

Review and reorientation of the “Programme for active health protection of mothers and children” for greater health equity in the former Yugoslav Republic of Macedonia

ROMA HEALTH — CASE STUDY SERIES NO. 2





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Review and reorientation of the “Programme for active health protection of mothers and children” for greater health equity in the former Yugoslav Republic of Macedonia

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Abstract

This publication presents the process of and lessons learned from the review and reorientation of a programme for active health protection of mothers and children for greater health equity, with an explicit but not exclusive focus on the Roma population, carried out in the former Yugoslav Republic of Macedonia. Using the methodological guide on integrating equity into health strategies, programmes and activities developed by the Ministry of Health, Social Services and Equality of Spain, the analysis of selected services within the programme shows that Roma and rural women benefit less than women from urban areas and with more education. Barriers and facilitating factors for using the services were related to their availability, accessibility and acceptability, contact with services and effectiveness of coverage. The review showed that barriers and facilitating factors were strongly related to the social determinants of health, both intermediary and structural. The analysis of the programme's context shows that most of the existing policy documents support its implementation and a number of mechanisms for social participation of target populations. Several facilitating factors were created and incorporated into the new proposed programme to improve the response to the health needs of all women in general and particularly the most vulnerable, such as Roma. The study concluded that the reorientation process is a systematic evaluation process, useful as a continuous cycle of improvement that could enhance the equity, effectiveness and quality of health programmes.

Keywords

Children, the former Yugoslav Republic of Macedonia, mothers, national health programmes, Romany, socioeconomic factors

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ISBN 978 92 890 5090 6

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The Series

The Roma Health — Case Study Series provides a forum for sharing knowledge on how to improve the health and well-being of the Roma population in the WHO European Region. The aim of the papers is to review the evidence and country experiences with an eye to understanding practice and innovative initiatives, and encouraging debate on the connections between Roma health, its social determinants and the broader policy environment. The papers are all peer reviewed.

Background

This paper was commissioned by the WHO Regional Office for Europe. The case study was produced to inform a resource package for health professionals to be used in multicountry capacity-building events to promote the reorientation of strategies, programmes and activities related to Millennium Development Goals 4 and 5 (child and maternal health) for greater health equity, with an explicit but not exclusive focus on the Roma population.

Acknowledgments

This paper was written by Brankica Mladenovik (Institute of Mother and Child Health, Skopje), Katerina Stavrik (University Children's Hospital, Skopje), and Dragan Tanturovski (University Obstetrics & Gynaecology Clinic), in coordination with Arta Kuli, WHO Country Office, the former Yugoslav Republic of Macedonia. Pilar Campos Esteban (Ministry of Health, Social Services and Equality, Spain) and Daniel La Parra (University of Alicante, Spain) acted as peer reviewers. Piroska Östlin, WHO Regional Office for Europe, had overall responsibility for the development of this paper. Financial support for the development and publication of this case study was provided through the WHO biennial collaborative agreement with the former Yugoslav Republic of Macedonia 2012–2013.

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Foreword

“We want to see better health and well-being for all, as an equal human right. Money does not buy better health. Good policies that promote equity have a better chance. We must tackle the root causes (of ill health and inequities) through a social determinants approach that engages the whole of government and the whole of society.”

– Dr Margaret Chan, WHO Director-General

Health equity means that all individuals are able to enjoy their highest health potential regardless of their social position or other circumstances determined by social factors.

Inequities in health are increasing in Europe. Power, income, goods and services are unequally distributed in our societies, leading to unequal chances for good health within and between countries across the European Region.

The need for commitment to address these root causes of health inequity was emphasized in a 2008 report by the WHO Commission on Social Determinants of Health (CSDH), the related 2009 World Health Assembly resolution, the Rio Political Declaration on Social Determinants of Health (2011), and the European review of social determinants and the health divide (2012). Improving health for all and reducing health inequities are also among the strategic objectives of Health 2020, the European policy framework for supporting action across government and society for health and well-being.

It is well known that achieving equity is not possible without improving the living conditions of social groups that are experiencing poverty and social exclusionary processes. One of these groups in Europe is the Roma. About 10–12 million Roma live in Europe, constituting one of the largest and most marginalized ethnic minorities. Most of them are disproportionately poor in many countries. They face serious social problems related to high unemployment, low education, inadequate housing and wide-ranging discrimination. These interrelated circumstances create a vicious circle of social exclusion, which seriously affects their health as do persistent inequities between Roma and majority populations, including in access to health care. While data are limited, existing data regarding life expectancy, infant and child mortality, maternal health, vaccination rates and prevalence of many chronic and infectious diseases reveal marked inequities between the Roma and the majority population, including (in some contexts) when Roma are compared to the poorest quintile of the majority population. The

inability of health systems to provide equity across all functions continues to undermine efforts to improve the health of Roma and other populations experiencing social disadvantage.

Ensuring the rights and social integration of Roma is a priority in Europe, as demonstrated by the international initiative Decade of Roma Inclusion, the European Union Framework for National Roma Integration Strategies, and the recent Council Recommendation on Effective Roma Integration Measures in the European Union (EU) Member States, adopted on 9 December 2013, which is the first legal instrument of the EU addressing the Roma issue.

The WHO Regional Office for Europe joined the Decade of Roma Inclusion initiative in 2011. Through its vulnerability and health programme, the Regional Office contributes to increasing awareness, political commitment and action relating to conditions that make people vulnerable to ill health. The programme addresses in particular the needs of the Roma, migrants and other ethnic minorities, guided by the values and principles of Health 2020.

Among other activities, the Regional Office is facilitating the interagency coordination initiative, Scaling up action towards Millennium Development Goals (MDGs) 4 and 5 in the context of the Decade of Roma Inclusion and in support of national Roma integration strategies, which also involves United Nations Population Fund (UNFPA), Office of the High Commissioner for Human Rights (OHCHR), United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF) and International Organization for Migration (IOM).

In 2012–2013, the Regional Office organized and facilitated in collaboration with the Spanish Ministry of Health, Social Services and Equality and the Interuniversity Institute for Social Development and Peace, University of Alicante (WHO Collaborating Centre on Social Inclusion and Health) a multicountry training on the reorientation of strategies, programmes and activities (SPA) related to MDGs 4 and 5 for greater health equity with an explicit but not exclusive focus on the Roma population. A multidisciplinary team consisting of public health decision-makers, experts and Roma association representatives from Bulgaria, Montenegro, Serbia and the former Yugoslav Republic of Macedonia participated in the training, which was carried out over an 11-month period from November 2012 to October 2013, using a mixed methodology of face-to-face workshops and online work.

The training drew on the Spanish training process for the integration of a focus on social determinants of health (SDH) and health equity into health SPA, carried out in 2010–2011¹, and followed the Methodological Guide to Integrate Equity into Health Strategies, Programmes and Activities (1) developed by the Ministry of Health, Social Services and Equality of Spain. This methodology is useful for integrating equity aspects into any health SPA and for focusing on any social or ethnic group. A more detailed description of the training process can be found in Annex 1.

¹ Merino B, et al. Integration of social determinants of health and equity into health strategies, programmes and activities: health equity training process in Spain. Geneva: World Health Organization; 2013 (Social Determinants of Health Discussion Paper Series 9 (Case studies); http://apps.who.int/iris/bitstream/10665/85689/1/9789241505567_eng.pdf, accessed 25 November 2014.

The purpose of this case study, commissioned by the Regional Office, is to present the review and reorientation process of the Programme for the active health protection of mothers and children (MCHP) – with focus on equity and the social determinants of health – carried out by the working team of the former Yugoslav Republic of Macedonia and to share the lessons learned from it.

Dr Piroška Östlin
Programme Manager, Vulnerability and Health
WHO Regional Office for Europe
Copenhagen, September 2014

Abbreviations

ANC	antenatal care
CSDH	Commission on Social Determinants of Health
EQUITY	the acronym is made up of the letters denoting the six steps of the review cycle
EU	European Union
ID	identification card
IMR	infant mortality rate
IOM	International Organization for Migration
LBW	low birth weight
M&E	monitoring and evaluation
MCHP	Programme for the active health protection of mothers and children (Mother and Child Health Programme)
MDG	Millennium Development Goal
MoH	Ministry of Health
MMR	maternal mortality ratio
NGO	nongovernmental organization
OHCHR	Office of the High Commissioner for Human Rights
PHC	primary health care
RHM	Roma health mediators
SDH	social determinants of health
SES	socioeconomic status
SPA	strategies, programmes and activities
SRH	sexual and reproductive health
UNFPA	United Nations Population Fund
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund

Executive summary

This report describes the Macedonian experience in reviewing and reorienting the national MCHP as a result of participation in the multicountry training process on the reorientation of SPA related to maternal and child health for greater health equity with an explicit but not exclusive focus on the Roma population (2012–2013), organized by WHO Regional Office for Europe in collaboration with the Spanish Ministry of Health, Social Services and Equality and the WHO Collaborating Centre on Social Inclusion and Health, located at the University of Alicante.

The MCHP integrates a number of public health interventions required for the improvement of mother and child health; nevertheless, according to national data it seems that it is not reaching all the population equitably.

The existing data show that the health of women and children is influenced by a complex mix of factors (socioeconomic status, educational level, place of living, mother's age, ethnicity, etc.). The infant mortality rate (IMR) in the former Yugoslav Republic of Macedonia shows disparities within the indicator, mainly influenced by educational level and ethnicity. In 2012, IMR among women with a low level of education was three times higher than among women with a high educational level (15.9 versus 4.7 per 1000 live births); IMR among Roma was 11.6 per 1000 live births, while among non-Roma it was 9.6 per 1000 live births.

The review and reorientation process aims to analyse how the SPA are working and for whom, looking to reinforce the most effective interventions and to make them equitable for all.

Methodology

After receiving the appropriate training, the nine members of the learning node (review working team) reviewed the programme using the Spanish methodology guide to integrate equity into SPA and the EQUITY review cycle proposed in this guide as a review instrument. Six meetings of the learning node were held, one for each of the five steps of the EQUITY review cycle. Group discussion was the main technique. Each member was additionally delegated with individual assignments that were raised during the working process.

Detailed information about the training process itself is available at Annex 1.

EQUITY review

The general aim of the review was to identify whether the activities in the programme were addressing the needs of all women, specifically of the most vulnerable groups, in order to bring the interventions closer to these groups. Owing to the complexity of the programme the learning node decided to focus the review on one specific activity, distribution and use of the Maternity Card, which is described in this case study.

The analysis of the inequities in the programme and in the selected activity (step E: Examine the SPA) showed that the programme as well as the chosen activity did not deal sufficiently with the heterogeneity of the target population and did not truly lead to greater health equity in an effective manner.

The prioritization of groups without access and who are not benefiting from the programme and from the use of the Maternity Card in each stage of the programme/activity was carried out taking into account available quantitative and qualitative information. The analysis showed that Roma and rural women benefit less than women from urban areas and well educated women (step Q: the question of who accesses the SPA and who benefits from it).

The Tanahashi model of effective coverage (2) was used to analyse whether the problems related to lack of access or benefits encountered by the prioritized groups are linked to the presence of barriers or the absence of facilitating factors (step U: Understanding the barriers and facilitating factors). Barriers and facilitating factors were related to all the stages of the Tanahasi model. Some of the main barriers found were:

- availability (inadequate distribution of gynaecologists) – many Roma and rural women do not have a nominated gynaecologist;
- accessibility – geographical barriers, financial barriers, transport costs, fees for services;
- acceptability – cultural beliefs, fear of physical examination, culturally inappropriate services;
- contact with and utilization of services – delayed visits to health services, language barriers, low level of literacy (Roma and women with a low educational level cannot fully understand the content of the Maternity Card);
- effective coverage – pregnant women who are given the Maternity Card do not respond fully to its recommendations.

In addition, several facilitating factors were identified (the Maternity Card is free of charge; it is coherent with national antenatal guidelines), but they were not sufficient to minimize or to remove the existing barriers.

Taking into consideration the SDH conceptual framework of the WHO CSDH, the review looked at whether barriers and facilitating factors were interrelated with SDH (Step I: Interrelating the SPA with SDH). Some barriers were linked with intermediary determinants, such as poor material circumstances, poverty and stressful living conditions, psychosocial and cultural factors (low awareness of the importance of regular antenatal care (ANC), uneven distribution of gynaecologists, obligatory fee for some services, lack of cultural competence among health professionals). Some other barriers were linked with structural determinants such as low socioeconomic status (SES), high level of unemployment and low educational level, all of them correlated as well to low level of receptivity to health education messages, poor living conditions, lack of material resources and psychosocial stress.

The process of reorientation of the programme was primarily a learning process but at the same time a good example of translation of theory into practice. It is a systematic evaluation process useful as a continuous cycle of improvement which will enhance quality, effectiveness and equitability of health programmes.

Introduction

1

This report describes the experience of the former Yugoslav Republic of Macedonia in the reorientation of SPA for MDGs 4 and 5 toward greater health equity with an explicit but not exclusive focus on the Roma population.

The former Yugoslav Republic of Macedonia actively participated in the WHO multicountry training process and its related events, demonstrating the Government's commitment both to the achievement of MDGs 4 and 5 (improvement of maternal and child health) and to the Roma integration policies.

The members of the working team (learning node) which was created ad hoc for this training process were appointed by the MoH. The programme selected by the MoH for review and reorientation toward equity with an explicit but not exclusive focus on the Roma population was the MCHP which is a high priority for the Government.

This document aims to present the main results of each step of the EQUITY review cycle, the more important conclusions and lessons learned, both from the review of the SPA and from the training process.

The review and reorientation process is a continuous cycle of improvement; therefore, after the reorientation and in the middle and long term, further results are expected.

2 Country context overview

The former Yugoslav Republic of Macedonia is an upper middle income country situated in south-eastern Europe, with US\$ 4800 gross national income per capita (2012) and unemployment at 31.4% (3). Average life expectancy is 75 years – 73 for men and 77 for women – and the percentage of the population aged under 15 years in 2011 was 17.2%. According to the most recent census on population, dwellings and households in 2002, it has a population of 2 022 547, of whom 53 879, or 2.66% of the total population, are members of the Roma ethnic community (4). However, other studies based on various research techniques indicate that the real figure of the Roma population is much higher and that approximately 135 490 Roma live in the former Yugoslav Republic of Macedonia (6.77%) (5).

The situation of most of the Roma living in the former Yugoslav Republic of Macedonia is characterized by high rates of poverty, unemployment, housing located in poor suburbs, substandard infrastructure, low level of education, and significant inequity in health status and access to the health system. The report of the vulnerability study developed by the UNDP (6) states that 65% of Roma men and 83% of Roma women have never held a job (compared to 50% of the non-Roma population living in their close proximity), 70% of Roma are unemployed, 80% are social welfare beneficiaries and 90% are without professional skills. The same study indicated that in the former Yugoslav Republic of Macedonia the number of Roma living in poverty is three times higher than for the rest of the population.

In addition, the percentage of teenage marriages is much higher in Roma than the national average (11.9% below the age of 15 and 47% below the age of 18); in the general population, the percentage of marriages for women below 15 and below 18 years of age is 1.4% and 10.7% respectively. The literacy rate among the general population of women aged 15–24 years is 97.4%, much higher than the level for Roma women (76.6%). The percentage of children completing primary school among the general population is 97.4% compared to 67.1% among Roma (7).

Despite a severe shortage of data on the health status of Roma, numerous studies have documented health disparities between Roma and non-Roma populations in the former Yugoslav Republic of Macedonia: life expectancy of Roma (64 years) is ten years lower than that of non-Roma; 27% of Roma men and 31% of Roma women suffer from chronic diseases (compared to 23% of the non-Roma population living in their close proximity); and differences exist in levels of immunization coverage and infant mortality.

According to a survey on public opinion and the Roma (8) conducted within the framework of the Decade of Roma Inclusion 2005–2015, the perception of the Roma themselves is that they do not receive the same treatment in comparison with the non-Roma population when they access the public institutions, including health care institutions.

The former Yugoslav Republic of Macedonia is a signatory to the Decade of Roma Inclusion 2005–2015, and made a political commitment to improve the social and economic condition and contribute to the social inclusion of Roma, with priorities in the fields of education, health care, employment and housing. The Government has been implementing a number of activities under the National Action Plan for Roma Health, aiming to reduce inequities, including inequities in health. So far, preventive programmes for children, women and youth have been expanded to reach Roma and rural communities. Some activities have been implemented for this purpose: work with women and/or parents in early child development centres; the introduction of Roma health mediators (RHM) in 2011; educational and promotional materials issued in the Roma language; and health professionals trained for working with vulnerable groups.

In addition, a focal point for Roma issues was appointed within the MoH, and the health information system is being improved, with the possibility of disaggregation of data by ethnicity. A network of youth-friendly services for sexual and reproductive health (SRH) has been established, with one being located in the largest Roma municipality in Skopje.

3 Training process

3.1 Background on health equity issues related to maternal and child health

Over the past decade, there has been significant progress in the former Yugoslav Republic of Macedonia towards improving the health of children and mothers, as measured through health indicators such as perinatal death, infant mortality rate (IMR) and under-5 mortality, as shown in Table 1. This improvement has come about mostly as a result of high immunization coverage, better nutrition, low morbidity from diarrhoeal and acute infectious diseases, improved technology and quality of antenatal and child health care, and free access to primary health care (PHC) (9).

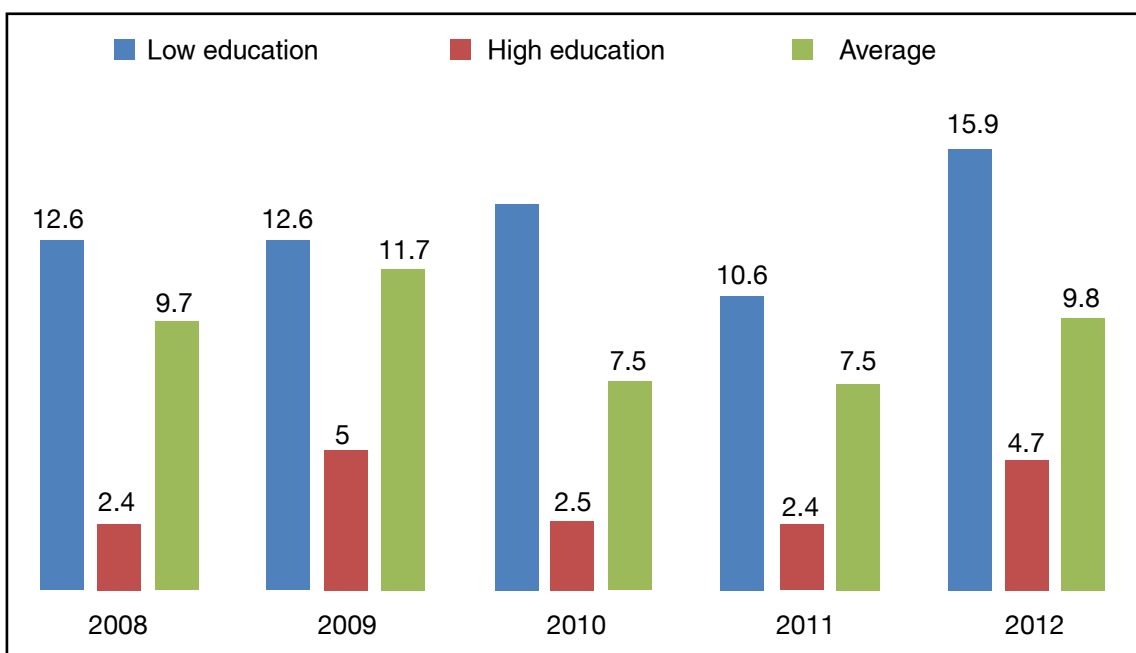
Table 1. Maternal and child health indicators in the former Yugoslav Republic of Macedonia (2006–2012)							
Indicator	2006	2007	2008	2009	2010	2011	2012
MMR (per 100 000 live births)	4.4	–	–	4.2	8.2	4.4	4.2
Perinatal death (per 1000 births)	15.3	15.3	14.6	16.4	12.6	12.3	12.8
IMR (per 1000 live births)	11.5	10.3	9.7	11.7	7.6	7.5	9.8
Under-5 mortality (per 1000 live births)	12.9	11.9	10.9	13.3	8.3	8.6	11.0
LBW (% of newborns < 2500 g)	6.8	6.6	7.2	8.0	7.8	7.0	7.2

MMR - maternal mortality ratio

LBW - low birth weight

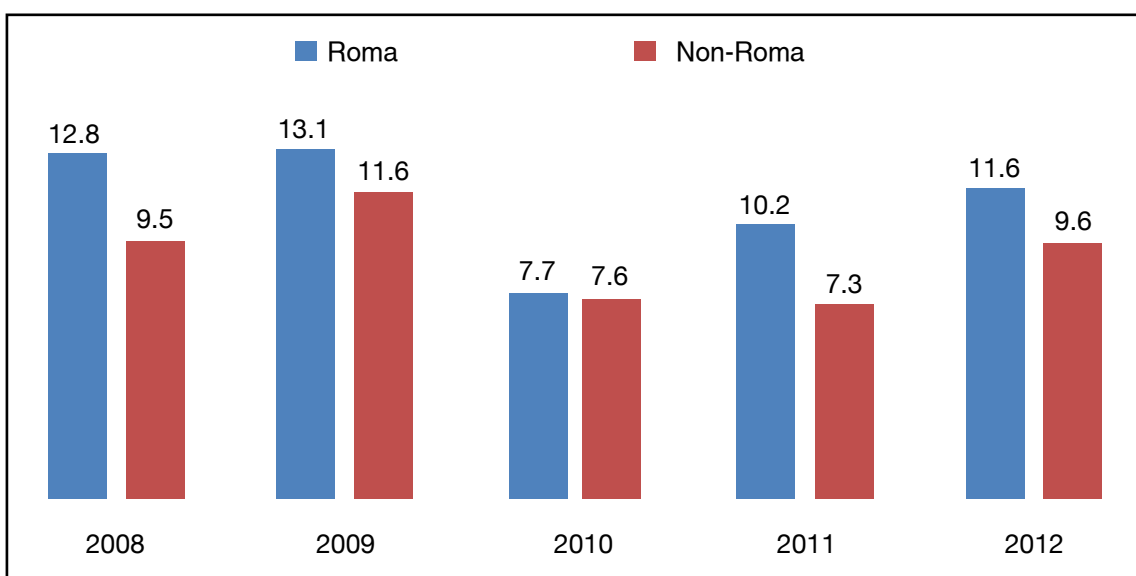
Despite this improvement, however, MDGs 4 and 5 have still not been reached, while health inequalities related to certain health indicators remain unchanged over time. IMR shows disparities within the indicator according to the socioeconomic characteristics of the mother. Data on IMR from 2012 show huge discrepancies within the indicator, as it is almost four times higher among women with a low educational level (mothers have or have not completed primary education – 15.9 per 1000 live births) than in mothers with a high educational level (4.7 per 1000 live births) (9) as shown in Fig. 1.

Fig. 1. Infant mortality in the former Yugoslav Republic of Macedonia: deaths per 1000 live births according to mother's educational level, 2008–2012



There are also some disparities in IMR between Roma and non-Roma, as shown in Fig. 2, but these differences are much smaller than those in regard to the mother's educational level.

Fig. 2. Infant mortality: deaths per 1000 live births among Roma and non-Roma, 2008–2012



In 2012, 51.7% of infant deaths occurred during the neonatal period or the first month of life (0–28 days). The main medical cause of neonatal deaths is preterm birth (77.4%). Data at global level show that preterm birth is highly associated with smoking during pregnancy, unhealthy diet, psychosocial stress, hard physical work, and inappropriate and untimely use of health services during the pregnancy (10, 11, 12). Factors associated with increased risk of preterm birth include maternal poverty, low levels of educational attainment and teenage pregnancy, while all these factors tend to accumulate in certain groups like Roma and poor people (13).

Aiming to further reduce inequities related to maternal and child health with an explicit emphasis on improving Roma population health, the Government of the former Yugoslav Republic of Macedonia assumed the commitment of participating in the WHO multicountry training, supporting the reorientation process of SPA related to maternal and child health. For this purpose, the Government appointed representatives from the MoH and other relevant institutions which work on maternal and child health to participate in the process. The Government also pledged to adopt and implement the recommendations and proposals that may arise as a result of the reorientation process.

3.2 Participants

An invitation letter for participation in the WHO multicountry training process was sent to the MoH through the WHO Country Office. The letter explained the goal of the training process, the criteria for the selection of the SPA and for selection of the members of the learning node (the name given to the working team of a country participating in this process). The MoH selected the MCHP for review and selected the following people (all of whom continue to be members of the learning node) to participate in the training:

- Dr Katarina Stavrik, University Paediatric Clinic, Skopje;
- Dr Brankica Mladenovik, MD, Msc PH, PhD, Institute of Mother and Child Health, Health Home, Skopje;
- Nermina Fakovik, MoH, Sector for Preventive Health Care;
- Senad Memeti, MoH, EU Integration Sector and Roma Health Focal Point for UNFPA Country Office, Skopje;
- Professor Elena Kosevska, National Institute of Public Health;
- Dr Dragan Tanturovski, Obstetrics & Gynaecology, University Clinic, Skopje;
- Sebihana Skenderovska, NGO National Roma Centre, Kumanovo;
- Serhan Ahmed, NGO Centre for Democratic Development and Initiatives, Skopje;
- Dr Arta Kuli, WHO Country Office, Skopje.

All the members of the learning node work at institutions linked with the implementation of the selected SPA (MCHP). Representatives from Roma nongovernmental organizations (NGOs) were also included in the working team since Roma was one of the subpopulations on which the training was focused. University representatives were also involved, so that they could become trainers of this methodology in the future and, strategically, because they are involved in the continuing education of health professionals.

3.3 Methodology

As described in Annex 1, there were three main events with representatives from the four countries that participated in this training process.

The first event took place in Belgrade, Serbia on 7–8 November 2012. It was planned as a two-day training-of-trainers course; three representatives of the former Yugoslav Republic of Macedonia attended this initial workshop. The course participants were provided with information, key documents and with the methodological guide as a practical tool for effective integration of equity into health SPA.

The members of the team who participated at this meeting were commissioned to translate their experience and share supporting materials with the rest of the selected members of the learning node.

A meeting was organized in Skopje in February 2013 with the rest of the selected members of the learning node. During this first in-country meeting, the three members who had participated at the Belgrade meeting translated their experience and knowledge, and shared the presentations and supporting materials. The aim of this meeting was to introduce the rest of the members to the concept of equity and to make initial analysis of the selected programme, using the checklist on page 45 of the methodological guide (1) as a tool. The main purpose of this analysis was to define potential equity problems in the programme definition, structure, organization, process of implementation and outcomes, and most of all, to start discussion about equity and SDH. This initial meeting was a starting point for the reorientation process.

All of the members of the learning nodes had the opportunity to participate at the second multicountry training, which was held in Skopje, 11–14 March 2013. The participants from the four countries presented the results of applying the checklist to each SPA, and were instructed on how to use the methodology for integrating equity into health SPAs. During this training, the participants had the opportunity to practise each step from the EQUITY review cycle and prepare themselves for the next phase. Each of the learning nodes committed to review the selected SPA using the EQUITY review cycle as a tool according to the country work plans developed during the training. The meeting also provided a good opportunity to learn how to tailor programmes that benefit Roma or other groups who face inequity.

After the Skopje multicountry training, the learning node of the former Yugoslav Republic of Macedonia held six in-country meetings, each lasting 3–4 hours, one for each step of the EQUITY review cycle. The number of meetings exceeded the planned number of meetings (three) according to the previously prepared work plan owing to the complexity of the work. Group discussion was the main technique. Each member was additionally delegated with individual assignments that were raised during the working process. Before each meeting, participants were recommended to read the appropriate chapter of the methodological guide. Online communications were used to exchange ideas and the results of individual tasks. The coordination team for the training process, and specifically the facilitator assigned to the learning node of the former Yugoslav Republic of Macedonia, gave technical support and on-line feedback to the different steps.

The final event, the workshop on strategies to reduce health inequities with focus on Roma, which took place in Istanbul, Turkey, 24–25 October 2013, gave the representatives from the four countries the opportunity to meet once again and share their conclusions and lessons learned, between themselves and with their facilitators. Three people from the former Yugoslav Republic of Macedonia participated at this meeting where each country's participants reported back on the reorientation of the SPA. The focus was on gathering lessons learned from the experience of applying the methodology.

3.4 Selected SPA: MCHP

The SPA that was chosen by the MoH for review, the MCHP, is an annual public health (preventive) programme issued and run by the MoH, designed to integrate different public health interventions required for the improvement of maternal and child health. The MCHP has a long tradition because maternal and child health has always been a high priority on the government agenda. Its content is continuously reviewed and adapted to the existing epidemiological needs and changes in the health system as a result of the ongoing health system reforms. This fact was considered a window of opportunity as it allows the integration of the recommendations after the process.

Several institutions are involved in the design and implementation of the MCHP activities, both from the public health system (MoH, Institute of Mother and Child Health) and health care institutions from different levels (university paediatric clinic, university obstetrics and gynaecology clinic, PHC centres). The MoH has the role of coordinator and is involved in the monitoring and evaluation (M&E) of the activities. Most of the activities are actually essential public health interventions addressing women's and children's health: monitoring and analysis of health status, health promotion and education including development of informational and educational materials, training of public health workforce, empowering communities about health issues, and neonatal screening.

Final recipients are newborn, children and women in antenatal and perinatal period. Some activities (such as breastfeeding or immunization campaigns) are targeted to the general population, while other activities focus on vulnerable groups of women and children. Intermediate recipients are health professionals (gynaecologists, preventive doctors, gynaecologists, community nurses).

The general aim of the MCHP before the review process was continuous improvement of women's and children's health in line with lowering IMR and improving maternal health, through essential public health functions in identified priorities.

Several specific aims were defined within the MCHP:

1. improvement of accessibility and quality of preventive health services for mothers and children;
2. raising the awareness of the population about the importance of immunization, breastfeeding, regular prenatal care and healthy lifestyles during pregnancy;
3. strengthening the capacity of health workers to improve the quality of their work; and
4. early detection of diseases in newborns, infants and young children.

3.4.1 Reasons for the selection of the MCHP

Several reasons contributed to the decision to select the MCHP.

The main one was political commitment: in its political agenda the Government is continuously prioritizing maternal and child health issues owing to the increased interest in the improvement of maternal and child health and in the achievement of MDGs 4 and 5. The high prioritization of this issue in the political agenda was identified as a window of opportunity.

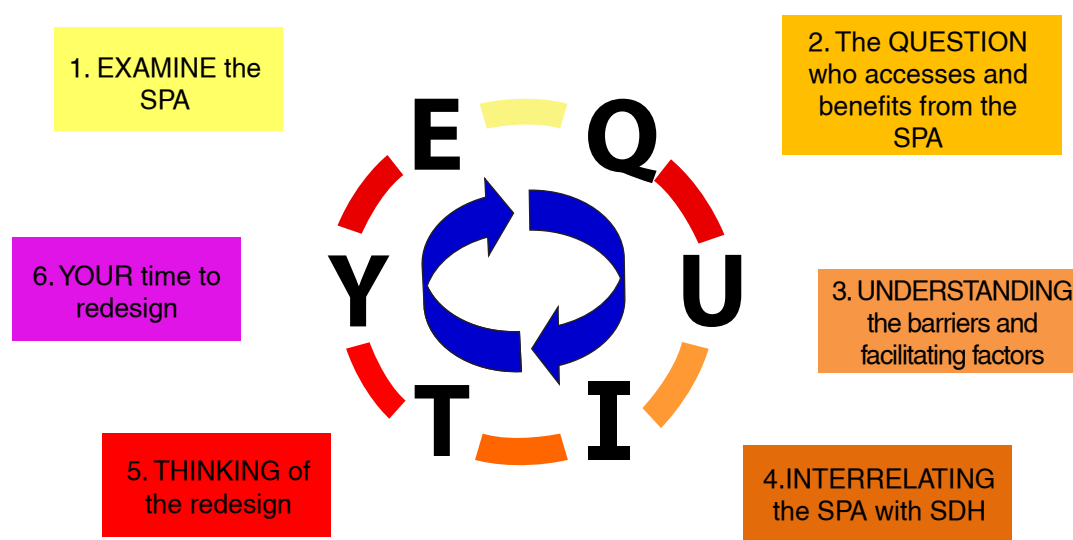
The existing data (global and national) that show how the health of mothers and children is influenced by a complex mix of factors (socioeconomic, demographic, availability and quality of health system, health-seeking behaviour and level of information, etc.) were another reason. All the evidence available raises awareness among policy-makers and leads to increasing support for the idea that interventions should be adapted to the different needs of the population, especially those who are most in need, based on the principle of equitable access and taking into account the SDH approach. There is also an increasing understanding among policy-makers of the need to improve the capacity of public health and the health-care system to address SDH and integrate health equity into existing or planned health policies.

The final reason for choosing the MCHP was that the objectives of the WHO multicountry training process were largely in line with the aim of this programme.

4 EQUITY review process

The EQUITY review process began after the initial analysis guided by the checklist. The aim of the review process is to analyse the MCHP by understanding its theory, how it works in practice, who benefits from it and who does not, and whether it is effective in terms of equity. The purpose is to develop a programme that integrates equity and SDH, taking into account a human rights approach. The review process comprises five steps (shown in Fig. 3), each of them further developed in detail. Each step in turn comprises different activities. For this case study only the most relevant ones are described.

Fig. 3. The EQUITY review cycle



The general aim of the equity review of the MCHP was to identify whether the activities addressed the different needs of the whole population, and specifically of those who are most in need in order to bring the interventions closer to vulnerable groups, and facilitate health equity.

As already mentioned, owing to the complexity of the MCHP and the large number of defined activities, the learning node decided to focus on one specific activity – distribution and use of the Maternity Card. Its implementation could actually lead to the achievement of two specific aims of the MCHP (specific aims 2 and 3 listed at 3.4 above).

4.1 Description of the prioritized activity

The Maternity Card was introduced in 2012 in accordance with national ANC guidelines and comprises two parts: an antenatal card and an information brochure for pregnant women. The antenatal card is a schedule of antenatal visits, fulfilled by gynaecologists who are expected to record all check-ups, investigations and results on the card. The information brochure gives pregnant women information and advice related to pregnancy and appropriate health care during the preconception, pregnancy and postpartum periods. The Maternity Card is distributed to the gynaecologists nominated by pregnant women and they are expected to give it to every pregnant woman during the first antenatal visit. The Maternity Card is free of charge as the cost for printing and distribution is covered by the state budget through the MCHP.

The Maternity Card fulfils multiple roles. For the gynaecologists it serves as a guideline for ANC. It also saves them time as much of the information they are expected to give to pregnant women is contained in the information brochure.

For the pregnant woman it provides information about the content of ANC and what she can expect from her gynaecologist during the antenatal visits. It also contains information on how to be healthier during pregnancy, early signs of risk for preterm birth, and additionally, information related to the postpartum period, including breastfeeding.

For coordination purposes for the health system, it is a link between the nominated gynaecologist and the gynaecologist from the maternity ward who performs the delivery. The card contains important information about the woman's pregnancy which is needed for the appropriate planning of the delivery and neonatal care. Women are expected to bring the card with them to the maternity ward on the day of delivery.

The expected indirect benefits include improvement of the quality of antenatal, intrapartum and postpartum care, and therefore improvement of mothers' and newborns' health.

In the former Yugoslav Republic of Macedonia, ANC is provided by the nominated gynaecologist. According to the law on health insurance, every woman over the age of 12 years with regulated citizenship and identification card (ID) is entitled to choose a gynaecologist at PHC level regardless of their place of residence and the location of the gynaecologist. The nominated gynaecologist is then responsible for her SRH including in pregnancy. Gynaecologists at PHC level sign a productivity-based capitation contract with the health insurance fund. To ensure quality of care and sufficient service coverage, the system has imposed a ceiling on the number of patients who can register with each gynaecologist.

All services provided by the nominated gynaecologist are free of charge, except for referral services which are performed outside the gynaecologist's office, such as laboratory blood and urine tests, microbiological smears, or genetic screening, for which women need to pay up to 20% of the cost.

Results of all examinations during the health visits are noted both in the pregnant woman's medical form, which is kept in the gynaecologist's files, and on the Maternity Card, which is kept

by the pregnant woman. All women who have a nominated gynaecologist have access to the Maternity Card.

Part of the ANC is provided by community nurses through home visits, mostly counselling and information about healthy lifestyles during pregnancy, appropriate ANC, early signs of pregnancy risks, etc.

4.2 Step E: Examine the SPA

The first step aims to understand the explicit or implicit theory of the MCHP, which means what is the underlying theory justifying the programme, and what are the key stages included in it for achieving the expected outcomes and impact. The first step gives the group an opportunity to go deeper into the equity and SDH concepts using the WHO CSDH framework.

The theory of the MCHP before the equity review is presented in Box 1.

Box 1. The theory of the MCHP before the equity review

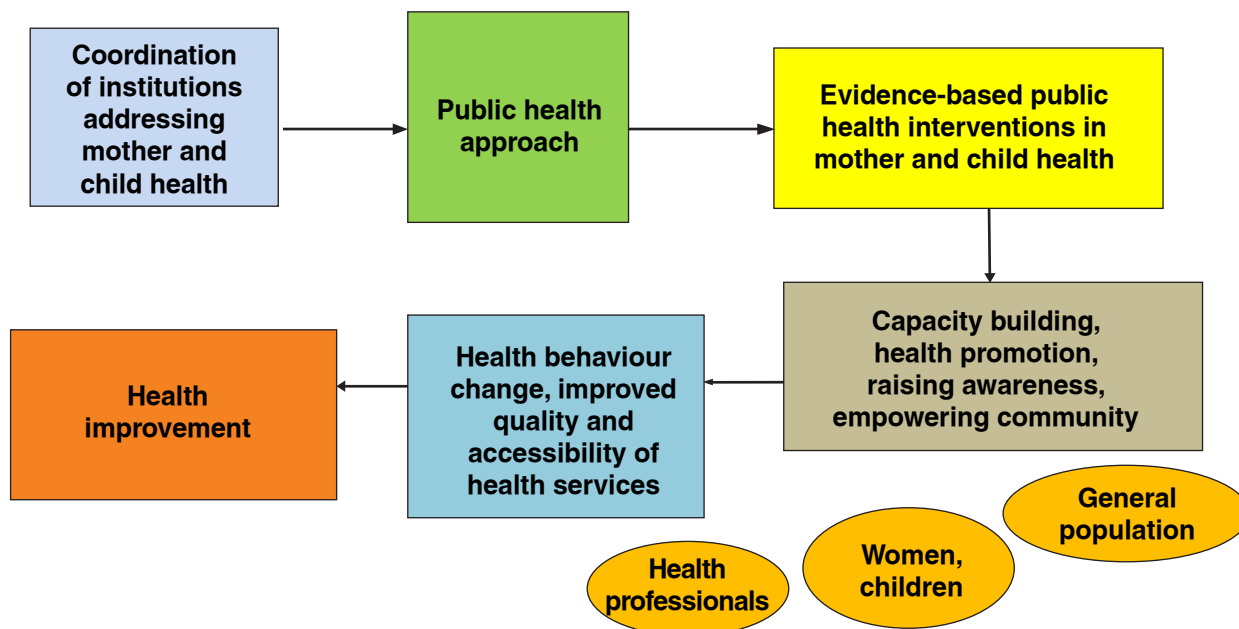
Certain public health interventions have proved successful in improving the health of women, infants and children and play an important role in disease prevention and in reducing mortality and morbidity in these population groups.

Taking this into account, the health of women and children would be improved by the coordination of different actors, through integrated public health evidence-based interventions such as early detection of diseases, modification of health behaviours, raising awareness among women and the general population, and strengthening health professional capacity.

Key stages are the essential phases of the development process of a programme (or activity) which are necessary for the achievement of the intended targets. The key stages of the MCHP are shown in Fig. 4.

For the development of the MCHP, the learning node agreed that the first stage was the coordination of the different institutions addressing women's and children's health. Then, using a public health approach, evidence-based interventions are created around identified priorities. Most of the interventions – such as capacity-building among health professionals, health promotion activities such as creation of health promotion materials, raising awareness through media campaigns, and empowering communities – actually relate to essential public health functions. These interventions are targeted to health professionals, women and children and the general population. After this, expected changes include the improvement of health behaviours and the improvement of the quality and accessibility of health services.

Fig. 4. Key stages of the MCHP



The key stages of the specific activity that was reviewed in detail – distribution and use of the Maternity Card – are shown in Fig. 5.

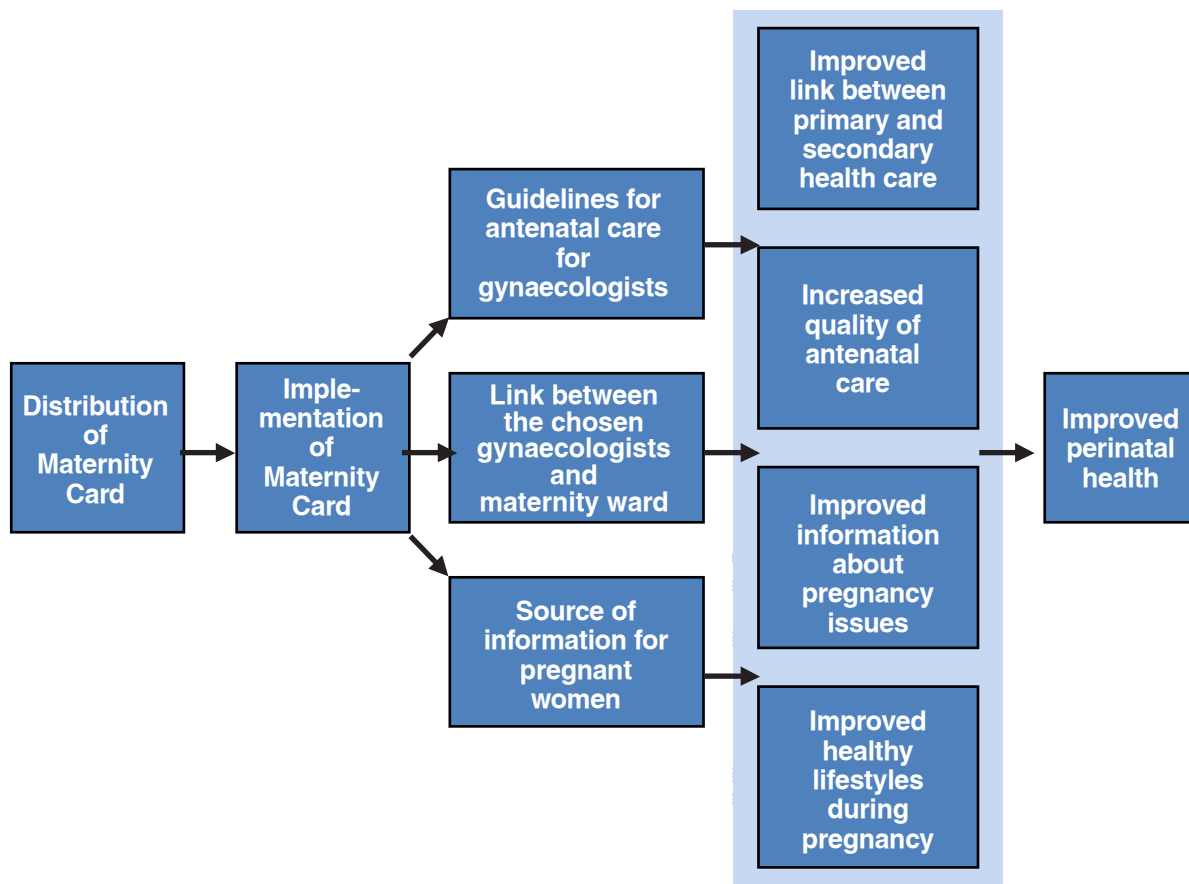
Fig. 5 shows the aims and expected results of the activity only, and did not take into consideration the possible barriers.

4.2.1 Analysis of the inequities in the programme and in the selected activity, and definition of equity challenges

Preliminary review of the whole MCHP showed that most activities were designed for women and children in the general population, and that only a small number of interventions were specifically designed for different population groups, taking into account their different needs and vulnerability (rural, Roma). The number of these interventions was not sufficient to cover all aspects necessary to attain health equity.

Preliminary review of the activity showed that this intervention does not reach 100% of pregnant women. It is estimated that only 60% of women of all ages have a nominated gynaecologist. The other 40% do not have a nominated gynaecologist for a variety of reasons. First of all, there is uneven geographical distribution of gynaecologists, as most of them are located in urban areas. Therefore women from rural and remote areas face geographical barriers as well as financial barriers for transport costs.

Fig. 5. Key stages of the prioritized activity: distribution and use of the Maternity Card



A number of women do not visit a gynaecologist until late in pregnancy owing to a low level of information about the importance of appropriate and timely ANC. Some women, mostly Roma without regulated ID and citizenship, also do not have access to ANC as they are not entitled; thus, they have to pay for antenatal services and for the Maternity Card. In that regard, certain groups of women (women from rural and remote areas, women with low SES, with low level of information and education, Roma women and women without ID) have less access to services and might not benefit from the Maternity Card.

Neither the MCHP nor the chosen activity deals sufficiently with the heterogeneity of the target population and neither truly leads effectively to greater health equity. Moreover, continuing to improve the health of those most advantaged while not taking care of vulnerable people may generate further inequities.

4.3 Step Q: the question of who accesses the SPA and who benefits from it

This step allows:

- analysis of the subgroups by equity stratifier (for example, SES, gender, ethnicity, religion, geographical location); and

- identification of those who access and benefit at each key stage of the SPA and those who do not.

The target population for the whole MCHP are women of reproductive age (15–49 years), infants (0–12 months) and children under 5 years old. The target population for the specific activity that was reviewed are pregnant women (approximately 24 000 per year).

4.3.1 Groups that access and benefit from the Maternity Card and those that do not

The learning node analysed which groups accessed the activity and which did not, taking into account available information (quantitative and qualitative). This step was really important for the reorientation, since knowing the specific needs of the subgroups can be useful for adapting the MCHP to these different needs. The quantitative data were not always adequate during this process, but very useful qualitative data were found from a number of surveys done by NGOs.

Those who have greater access to gynaecologists, and thus to the Maternity Card, are women from urban areas where the concentration of gynaecologists is higher, and women with a high level of education, owing to their higher level of information about the benefit of timely ANC. They are more likely to visit gynaecologists appropriately from the public health point of view (during the first trimester) and regularly, and benefit most from this activity. Forty per cent of all pregnant women in the former Yugoslav Republic of Macedonia visit a gynaecologist during the first trimester, and there are indications that the majority of these women are those with a higher educational level (9).

Roma women, women from rural and remote areas, women with low SES and women with low level of information and education are likely to face most of the barriers, and therefore not benefit from the Maternity Card.

A large number of Roma women encounter a variety of unfavourable conditions that cumulatively pose a greater risk to women's and children's health, which is confirmed by the existence of disparities in health indicators (IMR is higher among Roma women and women with low educational level). In Roma women, timely access to antenatal services and consequently to the Maternity Card is compromised for a variety of reasons: a low level of education and information, cultural factors that influence their health-seeking behaviour (irregular and delayed visits to the gynaecologist during pregnancy), economic barriers as a large number of antenatal services are fee-based so they avoid going to the gynaecologist; language barriers. Health services are not sufficiently sensitive to diversity, so sometimes they avoid health services fearing discrimination for being both poor and Roma. Important systemic factors influencing Roma health are unregulated civil status and lack of appropriate personal ID documents and other documentation required; lack of stable employment; failure to report to the unemployment office which results in the loss of right to health insurance, which is necessary for access to the health-care package guaranteed by health insurance (14, 15).

Based on documentation by the Roma NGOs, there are between 3000 and 5000 unregistered Roma individuals with no personal documents and around 500 Roma women without regulated civil status (16, 17).

Rural women are also at greater risk since they do not have appropriate access to ANC services and also because they seem to have more health problems during pregnancy and childbirth. According to official data, IMR is higher in rural areas. A significant proportion of newborns (43%) are to mothers living in rural areas. Geographical barriers are an important problem owing to uneven geographical distribution of gynaecologists, as well as information and economic barriers (9).

Following the analysis of the data, the groups prioritized by the learning node at this step were Roma women and women from rural areas. The results of the analysis for the prioritized groups is shown in Table 2.

4.4 Step U: Understanding the barriers and facilitating factors

The Tanahashi model of effective coverage (2) was used to analyse whether the lack of access or benefits confronted by the prioritized groups are linked to the presence of barriers or the absence of facilitating factors. Most of this work was done using the reflection, experience and knowledge of the working group but also by analysing existing data about the barriers and facilitating factors.

4.4.1 Barriers

A number of barriers were identified during all stages of the activity reviewed (distribution and promotion of the Maternity Card) and during its implementation.

Roma and rural women face several barriers in attempting to obtain ANC and thus benefit from the use of the Maternity Card. The Card is only distributed through nominated gynaecologists, but many Roma women do not have a nominated gynaecologist, or are visiting him/her in late pregnancy because of financial, information or other barriers. Although the number of women without regular health insurance is low, it is an additional barrier. Roma women who have a low level of education or are illiterate cannot fully understand the content of the Maternity Card and information brochure. The Card and brochure are not available in the Roma language, which is an additional barrier. The lack of communication skills and cultural competence of gynaecologists for working with women with different cultural and traditional values and with a low educational level could also be a barrier.

Pregnant women that are provided with the Maternity Card might not use it adequately or respond/adhere to its recommendations. The reason for non-compliance could be inappropriate counselling by gynaecologists, or subjective factors such as financial barriers or problems in adopting healthy behaviours during pregnancy owing to a low level of health literacy.

4.4.2 Facilitating factors

A number of facilitating factors were identified that contribute to the implementation of all stages of the revised activity (distribution, promotion and implementation of the Maternity Card).

- The distribution and implementation of the Maternity Card is one of the activities of the MCHP, which makes this activity obligatory for gynaecologists.

Table 2. Main findings of the analysis of groups that do not access or benefit from the SPA

Prioritized group	Health problems identified	Barriers to accessing or benefiting	Other barriers within the health system
Roma women	Higher IMR; higher teenage pregnancy rate (owing to early marriages); irregular visits to gynaecologist during pregnancy; late visits to gynaecologist during pregnancy	Low level of education; no nominated family gynaecologist; language barriers; economic barriers; gender imbalance; cultural factors; some do not have ID/citizenship; lack of understanding of how health-care services work; low level of health literacy	Uneven distribution of gynaecologists, concentrated in urban areas; health services not sufficiently culturally sensitive; co-payments for some antenatal services
Rural women	Higher IMR (10); irregular visits to gynaecologist during pregnancy (8)	Low level of education; language barriers; geographical barriers (owing to poor physical access to antenatal services); low level of information; gender imbalance; economic barriers; low level of health literacy	Uneven geographical distribution of gynaecologists, concentrated in urban areas; co-payments for some antenatal services

- The Maternity Card is coherent with antenatal protocols and helps gynaecologists to follow the recommendations.
- The Maternity Card is free of charge (costs for printing and distribution are covered by the state budget through the MCHP) which is very important for facilitating availability and accessibility to all pregnant women.
- The Maternity Card enables coordination between the nominated gynaecologist and the gynaecologist on the maternity ward who is performing the delivery.
- The professional association of gynaecologists at PHC level is in charge of the distribution the Maternity Card (involvement of health professionals).
- Nominated gynaecologists are obliged to provide appropriate ANC for pregnant women and to give them the Maternity Card during their first antenatal visit.
- Community nurses inform pregnant women during home visits that the Maternity Card is free of charge and explain to them how to benefit from it.

Analysis showed that although several important facilitating factors were taken into account during the implementation stage of the activity, they were not sufficient to minimize or remove the existing barriers. During this stage, a number of potential facilitating factors were identified to be taken into account in the redesign, which will be described further in the redesign stage, and a full list can be found in Annex 2.

The barriers and facilitating factors identified were linked to the different key stages of the activity. Fig. 6 displays this information visually (main barriers are shown in orange, existing facilitating factors in yellow, and potential facilitating factors in green).

4.5 Step I: Interrelating the SPA with the SDH

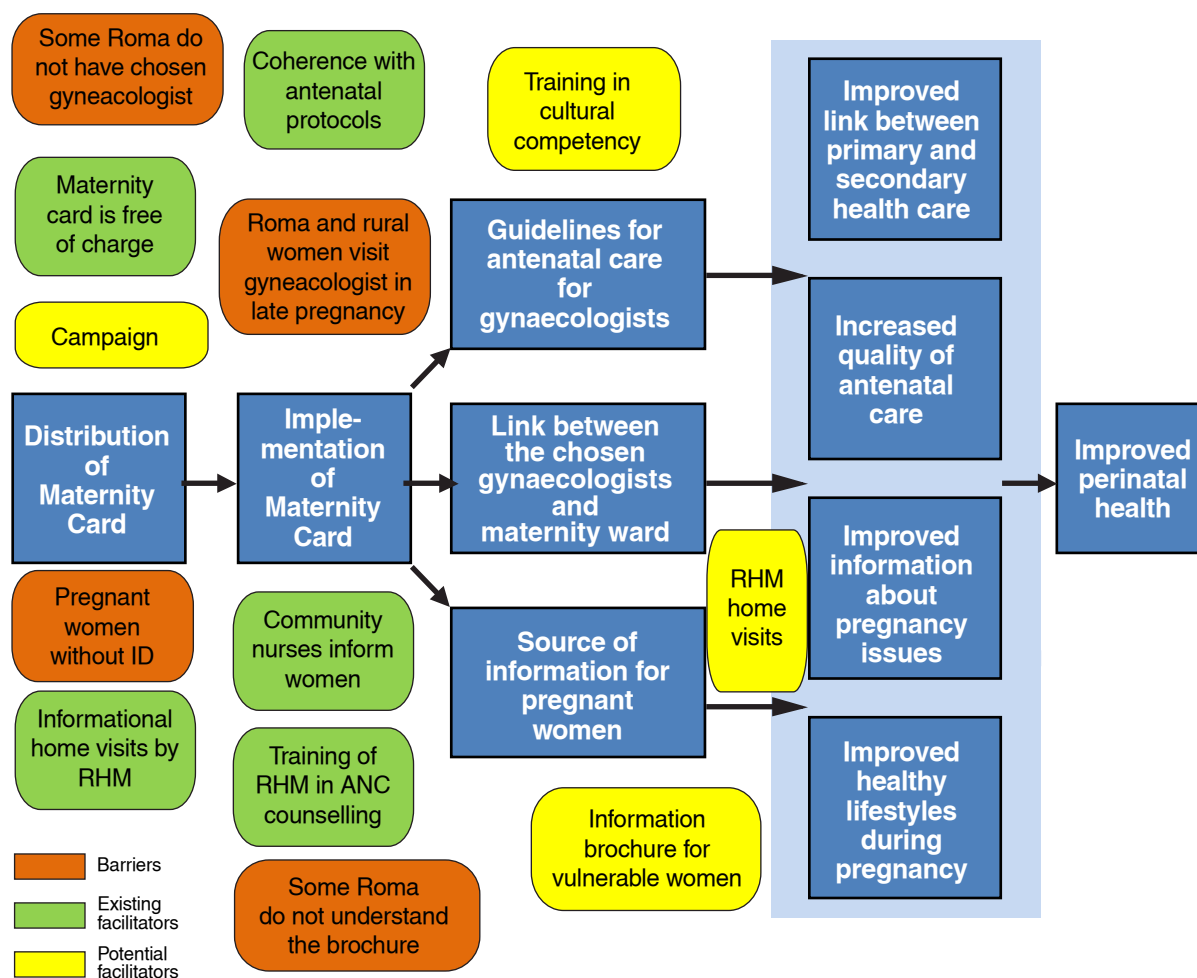
The CSDH framework was used to determine how barriers and facilitating factors are interrelated with SDH. Most SDH are structural, which imply that the health system is unable to address them itself and that intersectoral policies are required.

4.5.1 Interrelation of barriers with SDH

While some of the barriers (such as uneven geographical distribution of gynaecologists and the long distance between health-care centres) are at health-system level, there are many that are interrelated with other SDH. Many Roma women do not have a nominated gynaecologist, or they visit the nominated gynaecologist in late pregnancy for various reasons: low awareness of the importance of regular ANC or fear of physical examination during pregnancy (which are linked to psychosocial and cultural factors), or lack of finance and a low level of information (linked more to structural determinants).

Women who are illiterate or have a low level of education cannot fully understand the content of the brochure (psychosocial and educational factors), so it is possible they do not comply fully with the recommendations. In addition, low resources and lack of finance can contribute to not following the recommendations (structural determinants).

Fig. 6. Key stages of the activity, distribution and use of Maternity Card



4.5.2 Interrelation of facilitating factors identified with SDH

The facilitating factors identified are also interrelated with SDH. The Maternity Card is free of charge; some of the services for Roma women and women on social welfare are covered by the MCHP (linked to both material circumstances and structural determinants). New proposed facilitating factors (further elaborated in the redesign stage) are also related to SDH – most of them related to the health system but also to psychosocial factors, behaviour and habits. Furthermore, they can influence structural determinants: campaign for nominating a family gynaecologist and for timely and appropriate ANC, creation of information brochure to be distributed by RHM and community nurses through home visits, creation of simplified brochure for vulnerable women, and training of health providers in cultural sensitivity.

4.5.3 SDH that are interrelated with the selected activity and the prioritized groups

Intermediary SDH that affect the access to health services and health-seeking behaviour of marginalized and Roma women during pregnancy, in relation to benefiting from the Maternity Card are as follows.

- Material circumstances affect the timely and regular access to ANC, as some of the antenatal investigations are fee-based. Knowing this, pregnant women may avoid going to a gynaecologist. This lowers the probability that the pregnant woman will have access to the Maternity Card and benefit from it. Poor material circumstances also affect health behaviour.
- Poverty is associated with poor nutrition, smoking, alcohol consumption, hard physical work, all of which are in correlation with preterm birth and low birth weight (LBW).
- Psychosocial circumstances such as stressful living conditions affect health-seeking behaviour.
- Health-related behavioural factors are in direct correlation with the circumstances in which vulnerable women live and work, and this group of women tend to live in harmful conditions that turn into harmful behaviour patterns.
- The health system has uneven distribution of gynaecologists, an obligatory fee for some services, lack of cultural competence among health professionals, all of which have an impact on accessibility and quality of services.

Structural determinants that affect the health status and health-seeking behaviour of vulnerable women during pregnancy in relation to the Maternity Card are as follows.

- Level of education has been shown as the most important characteristic of the mother in regard to health-seeking behaviour, compliance with doctors' recommendations, and health behaviour patterns, all in strong correlation with maternal and infant health. A low level of education is correlated to low level of receptivity to health education messages and low ability for communication with health services, poor living conditions, lack of material resources, and unhealthy diet.
- Unemployment is directly linked with poor material living conditions, psychosocial stress, and low level of education.

4.5.4 SPA context – programmes and interventions influencing the SPA

A large number of existing national policy documents, such as laws, strategies and programmes, address mothers' and children's health and give priority to the health of these population groups (see Table 3). Most of these policy documents support the MCHP and thus create an enabling environment for its implementation. A number of activities envisaged by some of these policies – such as the National Strategy for Safe Motherhood 2010–2015, National Strategy for Sexual and Reproductive Health 2010–2020, action plan for improvement of maternal, perinatal and infant health 2013–2014, strategic framework for improving the health and social status of the Roma population in the former Yugoslav Republic of Macedonia by introducing RHM, etc. – have been implemented through the MCHP, thus accelerating implementation of these documents. The MCHP serves as an important means of implementation of strategic documents, at the same time being in line with the existing policy framework of the country. Bearing in mind that all these strategic documents have been created according to country context and the existing health needs of the most vulnerable population groups, their realization could contribute greatly to the improvement of the health of mothers and children in the country.

It is important to be aware of the context (micro and macro) and establish synergies with other policies, laws or strategies that reinforce the MCHP. The policies that create synergies with the MCHP are listed in Table 3 and Table 4.

Table 3. SPA macro context

Name of the programme or intervention	Description
Health Protection Law, 2012	Article 6. Principle of equal access to health services Article 6. Principle of equal fairness in providing health services
Public Health Law, 2010	Principle 2. Improvement of population health with focus on SDH
National Strategy for Safe Motherhood, 2010–2015	Specific goal. Improvement of quality of ANC and level of information of pregnant women Specific activity. Implementation of Maternity Card
National Strategy for Sexual and Reproductive Health, 2010–2020	Specific goal. Strengthening the role of PHC in providing quality and timely ANC
National Action Plan for Roma Inclusion	Improvement of access to health services and health information for Roma women
Strategic framework for improving the health and social status of the Roma population in the former Yugoslav Republic of Macedonia by introducing RHM	Main goal. To provide strategic directions and recommendations for introducing RHM in the former Yugoslav Republic of Macedonia
National Strategy for Sustainable Development, 2008–2015	Specific goal. To ensure a health system based on the principles of solidarity, equity and proper efficiency
National strategy on alleviation of poverty and social exclusion in the former Yugoslav Republic of Macedonia, 2010–2020	Objective 13. Improve conditions for women and reduce the degree of risk of poverty and social exclusion

Table 4. SPA micro context	
Name of the programme or intervention	Description
Action plan for improvement of maternal, perinatal and infant health, 2013–2014	Specific goal. Improve antenatal health of vulnerable groups of women, including Roma. Activity. Introduce special entitlements for Roma and other vulnerable groups, covering co-payments for antenatal services
Clinical guidelines for ANC, 2010	Maternity Card is created in accordance with clinical guidelines for ANC. It is expected that its use will improve its practical implementation at primary care level.

4.5.5 Intersectoral action

Confronting society’s health challenges cannot be done by the health sector alone, as health is mainly determined by factors outside the health sector. The structure and functioning of health-care systems is also largely a result of decisions made at political levels and in various other sectors beyond that of health. A health in all policies approach and intersectoral action is crucial to improve population health by addressing SDH. This policy approach addresses the social factors that influence health, but which reside outside the health system and in sectors other than health. Not all barriers identified within the programme could be addressed by the health sector alone, so intersectoral cooperation is crucial in minimizing the identified barriers.

In regard to the Maternity Card, local governance could have a role in improving women’s level of information about ANC. The need for financial support to cover the cost of health services during pregnancy is the subject of discussion with representatives from the MoH and the Ministry for Labour and Social Policy, in order to identify the most appropriate model for financial help for pregnant women.

The role that sectors other than health may have in addressing the barriers identified in the SPA is presented in Table 5.

4.5.6 Social participation

The participation of civil society and the empowerment of affected communities to become active protagonists in shaping their own health are a crucial policy direction to promote health equity.

Table 5. Analysis of the role of other sectors

Barrier	Sectors involved in addressing barriers (apart from health)
Many Roma women do not have a nominated gynaecologist	Local governance, education
Cultural factors – women are avoiding physical examination	Local governance, education
Lack of information among women about the importance of adequate ANC	Local governance, education
Lack of finance among women (many of the exams are fee-based)	Ministry for Labour and Social Policy, local governance
Lack of ID	Ministry for Labour and Social Policy, local governance

Civil society participation can strengthen people’s control over their health and the factors that affect their health. Social participation involving vulnerable groups could empower these groups, increase control over decisions that influence their health, and their access and use of health services.

Social participation can take a number of different forms including informing people, involving or working directly with communities, collaborating by partnering with affected communities, and empowering by ensuring that communities retain control over the key decisions that affect their health.

NGOs and civil-society organizations have an important role and can support the government in its responsibility to reach Roma and rural women and to improve their level of information about appropriate ANC, the function of health services and the need to nominate a gynaecologist. This is set out in more detail in Table 6.

4.6 Steps T & Y: planning the redesign and its implementation

The redesign stage is the final stage of the EQUITY cycle and is the process of integration of equity and SDH approach. The general aim of the redesign was to modify the programme in order to better respond to the needs of all women, specifically women of vulnerable groups who face barriers arising from their social characteristics, as part of overall national efforts to facilitate health equity as a way of achieving MDGs 4 and 5.

The specific aims of the redesign were:

- to minimize or remove barriers at all stages of implementation of the programme, with the focus on one specific intervention – distribution and use of the Maternity Card;
- to reinforce or create facilitating factors that will support the realization of each stage of the intervention(s), or the stages where the barriers are most prominent;
- to propose innovative interventions in line with the general aim of the programme that support the achievement of health equity; and
- to rewrite and improve the wording of the document so that it clearly reflects that the programme addresses the needs of all women and specifically those in a vulnerable situation.

Table 6. Analysis of the role that social participation may have in addressing the barriers identified in the SPA	
Barrier	The role of social participation in addressing the barrier
Design and include appropriate campaign within the MCHP	Give input into designing educationally and culturally appropriate campaign
Reaching subgroups	Target hard-to-reach groups
Cultural factors – women are avoiding physical examination	Implement projects to raise awareness among women about timely and regular ANC, and exploring why they are avoiding physical examination – try to understand the factors contributing to this decision (qualitative research, community-based research)
Lack of information among women about the importance of adequate ANC	Implement projects to raise awareness among women about timely and regular ANC, media coverage with professionals through interviews and articles
Uneven geographical distribution of gynaecologists	NGOs using mobile clinics for rural and remote areas to mitigate the lack of gynaecologists
Language barriers	Adaptation, translation of the brochures

New aspects following the review are highlighted in the revised objective of the MCHP:

- Continuous improvement of the health of all children and women of reproductive age, in line with lowering infant mortality and improving maternal health, through coordinated essential public health activities for identified priorities based on the of equitable access to all, and with a focus on the different needs of the population and specifically of vulnerable groups.

The revised specific aims of the MCHP are:

1. improvement of the M&E system for monitoring the health status of women and children;
2. advocacy for data disaggregated by social variables;
3. raising the level of information among the population about healthy lifestyles and appropriate health behaviour, during the preconception, antenatal and postnatal periods during infancy, with a focus on vulnerable groups (mainly Roma and rural populations);
4. improvement of the quality and accessibility of health services for mothers and children, with a focus on vulnerable groups;
5. timely screening for disease among newborns, infants and children under 5 years of age; and
6. strengthening intersectoral collaboration and partnership in communities through mobilizing all relevant partners in the identification and solving of the health problems of women and children, especially minimizing barriers in access to services.

During the review process a number of activities under each specific aim were proposed, but this case study only presents the new activities that will facilitate the activity, distribution and use of the Maternity Card.

New activities or facilitating factors that will facilitate the implementation of the distribution and use of Maternity Card are:

- the creation and conducting of a campaign to encourage nomination of a family gynaecologist and for timely and appropriate ANC, taking into account the specific needs of the population;
- the introduction of a budget to cover fees for antenatal services for Roma women and women on social welfare;
- training of health-care providers (gynaecologists, community nurses) in cultural sensitivity and communication skills for working with vulnerable groups of women;
- the creation of an information brochure adapted to the needs of vulnerable women from regions with the lowest perinatal indicators, and its distribution through RHM and community nurses in order to improve adherence. Its content should be simple but with a strong message about the importance of timely and appropriate ANC, about the content of ANC and what pregnant women should expect from the health system during pregnancy (from the Health Insurance Fund, gynaecologist, community nurses);
- training for RHM and community nurses in ANC counselling and in the functioning of the health-care system in relation to pregnancy and delivery, so they are better equipped to disseminate the information in the information brochure;

- an official letter from the MoH to gynaecologists requesting their collaboration to achieve the objective of 100% of women receiving the Maternity Card;
- the organization of a one-day meeting for different actors in the health system, including civil society organizations, to launch the information brochure, raise awareness and improve the collaboration and coordination between them to facilitate the success of this activity;
- the creation of mechanisms for greater collaboration with NGOs in approaching subgroups of the population; and
- advocacy to improve access to the health system for vulnerable groups of women and children.

In addition, RHM and community nurses will reinforce their work approaching the Roma and rural women in regions with the lowest perinatal indicators through individual home visits and group counselling. They will inform these women about the need for timely and appropriate ANC, their rights to health services and give them information about the content and purpose of the Maternity Card.

The revised SPA theory reflecting the equity approach is shown in Box 2, and Fig. 7 shows its key stages.

Box 2. Revised SPA theory including equity and SDH approach

The health of women and children and access to health services are largely influenced by SDH. Equitable access to the activities and services envisaged by the programme will be effective for the whole target population if it is taken into consideration that not all groups of women have equal access to them. Bringing the interventions closer to all women, specifically the most vulnerable ones, and minimizing the society-based barriers, will contribute to the realization of the programme and achievement of its objectives. Policies and interventions that take into consideration SDH and health inequalities, intersectoral collaboration and social participation can improve quality and accessibility of health services to all who are in need and thus improve health equity and further achievement of MDGs 4 and 5.

The new diagram more clearly reflects the main idea of achieving equity through targeting not only the general population of women and children, but also vulnerable groups, including Roma, through interventions that take into consideration SDH and health inequalities, intersectoral collaboration and community participation in the process of implementation.

Fig. 8 shows the revised diagram of the activity, distribution and use of the Maternity Card, which clearly shows that when devising interventions, especially when there is a risk of not fully reaching the target population, it is equally important to create facilitating factors that will minimize possible barriers to reaching all groups, and specifically vulnerable ones, which will facilitate the realization of the intervention itself.

Fig. 7. Key stages of the revised SPA

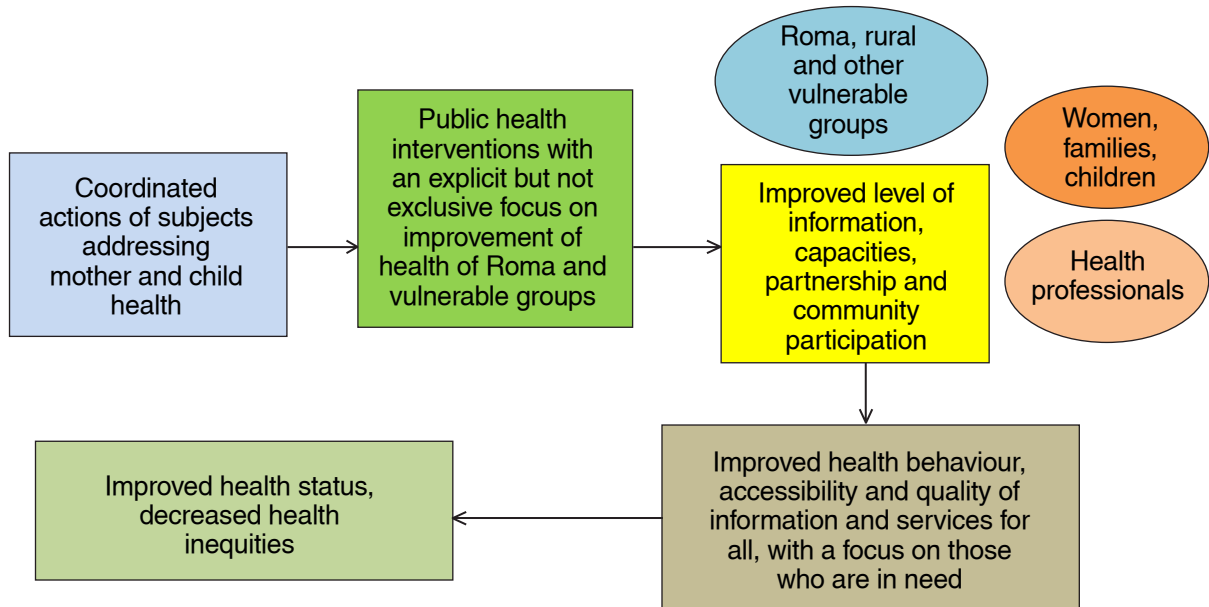
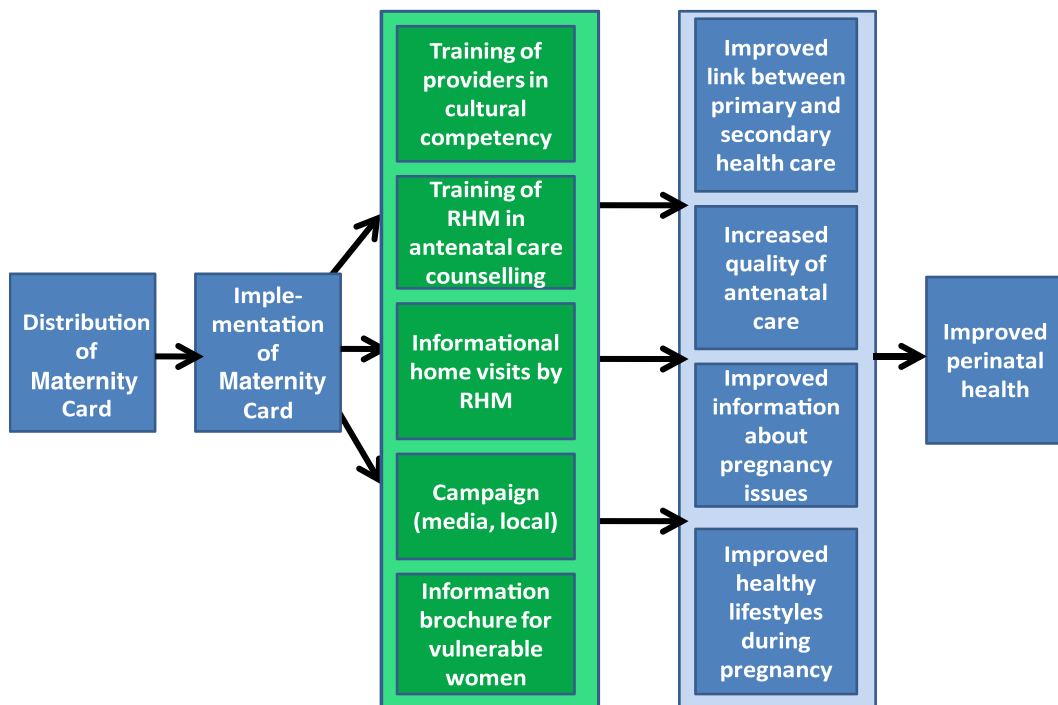


Fig. 8. Revised diagram of the activity, distribution and use of the Maternity Card



4.6.1 Role of other sectors in the redesign of the SPA

Despite the fact that the health sector has an important role in providing health with equity, most of the factors that create inequities come from outside this sector. One of the responsibilities of the health sector should be to provide evidence of the health inequities and visibility of certain population groups that need action from other sectors within the SDH approach. One of the benefits of this process of reorientation is raising awareness, giving it visibility and calling for action from other sectors which have an impact on health. For example, local government could support community nurses and RHM in their work through providing transport, and raising awareness among rural and Roma women; the Ministry of Labour and Social Policy could offer support to obtain ID and finance to cover fees for ANC and delivering services for women without ID. To make this possible, there is a need for a coordination meeting to introduce the MCHP to representatives from local authorities.

Another recommendation from the team members was the establishment of mechanisms for intersectoral action, such as a coordinating body in charge of the creation, implementation, and M&E of the MCHP with representatives from other sectors, including representatives from United Nations organizations and NGOs.

4.6.2 Role of social participation in the redesign of the SPA

During the reorientation process, an administrative model of participation was used. Civil society representatives were part of the learning node and participated in the review process.

They exchanged experiences and information from the Roma community. Feedback from the community was also taken into consideration, through research reports, which allowed the use of community-generated evidence (14,18).

Social participation undoubtedly added value to the redesign process and also initiated a channel of collaboration for improving other health programmes.

4.6.3 Implementation of the redesign of the SPA

The new proposed MCHP will be presented at a meeting shortly after the adoption of the programme by the MoH, to representatives from different stakeholders in order to obtain greater collaboration and more successful implementation. The Safe Motherhood Committee, NGOs, Roma community representatives, United Nations agencies, civil society and other partners will be invited to the meeting. The meeting will also be used to advocate for the establishment of mechanisms for collaboration between the MoH and civil society organizations and NGOs, as well as for the establishment of a coordinating body for M&E of the MCHP.

Some of the results that are linked directly to the MCHP include identification of the so-called hidden barriers to implementation of the activities. The new SPA is more focused and enriched with interventions that are expected to improve the quality of the MCHP and its implementation, which will lead to further availability, accessibility and coverage of the services for all women, specifically those from the most vulnerable groups, and therefore to the improvement of mother and infant health.

The importance of collaboration with different stakeholders and of social participation has been recognized by all participants in the review process and will be adopted as a practice in the future during creation and implementation of the MCHP.

Some of the results that are not linked directly to the MCHP, but could have an impact on participants' future work, are as follows.

- All participants agreed that the revision process was a learning opportunity, and at the same time they improved their capacities for integrating into SPA a health equity approach based on SDH and health inequities.
- As participants are all involved in the creation and implementation of different SPAs, they expected to use this experience in the creation/implementation of different SPAs in their everyday work.
- The redesign will give visibility to Roma and other vulnerable women and start a call for action from other sectors which have impact on health.
- The improvement of collaboration with different stakeholders and of social participation were also seen as important benefits.
- The process offered an opportunity to create strong networks and alliances between participants.
- The most important benefit for the participants was that they realized that the success of every intervention could be compromised if it does not take into consideration that vulnerable groups confront specific barriers, and that identification of and overcoming these barriers should be part of the creation and implementation of every intervention.

5.1 Difficulties and limitations

The main limitation encountered in relation to the proposed methodology was the time involved: team members held six meetings, of 3–4 hours each.

The main limitations identified in relation to the selected SPA during the process were: complexity of the SPA that was selected, which limited the detailed revision to only one activity; the SPA cannot influence all barriers, as some (such as geographical barriers, which influence and reinforce all other barriers) are beyond its scope.

The main results linked to the redesign of the MCHP are detailed in Table 7.

Table 7. Main results linked directly to the MCHP		
Aspect	Before the review	After the review
Equity	Barriers for equal access not fully identified	Identification of so-called hidden barriers
Quality	Diverse and complex	More focused, enriched with new and innovative interventions
Intersectoral action	Information (one-way relationship)	Cooperation
Social participation	Management model – decisions made by experts, minimal communication	Consultation (corporate participation model) – decision-making shared with Roma NGO representatives
Other	—	Innovative activities introduced

5.2 Lessons learned

Despite the MCHP having been designed to reach all populations, some groups are not accessing and not benefiting from it.

In the future, more attention should be given to equity – identifying appropriate ways to minimize the barriers and identifying facilitating factors – in order to fully implement the activities and achieve the defined goals. Since not all the barriers and facilitating factors can be addressed by the health sector, greater collaboration with other sectors is vital, so there is a need to create a mechanism for collaboration and coordination with governmental institutions, at national, regional and/or local level.

Improvement of social participation and moving from a technocratic and management model to a higher level of participation are important prerequisites for shifting from a top-down to a bottom-up method. The top-down nature of most initiatives is a severe limitation.

The main parallel results not linked directly to the programme are detailed in Table 8.

Table 8. Main parallel results not linked directly to the MCHP		
Aspect	Before the review	After the review
Raising awareness and advocacy on health equity and SDH	Only partial recognition of the importance of equity and SDH	Raised awareness about equity impact of SDH; importance of using so-called equity lens during creation/implementation of different SPAs
Participation of civil society	Anecdotal, rare	Importance of social participation recognized and introduced in practice (NGOs)
Working with other sectors	Anecdotal, rare	Collaboration with different stakeholders in creation and implementation of the SPAs
Changes in day-to-day working practice	Insufficient attention paid to the equity impact of SPAs	Improved capacities used during creation/implementation of SPAs in everyday work
Other	Vulnerable women not sufficiently visible	Vulnerable women visible

The team members will advocate for the creation of a coordinating body within the MoH and for the creation of a registry of NGOs. More important is to work on raising awareness among policy-makers about the importance of social participation and improve the receptiveness of public administration for social participation.

Collaboration with civil society is crucial, both using their innovative approach and capacities, as well as their network as feedback from the community. The MoH can create spaces that enable and encourage participation.

Use all available means. It is important to include more agents in the implementation of the SPA. RHM are relatively new actors and their role was not sufficiently clear because the process of their integration into the system also faces barriers – additional tasks could improve their integration and efficacy.

5.3 Conclusions

The EQUITY review process is a systematic evaluation process useful as a continuous cycle of improvement which will enhance the quality, effectiveness and equity of the programmes.

The reorientation process is useful (raised awareness, capacity building, implemented health equity in the SPA); applicable (participants will implement this expertise in the creation and implementation of different SPAs in their everyday work); and transferable (participants are now so-called champions of health equity and can raise awareness and influence others in reorienting existing SPAs and creating new SPAs). It could be further improved taking into account the experience and reflections of the different participants and countries. There is a need to transfer the concept of reorienting SPAs, for example by training policy-makers from health and other sectors on the impact on health and the simultaneous use of different models, such as implementation in teaching curricula.

The training session also provided a platform for exchange of experiences among the representatives from the four countries (Bulgaria, Montenegro, Serbia and the former Yugoslav Republic of Macedonia), which were using the guide on a pilot basis within their biennial collaboration agreements with WHO for 2012–2013.

Equity works not only for vulnerable groups but for the whole population, taking into account the specific needs of different social groups (social gradient and proportional universalism concepts).

In summary, the process of reorientation of the MCHP was primarily a learning process but at the same time a good example of translation of theory into practice. Reorienting the SPA is a continuous process. It does not end with the reorientation of one SPA; it is a way of thinking that will affect the further work of the team members and contribute to the improvement of accessibility, quality of services and health equity. As so-called champions of health equity, team members will further apply this expertise in the creation and implementation of different SPAs in their everyday work and will continue to transfer this expertise and influence others to spread the concept of health equity.

5.4 Recommendations

At programme level, the text of the new MCHP includes new potential facilitating factors. This was presented to the MoH for its adoption. Nearly two thirds of the proposed facilitating factors were adopted and included in the MCHP for 2014, with the possibility that the rest will be adopted in the following period, or next year.

At national level, the members of the learning node concluded that insufficient attention was explicitly paid to the health and equity impact of the SPAs and that the whole process should be expanded by:

- strengthening the governance capacity to address SDH and the health divide in existing or planned health (social and education) policies;

- building capacity among a greater number of public health professionals, both from health and other sectors which have an impact on health, on the concept of equity and the use of the methodology facilitated by WHO during the development, implementation and evaluation of different SPAs;
- simultaneous use of different models – for example, implementation of the concept of the equity lens in teaching curricula;
- empowering NGOs in these issues;
- training health professionals, health managers and policy-makers in sensitivity to diversity (both at individual and organizational level);
- improving intersectoral collaboration;
- improving social participation through greater collaboration primarily with civil society; a further role of civil society in the creation and implementation of the SPA can be strengthened through replication of their innovative models, using their capacity to mobilize patients from vulnerable groups to seek health care;
- organizing information meetings/workshops for safe motherhood issues in hard-to-reach communities/populations.

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Annex 1

The multicountry training process for reorienting SPA towards greater health equity¹

A multicountry training course on reorienting SPA to MDGs 4 and 5 for greater health equity with an explicit but not exclusive focus on the Roma population is an outcome of the interagency coordination initiative on scaling up action towards MDGs 4 and 5 in the context of the Decade of Roma Inclusion and in support of national Roma integration strategies. This initiative is facilitated by WHO Regional Office for Europe and also involves UNFPA, OHCHR, UNDP, UNICEF and IOM.

The multicountry training was organized and facilitated by WHO Regional Office for Europe in collaboration with the Spanish Ministry of Health, Social Services and Equality and the Interuniversity Institute of Social Development and Peace, University of Alicante (WHO Collaborating Centre on Social Inclusion and Health).

Four countries (Bulgaria, Montenegro, Serbia and the former Yugoslav Republic of Macedonia) included the training in their collaborative agreements with the Regional Office for the 2012–2013 biennium, and actively participated in the training process which was carried out for an 11-month period, from November 2012 to October 2013.

The main objectives of the multicountry training were:

- to raise awareness about SDH, the health equity approach, human rights and nondiscrimination;
- to train a multidisciplinary team of health professionals who are in decision-making roles, experts and Roma association representatives on how to reorient SPAs related to MDGs 4 and 5 (maternal and child health) towards pursuit of greater health equity with an explicit but not exclusive focus on the Roma population;
- to build participants' methodological capacity to apply the EQUITY review cycle, which is a practical tool, for reviewing SPAs and reorienting them to equity;
- to adapt SPAs to the different needs of the population groups, specifically Roma; and
- to involve the target population, in this case the Roma population, in the EQUITY review process.

Methodology

The multicountry training process was carried out over an 11-month period using a mixed methodology of face-to-face workshops and online work.

¹ The authors of this annex are (in alphabetical order): Pilar Campos Esteban, Ana Gil Luciano, Daniel La Parra, Begoña Merino, Piroška Östlin and María Santaolaya Cesteros.

The training drew on the Spanish training process on integrating a focus on SDH and health equity into health SPA, carried out in 2010–2011², and followed the *Methodological guide to integrate equity into health strategies, programmes and activities (1)*, developed by the Ministry of Health, Social Services and Equality of Spain.

Apart from the methodological guide, participants were also given some key documents related to equity, Roma and human rights, and other specific materials designed ad hoc for the training, such as a tool kit on social participation.

Participants were country representatives nominated by their governments, from country offices of United Nations agencies in pilot countries and from Roma NGOs. Around 40 people were involved in the whole process or in some part of it.

The participants were organized into country working teams and they analysed the following specific SPAs.

The working team of the former Yugoslav Republic of Macedonia reviewed the MCHP.

The Bulgarian working team reviewed the national programme on SRH.

The Montenegro working team reviewed the national strategy on protection and promotion of reproductive health.

The Serbian working team reviewed the national programme for screening for cervical cancer.

For the designing, planning, organization and teaching of the process, a coordination team was appointed. The coordination team members also acted as facilitators of the four country working teams at the different stages of the process, giving feedback both at face-to-face events and by email. This coordination team was composed of six experts from the WHO Regional Office for Europe, the Spanish Ministry of Health, Social Services and Equality and the University of Alicante.

- Piroska Östlin (WHO Regional Office) was the main coordinator, leading the coordination team and the organization of the whole process.
- Pilar Campos (Spanish Ministry of Health, Social Services and Equality) facilitated the review working team of the former Yugoslav Republic of Macedonia.
- Ana Gil Luciano (Spanish Ministry of Health, Social Services and Equality) facilitated the Bulgarian review working team.
- Daniel La Parra (University of Alicante) and Begoña Merino (Spanish Ministry of Health, Social Services and Equality) facilitated the Montenegro review working team.
- Maria Santaolaya Cesteros (Spanish Ministry of Health, Social Services and Equality) facilitated the Serbian review working team.

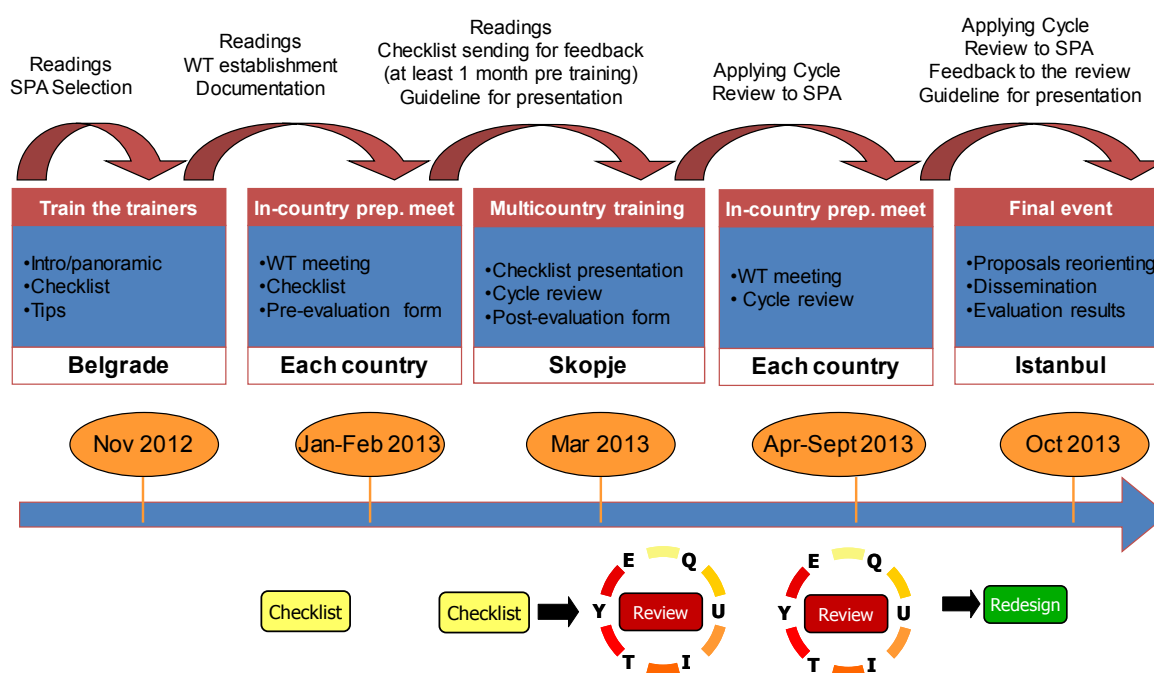
In the inception stage of the process, Theadora Koller (WHO Regional Office) led the design of the process, ensuring synergies with country workplans and linking it to the aforementioned interagency coordination initiative.

² More information about the Spanish training process is available at http://www.who.int/social_determinants/action/Social_Determinants_of_Health_Discussion_Paper_9/en/ (accessed 27 November 2014).

During the process design phase, Jeanette Vega and the Spanish Ministry of Health, Social Services and Equality provided strategic input on transferability and adaptation of the review methodology (previously piloted in Chile and Spain) to a multicountry training platform.

The training process included three main events with all four working teams together, in-country work with several in-country meetings between the three events, and work online, as shown in Fig. A1.

Fig. A1. Work plan of the multicountry training process

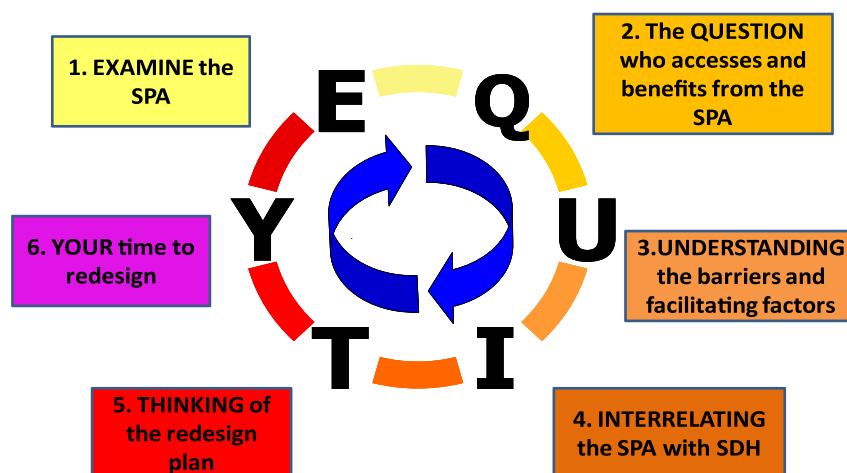


WT = working teams

The first meeting took place in Belgrade, Serbia, 7–8 November 2012 and it was planned as a train-the-trainer pilot session. This meeting had the goals of raising awareness on SDH, going deeper into the SDH framework of the WHO CSDH, and giving an overview of the EQUITY review process. A health equity checklist was presented, to be completed during the following months and before the next workshop.

The second event, the multicountry training, was a four-day meeting, 11–14 March 2013, in Skopje in the former Yugoslav Republic of Macedonia. At this meeting, the working teams presented the results of their checklist reviews. The main goal of the event was to build participants' methodological capacity to apply the EQUITY review cycle, a practical tool for integrating equity into health SPAs. During this workshop, participants started reviewing their SPAs with the EQUITY methodology, which has five steps, as shown in Fig. A2.

Fig. A2. The five steps of the EQUITY review cycle



Participants made a big effort after the Skopje event, going deeper into each step of the EQUITY review cycle. They organized in-country meetings for this purpose. Results of the analysis of the different steps were sent to the facilitator assigned to their team for feedback.

Finally, the four countries and the coordination team were invited to a workshop organized by UNFPA and the Regional Office, on strategies to reduce health inequities with a focus on Roma in Istanbul, Turkey on 24 October 2013, where each working team had the opportunity to present the overview of the process and the main results, conclusions and lessons learned.

Some general results of the multicountry training process were as follows.

- Health professionals in decision-making positions, Roma association representatives (in review working teams) and experts from international organizations were trained on how to reorient SPA related to MDGs 4 and 5 towards pursuit of greater health equity with an explicit but not exclusive focus on the Roma population.
- The training was useful for improving the knowledge and skills of members of the review working teams so that they can make use of tools such as the methodological guide for analysing equity.
- A platform was provided for technical guidance and sharing methods and approaches to review how SPA related to MDGs 4 and 5 address health equity.
- This multicountry training process supports the exchange and validation of country experiences towards reorienting SPA.
- It contributes to international efforts to ensure that Roma and other groups living in social disadvantage can access services that respond to their basic human rights (including the right to health), in accordance with the efforts of the EU Framework for National Roma Integration Strategies and the Decade of Roma Inclusion.
- A final evaluation of the training was carried out in February 2014. The comments and feedback on the process from participants will be used to improve it.

General conclusions of the multicountry training process are as follows.

- The training process for integrating equity into health SPAs and its methodology are transferable, but need to be adapted to each context.
- This process has been conducted with a focus on Roma population, but it was designed to identify any population group not properly accessing a SPA.
- The results of this process can go beyond the specific SPA that is analysed.
- Intersectoral action and social participation are key aspects for the integration of equity into health SPAs.

After the evaluation of the process, the main lessons learned from the participants were as follows.

- The review working teams valued what was learned during the training process as a useful tool for application in professional life.
- The teams considered that the experience gained in analysing the selected SPA could easily be transferred to other SPAs in the future.
- The working team experience, with the integration of people belonging to health administration, university and the associations, was positive and transferrable to other activities.
- The political will of the government in general, and of the MoH in particular, is important in order to reorient SPAs towards equity, which translates into provision of human and financial resources for the process and implementation of reorientation.
- The involvement of health sector institutions alone in the reorientation process may make communication with other sectors (such as labour, finance, education, urban planning, housing, etc.) more difficult in accordance with the Health in All Policies and the SDH framework.
- The methodological guide is useful but complex to apply when time is limited, so commitment and support at high level are key elements for allocating the time required for reviewing the SPAs.
- This training process focused on specific social groups (for instance, the Roma population), but sometimes an explicit approach towards a certain group could be in contradiction of general equity objectives (in terms of reducing the social gradient in health).

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Annex 2

Identified barriers and facilitating factors

Table A1 analyses the barriers and facilitating factors identified at each key stage of the SPA for the prioritized groups.

Table A1. Identified barriers and facilitating factors			
Key stage	Barriers	Existing facilitating factors	Potential facilitating factors to be taken into account during redesign
Distribution and promotion of Maternity Card	<p>Availability</p> <ul style="list-style-type: none"> • Uneven geographical distribution of gynaecologists <p>Accessibility</p> <ul style="list-style-type: none"> • Many Roma women do not have a nominated gynaecologist • Roma and rural women visit a gynaecologist in late pregnancy • Long distance between health-care centres <p>Acceptability</p> <ul style="list-style-type: none"> • Lack of information about timely and appropriate ANC • Low perception of risk 	<p>Availability</p> <ul style="list-style-type: none"> • Distribution and implementation of Maternity Card became an activity within the annual MCHP • The Maternity Card is free of charge <p>Accessibility</p> <ul style="list-style-type: none"> • All women with health insurance are eligible to choose a gynaecologist • Campaign for choosing a family gynaecologist 	<p>Accessibility</p> <ul style="list-style-type: none"> • Covering the copayments for services for Roma and women on social welfare • Campaign for timely and appropriate ANC through home visits and media campaign <p>Acceptability</p> <ul style="list-style-type: none"> • RHMs and community nurses approach Roma and rural women through individual home visits and group counselling

Table A1. Identified barriers and facilitating factors

Key stage	Barriers	Existing facilitating factors	Potential facilitating factors to be taken into account during redesign
<p>Implementation of Maternity Card</p>	<p>Acceptability</p> <ul style="list-style-type: none"> • Resistance from the gynaecologists to its use as it is seen as overburden in everyday work • Roma women cannot fully understand the content of the Maternity Card • Health services are not fully adapted to the needs of vulnerable women • Economic barriers as many antenatal services are fee-based <p>Contact</p> <ul style="list-style-type: none"> • Cultural factors – women are avoiding physical examination • Lack of communication skills and cultural competences of gynaecologists to work with women with different cultural and traditional values • Maternity Card and brochure are not available in the Roma language 	<p>Acceptability</p> <ul style="list-style-type: none"> • Training of gynaecologists in the use of the Maternity Card and its benefit for them as well as for women 	<p>Acceptability</p> <ul style="list-style-type: none"> • RHMs and community nurses approach Roma and rural women through individual home visits and inform them about the content and purpose of the Maternity Card <p>Contact</p> <ul style="list-style-type: none"> • Training of health-care providers in cultural sensitivity <p>Effective coverage</p> <ul style="list-style-type: none"> • Information brochure simplified for the use of women with low educational level • Information brochure created for vulnerable women and distributed through RHMs and community nurses to improve adherence to ANC • RHMs and community nurses trained in ANC counselling

	<p><i>Effective coverage</i></p> <ul style="list-style-type: none"> • Pregnant women do not respond/ adhere to the recommendations in the information brochure • Low level of information • Insufficient collaboration between the MoH and NGO sector 		<ul style="list-style-type: none"> • Meeting for different actors in the health system to improve collaboration and coordination • Create mechanisms for greater collaboration with NGOs for approaching sub groups • Advocacy activities for the improvement of access to the health system for vulnerable groups
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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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World Health Organization
Regional Office for Europe
UN City, Marmorvej 51
DK-2100 Copenhagen Ø, Denmark
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