Covenant on Economic, Social & Cultural Rights (CESCR)

The International Covenant on Economic, Social & Cultural Rights was drawn up in 1966 and entered into in 1976. To date (Dec. 2005), 151 countries have ratified the treaty. Article 12 regulates the right to health for all:

> *[…]*
> ***Article 12***
> *1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
> *2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
> *(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
> *(b) The improvement of all aspects of environmental and industrial hygiene;*
> *(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
> *(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.*
> *[…]*
> *(CESCR 1966)*

Germany ratified the CESCR in 1976, and submitted its last report to the UN committee monitoring treaty implementation in 2004.

In 2002, the committee watching over implementation of the treaty issued an interpretation of the article, called a General Comment. The General Comment No. 14 on the right to health explains its content, impact, state obligations and violations. It also suggests the necessary steps in order to implement the right into practice. Its cited in the appendix in detail because of its comprehensiveness and complex explanation of the legal issue[2].

[2] See appendix i.

1.2. International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

The International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was drawn up in 1979 and entered into force 3 September 1981, when a sufficient number of states had signed it. Germany signed the treaty in1981, ratified in 1985 and submitted its last report in 2004 (www.institut-fuer-menschenrechte.de). Article 10 points out that states are obliged to ensure "access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.". Specifically, states are obliged under Article 12:

> *[…] States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. […]*
> *(CEDAW, 1979)*

1.3. Convention on the Rights of the Child (CRC)

Turning to children, a central group of interest for this thesis, the UN has also adopted a Children's Rights Convention in 1989 which entered into force in 1990. Almost all member states of the UN have ratified the CRC to date (191 of 192 states), Germany has ratified in 1992 and submitted the last report in 2000. The treaty obliges states to ensure the fulfilment of the right to health for children, specifically to

> *[…]*
> *(a) To diminish infant and child mortality;*
> *(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;*
> *(c) To combat disease and malnutrition, including within the framework of primary health care […]*
> *(d) To ensure appropriate pre-natal and post-natal health care for mothers;*
> *(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;*
> *(f) To develop preventive health care, guidance for parents and family planning education and services.*
> *[…]*
> *(CRC , 1989)*

According to the state report of 2000[3] Germany believes that, as a matter of principle, the availability of individual complaints procedures is an apt way of strengthening the legal status of those involved, as well as their awareness of their rights, and of encouraging the States parties to implement their obligations.

The German States parties are committed to guarantee national compliance with international law and with relevant national provisions, inter alia, through an independent judiciary. International legal protection for individuals can be an important additional element.

The German government confirms that the existing international procedures for individual legal protection have proven their worth as vital components of international human rights protection.

2. Social inequality and Health

2.1. Definitions and concepts

Social scientists developed two main definitions of inequality with which one can distinguish: vertical and horizontal inequity. The vertical inequality measures differences concerning the socio-economic status (which is calculated by combining educational degree, occupational status and income) in a hierarchical scale. The socio-economic status allows the association with a social class with clear cut edges comparable with a geological stratum. Income plays a central role because income-poverty is understood as the predominant indicator for vertical social inequality.

The concept of horizontal inequality divides the population into groups by attributes like age, sex, nationality, marital status, number of children and size of residence. The division lines between these groups run cross to those of the vertical social inequality. The attributes age, sex and nationality are of greatest relevance for the model of horizontal inequality (Mielck,A., 2000).

But which impact has social inequality upon the health status of persons ?

The most famous study of the health gradient is the Whitehall study (Marmot et al. 1984) which examined mortality among British civil servants in1968-1970. It found health inequalities between every grade of employment. One of the conclusions of the study was: Being lower in hierarchy affects your health because of lower control of working environment, greater stress and lower feelings of self-worth. These factors are called psycho-social effects and they raise health risks indirectly by affecting health related behaviours such

[3] See state report, 2000

as diet, inactivity and smoking. But the stress of lower social position has also direct effects, by causing physiological or metabolic changes which increase the risk of disease and death. Chronic anxiety, insecurity, low self-esteem, social isolation and lack of control over work appear to undermine mental and physical health. They conclude that if the biological stress response is activated too often and for too long, there may be health costs like depression, infections, diabetes, high blood pressure, high cholesterol, heart attack, and stroke (Bottero, W., 2005).

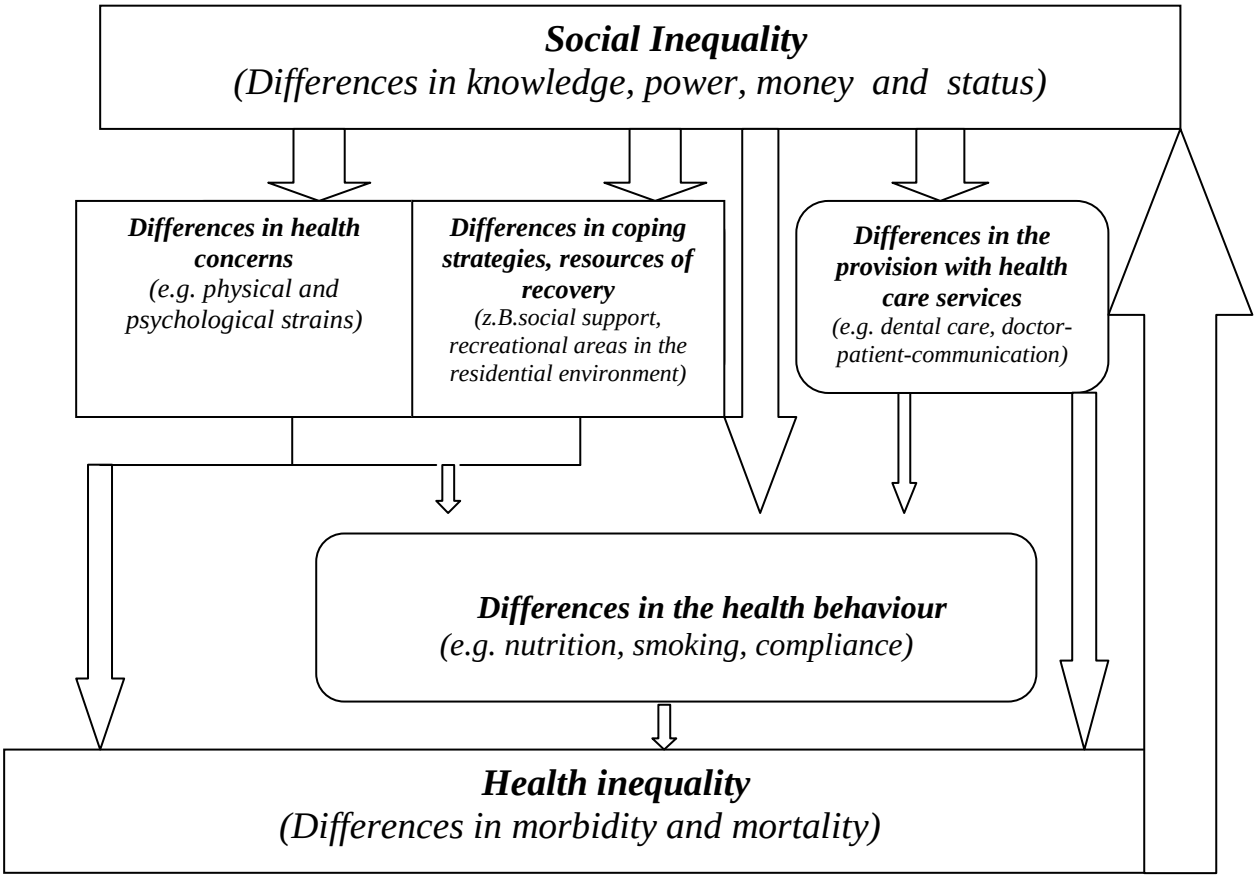


Figure 1: Model of explanation: Health inequality

(Mielck, A., 2000, p.173. Translation E.S.)

Mielck (2000) argues that differences in education, occupational status and income are generally accepted in the population, while it is not accepted in general that persons of the lower class suffer from a higher morbidity and mortality than persons of the upper class.

On the contrary, he says

> *[…] There does exist a societal consensus that health chances should be as independent as possible from the socio-economic status. […] (Mielck, A., 2000, p. 370. Translation E.S.)*

He also notes that disparities in health status have grown to the same extent as disparities in economic status.

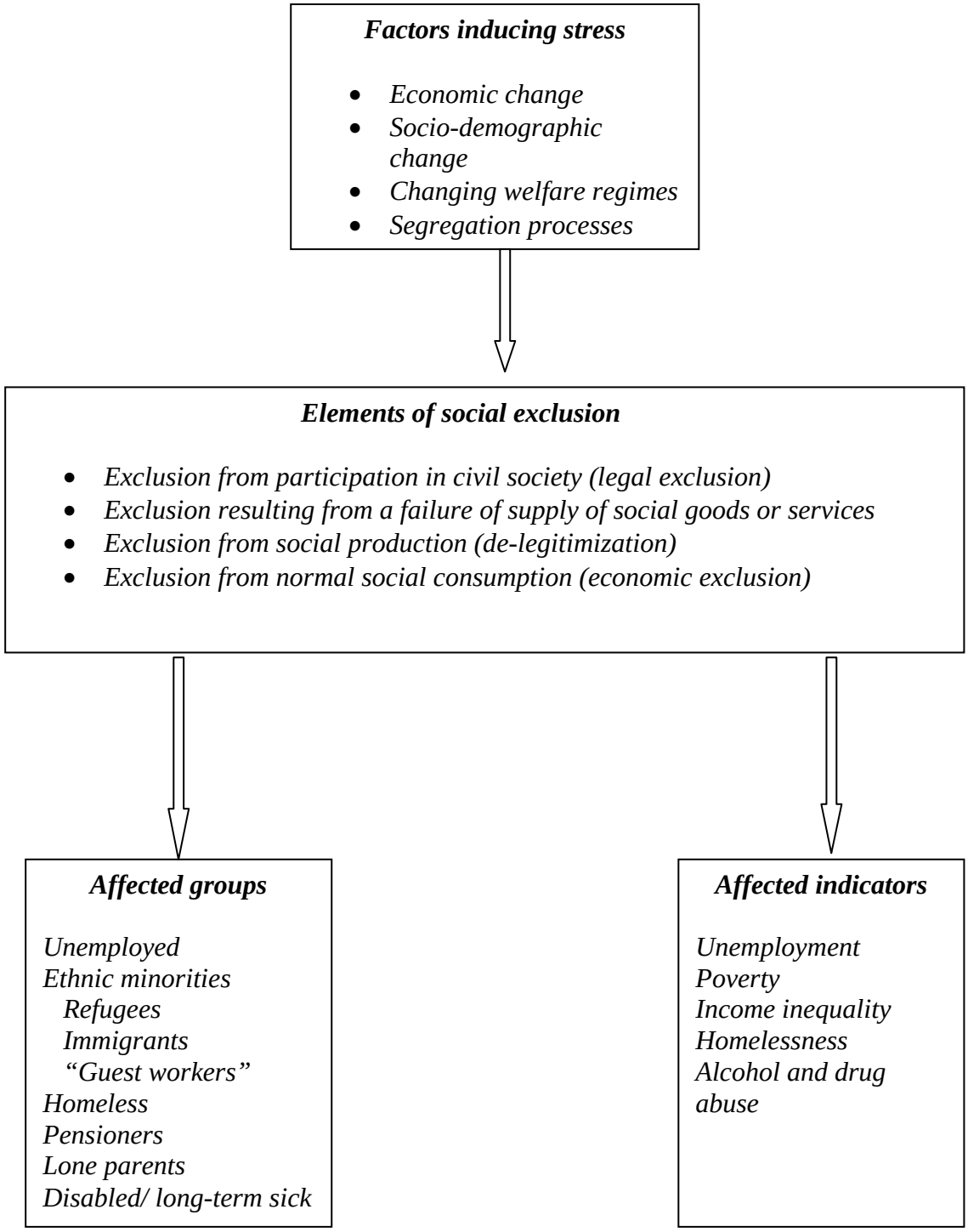
Inequality thus affects health not only through its impact on living standards, but also because relative social position affects psycho-social reactions:

> *To feel depressed, cheated, bitter, desperate, vulnerable, frightened, angry, worried about debts or job and housing insecurity; to feel devalued, useless, helpless, uncared for, hopeless, isolated, anxious and a failure; these feelings can dominate people's whole experience of life, colouring their experience of everything else. It is the chronic stress arising from feelings like these, which does the damage. It is the social feelings which matter, not exposure to a supposedly toxic material environment. The material environment is merely the indelible mark and constant reminder of the oppressive fact of one's failure, of the atrophy of any sense of having a place in the community, and of one's social exclusion and devaluation as a human being. (Wilkinson 1996: 215, quoted in: Bottero, W., 2005, p. 192)*

The social exclusion of particular demographic groups is based on political and economic processes of segregation which form the basis for structural injustice.

The following figure shows the preconditions and effects of social exclusion in Europe and which sub-populations are mainly affected by that process.

Figure 2: The process and outcome of social exclusion in Europe (adapted from White 1998 quoted in: Marmot, M./ Wilkinson, R. G., 1999; p. 224)



Marmot and Wilkinson (1999) describe the relevance of the social context and its various risk-factors to health in early life. The authors argue that early life of children is heavily influenced, if not determined, by socio-economic circumstances of the respective mothers.

> *[…] The processes of social determination in the health of mothers and children comprise family factors that are economic, educational, and psychological, and which form a dynamic process that affects lifetime opportunities, coping strategies and outlook. […] (Marmot, M./ Wilkinson, R. G. , 1999, p. 46 ff.)*

Marmot and Wilkinson (1999) add further examples for social risk-factors which have an impact on early health:

- Poverty, maldistribution of income, particularly for families
- High rates of unemployment of both parents
- High rates of family discord
- Gender biased and generally restricted opportunities for education, and low levels of literacy, especially in women
- Low levels of contraception and of breast feeding
- Isolation of women from the mainstream of social participation, and from legal and social security

Their general conclusion is expressed with the following citation:

> *[…] the primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social. Medicine and politics cannot and should not be kept apart (Rose 1992). […] (Marmot, M./ Wilkinson, R. G. , 1999, p. 57)*

While not adopting the position that inequalities pre-determine opportunities in life, this thesis will argue that inequality is responsible for lack of access to ante- and postnatal care of women encountered during the course of this study.

2.2. Indicators of social inequality

2.2.1. Education

Educational background is one of the indicators of social status. In conjunction with occupational status and income, educational background measures the socio-economic status of a person.

Especially the educational training of a person determines his/ her position in and skills access to the modern information society in which information has become a so-called primary good being an independent source of productivity and power.

Persons with poor educational background who have only completed nine or ten years of school in the West German school system are disadvantaged concerning their ability in gaining access to information compared to students at university. The school certificate is the main indicator for the chances to be accepted in a professional training which will later on allow applications for a more or less well-paid employment.

The following table demonstrates the strong association of having no school certificate or a low school degree and the dependency on social welfare.

Table 1: association of school certificate and dependency on social welfare

School certificate	***Dependants on social welfare 2003♣***		***Population in April 2003♣***	
	Number	*in %*	*Number in thousands*	*in %*
No school certificate	*180.494*	*13,9%*	*1.532*	*3.1%*
Nine years (Hauptschule)	*631.410*	*48.7%*	*19.072*	*28.3%*
Ten years (Realschule)	*274.857*	*21.2%*	*15.919*	*32.0%*
Thirteen years (Abitur)	*119.812*	*9.2%*	*12.730*	*25.6%*
Other school certificate	*90.322*	*7.0%*	*530*	*1.1%*
Total	*1.296.895*	*100.0%*	*49.783*	*100.0%*
Still in training	*126.960*	*x*	*2.991*	*X*
School certificate unknown	*346.046*	*x*	*2.284*	*X*
Sum total	*1.779.901*	*x*	*55.058*	*X*

x column closed because not useful
♣ Age 15 – 64 in private households
Source: Federal board of statistics, statistics of social welfare and microcensus; calculations of the Federal Ministry of Health and Social Security:
(Federal Ministry of Health and Social Security, 2005; p. 63. Translation E.S.)

Inequalities of skills access are bigger than the differences of material or physical access. The informational skills distinguished – operational, information, and strategic skills - expose an increasing level of inequality. All indications point in the direction of extreme unequal divisions of these skills, which are so important for the information and network society. This inequality rests more on the distribution of mental than of material resources and is in intellectual skills. The second most important type of resources for digital skills is social and cultural resources.

Positional (education, employment define the social context of learning digital skills in practice) and personal (age, intelligence, sex, gender) categorical inequalities are responsible for the unequal distributions of these resources (Dijk, J. A. G. M. van, 2005).

> *[…] First, information has become one of the most important primary goods in society. This means that a particular minimum of it is necessary to participate in it. With the rising complexity of society, this minimum is increasing. Moreover, all relative differences, above this minimum are leading to more or less participation, productivity, power, self-respect, and identity for different groups in society. These differences are a substantial basis for inequality in contemporary society.[…}*
> *Both information and its technology appeal to the unequal mental capacities of individuals. In the labour market, differential skills may lead to rising skill premiums. This is probably one of the reasons for the increase of income inequality in large parts of the world since the 1980s. Information technology and digital skills may play a role in current income polarization, as they lead to higher and more valuable for some employees and lower and less valuable skills for others. […]*
> *(Dijk, J. A. G. M. van, 2005, p. 142)*

Information and the ability to process information are key to our contemporary educational system As will be seen below, this ability is also key for the ability to access the health care system, and lacks in persons with educational degrees below a certain level.

2.2.2. Occupational status

Occupational status may be calculated in various ways which measure the social prestige of an occupation regardless of its educational preconditions or income. The 'International Standard Classification of Occupations (ISCO)' serves as the foundation of different scales for occupational status, of which the Treiman-scale (1977) and the Wegener-scale (1988) are examples of. Statements concerning the occupational status are difficult to handle; four or five classifications are possible in this context: Self-employed/ civil servants/ employees/ manual workers or: unskilled manual worker, civil servants of the lower service (lower class)/ lower employees (lower middle class)/ skilled manual workers, technicians, civil servants of the middle service (medium middle class)/ self-employed with less than ten employees (upper middle class)/ academics, highly-qualified employees or employees in a leading position, civil servants in the upper service, self-employed with ten or more employees (upper class) (Mielck, A., 2000, p. 24).

These scales are gender-biased, they do not, for example, take account of housewives.

Contrary to that the educational background is an attribute which enables one to estimate as well the individual social status of women as the one of men (Mielck, A., 2000, p. 49).

The discrimination of women who work as housewives and mothers without being acknowledged in terms of being associated with an occupational status is reflected in the higher percentage of women living in poverty globally.

> *[…] The starting point is that more women than men experience poverty – for all types of society for which a reasonable range of information exists. This poverty is compounded over a lifetime. The expectation that women will reproduce, perform the predominant roles in rearing children and caring for family members in sickness, disablement and old age unpaid, and will not even have a formally constituted or defined claim on the income and other resources obtained by their male partners or other males in the family, underlies their economic dependence. […] (Townsend, P., 1993, p. 106)*

The fact that being a housewife and mother is not respected to be an occupation adds to the various discriminations which the women of the in part II described case-studies are suffering from.

2.2.3. Income

Income is considered to be the central indicator of vertical social inequality. The discourse about the correlation of income and health focuses mainly on the extent, distribution and development of income poverty.

Income poverty is defined by two different indicators: dependence on social security benefits or a household income of maximum 50 % of the average household net-income[1]. This definition stresses the fact that poverty cannot only be measured in absolute but also in relative terms. Relative poverty describes the situation of people who possess significantly less resources than the majority of the population and whose living conditions are heavily burdened by financial strains.

The number of persons who live under the poverty-risk-ratio (maximum 50 % of the equivalent income) is much higher than the number of recipients of social welfare payment. As a consequence, the extent of poverty is underestimated in the official German social security benefits-statistics.

Poverty is predominantly prevalent among children, migrants, unemployed, families with many children, single parents and persons without employment.

Thus, in 2003 children until fifteen years had a poverty-risk ratio of 15% and adolescents between sixteen and twenty-four years had a risk of 19,1%. Single parents with a poverty-risk

[1] The equivalent income is calculated by adding the net-income of all persons living in the household at first and at second by putting a weight to it according to age and number of the household members.

ratio of 35,4% were only topped by unemployed persons with the highest poverty-risk ratio of 40,9%. Since 1998 the poverty-risk ratio has increased from 12,1% to 13,5%[2].

In the same year 2003 8,4% of migrants collected social welfare payments compared to 2,9% of German citizens[3].

Since the income distribution is marked by a sharp gradient the distribution of private property in Germany proves to be very uneven. The lower 50% of households possess less than 4% of the total net-property whereas the upper 20% of households own two thirds of the net-property total. The upper 10% of households own almost 47% of the net-property total; their share has grown 2% since 1998[4].

During the past years poverty has grown and especially citizens of the new federal states (neue Bundesländer) have experienced an increase of poverty due to a high percentage of unemployment. Poverty is associated with various strains like social isolation which is intensified by unemployment and one may assume that poverty is correlated with a higher morbidity. This assumption proves to be right as it is shown in various reports (Black, Sir D. et al., 1982; Federal Ministry of Health and Social Security, 2005; etc.)

> *[…] The extent of poverty and relative deprivation has increased in European countries in the past two decades. Between 1980 and 1988 poverty rates increased in all European Community countries, with the exceptions of the Netherlands, Portugal, and Spain (Oppenheim and Harker 1996). The sharpest rises were seen in Italy, Germany, and the UK. In terms of income inequality, the UK, Sweden, Denmark, Norway, the Netherlands, and Belgium have all experienced increases over the time period 1967-92; the UK, Norway, the Netherlands, Belgium and Germany all experienced increases in child poverty (Goodman et al 1997). […](quoted in: Marmot, M./ Wilkinson, R. G. , 1999, p. 217)*

In the light of correlations between mortality rates and national measures of income inequality (such as the percentage share of income received by the least well-off 70 per cent of the population), it has been argued that relative inequalities affects population health by disrupting social cohesion (undermining trust, corporation and civic participation, and increasing hostility and stress). The most famous exponent of such claims, Richard Wilkinson (1999), argues that relative social location affects the quality of social relationships and psychological reactions to unequal situations:

[2] See 2. report on poverty and wealth (‚2.Armuts- und Reichtumsbericht'), 2005; p.21
[3] See 2. report on poverty and wealth (‚2.Armuts- und Reichtumsbericht'), 2005; p. 60
[4] See 2. report on poverty and wealth (‚2.Armuts- und Reichtumsbericht'), 2005; p. 35

> *[…] greater income inequality is one of the major influences on the proportion of the population who find themselves in situations that deny them a sense of dignity, situations that increase the insecurity they feel about their personal worth and competence, and that carry connotations of inferiority in which few can feel respected, valued and confident. […] (Wilkinson, 1999a: 267, quoted in: Bottero, W., 2005, p. 191).*

Wilkinson observes that societies with lower levels of relative inequalities have not only better overall health but also higher levels of social capital[5].

> *[…] Looking at a number of different examples of healthy egalitarian societies , an important characteristic they all seem to share is their social cohesion. They have a strong community life.[…] People are more likely to be involved in social and voluntary activities outside the home. There are fewer signs of anti-social aggressiveness, and society appears more caring […] What this means is that the quality of the social life of a society is one of the most powerful determinants of health and that is, in turn, is very closely related to the degree of income inequality. […] (Wilkinson 1996: 4, 5, quoted in: Bottero, W., 2005, p. 195)*

The fact that material deprivation is such a powerful predictor of health inequalities is significant, but to be expected, given that the relationship between health and inequality is curved. The steepest end of the health inequalities curve (and thus the greatest variation in health) is at the bottom of the social scale, where we would expect material deprivation to be the most severe and to have the greatest impact on health (Bottero, W., 2005, p. 199).
Poverty cannot be understood as a single event in a person's lifetime but develops by process and has a cumulative effect over one's life span or over generation chains.

> *[…] Adverse socio-economic conditions in early life can produce lasting increases in the risk of cardiovascular disease, respiratory disease, and some cancers late in life. Adverse socio-economic conditions in adulthood compound these earlier-life influences, resulting in health differentials in adulthood which reflect the social patterning of exposure acting across the life course. The particular influence of deprivation in childhood should focus attention on some current social policies which are leading to an increasing concentration of poverty in households with young children. [...] (Davey Smith 1998, quoted in : Marmot, M./ Wilkinson, R. G. , 1999, p. 216)*

In Germany income has a strong influence on the health behaviour and outcome, respectively it is highly correlated with morbidity- and mortality-ratios. Population groups which suffer from income-poverty like single parents, children and migrants are affected by adverse health outcomes to a greater extent than financially well-established demographic groups.

[5] The sociological term 'social capital' was introduced by the French sociologist Bourdieu. It describes the number and hierarchical positioning of personal social relations as social capital. (Bourdieu, P, 1997)

3. Principles of Health Care Organisation

3.1. Provision of health care services

The extent of health inequality is influenced strongly by the organisation and provision of health care services. The 'solidarity principle' of the statutory health insurances (SHI) guarantees a supply with health care services for each citizen regardless of his/ her income and of his/ her state of health. The regional coverage of health care services should be distributed evenly. Nevertheless was the 'solidarity principle' weakened during the past years by the increase in co-payments and the reduction of the SHI-benefits catalogue. It is a fact that many eligible persons do not claim the exemption from co-payments despite hardship case-regulations which allow insured members with a low income the exemption from co-payments; and this happens due to the following reasons: the procedure is complicated and the poor economic situation is often associated with feelings of shame (Mielck, A., 2000).

A particularity of the German health care system and its screening programmes is the mandatory character of services. The extensive utilization of services implies a high health literacy which is dependant on several factors as it will be demonstrated in chapter three of part II. On the other hand, there are no effective instruments implemented in the system to avoid or diminish non- or under-utilization by marginalized demographic groups.

Various practice experiences and scientific study results have proven that special sub-populations have higher health-risks despite equal formal claims concerning the benefits catalogue. Disadvantaged demographic groups are for example single parents, migrants, recipients of social security benefits, unemployed persons, teenage mothers, families with many children living in burdened circumstances, persons without a shelter and drug-addicts.

An analysis of the West German birth and death registry for 1980-1996 done by Razum et al. resulted in the finding that:

> *[…] Socioeconomically disadvantaged women, as defined by the risk marker 'unmarried', do incur a significantly increased risk of maternal death in West Germany. This increase persists over time, at least among women of German nationality, in spite of a liberalization of societal norms and an increase in the proportion of single mothers. […] (Razum, O. et al., 1999; p.923)*

As a consequence to that it appears that equal health chances for all members of society in fact are not realised by legal formal claims (Eßer, P., 1994).

Hence, barriers of access to the health care system need to be identified because they lead – among other reasons - to the unequal distribution of health chances among the population. Examples for access-barriers are an insufficient transparency and cordination of the

ambulatory medical care, co-payment regulations, lack of language and cultural skills, opening hours and distant-to-residence services. In Hamburg there does no regional restriction of establishment exist which steers the equal regional coverage with medical or midwife services. As a result of the missing regulation there are under- and over-provided regions concerning medical care. Traditionally, poor areas inhabiting a high percentage of persons with a low socio-economic status are under-served.

The selected case-studies of Part II will demonstrate the many-fold access hindrances incorporated in the contemporary German health care system.

Since health care systems are embedded in societies they reflect the prevalence of social inequality as Macintosh (2001) has described it:

> *[…] It analyses health care systems as a core element of social inequality in any society, in the sense that unequal claims upon a health care system, and unequal experiences of seeking care, are important elements of poverty and social inequality in people's experience. It argues that health care systems, as social institutions, are built out of the existing social structure, and carry its inequalities within them. However, health care systems are also, and at the same time, a key site for contestation of existing social inequality: they offer a representation back to us of our societies' capacities for care, and a public space for reworking those capacities. […] (Mackintosh, M., 2001, p.175)*

3.1.1. Preventive ante-natal service

The provision of gynaecological preventive ante-natal service is described and legally granted by the motherhood-regulations ('Mutterschafts-Richtlinien') which were developed by the National Committee of SHI-Physicians and Sickness Funds in 1985[1]. They contain benefits which are delivered to all pregnant women without co-payments.

The supply of midwifery-led preventive ante-natal service is documented in the professional code of midwifes from 1992[2] and in the professional law of midwives.

Both professions, gynaecologist and midwife, are entitled to supply a healthy pregnant woman without risk-factors[3] with preventive ante-natal services. Excepted for midwifes are the ultrasonic examinations which are part of the exclusive medical domain and the delivery of ante-natal care for women with high-risk pregnancies.

[1] See ‚Mutterschafts-Richtlinien'

[2] See ‚Hamburgisches Gesetz- und Verordnungsblatt': 'Berufsordnung für die hamburgischen Hebammen und Entbindungspfleger', 1992

[3] Catalogue of risks according to the 'Mutterpass' (document about the pregnancy containing the basic medical information, especially anamnestic and actual risk factors, as well as the results of the preventive examinations), which was designed by the National Committee of SHI-physicians and health insurance funds in 1985. The number of risk-factors steadily increased and has reached fifty-two by now.

Midwifes are entitled[4] to support pregnant women with midwifery advice in case of inconveniencies due to pregnancy as often as necessary. Midwifes provide preparatory birth classes which each pregnant woman is eligible to without co-payments.

Despite the choice pregnant women have the vast majority of them (approximately more than 95%) are provided with ante-natal care by their gynaecologists exclusively.

The benefits-catalogue relating to a physiological pregnancy includes one monthly examination until the thirty-second week of gestation age and from then on one examination every two weeks until the fortieth week of gestation. This adds to twelve regular consultations until the calculated date of birth. After the calculated date of birth the prescribed examinations should take place for another ten days every second day until the pregnant woman usually is referred to hospital.

The general examinations include diagnostics like blood pressure, weight control, urine control concerning sugar, protein, sediment, haemoglobin control, control of the uterus growth by palpation of the fundus uteri, control of the fetal heart activity, control of the fetal position by palpation.

Three ultrasonic-screenings are prescribed in a low-risk pregnancy:

- Beginning of the ninth week until the end of the twelfth week of gestation (first screening)
- Beginning of the nineteenth week until the end of the twenty-second week of gestation (second screening)
- Beginning of the twenty-ninth week until the end of the thirty-second week of gestation (third screening)

This screening serves the observation of a physiological pregnancy and has the purpose to:

- measure the exact gestation age
- control the fetal growth
- search for striking fetal characteristics
- early diagnose twin-/ triplet-pregnancies

In the case of abnormal ultrasonic diagnostics the referral of the pregnant woman to an expert in ultrasonic pre-natal diagnostics is indicated; the further examinations are not part of the screening but part of the motherhood regulations.

The obligatory serology contains TPHA (search for lues antibodies), German measles, eventually HIV, blood group, respectively its Rhesus-factor D and the search for antibodies. The serology should be taken at the earliest possible date of pregnancy. A second search for

[4] According to the ‚Hebammenhilfe-Gebührenverordnung (HebGV)' (midwife fee schedule), 2004

antibodies is to be done between the twenty-fourth and twenty-seventh week of gestation and after the thirty-second week of gestation the serology of hepatitis-B antibodies has to be taken.

If the pregnant woman proves to be a high-risk patient the regular twelve examinations are to be completed by additional consultations. The percentage of pregnancies with one or more risk-factors has meanwhile reached about 73% in Germany; pregnancies without risk-factors turn out to be a rare event in the high-tech obstetric care (Urbschat, I., 2001; Stahl,K., 2006).

If a pregnant woman wishes additional diagnostics without having an indication according to the risk-factor catalogue she has to pay out-of-pocket[5].

3.1.2. Usage of ante-natal services

The usage of gynaecological ante-natal services is high; according to a survey study on the perinatal data in Lower Saxony from 1992 until 1996 87,3% of all pregnant women participated in the ante-natal screening programme. The percentage of pregnancies with one risk-factor has continually increased over the years and has reached 72,2% in 1996; although there is no empirical evidence that today's pregnant women suffer from a higher morbidity than their predecessors.

Despite the above-standard-coverage of low-risk pregnancies (29,7% of the pregnant women without risk-factors were over-provided in 1996) there exists an under-provision of socially disadvantaged women who are not reached by the ante-natal preventive services to a satisfactory extent. This discrepancy proves to be even more harmful since the effectiveness of ante-natal screening programmes appears to be greatest for women with social risks The need for low-threshold-services is still valued to be high in order to increase the coverage of these under-served sub-populations (Urbschat, I., 2001).

According to a questionnaire-, interview- and patient file-based study among migrants in West Berlin 1997-1999 (David, M. et al., 2001) do migrants change their gynaecologist significantly more often than German women. The doctor hopping is practised mainly because of discontent with the treatment, lack of understanding on the patient side, lack of medical and social-cultural competence on the gynaecologist side.

Migrants use the gynaecological emergency ambulance of hospitals to a significant extent more often than Germans. If documentation of the anamnesis is considered to reflect the patient-doctor communication the results of the study show that the documented anamnesis of migrants (measured in number of written words and content) is kept shorter significantly. The

[5] See appendix ii

anmanesis of migrants did contain rarely information concerning development of actual disease, former diseases and the social background. This is true for hospital- as well as office-based gynaecologists.

About 90% of all pregnant women choose the utilization of gynaecological ante-natal preventive services compared to less than 5% of all pregnant women who search for a midwifery-based ante-natal screening programme.

The participation in preparatory birth-classes is also highly correlated with higher socio-economic status[6].

The above described phenomenon is prevalent in Great Britain as well according to a British study:

> *[…] In addition to this, the Commission for Racial Equality (1994) note that women from varying social and cultural backgrounds were treated differently during their use of the maternity provision. The ability to articulate needs and wants is undoubtedly a factor in involvement and overall satisfaction. Furthermore, the desire to be involved in healthcare or take ownership in care is an individual choice. […] (Tinson, J., 2000, p.160)*

3.2. Postnatal care

Postnatal care starts two hours after delivery and ends six weeks after childbirth, thus it covers the period of childbed. Since women are discharged from hospital within two to three days after childbirth the puerperal period takes place at home and leave mothers often without professional support during a sensitive, complex process of changes.

> *The post partum time is the time after childbirth that is particularly significant to both mother and baby. It has been recognized as a time of immense physical and psychological adjustment that can be both exiting yet stressful for the post partum woman. […] (Scrivens, L./ Summers, A.D., 2001, p.28)*

The extent of maternal postnatal care is documented in the already mentioned motherhood-regulations[7] and in the professional code[8] and law of midwifes.

According to the motherhood-regulations two medical postnatal examinations are prescribed:

[6] See also part I chapter 3.3.1.
[7] See ‚Mutterschaftsrichtlinien'
[8] See ‚Hamburgisches Gesetz- und Verordnungsblatt': 'Berufsordnung für die hamburgischen Hebammen und Entbindungspfleger', 1992

- First examination within the first week after delivery; it includes the control of haemoglobin.
- Second examination six weeks and latest eight weeks after delivery. It includes: gynaecological and general examination; control of blood pressure; eventually control of haemoglobin; control of urine concerning protein, sugar and sediment; consulting of the mother.

The benefits-catalogue[9] of midwife-based postnatal care include up to twenty home or hospital visits during the first ten days after delivery. In the period starting from the eleventh postpartum day until eight weeks after delivery midwives are entitled to perform up to thirty-two home visits in case of particular indication. The home visits include maternal and infant care: control of fundus uteri, control of lochia uteri, control of wound-healing, control of vital functions, support in breast feeding, psychological support, consulting (e.g.: baby care, nutrition, family-planning, health behaviour); control of infants weight increase, control of neonatal hepatitis, observation of baby's behaviour and development, observation of infants vital functions, observation of skin irritations.

Additional telephone consultations and a package of medical material add to the provision of midwifery-based puerperal care.

During the period of changing from breast feeding to infants nutrition the midwife is entitled to make two additional consultations at home and two telephone consultations.

Gymnastic classes after birth are provided by midwifes.

In chapter 3.2.1. a quantitative study of 1999 is quoted which demonstrates the social gradient of utilization of midwifery-based postnatal-services in Hamburg.

3.2.1. Usage of midwifery-led postnatal care

The utilization of midwifery-led postnatal care is linked to socio-economic status as various studies have described it (Staschek, B., 1999; Richthofen-Krug, B.v., 1999). Since the access to midwifery-based care depends on health literacy, language skills and the own choice women lacking these skills are disadvantaged. Primi-gravidae who are not told by heir gynaecologists that they are eligible to midwifery-care might not know of their claim until birth-registration in hospital. At that late point in pregnancy women often face difficulties in booking a midwife because of the under-provision of midwifes in Hamburg.

[9] See midwife fee schedule ('Hebammenhilfe-Gebührenverordnung'), 2004

A study of 1999 (based on standardised telephone interviews) which measured the provision of midwives in all districts of Hamburg demonstrated the following results (Richthofen-Krug, B.v.):

- The supply of midwifes increases in districts with a higher average socio-economic status of its inhabitants (Only 6% of under-provision in districts with a high average of socio-economic status compared to 42% in districts with a low socio-economic status)[10].
- A total of 5.852 women in Hamburg were not provided with midwifery-based care in 1999. Considering a midwife-capacity of supplying 10.555 women per year with care and the annual birth rate of 16.407 (1994-1997) this adds to a general non-provision of 36%.
- Women with a lower socio-economic status either do not book at all for a midwife or can not register anymore with a midwife because they started too late to search for a midwife with free capacities.

Women with a lower socio-economic status tend to exclude themselves from professional support and rather rely on informal advice from peer groups or family members (Murray, L. et al., 2003; Tinson, J., 2000). They prefer to leave hospital at an earlier stage often without having registered with home-based midwifery care. This leads besides other reasons to decreasing breast-feeding rates among lower status groups (Bailey,C.et al., 2001).

The early discharge after delivery is part of the latest Health Policy which focuses on cost reduction of clinical postpartum care and the extension of ambulatory services. Since the capacities of midwifery-based postnatal care are not sufficient yet socially disadvantaged women and their babies pay the price by being under-provided with home-based midwifery care (Scrivens, L. et al., 2001)

3.3. Neonatal and infant preventive screening services

The National Committee of SHI-Physicians and Sickness Funds have conceptualized a screening program for neonates, infants and children which is documented in the 'Kinderuntersuchungheft'[11], a yellow booklet containing documentation room for nine examinations; pediatrics screen the physical, motoric, mental and psychological development of children at age newborn to five years old and perform the recommended vaccinations[12].

[10] See appendix iii. for the detailed data of all districts in Hamburg

[11] The original ‚Kinderuntersuchungsheft' was designed in 1993.

[12] Vaccinations are recommended by the STIKO (permanent vaccination committee 'Ständige Impfkommission') which develops guidelines and hand them out to the pediatrics (national recommendations for vaccination 'Nationale Impfempfehlungen').

The nine screenings have to be performed during particular time periods:

- First screening: first day of life (to be performed either by a pediatric, gynaecologist or a midwife)
- Second screening: 3.-10. day of life
- Third screening: 4.- 6. week of life
- Fourth screening: 3.- 4. month of life (first combined vaccination recommended)
- Fifth screening: 6. – 7. month of life (second combined vaccination recommended)
- Sixth screening: 10. – 12. month of life (third combined vaccination recommended)
- Seventh screening: 21. – 24. month of life
- Eight screening: 43. – 48. month of life
- Ninth screening: 60. – 64. month of life

The pediatric screening program is available for all children without co-payments but since it is not obligatory not all parents let their children take part in the program.

3.3.1. Usage of neonatal and infant preventive screening services

The utilization of infant preventive screening services has a clear social gradient; the higher the social status of the family the greater is the usage of pediatric and dental preventive screening programs. That leads to the fact that

> *The impact of poverty on the health status and the health behaviour of young people can be demonstrated on survey data and school entering medical screenings. The main findings is that young people from less well-off families have a significant less favourable health-status than children from higher status families. (Klocke, A., 2001, p.21)*

The well described associations of social origin and development retardation show a cumulating effect and interdependency of disadvantages concerning children of low-status families. Besides having worse education chances these children suffer from a poorer health status and a risky health behaviour. Children of families living in poverty carry a high risk of a burdened health-biography.

The following table demonstrates the social gradient in utilization of infant screening programs:

Table 2: Non-utilization of preventive infant screening program (in percent)

Screening	***Low socio-economic status of family***	***Middle or high socio-economic status of family***	***Odds Ratio***
Screening 1 (first day)	*4,8*	*1,9*	*2,53*
Screening 2 (3.-10. day)	*4,6*	*2,1*	*2,19*
Screening 3 (4.-6. week)	*7,4*	*2,8*	*2,64*
Screening 4 (3.-4. month)	*7,9*	*2,8*	*2,82*
Screening 5 (6.-7. month)	*9,4*	*4,0*	*2,35*
Screening 6 (10.-12. month)	*10,5*	*4,8*	*2,19*
Screening 7 (21.-24. month)	*12,2*	*6,7*	*1,82*
Screening 8 (43.-48. month)	*13,5*	*9,4*	*1,44*
Screening 9 (60.-64. month)	*31,4*	*29,8*	*1,05*

Data: school entering medical screening 1993, Braumschweig, N =1.588
Source: Schubert, 1996 quoted in: Mielck, A., 2000
(Klocke, A., 2001, p.7. Translation E.S.)

Despite the obvious disparities in health-status of children from different socio-economic origin health professionals still do not know enough about the immanent mechanisms for a negative health behaviour. As a consequence, there exists a lack of strategies for changing parental health behaviour which tend to neglect the needs of their infants into a supportive, foreseeing one.

In order to diminish the gap between the health-status and - behaviour of low-status children and children of high-status the Robert-Koch institute performed the first German health survey for children and adolescents from 2003-2005. During three years, a representative sample of children between 0 and 18 years of age, was examined and were, together with their parents, interviewed on health-relevant issues. With this survey, health information on about 18,000 children was gathered.

With this survey, the occurrence of certain unhealthy behaviour characteristics might have been documented and risk groups might have been identified. This may help to conceptualise prevention measures (Kurth, B.M. et al., 2002; Thefeld, W.et al., 2002). To date, the results of the survey have not been published yet.

Part II From Principle to Practice

1. Access to the field by midwifes

1.1. Family-midwifes: Health care professionals with a low threshold outreach approach

The WHO has formulated the global goal: Health for all (WHO, 2003). The family health nurse plays a central part in realising the aim by home-visits and interdisciplinary corporation with other professions. The concept of the family health nurse implies the fields of

- Health promotion
- Ill-health prevention
- Rehabilitation
- Care of dying patients

The family health nurse works at the levels of primary, secondary and tertiary prevention and care. Her main focus is the home-based supply of care and information concerning the effective utilisation of the health care system. She promotes the program of integrated care by her professional support (Schneider, E., 2004).

The concept of the family-midwife is based upon a similar approach like the concept of the family or community health nurse. Her competence focuses on the provision of midwifery-led ante- and postnatal care of vulnerable sub-populations. The work of (family-)midwifes serves the achievement of Millennium Development Goals three 'Promote gender equality and empower women', four 'Reduce child mortality' and five 'Improve maternal health' (Millennium Project, 2005).

The first family-midwifes in Germany started to work in Bremen 1980-1983 as part of a pilot project which targeted at:

- Reduction of the infant mortality in Bremen and Bremerhaven which was above the German average
- Primary, secondary and tertiary medical and social prevention of infant and maternal ill-health
- Low-threshold home visit-based provision of midwifery-led pre- and postnatal care
- Corporation and networking with other health care professionals (doctors, nurses, social workers) and institutions (hospitals, Office of Youth and Social Affairs, Department of Health, sociopediatric institutions)

Target group were all mothers of Bremen and Bremerhaven.

The health care system of the Scandinavian countries and the Netherlands served as a model for the first implementation of family-midwifes in Germany; these countries convinced by comparable low numbers of their maternal-, respectively infant death rates.

The twenty-five midwifes of the pilot project received an eight-month training by the department of medical sociology at the medical university Hanover before they began to work as family-midwifes (Collatz,J. et al., 1981).

Midwifes were chosen for this training because they are professional experts concerning pregnancy, birth, child-bed and the care of a new-born. Midwifes have a positive image in the population and are not associated with control like social workers and the Office of Youth and Social Affairs. According to the Scandinavian model midwifes were selected because they are considered to be trustworthy health professionals who function as mentors for mothers and their babies during the first year of life.

The results of the pilot project were convincing (Collatz, J. et al. (ed.), 1986) :

- almost complete and early access to the target group
- guaranty of the regional sufficient supply of support by midwifes
- remarkable reduction of postnatal infant mortality in the course of the pilot project – also compared to the average German trend
- excellent image of the project within the population

The pilot project was followed by a follow-up measure until May 1985. Today the provision of 5,5 full-time positions for family midwifes is granted by the Constitution of Bremen and part of the health care services offered by the Ministry of Health financed by the City of Bremen.

The midwife-pioneers of Bremen were followed by different family-midwife projects in North Rhine-Westfalia in the 1990's (Schneider, E., 2004).

In the City of Hamburg the first family-midwife project was implemented 1998 with two midwifes. Until 2005 another five projects with a total of eight family-midwives were installed in low-status areas of Hamburg. The family-midwifes are partly adjoined to family-centres and partly to the Department of Health. Thus, they are financed by various sources (federal and municipal finances, fees of the sickness funds and foundation capital).

Since its beginning in 1980, the concept of a family-midwife has experienced changes and developments which will be described in the next chapters.

1.2. Objectives of a family-midwife

The original targets of the pioneer family-midwives in Bremen have been extended and can be summarised as the following:

- Reduction of the infant mortality rate
- Provision of midwife-led pre-and postnatal care of socially disadvantaged women
- Supply of postnatal care of infants born into socially deprived families until their first birthday
- Raising awareness for the usage of the health care system and self-evident access to pre- and postnatal care.
- Improvement of the preventive maternity and infant screenings-utilisation by vulnerable demographic groups
- Empowerment of marginalised families and their infants
- Creation of neighbourhood-networks of mutual support
- Early embedding of families with a need of professional support in social/ medical/ educational institutions
- Corporation with other relevant professionals and institutions (doctors, midwives, nurses, social workers, hospitals, sociopediatric institutions, health department, etc.)
- Networking (round table/ community committees)
- Supervision
- Documentation/ annual reports
- Evaluation and statistics
- Participation in workshops, congresses, training programs

1.3. Target group of a family-midwife

The family-midwives of Hamburg work in various projects; each project covers a certain region or district which has a high density of low-status demographic groups. The selected areas are part of the Active City District Development Program which is described in the next chapter.

The clients of the family-midwife belong to the following sub-populations:

- Single parents
- Recipients of social welfare benefits
- Teenage mothers
- Migrants
- Handicapped mothers
- Drug-addicted mothers
- Mothers suffering from a chronic disease
- Mothers without a shelter

These marginalised families are often not reached by the health care services because they do not manage to climb over the high-thresholds of restricted opening-hours and bureaucratic registration processes. Since screening programs are mandatory it happens that vulnerable families and their infants do not participate in preventive services at all.
The out-reach approach of the family-midwife aims at diminishing the gap of over- and under-provision of particular population groups in the German health care system.

1.4. Home-visits: the predominant tool of the family-midwife

The success of the family-midwife concept is built upon the low-threshold approach of the home-based supply of midwifery care. Ideally, the family-midwife contacts herself or is contacted by the family during pregnancy and starts to deliver ante-natal care at the home of her clients. The fact that vulnerable groups are reached early in pregnancy is an important indicator for creating a sustainable relationship which is marked by trust. Being visited by a family-midwife in their known environment enhances the chances for a successful support of disadvantaged families who often feel misunderstood and do not understand the medical language of health care professionals.
The home-visits last one hour in average and offer room for extensive questions and exchange of information.
The family-midwife gains a deeper insight into the living conditions of a client by home-visits and thus, is capable of adjusting her support strategy to the predominant domestic challenges.
The early onset of the first contact is one precondition for a lasting relationship in order to provide the family with postnatal care until the first birthday of the child.
Continuity of care is an indicator for a successful relationship between family-midwife and the family system. Continuity of care is a marker for good quality of midwifery-led care and it is granted by regular home-visits of the family-midwife over a period of approximately two years per child.
Home-visits are an indispensable tool in the work of family-midwives.

2. The field: an area of the Active City District Development Program[1]

2.1. Demographic data

The region which is covered by the family-midwife is an area of the Active City District Development Program. Starting from 1998 the City of Hamburg implemented the Social City

[1] See 'Bürgerschaft der freien und Hansestadt Hamburg' 2005

District Development Program which is subsidised by the German federal government since 2000.

The program aims at:

- improving the image and quality of living-conditions of low-status areas
- avoidance of a drain-off of middle-status families
- support of move-in of well-off families

The program distinguishes between quarters of development ('Entwicklungsquartiere') and topic-areas ('Themengebiete'). The quarters of development are selected by the senate of Hamburg, the topic-areas are selected by the Office of City Development and Environment.

The field of data collection described in this thesis is a quarter of sky scrapers which is marked by high numbers of unemployment, a high density of recipients of social security benefits and a high percentage of migrants[2].

The population density per hectare of the quarter is almost fifteen times higher than the average population density of the City of Hamburg. The percentage of persons without employment is twice as high compared to the average percentage in Hamburg. The percentage of migrants is two and a half times higher than in the City of Hamburg in general.

The quarter is situated at the edge of a middle class district of Hamburg.

2.2. Data collection

The data collection took place from November 2002 until October 2004 and was done by collection of the social, occupational and medical anamnesis which the family midwife documented in interviews with the clients at their homes.

The chosen method of presenting selected case-studies is an instrument of the qualitative social research. Its intention is the description of social conditions embedded in a societal context which have an impact on the health-behaviour and -outcome of the cases; the cases need to be representative examples for characteristics of distinct demographic groups.

The method is inductive and serves the purpose to describe phenomena of social reality; it does not claim to draw a complete picture of complex issues with general solutions at hand.

It rather invites the reader to shift his/ her perspective of social reality to a new, unexpected point of view.

Drawing conclusions in the context of qualitative research remains a process of interpretation and is marked by open questions and various approaches of understanding.

[2] See appendix iiii. for a detailed list of data collected by the Office of Statistics, Hamburg and Schleswig-Holstein 2006

Thus, the gained insights by analysis of the case-studies yield in recommendations and not in quantitative results.

3. Case-Studies[1]

3.1. Social anamnesis: A single mother of former East Germany with six children

Mrs. B. is 30 years old and pregnant with her sixth child. She lives with four of her five children in a flat of 90 square metres. The apartment consists of one living room, three bed rooms, a kitchen, a bathroom and a separate toilet. The floor of the flat is not covered by a carpet but shows the naked concrete. The walls of the apartment are partly covered by ripped paper-wall, and partly reveal the underlying concrete. The bed rooms are furnished with metal beds, there are neither toys nor desks or chairs for the children. The living room is dominated by a big television set and a sofa with a couch table; a dinner table does not exist. The bath room cannot be closed by a door since the door is hung out of its frame. The separate toilet is partly used as a storage closet as is the balcony and parts of the corridor.

The flat bears the imprint of depression, resignation, deprivation, carelessness, contingency and uprootedness. It is not a cosy home which gives shelter to a mother in good hope with four of her five children. The flat does not breathe the atmosphere of a vivid family life but rather leaves the impression of a functional sleep-in.

Mrs. B. grew up in the German Democratic Republic and moved to Hamburg three years ago. Since she was eight years old, she was raised in children's homes because her parents physically abused her. Mrs. B. has two younger brothers and six step siblings but except with her younger brother she does not have any contact with her family. The father of Mrs. B. was twenty-two years older than his second wife, the mother of Mrs. B., who suffers from diabetes since her twenty seventh birthday. The diabetes meanwhile led to the amputation of both feet, to cataract and to the necessity of a dialysis. The mother of Mrs. B. is taken care of by her son, the younger brother of Mrs. B., who himself is disabled to a degree of 50% due to cataract. The father of Mrs. B. died two years ago at the age of seventy because of a heart attack. The maternal grandmother of Mrs. B. committed suicide at the age of seventy.

Mrs. B. completed nine years in school and started an apprenticeship as a nurse. She did not complete her apprenticeship due to her first pregnancy at age 19. Her first child was born in the 31. week of gestation age by caesarean section and had to spend four month in a neonatal intensive care unit.

[1] The case-studies are based on my observations during many home visits.

During the following three years, Mrs. B. gave birth naturally to three children after she had married an asylum seeking migrant from North Africa who started abusing her physically at the beginning of their marriage. He also abused all of the children. Her fifth child was born another three years later, in 2000, by a re-caesarean section. The wound-healing of the inguinal incision lasted one year.

The family moved from former East Germany to Hamburg, a literally unknown city to them with no social network at all due to a complete lack of contacts .

Since the domestic violence against Mrs. B. and her children never stopped she separated from her husband and moved into the present flat. Shortly after her separation she started a new relationship with an asylum seeking migrant from West Africa who is the father of her sixth child.

Being a child, Mrs. B. suffered from dermatitis, as an adult she developed asthma, chronic bronchitis, nicotine abuse and obesity per magma. Being 164 centimetres tall Mrs. B. weighs 130 kilo. Besides her six completed pregnancies Mrs. B. suffered from three miscarriages and one abortion.

Mrs. B. is receiving social welfare payment. Her oldest nine-year old-son lives in a SOS-children's village because of his aggressive behaviour against his mother which she could not adequately deal with.

Asking Mrs. B. how she would describe the predominant experience in her life she answered that it is mainly shame that she is feeling inside and when she is presenting herself to the outside. The patient-doctor relationship is shaped by her feeling ashamed of her physical constitution and poor living conditions. Nevertheless Mrs. B. is interested in learning about the topic health and shows a good compliance concerning the usage of preventive services.

3.1.1. Health Care perspective

Mrs. B. is a high-risk[2] gynaecological patient for the following reasons:

- Genetic risk to be affected by (gestation) diabetes
- Genetic risk to be affected by a cardiovascular disease (gestation induced high blood pressure/ pre-eclampsia)
- Prevalence of three chronic diseases: Asthma, chronic bronchitis and obesity per magma
- Nicotine-abuse

[2] Catalogue of risks according to the 'Mutterpass' (document about the pregnancy containing the basic medical information, especially anamnestic and actual risk factors, as well as the results of the preventive examinations), which was designed by the National Committee of SHI-physicians and health insurance funds in 1985.

- Multi-para
- Re-caesarean section (one caesarean section was done by an inguinal incision)
- One premature birth
- Three miscarriages and one abortion
- Poor economic conditions
- Poor housing conditions
- Missing social support
- Single mother

Due to the above listed risk factors, Mrs. B. would have needed an intense preventive maternity care in a specialised ambulatory unit, where she would have been checked by a gynaecologist on to her various risk factors more often than prescribed by the regular preventive service. Mrs. B. should have been referred to hospital at the calculated date of the birth, if not before, in order to induce labour by medication and to be under clinical observation.

Instead of her referring to a specialised clinical unit, her gynaecologist conducted the prescribed twelve regular preventive examinations. Mrs. B. entered the hospital six days after her due date, when her labour set in. Because of the commitment of one of the senior gynaecologists, she gave birth naturally and left the hospital one day after delivery.

Either the office-based gynaecologist of Mrs. B. communicated directly with the senior gynaecologists at the clinical maternity facility nor did the hospital check with Mrs. B. prior to her referral if she was provided with domestic midwifery-led puerperal care.

Having in mind that Mrs. B. blames herself for being in such devastating state of reproductive health and living conditions, one may assume with considerable evidence that the patient-doctor-communication was of poor quality. That fact leads despite her willingness to be compliant to a low level of understanding on the patient side. This again is one of the main causes for bad (not deliberately intended bad) compliance of patients which may have fatal consequences, especially concerning high-risk patients as Mrs. B.

Would Mrs. B. not by chance have been an inhabitant of the district where the project of the family-midwife is implemented she would not have been provided with ambulatory domestic midwife-led ante- and postnatal care, because firstly her gynaecologist would not have told her that she is legally entitled to search for a midwife and secondly Mrs. B. would not have been health literate enough to gather that information by herself. Being raised in the German Democratic Republic, she grew up in a Health care system which was controlled by the state and where all pregnant women had to participate in the compulsory ante-natal preventive

services. High-risk patients were by obligation transferred to 'Schwangeren Dispensaires' (specialised maternity facilities adjoined to hospitals) in order to be under rigid medical control. Pregnant women and mothers of a new-born who did not appear at the preventive examinations were visited at home by 'Fürsorgerinnen' (social workers) and were stimulated by considerable financial incentives to make use of the preventive services. In addition to that an attractive amount of 'Still-Geld' (breast feeding-money) was paid exclusively to breast feeding mothers. Infants were handled by day-care institutions at the age of three month. All day care institutions employed a clinical paediatrician who regularly performed preventive examinations and vaccinations and could be called for emergencies.

> *The provision of health care services especially for women has according to former East German doctors changed to the worst since the reunification. In the GDR highest attention was paid to the medical care of women – although reduced to gynaecology and occupational diseases. The abolition of the maternity facilities providing compulsory pre- and postnatal care is judged upon as a 'catastrophe' by the doctors. […] (Lützenkirchen, A. 2000, p. 76. Translation E.S.)*

Being familiar with a rigid,. professionally controlled and prescribed delivery of preventive services, Mrs. B. does neither possess the knowledge how to take responsibility in making use of the available different medical preventive services in the Federal German health care system nor does she have any social capital (friends, family, networks) [3] which could help her to close the gap of missing navigation skills while moving through a health care system which forces her to make many choices on her own. As a German citizen Mrs. B. has the legal claim on the right to information which is transparent to her despite her poor educational background[4]. As mentioned before, Mrs. B. was contacted by the family-midwife. This coincidence led her to be accompanied by midwife-based pre- and postnatal care, including home visits; it enabled her to participate in a preparatory birth class and in a gymnastic class eight weeks after birth and in an open monthly breakfast for mothers with their babies.

The home visits usually lasted for one hour. They offered Mrs. B. the opportunity to ask questions concerning her pregnancy, nutrition, psyche, necessary medical treatment, etc. By encountering the domestic environment of Mrs. B., the family-midwife reached a deeper understanding of her social background and her need of psycho-social support.

Mrs. B.'s participation in the preparatory birth class gave her the chance to enhance her knowledge about the processes of pregnancy, birth and childbed, to perceive her body in

[3] The sociological term 'social capital' was introduced by the French sociologist Bourdieu. It describes the number and hierarchical positioning of personal social relations as social capital. (Bourdieu, P., 1997)

[4] see part I chapter 1.1.

relaxation and physical exercise and to get in contact with other pregnant women living in her direct neighbourhood.

The postnatal midwife-led care until the baby's first birthday supported Mrs. B. in breast feeding her child four and a half months exclusively, in building up a safe mother-child relationship and in making use of the infant preventive services. The gymnastic class after birth allowed Mrs. B. to experience physical training and wellness within a group setting; the open breakfast for mothers served as a platform to exchange positive and difficult experiences with the baby, and to start networking with neighbours. In sum, it served the purpose of breaking the social isolation of Mrs. B., an aim, which was not accomplished sustainable.

Mrs. B. turned out to become eager to enhance her health literacy in the interest of herself and her children; she participated regularly in the classes of the midwife and she turned out being not only a compliant client but also felt empowered by the dates of home visits and recommendations given by the midwife.

3.1.2. Socio-economic perspective

Mrs. B. has finished nine years of schooling in the German Democratic Republic (GDR) and has not learnt an occupation. She began an unsuccessful apprenticeship as a nurse shortly after the reunification of Germany and experienced the change of the political system socialism with practically no (officially admitted) unemployment to the West German social market economy with high unemployment.

Along with the almost 100 per cent "employment" of the East German working population (men and women) went the complete regional coverage of day care institutions for infants above three months of age. With the availability of day care institutions even for infants, women in East Germany were thus able to enter the labour market, very much unlike women in West Germany where to this date availability of day care for infants and toddlers is substandard. The women of the GDR were therefore lost out after reunification in 1990.

Mrs. B. has a low educational background and since she has no professional training, she lacks any occupational status because mothers and housewives are not given an occupational status in the official statistical categories. Being a single mother, Mrs. B. belongs to the largest group (in numbers) of the population which is dependent upon social welfare[5]and suffers from income poverty. Being a single mother with three or more children increases

[5] According to the '2. Armuts- und Reichtumsbericht der Bundesregierung' (second governmental report on poverty and wealth in Germany) 2005, p. 63f.

Mrs. B's risk of becoming a long-term poor[6] significantly and raises the percentage from 26,3% (share of single mothers being dependent upon social welfare) up to 46,5%. Applying the class index by Helmert[7] to Mrs. B., she is part of the lower class. Therefore she is highly susceptible for the experience of discrimination concerning her state of health measured in QUALY'S[8] and her life expectancy.

> *The higher prevalence of health risks and diseases in the low income-groups of a population correlate with the mortality-rates. The lowest income-groups have a two times higher mortality-rate than the highest income-groups. […]*
> *Taking into account the age-factor the risk of suffering from a chronic disease or ill-health is 1,2 times higher for people with a low educational status.*
> *(Federal Ministry of Health and Social Security, 2005; p. 132f.. Translation E.S.)*

Table3: Income and life expectancy[9]

	Life expectancy in years	***Life expectancy in years***
Equivalence income	***Men***	***Women***
a) upper 50% of the income distribution	***81***	***85***
lower 50% of the income distribution	***77***	***83***
b) upper 25% of the income distribution	***82***	***86***
lower 25% of the income distribution	***72***	***81***

Data: socio- economic panel (1984-1997);Sample: 2.675 men and 3.136 (new federal countries, Germans); 939 deaths
Source: Reil-Held, A. (2000) (Translation E.S.)

The fact that Mrs. B. is part of a disadvantaged sub-population due to her missing profession, her poor income and the number of her children leads to the consequence that she suffers from discrimination concerning morbidity and life expectancy.

3.1.3. Legal Perspective

Mrs. B. is disadvantaged in claiming her right to health due to the following reasons:
She does not possess the digital skills which are needed in the German information society in order to acquire available new medical information. Mrs. B. is not capable to express her

[6] Collecting social welfare payment more than 60 months (according to 'Alleinerziehende und Sozialhilfe', page 53)
[7] See part I chapter 2.1
[8] Quality Adjusted Life Years; definition according to the WHO.
[9] Gutachten Sachverständigen Rat ' Koordination und Qualität im Gesundheitswesen' (coordination and quality of the health care system. expert evidence of the expert's committee; page 123) 2005.

medical complaints in a distinguished way because she has a low educational background; for this reason she does not take sufficient profit out of the patient-doctor-relationship. In addition, Mrs. B. cannot compensate her intellectual deficiencies by financial incentives while consulting the doctor. As a result, she experiences short duration of doctor-contact and a lack of transparency concerning the medical advice.

Being a single mother adds to the compilation of disadvantages in Mrs. B.'s life. The poor day-care infrastructure (insufficient regional coverage, limited opening hours) in Germany leads to the fact that mothers are discriminated in regard to employment or training measures. The poor employment rate of mothers is one reason for the high risk of age-poverty among German women.

The children of Mrs. B. are at high risk to develop damaging health behaviour as a result of the low socioeconomic milieu they live in. The fact that their mother depends on social security benefits increases the probability of their failure in school and their great difficulty in being accepted for an apprenticeship.

The above listed disadvantages which mark Mrs. B.'s biography due to a complex set of conditions cumulate in the discrimination regarding the health chances of her and her children and their right to education.

3.2. Social anamnesis: A single juvenile mother with one child

Ms. D. is a nineteen-year old primi-gravida. She lives between the twenty-second and thirty-fourth week of gestation age under the protection of an association [10] which offers refuge to teenager mothers without shelter. Ms. D. had escaped from prostitution under dramatic circumstances and found refuge in that institution. Her former boyfriend and father of her child, a German-Nigerian, had forced her into prostitution. He financed his drug addiction by Ms. D.'s income. She reported him to the authorities and he was arrested and spent one year in jail.

Until the twenty-second week of gestation age, Ms. D. was a heavy Marihuana and cigarette smoker; while having to work as a prostitute and being pregnant she lived in a permanent state of despair, anxiety and disgust against herself and her clients.

Ms. D. grew up as the only daughter of a single juvenile mother who refuses until today to tell the name of Ms. D.'s father who is supposed to be an Italian and a one-night affair of the

[10] The social workers of this association also support mothers who decide to deliver their babies anonymously either by accompanying them to one of the five confessional hospitals in Hamburg which allow anonymous births or by offering the permanent opportunity to put their new born anonymously into a 'Babyklappe' (permanently observed, safe and warm place) where the baby is professionally taken care of and eventually adopted by adoptive-parents. (Swientek, C., 2003)

mother. Being ten years old, Ms. D. was taken away from her mother by the department of youth protection and placed in various professionally led youth-apartments until she was able to live by herself. Ms. D.'s mother is an alcoholic who was not able to protect her daughter from the sexual abuse by her changing partners.

The maternal grandparents of Ms. D. were refugees from former East Prussia, today's Poland, and lived in poor economic and housing conditions: two grown-ups and three children in an apartment consisting out of two rooms. The maternal grandfather, two maternal uncles and the mother of Ms. D. were alcoholics. Her grandfather had two by-passes, cancer of the testis and committed suicide at the age of seventy-five by jumping from a sky-scraper.

Ms. D. developed dermatitis as a child and started to smoke Marihuana excessively at the age of fifteen. She broke up her school education and therefore does not possess a school certificate which would be a precondition for a professional training. Ms. D. is underweight; being 187 centimetres tall she weighs sixty kilo.

Her first intimate boyfriend became the father of her child and turned out to be her pimp who also abused her physically.

After the thirty-fourth week of gestation Ms. D. moves to her seventy-eight year old maternal grandmother who lives in a two-room apartment of approximately 45 square metres. Ms. D. prefers to share the narrow flat and even the bed with her grandmother instead of moving into her own rented apartment because she is still dominated by fear and panic after her traumatic experiences as a prostitute against her will.

Within the old-fashioned furnished cosy apartment of her grandmother Ms. D. finds a safe environment for herself and her baby. While leaving the house she feels safest and most protected within the company of her still-working grandmother who has a dominant, strong, rigid personality but also a generous, loving attitude towards her granddaughter.

Ms. D. is a recipient of social security benefits; she has a high motivation to create a better family-life for her child than she had experienced it during her own childhood.

3.2.1. Health Care perspective

Studying Ms. D.'s social and medical family- and individual anamnesis one identifies the following risk-factors which are categorised by the risk-factor-catalogue of the "Mutterpass":[11]

- Genetic risk of alcoholism
- Nicotine abuse

[11] See part I chapter 3.1.1.

- Illegal drug abuse
- Trauma patient
- Poor economic conditions
- Poor social conditions
- No preventive gynaecological examinations until the twentieth week of gestation
- Underweight
- Single mother

Ms. D. did not participate in the ante-natal preventive service until she has accomplished half of her pregnancy because she was forced into prostitution and forbidden by her pimp to move freely through the city of Hamburg. Being existentially threatened by psychological, physical and sexual violence, Ms. D. numbed herself by drug abuse and kept her pregnancy secret until her successful escape from the traumatic living conditions.

Her courageous flight was a sign of mental strength and the activation of survival instincts. Nevertheless, the gynaecologist should have referred Ms. D. to a psychologist or trauma expert in order to give her the chance to begin a healing process of her so far traumatic pregnancy.

During the ante-natal diagnostics, it would have been indicated to transfer Ms. D. to a specialised ambulatory unit for three-dimensional ultra-sound examinations in order to check the foetal organs if there were any abnormalities as a consequence of the excessive drug abuse. Instead of being referred to a psychologist and gynaecologist who is specialised in ante-natal diagnostics, Ms. D. was sent to hospital by her gynaecologist because of pre-term labour in the thirty-fourth and thirty-ninth week of gestation. Both times Ms. D. spent around one week in hospital being treated with tocolytical[12] infusion therapy but without being seen by a psychologist or psychiatrist.

Since Ms. D. does not possess a school certificate and is neither eloquent nor well informed about her patient rights, she belongs to the group of patients whose communication-skills with doctors are poor and may lead to a shorter duration of doctor-consultation. In addition to that she feels ashamed of her past as a prostitute and did not reveal herself to the doctor so that her specific risk-factors were not known to her gynaecologist.

> *[…] The patient-doctor-relationship is influenced by the social situation of the patient directly. It is not only the personal communication with the doctor which is touched by it but also the mode and quality of the further treatment. Patients who are not able to tell their complaints in detail are treated by their doctors rather by routine. This may lead*

[12] Tocolysis: stopping of labour by pharmaceutical treatment. Predominantly used are beta 2-sympaticomimetica (Fenoterol). Its effectiveness in long-term therapy is discussed controversially.

to the doctor explaining the results of diagnostics and therapy only insufficiently and medical action will remain unclear for the patient. As a consequence, doctor-hopping or consultations at a later, for the therapy worse, point of time is a common behaviour among patients when success of treatment is missing. [...]
(Eßer, P.,1994; p. 171. Translation E.S.)

Seen from a sociological perspective it may be expressed by the following citation:

'A person's past social experiences become written into the physiology and pathology of their body. The social is, literally, embodied; and the body records the past, whether as an ex-officer's duelling scars or an ex-miner's emphysema. The duelling scar as mark of social distinction, in turn, predisposes to future advancement and social advantage, while the emphysema robs the employee of their labour power and predisposes to future deprivation and social disadvantage… the social distribution of health and disease results from these processes of accumulating advantage or disadvantage.' (Blane 1999: 64 quoted in: Bottero, W., 2005; p. 204.)

Ms. D. contacted the family-midwife because of a recommendation of the social workers employed at the association which initially gave her shelter after having escaped from prostitution and participated in the preparatory birth class. This gave her the chance to get in touch with her pregnancy and her unborn baby in a protected, safe atmosphere and to start enjoying the process of being pregnant. For the first time Ms. D. experienced her body not only as a field of physical and sexual abuse but also as a well-working organism which offers perfect room for her growing child. She collected essential information about physical and psychological changes during pregnancy, the process of birth-giving and the needs of a new-born.

Ms. D. learnt to share her difficult experiences and questions concerning the pregnancy within a small group of pregnant women; she started to become a health-literate person who takes on responsibility for her own and for her baby's physical well-being. She quit smoking and delivered her daughter naturally in the fortieth week of gestation. Ms. D. breast fed five months exclusively. The postnatal home visits of the family midwife accompanied Ms. D. until the first birthday of the child and supported her in building up a strong bond towards her infant.

She proved to be a compliant, reliable mother who went over a period of more than one year regularly once or twice a week to the prescribed infant's physiotherapy because of its retarded physical development.

3.2.2. Socio-economic perspective

Ms. D. is a single, juvenile mother who has not attained the lowest available school certificate and therefore has a high risk to become a long-term poor citizen depending on social welfare payment.[13]

> *[…] Dependants without a school-certificate collect with an average of 27 months longer social welfare payment than dependants with a school-certificate (average duration of dependency: 24 months). [...]*
> *(Federal Ministry of Health and Social Security, 2005; p. 64. Translation E.S.)*

The social integration of Ms. D. in the German society depends to a great extent on her capability of finding access to the labour market which will be an almost impossible endeavour as long as she does not possess a school certificate.

> *[…] Despite their different history since the second World War, East and West Germany have in common: they are – like most of the industrial societies –societies based upon employment. Within society income chances as well as participation and chances in life are bound to employment. With other words citizens of these countries are integrated in society especially through their employment. […]*
> *(Federal Ministry of Health and Social Security, 2003; p. 39. Translation E.S.)*

Ms. D. faces many obstacles in struggling for accomplishing school but one of the main hindrances is the lack of flexible day-care institutions for infants.

> *[…] Despite its excellent quantitative provision of day-care institutions for infants under three years of age in the new federal countries ('Neue Bundesländer') Germany stands with a percentage of 8,6% coverage by day-care institutions clearly back compared to Sweden, Denmark or France. That and the lower employment rate of mothers compared to other European countries make a change of family-policy necessary. […]*
> *(Federal Ministry of Health and Social Security, 2005; p. 80 f.. Translation E.S.)*[14]

Ms. D.'s many disadvantages concerning her economic, social and cultural integration in society which are rooted in her social origin, lack of adequate education, missing social network and cultural capital cumulate in the fact that she is a single mother having to depend on social welfare payment and insufficient coverage by day-care institutions.

[13] See part I chapter 2.2.2. and part II chapter 3.1.2.
[14] see part I chapter 1.2.

3.2.3. Legal Perspective

Ms. D.'s access to health care services is burdened because she misses necessary information and education skills which are a key for discovering the hidden health care service dimensions. Ms. D. is at risk to not take full advantage of her legally granted right to health without distinct communication abilities and with a lack of financial resources.

As long as she will not claim her being eligible to have full accessibility to health care services the German health care system will not offer support to her in doing so.

Since Ms. D. is a juvenile single mother her chances in accomplishing a school degree decrease because of the structural deficiency of day-care institutions with flexible opening hours. If Ms. D. will not manage to finish her school degree she will face many-fold obstacles in being accepted for a professional training. If Ms. D. remains unskilled she will suffer from a high income-poverty-risk.

The socioeconomic status of Ms. D. has a strong impact on the education chances of her child. The lower the status of Ms. D. the worse the chances of her daughter to participate in a high school and professional training.

Ms. D. is discriminated in claiming her right to health and education mainly because she is poor, not educated and a single juvenile mother.

3.3. Social anamnesis: An asylum-seeking Iraqi mother with one child

Mrs. F. is an asylum-seeking migrant from Iraq who is pregnant with her first child. She emigrated from Iraq in 2002 because of her refusal to become a member in the reigning Baath-party of Saddam Hussein. Mrs. F. finished twelve years of school and after having completed the study of art she worked six years as a teacher in Iraq.

Mrs. F. has ten siblings; her mother got married at the age of twelve and, at age fourteen, she gave birth to her first child. Despite her many pregnancies, the mother of Mrs. F. is of good health. Whereas the father of Mrs. F. died of a heart-attack at the age of fifty after he got to know that his oldest son had died in the first Gulf-war in 1991. Mrs F. family still lives in Iraq; she has not one single relative living in Germany.

After immigration to Germany, she met her Iraqi husband who is twenty-one years older than herself and who lives in Germany since 1992, seeking political asylum. Mrs. F.'s husband is a carpenter but he is not employed so that the family has to depend on social welfare benefits.

Mrs. F. and her husband live in a single-room apartment of forty square-metres. The one room serves as dining-room, reception-room for guests and bed-room. Mrs. F. has no extra room where she could withdraw to during pregnancy and take a rest.

Mrs. F. speaks almost no German when she discovers her pregnancy although she had visited a German language course for migrant women and is eager to improve her German.
Before Mrs. F. got pregnant she had to be treated with hormonal therapy because of lacking luteous hormone. The fact of her inability to communicate with the gynaecologist and to understand the treatment is a permanent source of frustration to Mrs. F.: she feels misunderstood or not understood at all by her gynaecologist.
Mrs. F. suffers from solitude and social isolation since her husband is the only person she trusts, communicates directly with and is in relationship with. Mrs. F. finds inner strength, consolation and encouragement in her Islamic belief which she practices out of a deep conviction.
Her strong wish to become the mother of a child needs to be understood besides other aspects as the desire to found and to be part of a family in a foreign country where Mrs. F. has no relatives.

3.3.1. Health Care perspective

As a gynaecological patient Mrs. F. combines the following risk-factors listed in the "Mutterpass"[15]:

- Genetic risk of gestation diabetes (father of Mrs. F. suffered from diabetes)
- Genetic risk of a cardiovascular disease
- Gestation-inducing hormonal therapy
- Migrant, lack of language skills
- Poor economic conditions
- Missing social network
- Poor housing conditions

The gynaecologist did not have the chance to communicate directly with Mrs. F. because she did not speak German and the gynaecologist did not know any Arabic. If Mrs. F. was accompanied by her husband while visiting the doctor the husband probably served as a lay translator who is not familiar with medical expressions and who may not be allowed (due to traditional habits) to know everything about his wife's medical history. But since there does not exist a professional medical translation service for migrants which is paid and offered by the health insurance funds[16] the gynaecologist has to ask relatives – mostly the husbands of his/ her patients – to function as translators in order to gather medical information about his or

[15] See part I chapter 3.1.1.
[16] There are private medical translation services , e.g. 'lingua medica' in Hamburg. But these have to be paid for by the patients or hospitals themselves.

her patients. If the gynaecologist does so s/he may at least collect some important anamnestic facts but it will not be checked by any institution if s/he simply cannot communicate with migrant patients because of missing translation skills[17].

Mrs. F. has to trust her medical treatment blindly because she is not able to understand her doctor's therapy or to ask questions concerning the pregnancy. She does not know of her patient right to give informed consent which Western medical professionals have agreed upon.

Mrs. F. does not know about the preventive services she is entitled to claim or that she has the right to choose a doctor and a hospital because she was raised in a country where medical services are either state-run or financed by out-of–pocket-expenses.

Mrs. F. is a health-illiterate in the German health care system and she cannot count on systematic professional support while moving through an unknown medical topography. Again, this demonstrates that German health services do not cater to migrants effectively, and in a human rights perspective could be seen as inadequate. The Federal Ministry of Health and Social Security acknowledges this:

> *[...] Nevertheless do exist deficiencies in the provision of pregnant migrants. They still participate less than German women in preparatory birth classes or gymnastic classes for pregnant women. Concerning an adequate supply of female and male migrants within the German Health care system there is a demand for a migrant-specific delivery of services and a flexible adjustment of the existing, well designed medical infra-structure to the needs of migrant patients. […]*
> *(Federal Ministry of Health and Social Security, 2005; p.165. Translation E.S.)*

Mrs. F. was transmitted to the family-midwife by her German teacher who happened to work door to door with the midwife. It was thus by mere coincidence that Mrs. F. came across a medical professional with suitable translation skills as well as midwifery-based gynaecological knowledge and practical support. Mrs. B. searched for midwifery advice intensely throughout the pregnancy and during her baby's first year. She participated in a preparatory birth class which gave her the opportunity to learn about the physiological process of pregnancy, delivery and childbed. This strengthened her bodily self-confidence in mastering the difficulty of giving birth. Besides these aspects, Mrs. F. improved her social and German language skills by listening to and sharing experiences with other pregnant women.

Except an interval of hyperemesis[18] until the twelfth week of gestation Mrs. B. experienced a pregnancy without complications and gave birth naturally three days prior to the calculated

[17] Borde,T./ David, M., 2001 describe deficiencies in provision of care for Turkish migrant women in the German health care system.

date of birth. She took part in the post-natal gymnastics class eight weeks after birth and breast fed her son six months exclusively. She continued breast feeding partly until his second birthday.

3.3.2. Socio-economic perspective

Despite her high educational and occupational background[19] Mrs. F. is a migrant and depends on social welfare. At the end of 2003 3,4% of all citizens collected social welfare payments. 8,4% of these were migrants compared to 2,9% of dependants with German nationality[20].
Being a migrant in Germany raises the risk of being poor significantly, regardless of existing educational, respectively occupational resources.
Mrs. F.'s high risk of being poor because of her migrant status increases the probability of social exclusion which itself has an impact on health chances and access to health care services.

> *[…] Exclusion processes are dynamic and multidimensional in nature. They are linked not only to unemployment and/ or to low income, but also to housing conditions, levels of education and opportunities, health, discrimination, citizenship and integration in the local community (European Social Policy White Paper 1994,quoted in: Oppenheim and Harker 1996, p. 156). […] (Marmot, M./ Wilkinson, R. G., 1999; p. 222)*

The importance of social position in determining the health of migrants is described in the following quotation by Nazroo (1998):

> *[…] The ethnic classification we use do not reflect unchangeable and natural divisions within groups. Also ethnicity does not exist in isolation, it is within a social context that ethnicity achieves its significance, and part of that social context is the ways in which those seen as members of ethnic minority groups are racialised. Indeed, one of the most important purposes for undertaking work on ethnicity and health is to extend our understanding of the nature and extent of the social disadvantage faces by ethnic minority groups. Not only is health part of the disadvantage, it is also a consequence. […] (Nazroo 1998, p.8, quoted in: Marmot, M./ Wilkinson, R. G., 1999; p. 227)*

Mrs. F.'s discrimination appears in several facts: due to her migrant status she is suffering from income poverty and lack of language skills; being a mother of an infant she is disadvantaged in visiting an intense language program for migrants.

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[18] Hyperemesis gravidarum: excessive vomiting during the first four -five months of pregnancy which mostly is of psychosomatic origin
[19] Foda, F./ Kadur, M., 2005 detail life stories of a number of refugee women with high educational attainment who are, despite of their attainments, unable to participate in the German labour market.
[20] 2. report on wealth and poverty (Federal Ministry of Health and Social Security, 2005; p. 60. Translation E.S.)

3.3.3. Legal Perspective

Being a migrant Mrs. F. is considered to be a health illiterate in the German health care system because she does not know German and she is not familiar with German health care standards.

These preconditions are the basis for the discrimination in attaining her highest attainable state of health. The main factor of being discriminated is the burdened access to health care services in Germany.

Besides the absolute lack of language skills Mrs. F. suffers from discrimination due to her poor economic resources and due to her motherhood. Being a mother of an infant makes it extremely difficult to visit an intense language training which would improve her German and her chance to eventually find a job.

Being born into a migrant family increases the risk of Mrs. F.'s son to have a negative school career and diminishes his chances on the labour market.

Mrs. F.'s example demonstrates the discriminating effects migration has for migrants and in regard to reproductive health how migrant women are discriminated in a particular way.

4. Recommendations

The selected case-studies demonstrate the association of social inequality and health inequality. Due to various conditions which can be derived from social, educational, rhetoric, lobby and financial disparities, socially disadvantaged demographic groups suffer from hidden discrimination in the German health care system.

This concealed discrimination needs to be understood as a contradiction to one of the main goals of German health policy: every German citizen has the same legal claim to health care service-access.

This thesis intends to discover blank spots and pitfalls within the health care system illustrated by the provision of ante- and postnatal care.

Since hidden discrimination is not easy to detect and to explain there cannot be one strategy to close the gap between formal claim and societal reality. The solution is rather to be found in an strategic approach which aims at steering policies and regulations as well as changing professional consciousness in order to give health equality a chance in practice[1].

Starting from the policy level it is evident that a policy regulation is missing which steers the regional establishment of health care professionals (doctors, midwifes, physiotherapists, etc.).

[1] See Appendix iiiii.

The even regional distribution of health care services in accordance to the population density is a precondition for diminishing the gap between over- and under-provision of demographic groups. Offices of health care professionals which are situated in low-status areas need to get financial compensations by the sickness funds due to their lack of privately insured patients.

The fee schedule item for consultation time has to be valued higher, especially concerning patients with a lack of information or language skills.

The sickness funds have to introduce a fee schedule item for medical translator services which have to be proposed by hospitals or health care professionals in cases of missing communication skills. The interdisciplinary corporation of health care services and social services needs to be promoted and enhanced systematically by their professionals.

Besides adjusting the office-based and stationary health care setting to social reality the health policy has to focus at the community setting in order to improve the health chances for all. Here, low-threshold outreach approaches have to be promoted and play a central role in attaining better utilisation-rates of screening services. The concepts of family health nurses and family midwifes are examples for approaches which serve the needs of marginalised sub-populations; the existing sporadic projects have to be added and extended regionally.

The usage of ante-natal and infant screening programs will be improved by changing them from mandatory to obligatory or by offering attractive financial incentives for participating parents.

Last not least, the training of health professionals has to be reformed and adjusted to the needs of clients and a modern societal reality. The curricula of students in medicine, care, midwifery, physiotherapy, etc. have to be expanded and deepened in regard to their modules ‘patient-communication’, ‘psychology’, ‘epidemiology’, ‘prevention-medicine’ and ‘health promotion’. The enhancement of communication-skills concerning anamnestic data collection and explanation of therapy deserves a great priority; not only, in terms of improving the accessibility of vulnerable groups to the health care services, but also in terms of continuity of care, of sustainable quality assurance, medication reduction and cost reduction.

Patients compliance depends to a great extent upon the understanding of a proposed therapy; the patient of today is not willing to put blind trust in the medical advice like he used to do it fifty years ago. Thus, all health care professionals have to change their hierarchical attitudes and communication behaviour towards their clients in order to improve their therapy outcomes. A successful client-professional relationship may lead to greater mutual respect, to a more satisfying professional self-evidence and eventually to a better health outcome.

Finally, all recommendations aiming at reduction of health inequality which have been documented by experts during the past thirty years will remain idealistic guidelines as long as the political will for action is missing.

Outlook

The Senate of Hamburg has decided to implement five new family-midwife projects in areas of the Active City District Development in 2006. The public discourse about the need of societal solidarity and particular support for disadvantaged families and their children is vivid. The federal government of Germany has put a family-promoting policy high on its agenda, because the birth rate of Germany is one of the lowest in Europe and the demographic change draws a threatening picture of future German society.

The future will discover if political will based on expert knowledge will possess enough impact to put the human right to health into practice and to make health policy just for all members of society.

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Appendix

Contents

i. General Comment No.14/ 2000 on the right to health

1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable.

2. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties ... to achieve the full realization of this right". Additionally, the right to health is recognized, inter alia, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments.

3. The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and

movement. These and other rights and freedoms address integral components of the right to health.

4. In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However, the reference in article 12.1 of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

5. The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.

6. With a view to assisting States parties' implementation of the Covenant and the fulfilment of their reporting obligations, this General Comment focuses on the normative content of article 12 (Part I), States parties' obligations (Part II), violations (Part III) and implementation at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V. The General Comment is based on the Committee's experience in examining States parties' reports over many years.

I. NORMATIVE CONTENT OF ARTICLE 12

7. Article 12.1 provides a definition of the right to health, while article 12.2 enumerates illustrative, non-exhaustive examples of States parties' obligations.

8. The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

9. The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

10. Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. Moreover, formerly unknown diseases, such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12.

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and

reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

(b) Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged

groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

13. The non-exhaustive catalogue of examples in article 12.2 provides guidance in defining the action to be taken by States. It gives specific generic examples of measures arising from the broad definition of the right to health contained in article 12.1, thereby illustrating the content of that right, as exemplified in the following paragraphs.

Article 12.2 (a). The right to maternal, child and reproductive health

14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a)) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.
[…]
(CESCR, General Comment No. 14/2000)

ii. Additional, individual preventive services

The following services have to be paid by the patients out-of-pocket.

Medical costs:

- Pregnancy test 10 Euro
- Ultrasound until the eighth week of gestation 25 Euro
- Additional ultrasound in pregnancy 40 Euro
- Consulting and blood-sample (toxoplasmosis, triple-test, ß-HCG, Chicken-pox…) 15 Euro
- Blood-sample 4 Euro
- Diabetes screening 20 Euro
- First trimester screening (neck transparency-ultrasound) 65 Euro
- First trimester screening (neck transparency-ultrasound and laboratory) 70 Euro

Laboratory costs:

- Chicken-pox serology 14 Euro
- Chlamydia-smear, diagnosis 29 Euro
- Bacteria (various)-smear 30-100 Euro
- ß-HCG serology 15 Euro
- Toxoplasmosis serology 14 Euro
- Abnormal toxoplasmosis serology 40 Euro
- First trimester screening (free ß-HCG, PAPP-A, 11.-14.week of gestation) 34 Euro
- Triple-test (ß-HCG, fetoprotein, oestradiol, 16.-18.week of gestation) 44 Euro
- HIV-serology 17 Euro

('Bundesärztekammer' German medical association, 2002. Translation E.S.)

iii. Original data of the study 'provision of midwifery-based postnatal care in Hamburg, 1999'

	Author: Barbara von Richthofen-Krug 1999		
District	**Non-provision**	**average annual birth rate (1994-97)**	**Average capacity of midwifery-based postnatal care per year (1999)**
(Hamb.-Old City	*15,75*	*20,25*	*36)*
(New City	*-69,5*	*105,5*	*36)*
Old-and New City (Total)	-53,75	125,75	72
St.Pauli	65,15	351,25	416,4
St.Georg	-46,5	100,5	54
Klostertor	-12,5	12,5	0
Hammerbrook	-6,25	6,25	0
Borgfelde	-53	53	0
(Hamm-North	*-158,25*	*198,25*	*40)*
(Hamm-Center	*-67,75*	*107,75*	*40*
(Hamm-South	*5,75*	*34,25*	*40)*
Hamm (Total)	-220,25	340,25	120
Horn	-227,5	353,5	126
Billstedt	-543	687	144
Billbrook	-39,25	39,25	0
Rothenburgsort	-20,25	98,25	78
Veddel	-51	81	30
Kleiner Grasbrook	-35	35	0
Steinwerder	-0,75	0,75	0
Waltershof	-0,25	0,25	0
Finkenwerder	-26,75	146,75	120
(Altona-Old City	*-42,3*	*331,25*	*288,95*
(Altona-North	*30,7*	*258,25*	*288,95)*
Altona (Total)	-11,6	589,5	577,9
Ottensen	-265,25	397,25	132
Bahrenfeld	-98,5	248,5	150
Gross Flottbek	18,9	91,5	110,4
Othmarschen	-22,25	88,25	66
Lurup	-68,75	284,75	216
Osdorf	-158,25	224,25	66
Nienstedten	-51,25	63,25	12
Blankenese	14,5	111,5	126
Iserbrook	-83,5	89,5	6
Suelldorf	-28,5	64,5	36
Rissen	-59,35	109,75	50,4

Eimsbüttel	277,4	561	838,4
Rotherbaum	-149,5	161,5	12
Harvestehude	-118	136	18
(Hoheluft-West	*-128*	*128*	*0)*
Lokstedt	-135,5	201,5	66
Niendorf	-36,25	312,25	276
Schnelsen	-96,75	294,75	198
Eidelstedt	-145	241	96
Stellingen	-154,5	196,5	42
(Hoheluft-East	*-94*	*94*	*0)*
Hoheluft (Total)	-222	222	0
Eppendorf	324,75	229,25	554
Gross Borstel	-17,5	71,5	54
Alsterdorf	-32,5	98,5	66
Winterhude	127,5	502,5	630
Uhlenhorst	7,75	130,25	138
Hohenfelde	-89,5	89,5	0
(Barmbek-South	*-61,75*	*268,75*	*207)*
Dulsberg	-188,75	200,75	12
(Barmbek-North	*-188,75*	*395,75*	*207)*
Barmbek (Total)	-250,5	664,5	414
Ohlsdorf	-134,5	134,5	0
Fuhlsbüttel	30,25	107,75	138
Langenhorn	-220,75	364,75	144
Eilbek	-132	174	42
Wandsbek	12,75	305,25	318
Marienthal	-70,5	88,5	18
Jenfeld	-196	256	60
Tonndorf	-86	122	36
Farmsen-Berne	-55,25	253,25	198
Bramfeld	-329	449	120
Steilshoop	-109,75	181,75	72
Wellingsbüttel	53,25	72,75	126
Sasel	75,5	164,5	240
Poppenbüttel	79,25	142,75	222
Hummelsbüttel	-15	147	132
Lemsahl-Mellingstedt	-42,75	72,75	30
Duvenstedt	-24	48	24
Wohldorf-Ohlstedt	-9,25	33,25	24
Bergstedt	27	69	96
Volksdorf	125	133	258
Rahlstedt	-322,25	736,25	414
Lohbrügge	-237,25	303,25	66
Bergedorf	3	495	498
Curslack	-22	34	12
Altengamme	-11,75	23,75	12
Neuengamme	-19,75	31,75	12

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Kirchwerder	-68,25	104,25	36
Ochsenwerder	-12,75	24,75	12
Reitbrook	10	2	12
Allermoehe	-19,25	43,25	24
Billwerder	-12,5	12,5	0
Moorfleet	-9,5	9,5	0
Tatenberg	-5	5	0
Spadenland	-3,75	3,75	0
Harburg	491,25	226,75	718
Neuland	-17,5	17,5	0
Gut Moor	-1,5	1,5	0
Wilstorf	-167	167	0
Roenneburg	-33,5	33,5	0
Langenbek	-40,75	40,75	0
Sinstorf	-24	24	0
Marmstorf	-66,5	66,5	0
Eissendorf	-208,75	208,75	0
Heimfeld	-194	218	24
Wilhelmsburg	-426,75	636,75	210
Altenwerder	-4	4	0
Moorburg	-12,25	12,25	0
Hausbruch	-148,25	148,25	0
Neugraben.-Fischbek	-179,75	263,75	84
Francop	-6,5	6,5	0
Neuenfelde	-53,75	53,75	0
Cranz	-22,5	22,5	0
Total	**-5.852,25**	**16.407,75**	**10.555,5**
blue = low social status area	black = middle social status area	grey = good social status area	
red = non-provision of women in low status districts	Pink = district total		

(Translation E.S.)

iiii. Office of Statistics, Hamburg and Schleswig-Holstein

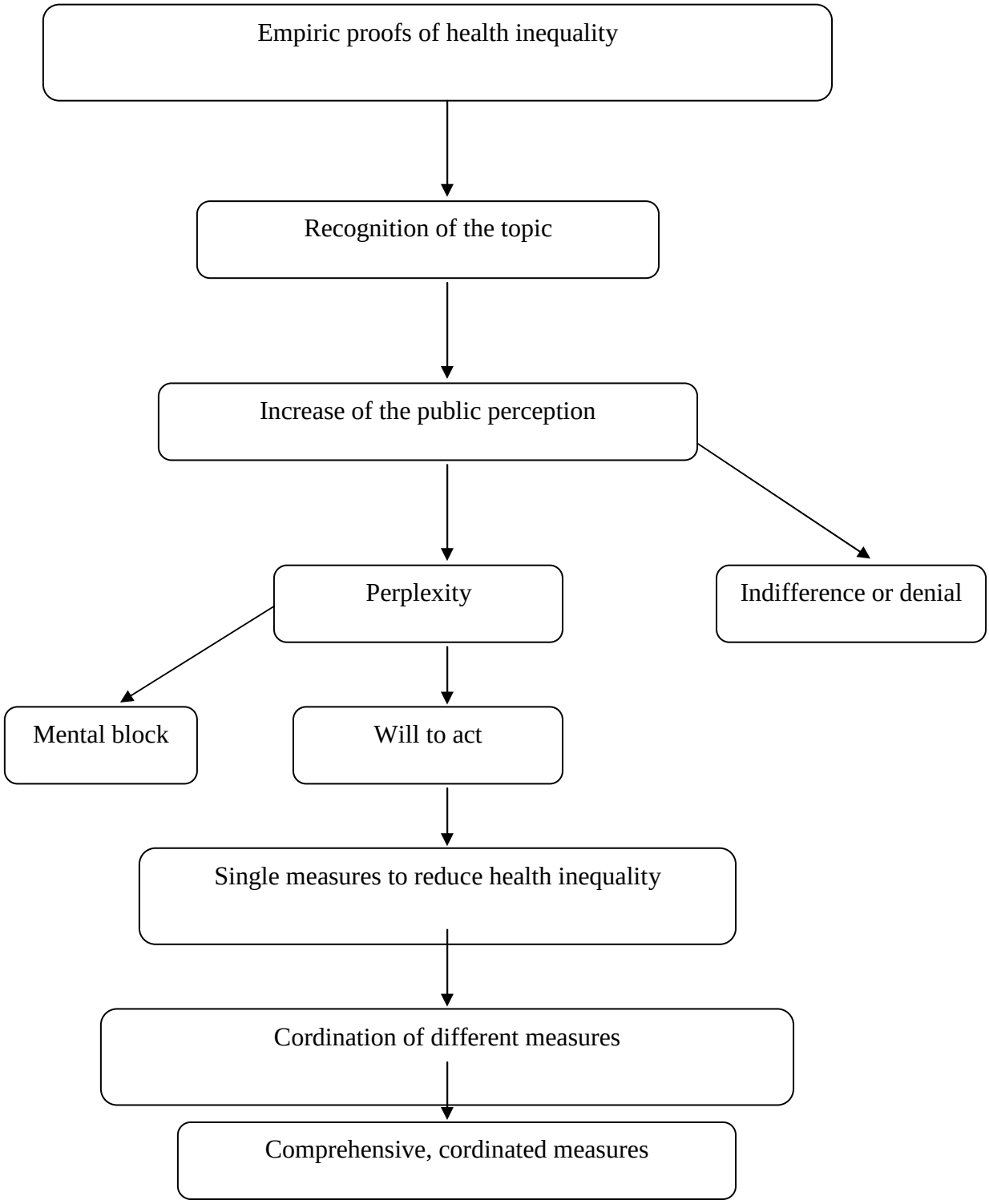
Indikator	quarter	district	Hamburg
Statistical area			
Total population 31.12.2004	3 072	244 268	1 715 225
Number of children at the age 0 – below 1 year	29	2 016	15 037
Percentage children at the age 0 – below 1 year of total population	0,9 %	0,8 %	0,9 %
Number of children below the age 6	257	11 675	90 801
Percentage children below the age 6 of total population	8,37%	4,78%	5,29%
Women	1 631	128 407	887 035
Number of women at the age 15 - below 35 years	464	33 317	227 204
Percentage women 15 – below 35 years of female population total	28,4 %	25,9 %	25,6 %
Percentage adolescents at the age 15 – below 20 years of total population	9,3 %	3,9 %	4,7 %
Percentage children at the age 10 - below 15 years of total population	8,8 %	3,8 %	4,4 %
Population density in hectare	402	58	27
Percentage migrants of total population	37,9 %	13,3 %	14,9 %
Percentage unemployed at the age 15 - below 65 years of total population	17,0 %	6,9 %	8,5 %
Percentage unemployed (SGB III) at the age 15 - below 65 years of total population	3,0 %	2,6 %	2,6 %
Percentage unemployed (SGB II) at the age 15 - below 65 years of total population	14,0 %	4,3 %	5,9 %
Percentage unemployed below 25 years of age (SGB III +II) of the population at the age 15 - below 25 years	11,1 %	5,1 %	5,6 %
Percentage unemployed below 25 years of age (SGB III) of the population at the age 15 - below 25 years	2,7 %	1,9 %	2,1 %

Percentage unemployed below 25 years of age (SGB II) of the population at the age 15 - below 25 years	8,4 %	3,2 %	3,5 %
Recipients of social security benefits	47	1 246	15 664
Percentage recipients of social security benefits of total population	1,5 %	0,5 %	0,9 %
Percentage single parents receiving social security benefits of recipients of social security benefits total	12,8 %	17,1 %	17,7 %

Special measurement by PROSA, 3.quarter of 2005; the data of the recipients of social security benefits according to the Federal Law concerning social security benefits (BSHG) and the data of the recipients of social security benefits according to the Federal Law concerning asylum seekers AsylbLG) were measured by the project ‚Sozialhilfeautomation' (PROSA) of the senate office for regional affairs. Contrary to the official statistics of social security benefits, which depend on a sample collected on a single day, the data measured by PROSA contain all persons who received social security benefits according to BSHG and AsylbLG within one quarter of a year.

(Translation E.S.)

iiiii. Public perception of health inequality



(Whitehead 1998 quoted in: Mielck, A. 2000, p.43. Translation E.S.)

Eidesstattliche Erklärung

Ich versichere, dass ich die Thesis selbständig und ohne fremde Hilfe verfasst und nur die angegebenen Quellen und Hilfsmittel benutzt habe.

Hamburg, den: 27.02.2006 .....

(Eva Schöning)