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Review and reorientation of the Serbian national programme for early detection of cervical cancer towards greater health equity

ROMA HEALTH – CASE STUDY SERIES **NO.3**





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ABSTRACT

Studies conducted in Serbia and worldwide concluded that socioeconomic determinants of health, such as gender, wealth, ethnicity and place of living, are strongly associated with health status. Recognized inequalities in health due to differences in socioeconomic status require a structured institutional response and multisectoral actions at many levels. The WHO Regional Office for Europe proposed using methodology developed to review and reorient national strategies, programmes and actions (SPAs) towards greater equity. The Serbian Ministry of Health appointed a working team to review their national programme for early detection of cervical cancer, the chosen SPA. This case study presents the review of the SPA, which identified Roma women and other groups who might not benefit from this programme due to barriers they face at many levels. Along with analysing barriers, it also identifies factors that might facilitate access to this programme. Key recommendations include the need for a multidisciplinary approach focusing on social determinants of health, and intersectoral collaboration of different stakeholders at national, regional and community levels.

Keywords

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EARLY DETECTION OF CANCER
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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.

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This paper was written by Associate Professor Bosiljka Djikanović, Institute of Social Medicine, Faculty of Medicine, University of Belgrade, Serbia. The case study was informed by the activities of the national review working team, appointed by the Ministry of Health of Serbia, and consisted of representatives from the Ministry (Dr Dubravka Šaranović and Dr Jugoslav Kelečević); from the Ministry and Roma organization (Dr Dragan Đordjević); the Dr Milan Jovanović Batut Institute of Public Health of Serbia (Dr Katarina Boričić); the Dr Vukan Čupić Institute for Mother and Child Health Care (Dr Katarina Sedlecky); the United Nations Population Fund (Ms Marija Raković); the United Nations Children’s Fund (Dr Jelena Zajeganović Jakovljević) and the WHO Country Office, Serbia (Mr Ivan Živanov). Associate Professor Djikanović represented academia in the review team and was team leader.

The review working team is grateful to the facilitators of this process who provided valuable input to their work: Dr Daniel La Parra, Interuniversity Institute for Social Development and Peace, University of Alicante, Spain (WHO Collaborating Centre on Social Inclusion and Health); Ms Maria Santolaya, Ministry of Health, Social Services and Equality, Spain; and, last but not least, to Dr Piroška Östlin, WHO Regional Office for Europe.

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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, 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 (EU) Framework for National Roma Integration Strategies, and the recent Council Recommendation on Effective Roma Integration Measures in the 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 the International Organization for Migration, the Office of the United Nations High Commissioner for Human Rights, the United Nations Children's Fund, the United Nations Development Programme and the United Nations Population Fund.

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 (SPAs) 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 eleven-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 and health equity into health SPAs, carried out in 2010–2011,¹ and followed the methodological guide to integrate equity into health strategies, programmes and activities developed by the Ministry of Health, Social Services and Equality of Spain.² 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.

The purpose of this case study, commissioned by the Regional Office, is to present the review and reorientation process of the national programme for early detection of cervical cancer – with a focus on equity and the social determinants of health – carried out by the working team of Serbia and to share the lessons learnt from it.

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1 Merino B, Campos P, Santaolaya M, Gil A, Vega J, Swift T. 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 9 (Case studies); http://www.who.int/social_determinants/action/Social_Determinants_of_Health_Discussion_Paper_9/en/, accessed 13 March 2015).

2 Methodological guide to integrate equity into health strategies, programmes and activities. Version 1. Madrid: Ministry of Health, Social Services and Equality; 2012 (http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/jornadaPresent_Guia2012/docs/Methodological_Guide_Equity_SPAs.pdf, accessed 13 March 2015).

Executive summary

A strong relationship exists between health status and the socioeconomic determinants of health, such as gender, wealth, ethnicity and place of living, as concluded by a number of studies conducted in Serbia that found that being Roma is a main predictor of poor health outcomes. Recognized inequalities in health due to differences in socioeconomic status require a structured institutional response and multisectoral action at many levels. The WHO Regional Office for Europe held an initial meeting (train-the-trainers session) in Belgrade, Serbia in November 2012 to introduce participants to the EQUITY methodology^{3,4} that was developed to analyse equity in different national SPAs. This methodology proposes establishing national working teams to apply this methodology on a chosen SPA. The national review working team in Serbia, appointed by the Ministry of Health, chose to review their national programme for early detection of cervical cancer as the SPA, due to Serbia's high burden of cervical cancer (an incidence of 27.3 per 100 000 population, among the highest in Europe), and high mortality (the fourth cause of mortality among women in Serbia). This programme also fulfilled requirements proposed by the EQUITY methodology: action-oriented, operational and feasible for reorientation and review.

The working team performed the EQUITY checklist and EQUITY review cycle using a consultative process conducted at team meetings and by e-mail.

To detect cervical cancer as early as possible (the chosen SPA), screening will be offered to women aged 25–64 years in Serbia. But this review process found that cervical cancer screening might be less available to women who experience discrimination and to whom health care services are less accessible.

The working team identified subgroups of women who might be less likely to receive and accept screening invitations. These health equity challenges are related to women who do not realize their right to statutory health insurance; lack personal identification documents; lack a permanent home address; are Roma; live in institutions (in prisons, social care institutions) or in rural areas; have disabilities and are poor. This case study focused on the **Roma population**, the largest group of deprived women whose health status is worse than the general population.

This process also identified a bottleneck in the screening programme: cytopathological analysis of pap smears, due to the lack of equipment and educated personnel. This is an important barrier to the success of the screening programme, affects all subgroups of women and does not generate inequity.

³ The acronym EQUITY stands for the five steps of a review cycle: examine, question, understanding, interrelating, thinking, your (time to design) (Annex 1).

⁴ Methodological guide to integrate equity into health strategies, programmes and activities. Version 1. Madrid: Ministry of Health, Social Services and Equality; 2012 (http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/jornadaPresent_Guia2012/docs/Methodological_Guide_Equity_SPAs.pdf, accessed 16 January 2015).

Barriers that Roma women might face are related to things they lack, such as personal documents (identification and health records), health insurance or a permanent household address. Many Roma women are not educated (did not complete primary school), live in poverty, are marginalized, and face stigma and discrimination at many levels. Their health literacy is very low, as is their awareness of the need for preventive health care services. Some do not speak Serbian, so there might be language barriers as well.

Facilitators are related to the availability of Roma health mediators, established by the Ministry of Health in 2008, who facilitate the utilization of health care services by Roma. They cover many Roma settlements and work directly with Roma families. Another facilitator is the availability of the *Strategy for Improvement of the Status of Roma in the Republic of Serbia*,⁵ which includes an Action Plan to implement it. Media promotion and educational programmes targeting health care professionals have made the general public more aware of Roma's rights and their need for inclusion.

The last step in the EQUITY methodology is redesigning the SPA. The SPA was redesigned to make the screening programme more available to Roma women by taking into account the barriers they face; Roma representatives participated in all phases of the redesign process, and intersectoral collaboration helped to enable and facilitate the access of Roma women to this preventive screening programme. Professionals from various sectors worked on the review and reorientation of the SPA with the goal of promoting health equity. They became familiar with the EQUITY methodology and capably conducted the equity analysis of the SPA.

⁵ Strategy for Improvement of the Status of Roma in the Republic of Serbia. Official Gazette of the Republic of Serbia, No. 27/2009; 2010 (<http://www.inkluzija.gov.rs/wp-content/uploads/2010/03/Strategija-EN-web-FINAL.pdf>, accessed 16 January 2015).

Country background

1

According to the 2011 census, more than 7 million people live in Serbia (7 186 862), and Roma are the second largest minority ethnic group (after Hungarians), accounting for 2.05% of the population (147 604) (1). In Serbia, several surveys provided important insights into the social determinants of health and the various outcomes, lifestyles and behaviours related to health. These include national health surveys, conducted periodically among the population in Serbia with the support of the Ministry of Health and the Dr Milan Jovanović Batut Institute of Public Health of Serbia. The last national health survey whose results are available for detailed analysis and interpretation was conducted in 2006 (2).

Another important and informative series of national surveys related to health is the Multiple Indicator Cluster Survey (MICS) of children and women in Serbia, periodically conducted by the Statistical Office of the Republic of Serbia and the United Nations Children's Fund (UNICEF). In addition to surveying the general population, the main characteristic of MICS is that it is conducted in Roma settlements that are otherwise difficult to cover. MICS collects data on women's, men's and children's health and well-being, and generates indicators on child mortality, nutrition, child health, water and sanitation, reproductive health, child development, literacy and education, child protection and subjective well-being (3–4). These reports are very informative, analysing the differences in social and ethnic status and their associations with various aspects of health, and help to better understand the situation of Roma and draw attention to existing problems. The fourth round of MICS (MICS4) was conducted in 2010 and the survey results were published in 2011 (3). The fifth round of MICS (MICS5) was conducted in 2014 and key findings were available in July 2014 (4); the full report is not yet published. The studies show that the Roma population in Serbia lives in different (worse) housing conditions than the general population; their health status is compromised, as well as their level of literacy.

Most of the Roma population, whether living in a village or town, live in extremely poor housing conditions (slums). Dysfunctional and inadequate infrastructure, unregulated legal status and high-density housing often characterize their living environment. As mentioned in the *Strategy for Improvement of the Status of Roma in the Republic of Serbia* (5), only 61% of Roma households have an adequate water supply; about 32% are connected to the central sewage system and 5% of the Roma population have no sanitary facilities at all. The worst living conditions are in shantytowns and slums where 25% of the Roma population lives: "Around 27% of Roma live in ... rural settlements in the city where the conditions are also poor, around 26% of them are in poor villages and hamlets, while 22% live in newer urban and suburban settlements, which often means living in residential buildings." (5).

The results from MICS4 indicated a strong relationship between health status and the socioeconomic determinants of health, such as gender, wealth, ethnicity and place of living, and that being Roma is a main predictor of poor health status (3). Child mortality in Roma settlements is still twice the national average; infant mortality rates range from 7 to 14 live births per 1000 population, and the under-5 mortality rates range from 8 to 15 live births per 1000 population (3). Key findings from MICS5 indicated slight improvement in these indicators in Roma settlements, i.e. the infant mortality rate decreased to 13 per 1000 live births and the under-5 mortality rate decreased to 14 per 1000 live births, which might be ascribed to the successful outreach role of Roma health mediators (4).

Where early childhood education is concerned, the percentage of children aged 3–5 years in preschool has increased since 2005. Nevertheless, only 44% of children in Serbia attend either public or private preschool programmes (3). The gaps are immense: the higher the social status, the higher the percentage of kindergarten attendance. Among poor families, the percentage reaches just half of the national average and is extremely low for Roma children at just 8%.

Since the 2006/2007 school year, all children in Serbia have to attend a six-month compulsory preparatory preschool programme, which was extended to nine months in 2009 (6). In 2010, the percentage of children attending the first grade of primary school who attended preschool the previous year was 97.2%, but just 78% among children from Roma settlements (3). However, four years later, in 2014, these figures improved incrementally in both groups; preschool programme attendance was 98.1% overall and 79.9% in Roma settlements (4).

Cultural context introduces a gender gap in the education of Roma girls as well. As many as 14% of Roma girls aged 15–19 years were married before the age of 15, and one third have their first child before the age of 18. This situation is associated with the low primary school attendance rate of girls from Roma settlements who usually leave school around the age of 12. Therefore, almost one in four women living in Roma settlements is illiterate (76.5% literacy level), while the literacy level in Serbian women aged 15–29 years is 99.3%. Literacy indicators for men are a little better, but the same gap associated with ethnicity is identified (77.8% vs. 99.5%, Roma and Serbian men, respectively) (3).

In Serbia, antenatal care is traditionally fairly well developed, covering the majority of the population. Almost all childbirths within the two years preceding the 2010 MICS survey took place in health care facilities, with a slight difference between women in the general population (99.8%) and in Roma settlements (99.3%) (3), although previous MICS surveys conducted in 2005 found this percentage was lower for Roma women (92.9%) (7).

It should be noted that the health gap between certain population groups and the general

population is a result of broader social and economic health determinants, including social vulnerability and exclusion, unemployment, a low level of education and a lack of access to information. Official governmental institutions in Serbia have recognized the vulnerability of the Roma population and their disadvantaged position in society; so as of 2000, a number of policy documents and strategies have been launched at national, regional and community levels. They often involve multisectoral collaboration, with an aim to improve Roma's position in society through facilitating their inclusion and access to institutions and services.

In 2003, the Government of Serbia adopted the *Poverty Reduction Strategy Paper for Serbia*, a medium-term development framework to reduce key forms of poverty (8). This strategic, national document contains an analysis of causes, characteristics and profiles of poverty in Serbia, as well as main strategic guidelines for social development and the reduction of the number of poor citizens. One of the priorities envisaged in this Strategy is health care programmes for the most vulnerable population groups, including Roma. The objectives of the Strategy include fair and equal access to health care for all citizens of Serbia.

In 2005, Serbia signed the Declaration of the Decade of Roma Inclusion 2005–2015, expressing its political commitment to eliminate discrimination against Roma and to close the unacceptable gap between Roma and the rest of society. Then Serbia adopted the *Strategy for Improvement of the Status of Roma in the Republic of Serbia* in 2009 (5), which focuses on health care, education, housing, employment, internally displaced persons, return on the basis of readmission agreements, personal documents, women's position in society, social security and social welfare, culture, discrimination and other related issues. The objectives of this Strategy, envisaged in its Action Plan for 2009–2015, are to:

- determine the health status of Roma
- support Roma to exercise their right to health care
- improve access of Roma to health care
- improve the living conditions of Roma (5).

Many initiatives aim to improve the situation of Roma and their health status in Serbia. The Ministry of Health is implementing an action plan for health care for Roma within the programme for improving the health of distinctive population groups (8–9). This action plan covers various projects related to Roma health. During 2006, 64 projects were completed, covering 6628 Roma, and in 2007, 39 projects covered approximately 10 000 Roma.

In 2008, Roma health mediators were introduced in the health care system, in primary health care centres, to provide outreach for the Roma population and to collaborate with health care professionals, centres for social work, branches of the National Health Insurance Fund and local governments, in order to facilitate access of the Roma

population to these services, and to help them realize their civil rights (8–9). Roma health mediators connect the Roma population to the health care system in various areas such as immunization, reproductive and sexual health, substance abuse prevention, antenatal care for Roma women, child care and nutrition, prevention and early detection of risk factors for chronic non-infectious diseases, prevention of communicable diseases, assessment of hygienic epidemiological conditions in Roma settlements, and in the creation of a safe environment and the provision of health protection of Roma who recycle secondary raw materials.

The engagement of Roma health mediators proved to be very successful and critically important for improving the health indicators of Roma throughout Serbia (8–9).

2.1 Working team

The working team consisted of representatives from the Ministry of Health, Roma organization, the Dr Milan Jovanović Batut Institute of Public Health of Serbia, the Dr Vukan Čupić Institute for Mother and Child Health Care, the United Nations Population Fund (UNFPA), UNICEF, the Regional Office and from academia, the Institute of Social Medicine, University of Belgrade, Serbia.

The Ministry of Health appointed the members of the working team.

2.2 Selection of the SPA

After the initial WHO meeting (train-the-trainers session) held in Belgrade, Serbia in November 2012 and the introduction of the EQUITY methodology for the analysis of inequities (10), the working team chose to review the national programme for health care of women, children and youth. The selection was based on the working team's recommendations and was in line with the aim of the EQUITY review and reorientation. An initial equity analysis was conducted on this SPA, using the EQUITY checklist, and was submitted to facilitators of the EQUITY methodology prior to the second meeting in Skopje, the former Yugoslav Republic of Macedonia in March 2013.

However, at the third meeting, after an in-depth introduction to each step in the EQUITY methodology, the working team decided to change the SPA to one that was less extensive and more feasible and operational for review and reorientation. Therefore, the working team decided to focus on the regulation of the national programme for early detection of cervical cancer, which seemed to be more appropriate for review and reorientation (11).

The working team chose to focus on this programme due to the high burden of cervical cancer disease and its corresponding high mortality rate in Serbia. Women in Serbia in 2002 had the highest incidence of cervical cancer in Europe (at 27.3 per 100 000 population), which also was the fourth cause of mortality among women in Serbia (11). The age distribution of cervical cancer showed typical increases after the age of 30 years, with a peak in the age groups 45–49 years and 70–74 years. However, the peak in the morbidity of cervical cancer is moving toward younger ages. Such high incidence and mortality rates have been ascribed to insufficient regular preventative gynaecological examinations, which mean that diagnosis of cervical cancer by Pap smear does not occur in an early phase when the disease is most treatable (11).

The major factor for prognosis is which stage the disease is discovered (diagnosed). When disease is identified in its early stages, surgical interventions (operations) are

often sufficient. When identified in a progressed stage, extensive treatment consisting of postoperative or radical radiotherapy, often combined with chemotherapy, is required. These interventions significantly prolong treatment duration, lead to various complications and greatly increase overall treatment costs (11).

Although no data on morbidity and mortality of cervical cancer stratified for socioeconomic status and ethnicity exist, it could be expected that this problem might disproportionately affect women for whom health care services are less available and accessible – Roma women, women with disabilities, women in institutions (prisons), etc. – than women in the general population.

This SPA was considered adequate for EQUITY review and reorientation because it is more operational and has an algorithm of actions (key stages presented in a flowchart) that lead to intermediate and final results (see subsection 3.2.3).

This publication uses the term “SPA” when discussing the overall training process in general, and “programme” when focusing on the Serbian Government’s programme for early detection of cervical cancer.

2.3 Internal methodology

Members of the working team attended meetings held with the support of the Ministry of Health and the WHO Country Office, Serbia. In general, members discussed which SPA to choose for review and reorientation, how to respond to the EQUITY checklist and EQUITY review cycle, and which population groups to prioritize for action (10). Between meetings, the consultative process was conducted by sending draft documents in circular emails for comments and suggestions, which was a very efficient way to communicate.

A member of the working team who comes from academia acted as team leader and was responsible for writing draft versions of the documents according to the methodological guidelines (10), initiating communication with other team members and organizing meetings, corresponding with the international trainers and incorporating their feedback, as well as using forward and back translations to provide documents in English and Serbian.

3.1 Aim

The aim of the EQUITY review is to analyse the national programme for early detection of cervical cancer in order to identify whether all population groups of women have equal access to and benefit equally from the programme, and to suggest future directions for implementing the programme to take into account Roma women and the barriers they face.

3.2 SPA description

3.2.1 Aim of the SPA

The aim of the SPA, the national programme for early detection of cervical cancer, is to decrease the incidence and mortality of this disease. The programme's goals are to:

- raise women's awareness of the importance of regular preventive examinations and early detection of cervical lesions, and spread information about the importance of screening;
- strengthen the capacities of health care services to conduct screenings in terms of providing a sufficient number of educated personnel and equipment;
- establish a system for data collection and management needed to perform screenings, and
- establish quality control mechanisms related to screening.

The major strategy of this programme is organized screening. Organized screening for early detection of cervical cancer enables identification of not only cervical cancer in its early stage, but also precancerous lesions on the cervix that precede cancer. Removal of precancerous lesions prevents development of malignant tissues. When organized screening programmes have been successfully implemented for decades (mostly in developed countries), mortality due to cervical cancer was significantly decreased. In Finland, for example, the reported reduction in mortality due to cervical cancer was 80% (11).

3.2.2 SPA's theory

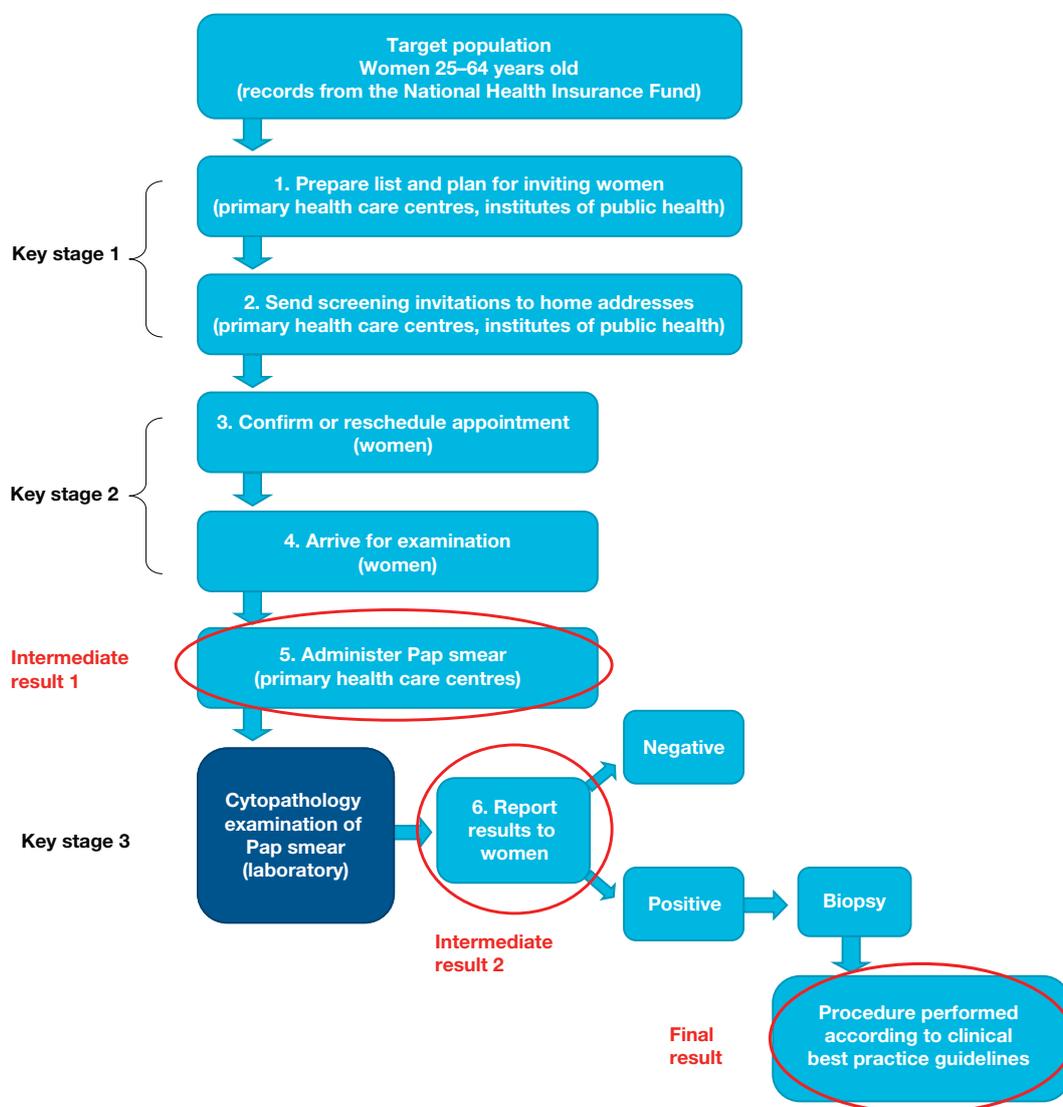
The national programme for early detection of cervical cancer aims to decrease the morbidity and mortality of cervical cancer. The theory behind this programme is that morbidity and mortality of cervical cancer greatly depends on the successful implementation of preventive programmes. Preventive programmes comprise well-organized screenings that use cervical Pap smears, quality control and an established system for data collection and analysis, but also require health education in schools, public

promotion of healthy lifestyles and social mobilization of the population. Altogether, they contribute significantly to the reproductive health of women and their well-being. In addition, successful implementation of these programmes assures considerable long-term savings for the health system and society.

3.2.3 SPA's key stages

The national programme includes a methodological guide for cervical cancer screening. The guide lists three key stages in the screening process, and they are presented as a flowchart (Fig. 1). The box sizes in Fig. 1 shrink with each subsequent phase, symbolizing the decreasing number of women involved in each screening stage.

Fig. 1. Flowchart of the methodological guide for conducting cervical cancer screening



Key stage 1 is preparing the list and plan for inviting women to screening, and then, sending screening invitations to their home addresses (delivery of invitations). The target population is women aged 25–64 years. The list of women to be invited for screening is based on the register of insureds of the National Health Insurance Fund and other citizens who are entitled to health care; identification of the target population follows laws that regulate the protection of personal data.

Preparing the plan for inviting women is organized and conducted by the coordination team for cervical cancer screening, established in the primary health care centre (*Dom zdravlja* in Serbian) in each municipality, in collaboration with the institute of public health responsible for that area. The coordination team appoints a person/team responsible for:

- making a list of the target population in its municipality (first name, surname, date of birth, unique identification number, home address);
- developing an invitation plan;
- communicating the number of women to be invited for screening to the National Cancer Screening Office so they may print the required number of invitations, according to the prepared lists and invitation plan; and
- keeping a record of the number of invitations sent, received and accepted (these activities are to be conducted by health professionals, according to the recommended standards).

Screening invitations are prepared based on the aforementioned list of the target population in each municipality, and each person on the list should receive:

- an invitation letter (the call for screening) with a pre-scheduled date and time⁶ for a cervical Pap smear in a primary health care centre, and the contact telephone number to confirm or reschedule the appointment; and
- an information leaflet with concise and simple information about the purpose and importance of the screening.

In collaboration with the institutes of public health, the coordination team periodically (every 1–2 months) examines the response to screening invitations, using the database where these data are recorded and periodically updated. If invited women do not respond, the invitation should be resent within six months. If that attempt is also unsuccessful, that person should be excluded from the screening and invited in the next screening cycle.

Institutes of public health and primary health care centres prepare the plan (schedule) for delivering invitation letters. That plan depends on the capacities (personnel and facilities) of each primary health care centre for preparing invitation letters and performing Pap smears. However, each year, invitations should be sent to at least one third of the target population.

⁶ Appointments are offered in the morning and afternoon to accommodate the schedules of working women.

Key stage 2 is responding to the screening invitation. Women who receive the invitation letter should confirm their appointment by telephoning, sending an SMS message or an email, or in person. Then they should arrive for the screening at their scheduled date and time.

Key stage 3 is related to the technical aspects of the screening, after the cervical Pap smear is performed. These tests are subjected to cytological examination, conducted in accredited cytological laboratories. Cytology screeners interpret Pap smears as positive or negative. Each result that tested positive and 10% of the tests that tested negative (sampled for quality control) will be reviewed by an accredited supervisor (cytopathologist or pathologist, gynaecologist or a biologist trained in the interpretation of Pap smears), in accordance with the methodological instructions for the operation of the cytological laboratories.

Within three weeks from the date of receipt of the Pap smears, the cytological laboratory reports the test results to the primary health care centres and physicians, i.e. gynaecologist.

3.2.4 Inequities in SPA

Early detection of cervical cancer (SPA) will be organized as a screening, which might not equally cover all women aged 25–64 years. Two key stages of this SPA (actions 1 and 3) are deemed very important for equity (Fig. 1).

Key stage 1 (action 1) is related to preparing the list of women invited for screening (Pap smears), according to the National Health Insurance Fund's register. It means that some women may be excluded if they are not on that list due to various reasons, e.g. they do not have a permanent home address or their addresses have changed.

The second key stage (action 3) is related to responding to the screening invitation and confirming or rescheduling the appointment. The working team discussed subgroups of women who might be less likely to receive an invitation and accept it. Thus equity challenges are related to women who do not realize their right to statutory health insurance; lack personal identification documents; lack a permanent home address; are Roma; live in institutions (in prisons, social care institutions), in rural areas or in poverty; have disabilities or come from other deprived population groups. It is also important to know that illiterate women, every fourth Roma woman, might not comprehend information about the screening nor realize its importance, especially if that information is not culturally sensitive and written in a language they understand. Responding to the invitation for screening implies availability of and access to communication technology, either mobile phones or landlines, which could also present a challenge given their limited resources.

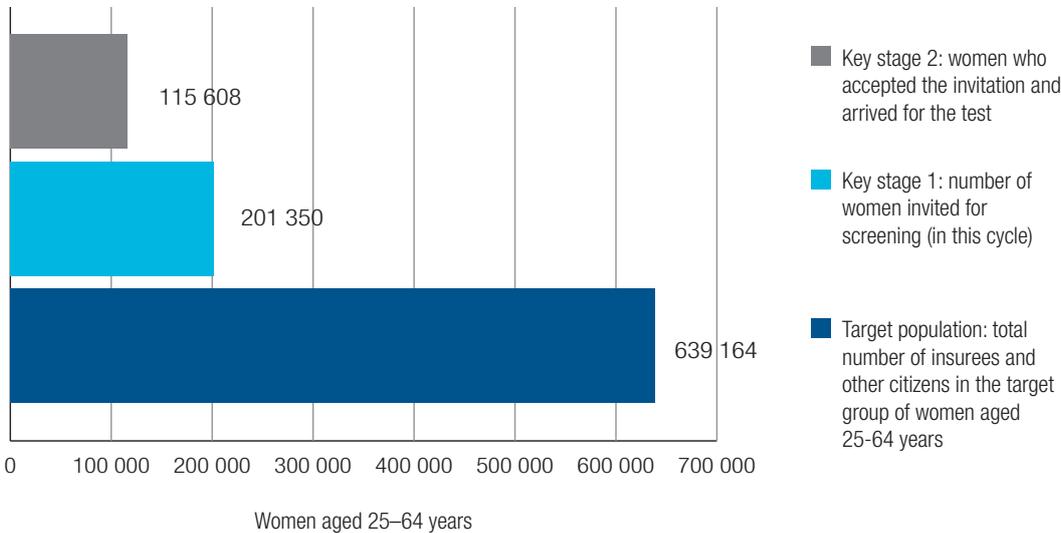
During the analysis of the key stages, it was realized that the successful implementation of the screening programme is related to key stage 3, cytopathological analysis of Pap smears.

The availability of resources needed for cytopathological analysis is a very important prerequisite for the success of the programme.

Based on the last available official data of the National Cancer Screening Office (as of 30 November 2014), the screening programme has been conducted in 17 (out of 156) municipalities throughout Serbia. Target population size, coverage and responses to invitation, according to the key stages, are in Fig. 2. The discrepancy in the number of women invited (201 350 for key stage 1) and the number who accepted the invitation and had a Pap smear (115 608 for key stage 2), which is slightly more than half of invitees (57.4%), may be due to the equity challenges mentioned previously (13).

These data come from the implementation of the first cycle of the national screening programme. This first cycle is considered a training phase (learning by doing) and will be completed by the end of 2015. In the first cycle of three years, six municipalities started in December 2012, then an additional 11 municipalities were included, with a plan to gradually add in the remaining municipalities planned for the first cycle (45 altogether), if current capacity allows it. The first cycle is expected to cover about 60% of women aged 25–64 years in Serbia (13).

Fig. 2. Target population, coverage in first cycle (invitees) and response to screening invitations (30 November 2014)



Source: National Cancer Screening Office, Dr Milan Jovanović Batut Institute of Public Health of Serbia (13).

This first cycle is considered a transitional phase, and the Ministry of Health will decide what model to use in the next screening cycle. Currently, there are 15 centralized

cytology laboratories, and the equipment for these laboratories is part of a donation from the EU.

In general, factors for a successful screening programme include:

- large population coverage (at least 75% of target population);
- human papillomavirus triage and test (if possible);
- available and adequate treatment and follow-up of women whose Pap smears return positive results;
- data collection using an information system; and
- quality control.

3.3 Analysis of target population

3.3.1 Description of target population

The target population of the national programme for early detection of cervical cancer are women in Serbia aged 25–64 years. Identification of the target group for screening will be performed in every municipality in Serbia, according to the screening methodology in subsection 3.2.3.

The target population for cervical cancer screening can differ depending on the age of women and on many factors such as epidemiological, demographic, organizational and financial factors, as well as human resources factors. Recommendations from European guidelines are that screening should be initiated for women aged 20–30 years and last until 60–65 years.

3.3.2 Identification of groups who access and benefit and those who do not

Several prerequisites are required to access this programme. The first is health insurance, i.e. to be registered at the National Health Insurance Fund. According to the Law on Health Care, every person has the right to insurance based on employment or as part of the population group whose health care is paid for by the Government of Serbia (12).

Another prerequisite is a permanent home address (registered with the National Health Insurance Fund) to receive the screening invitations. Being literate and having a sufficient level of health literacy are also necessary to understand the importance of responding to the invitation. Furthermore, women need access to communication equipment (landline, mobile phones, etc.) in order to confirm or reschedule their appointment.

Another factor limiting coverage of the target population is related to the feasibility and sustainability of the screening programme itself, which generates inequity at the territorial axis. The involvement of additional municipalities and their primary health care centres is determined by the number of trained professionals. Sustainable financing is needed to permanently engage laboratory staff (cytology technicians) and supervisors in all 15

centralized reference cytometry laboratories. In addition, the training and licensing of staff who are involved in the screening do not yet exist but is planned for the beginning of 2015.

3.3.3 Summary of main findings

Three key stages of this SPA are presented in Fig. 1. Early detection of cervical cancer is organized as screening that might not equally cover all women aged 25–64 years. Two key stages of this SPA (actions 1 and 3) are deemed very important for equity. Action 1 is related to preparing the list of women to be invited for a Pap smear, according to the National Health Insurance Fund's register. It means that women who are not on that list due to various reasons or who lack a permanent home address might not receive the screening invitation. The second key stage (action 3) is related to accepting the invitation and confirming or rescheduling the appointment. Women who might be less likely to receive and accept the invitation are those who do not realize their right to statutory health insurance; lack personal documents; lack a permanent home address; Roma women; women living in institutions (in prisons, social care institutions) or in rural areas; women with disabilities; poor women; and others.

3.3.4 Description of prioritized group chosen for the SPA review

According to the 2011 census, almost 150 000 Roma (147 604) or 2.05% of the overall population live in Serbia, and less than half (72 563 or 49.16%) are women (1). The working team focused on the population of Roma women, as they present the largest group of deprived women on many levels. They live in harsh housing conditions, are undereducated and very often unemployed, as described in section 1. Their health status, including reproductive health, is worse than in the general population (3–4). Roma women commence sexual relationships early, before the age of 18 and are often engaged in unprotected sex. According to data from the last MICS survey (4), they rely mostly on traditional methods of contraception (withdrawal 51.6%) and rarely use modern methods of contraception, such as male condoms (2.8%) or birth control pills (1.2%), which puts them at an elevated risk of unwanted pregnancies and sexually transmitted diseases. Almost every third Roma woman has experience with abortion (30.6%), compared to 14.6% of women in Serbia (4).

Due to the early initiation of unprotected sexual relationships, Roma women are also at increased risk for developing cervical cancer. Other factors that contribute to their risk are related to the lower access to health care services and lack of awareness of preventive practices and regular check-ups (3–4).

3.4 Analysis of barriers and facilitators for the target group

3.4.1 Barriers

Barriers that Roma women might face are related to the lack of personal documents such as identification and health records, lack of health insurance or lack of a permanent

household address. Also, most are not sufficiently educated to comprehend information related to health (did not complete primary school), live in poverty, are marginalized and face stigma and discrimination at many levels. Their health literacy is on a very low level, as is their awareness of the need for preventive health care services. Some do not speak Serbian, so there might be language barriers as well.

3.4.2 Facilitators

As mentioned in section 1, in 2008, the Ministry of Health supported the introduction of Roma health mediators who work directly in the field with the Roma population. More than 130 Roma health mediators facilitate the access of inhabitants of Roma settlements to health care services and other public services in the community, track their health status, work to raise awareness of the need for vaccination of children and emphasize the importance of proper nutrition and hygiene habits (9,14). They provide health care institutions with a better understanding and insight into the situation in Roma settlements. A health mediator is not a doctor, medical nurse, social worker, psychologist, lawyer or judge, but connects the Roma population with the health system. This ongoing project is a great achievement and a success of the Ministry of Health, which is realized in collaboration with international organizations and mobile telephone providers in Serbia. Roma health mediators cover large proportions of Roma populations and accomplish many of their goals.

Apart from establishing and supporting the work of Roma health mediators, The Ministry of Health provided financial support to the National Council of the Roma National Minority that conducted the Become a Citizen project. This project collects the data needed to issue health insurance cards to members of the Roma minority so they acquire insured status and access to health care services (5).

The European Agency for Reconstruction and Development supported several projects aimed at Roma inclusion in the health care system, and a number of Roma citizens' associations are active in advocating the rights of Roma in the health care system (5). These projects are of great importance, especially in improving certain segments of the health care system and the health status of Roma, as well as in establishing relations and better understanding between the health service, the Roma population and civil-society organizations.

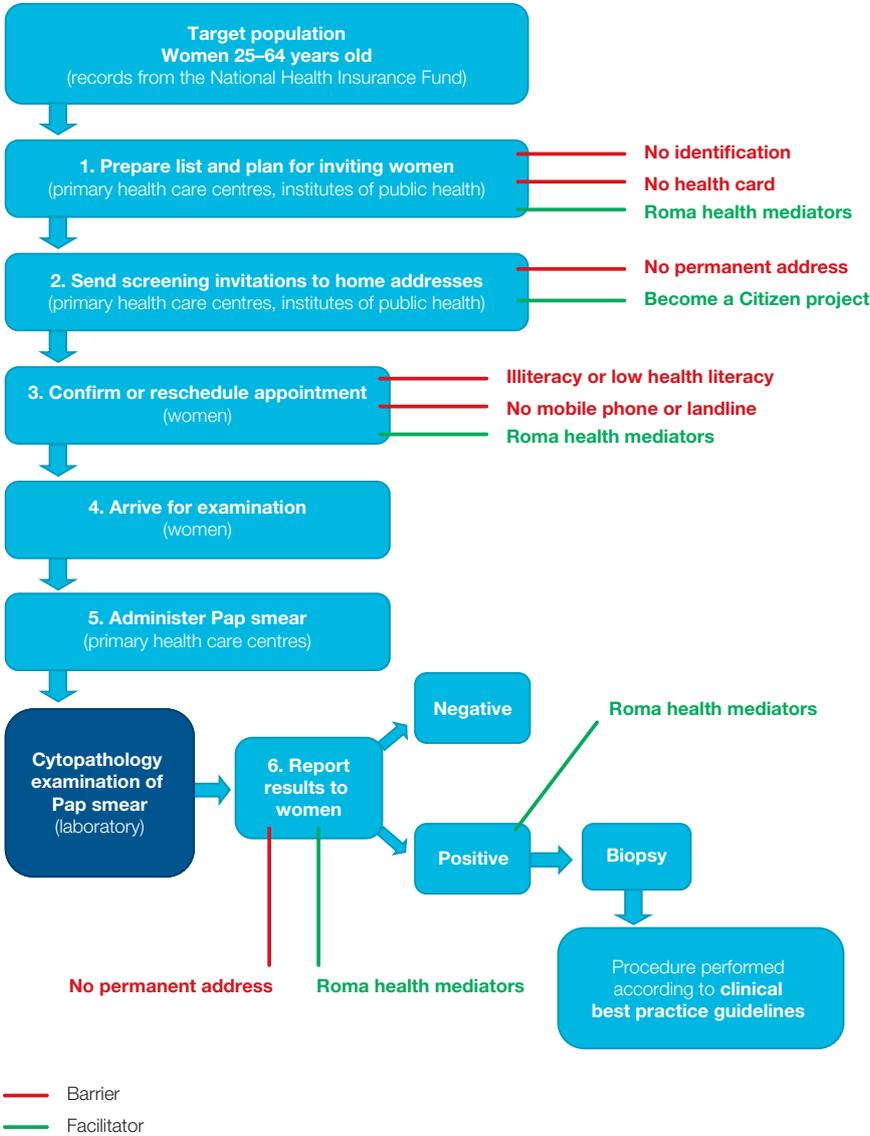
3.4.3 The key stages diagram with barriers and facilitators

The key stages diagram with barriers and facilitators for the access of Roma women to the screening programme is presented in Fig. 3. Roma women face many barriers in accessing this screening programme, while the major facilitator is the availability of Roma health mediators.

3.5 Analysis of social determinants of health within the SPA

Many social determinants of health are associated with the barriers and facilitators identified by implementing the national programme for early detection of cervical cancer

Fig. 3. Flowchart of methodological guide for conducting cervical cancer screening with barriers and facilitators for the access of Roma women



among Roma women in Serbia. Structural social determinants of health are associated with the very low socioeconomic position of Roma women, due to ethnicity, poverty and, above all, gender. Roma women have a very low level of education, which gives them extremely limited opportunities for employment and earning their own income. These factors often result in Roma not having health insurance cards and therefore, being unable to access health care services to which they are entitled as unemployed citizens. The health literacy of Roma women and their ability to comprehend basic health information are also low, so they might not understand the need for preventive health care services. Poverty

and the lack of basic hygiene resources (soap) might also prevent women from accepting the screening invitations. Roma behaviour related to health and their compliance to preventive practices, as an intermediary social determinant of health, are greatly influenced by these structural determinants of health.

National political documents such as the *Strategy for Improvement of the Status of Roma in the Republic of Serbia* and the *Poverty Reduction Strategy Paper for Serbia* recognize, acknowledge and tackle social determinants of health in the Roma population, and as such, are great facilitators for overcoming these multidimensional barriers (5,8).

The main impetus for overcoming intermediary determinants of Roma health (material circumstances and psychosocial and behaviour factors) are Roma health mediators, employed by the Ministry of Health in order to facilitate access of Roma to health care services and other public services, through direct contact with the Roma population (9,14).

3.6 Intersectoral action

Intersectoral action is very important to help Roma women access this programme, and apart from health institutions – primary health care centres, secondary and tertiary levels of health care services, institutes of public health, the Ministry of Health and the National Cancer Screening Office – other sectors play an important role. Other participating institutions are envisaged as well, including local self-governance, representatives of religious and ethnical minority communities, organizations of civil society, i.e. associations of citizens, and the media.

Collaboration with other sectors is required to overcome different barriers related to structural social determinants of Roma health, particularly when official documents are lacking or when housing conditions are unacceptable and illegal. Local authorities are responsible for these issues, as well as the social services and educational sectors, international development organizations and international donor organizations. Civil-society organizations (Roma organizations) are very important partners and need to be included in the planning and implementation of the programme and its key stages, which are critically important for inviting Roma women to screenings and assuring their acceptance.

3.7 Social participation

Social participation, in terms of empowering civil societies to undertake greater control over decisions that will impact them, has different mechanisms and modalities. They are realized through the process of informing the Roma population about all relevant aspects of the screening programme, and consulting with the Roma community to understand their perspectives and solicit their involvement and active participation in all phases of development and implementation of the programme.

As envisaged in the screening programme, in order to achieve social mobilization and to redistribute power, information related to screening has to be adjusted and harmonized with the demographic, social, educational and religious structure of the target population, with special attention paid to marginalized groups and minorities (see subsection 5.12 in (11)). It is also envisaged that representatives of the local self-governance conduct the action with an aim to educate and motivate large numbers of women to respond to the screening invitations (see subsection 4.2.8 in (11)). This action will be conducted in collaboration with the other participants in the organized screening, such as institutes of public health, primary health care centres, representatives of religious and ethnical minority communities and associations of citizens and the media.

In this process, the role of media is strongly emphasized. Media plays an important role to educate and motivate women to accept the screening invitation. Broadcast, electronic and print media should be used: national and local media campaigns, leaflets, brochures, posters, billboards, radio jingles, television spots, video clips presented on the websites of the Ministry of Health and the National Cancer Screening Office, social networks, press conferences, press releases, interviews, etc. (see subsection 4.2.9 in (11)).

Effective social mobilization through these strategies and mechanisms might contribute significantly to the increased awareness of the importance of screening among underprivileged population groups such as Roma women.

3.8 Redesign of the SPA

The purpose of redesigning the SPA, the national programme for early detection of cervical cancer, is to take into account the barriers Roma women face in accessing and using this programme. Steps to reduce these barriers should be introduced to the planning and implementing phases of this programme. Each phase should be sensitive to socioeconomic determinants of health and carefully planned in collaboration with other sectors, such as local self-governance, social services, associations of Roma citizens, and above all, Roma health mediators (Fig. 4).

National health authorities should assess the most feasible way for underprivileged populations, such as Roma women, to achieve equitable access to the screening programme.

When it comes to social participation, collaboration between representatives of governmental, health and civil-society organizations and the target group could help educate and motivate Roma women and potentially increase their response rate to screenings (subsection 3.2.4).

The methodological guide for conducting screening on cervical cancer notes that “Before commencement of the screening, it is necessary to define strategies for information, education, communication and social mobilization, an operational plan for its

Fig. 4. Intersectoral collaboration and social participation in Serbia to increase coverage of Roma women by the national programme for early detection of cervical cancer



implementation, its timeframe, and to allocate responsible persons for implementation of the above-mentioned activities” (subsection 5.2 in (11)). This case study provides valid and reliable information on Roma women who might have difficulties accessing this programme and could be used to help define the above-mentioned strategies.

Main results

4

Professionals from various sectors worked on the review and reorientation of the SPA with the goal of promoting health equity. They became familiar with the EQUITY methodology and capably conducted the equity analysis of the SPA.

The review process helped to identify inequalities and make them more visible. It identified existing inequities in structural and intermediary social determinants of health of different (vulnerable) population groups, which to a great extent influence their access to health care services, and eventually, health outcomes. It also identified facilitators to help Roma women access the cervical cancer screening programme.

5 Main difficulties

The main difficulty encountered during the review process was changing from the initially selected and reviewed SPA (national programme for health care of women, children and youth) to one that is more concrete, operational and feasible for analysis and possible reorientation (national programme for early detection of cervical cancer). An additional challenge was translating materials and preparing documents in both Serbian (for members of the working team) and English (for facilitators' feedback). As members of the working team are high-level professionals, it was sometimes challenging to find a time and date when all members were available.

During this process, the working team received great support from international organizations (the WHO Regional Office for Europe); their collaborative partners (Interuniversity Institute for Social Development and Peace, University of Alicante, Spain (WHO Collaborating Centre on Social Inclusion and Health)); the Spanish Ministry of Health, Social Services and Equality; and the WHO Country Office, Serbia. This assured the credibility of the process, and international experts supervised and provided critical feedback on each phase in the revision of the programme.

Key preconditions for the success of this case study are: the support and genuine interest of national health authorities in the outcomes of this methodology, professionals trained in the EQUITY methodology (a tool to analyse inequities), and a national working team consisting of representatives of various institutions who freely shared their perspectives during the process.

Apart from the willingness of decision-makers and politicians to undertake actions to eliminate inequalities and to overcome structural barriers, advancing towards the uptake of recommendations could have been accelerated by providing additional resources to specifically address these barriers.

The support of decision makers is necessary in order to apply the EQUITY methodology, review and reorientation process to integrate equity into SPAs.

7 Improvement proposals

During the training process, little time was devoted to the last step in the EQUITY methodology, step Y: “Your time to redesign SPA”. Within given capacities, the working team did its best to develop this step while being aware that it might require further work. However, it should be acknowledged that careful analysis of all the previous steps built the capacities of the working team and enabled them to proceed with the reorientation and redesign of the SPA. Future plans should allocate more time, support and incentives to step Y, reorientation and redesign of the SPA, because it is critical and might assure a long-term, positive effect.

Step Y might be strengthened by having the national stakeholders who are important for providing greater coverage of Roma women by the SPA meet. The meeting might be in the form of a roundtable with which the working team has very good experience. Such a roundtable was organized in Belgrade, Serbia where relevant stakeholders (Fig. 4) were invited to attend the presentation of this case study and to discuss its findings. This roundtable might be considered an initial step in establishing intersectoral collaboration that is necessary to increase the coverage of Roma women by the national programme for early detection of cervical cancer.

Next steps towards equity

8

Next steps toward equity might employ different strategies that take into account the heterogeneity of the target population and their vulnerability, and to ensure that barriers preventing access to these screening services are acknowledged and addressed. These strategies might include multisectoral collaboration and partnership in planning, developing, implementing, monitoring and evaluating the programme, with the active involvement of the facilitators that help increase access of vulnerable population groups to health services.

The results of this case study might be used to develop and implement strategies for information, education, communication and the social mobilization of Roma women, taking into account the barriers, and with the collaboration of other sectors at national, regional and community levels.

9 Conclusions

Professionals from various sectors worked on the review and reorientation of the SPA with the goal of promoting health equity. They became familiar with the EQUITY methodology and capably conducted the equity analysis of the SPA.

The review process helped to identify inequalities and make them more visible. It identified existing inequities in structural and intermediary social determinants of health of different (vulnerable) population groups, which to a great extent influence their access to health care services, and eventually, health outcomes.

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Annex 1. The multicountry training process for reorienting SPA towards greater health equity⁸

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 the WHO Regional Office for Europe and also involves the International Organization for Migration, the Office of the United Nations High Commissioner for Human Rights, UNICEF, the United Nations Development Programme and UNFPA.

The multicountry training was organized and facilitated by the Regional Office 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 eleven-month period, from November 2012 to October 2013.

The main objectives of the multicountry training were:

- to raise awareness about social determinants of health, 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.

⁸ The authors of this annex are (in alphabetical order): Pilar Campos Esteban, Ana Gil Luciano, Daniel La Parra, Begoña Merino Merino, Piroška Östlin and María Santaolaya Cesteros. See p. 28 for their affiliations.

The training drew on the Spanish training process on integrating a focus on social determinants of health and health equity into health SPA, carried out in 2010–2011 (1), and followed the *Methodological guide to integrate equity into health strategies, programmes and activities* (2), 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.

Country working teams

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

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

The working teams of the former Yugoslav Republic of Macedonia reviewed the maternal and child health programme.

The Bulgarian working team reviewed the national programme on sexual and reproductive health.

The Montenegrin 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.

Coordination team

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 Regional Office; the Spanish Ministry of Health, Social Services and Equality; and the University of Alicante.

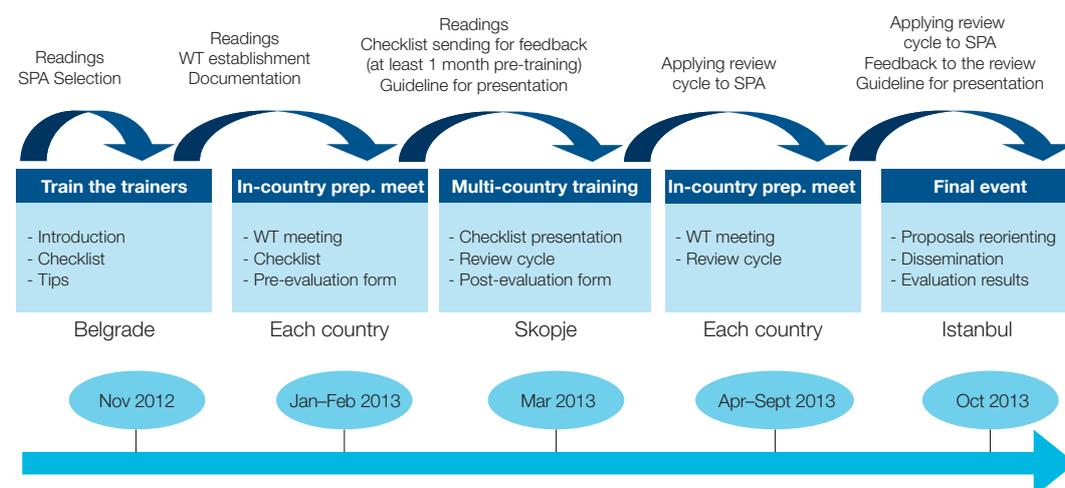
- Piroška Östlin (Regional Office) was the main coordinator, leading the coordination team and the organization of the whole process.
- Pilar Campos Esteban (Spanish Ministry of Health, Social Services and Equality) facilitated the review working team of the former Yugoslav Republic of Macedonia.
- Ana 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 Merino (Spanish Ministry of Health, Social Services and Equality) facilitated the Montenegrin 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 headquarters) led the design of the process, ensuring synergies with country workplans and linking it to the aforementioned interagency coordination initiative. During the process design phase, Jeanette Vega (University of Development, Chile) 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 (Fig. A1.)

Fig. A1. Workplan of the multicountry training process

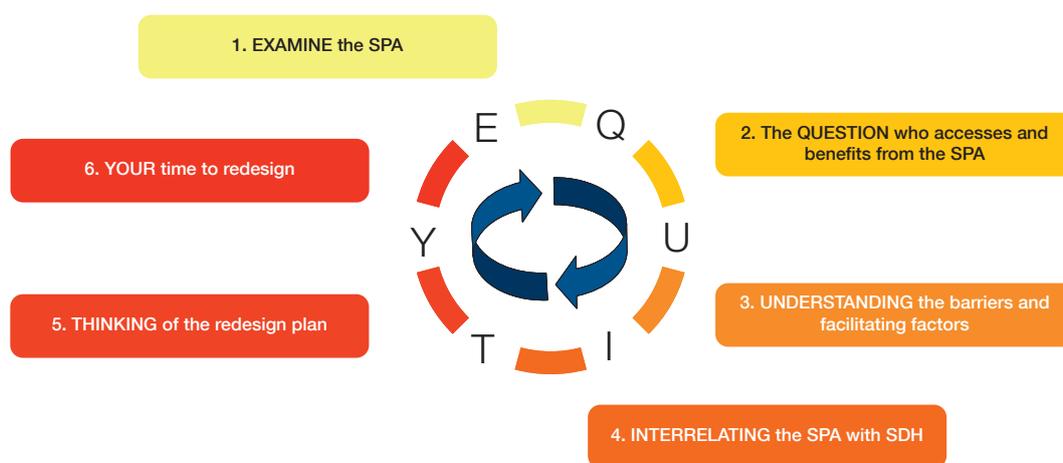


PM: preparatory meeting; WT: working team.

The first meeting took place in Belgrade, Serbia on 7–8 November 2012 and was planned as a train-the-trainer pilot session. This meeting had the goals of raising awareness on social determinants of health, going deeper into the social determinants of health framework of the WHO Commission on Social Determinants of Health 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 multicounty training, was a four-day meeting, 11–14 March 2013, in Skopje, 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 (Fig. A2).

Fig. A2. The steps of the EQUITY review cycle



Source: adapted and reproduced by permission of the publisher from the *Methodological guide to integrate equity into health strategies, programmes and activities* (2).

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 learnt.

Results

The multicountry training process produced some general results.

Health professionals in decision-making positions, Roma association representatives (in review working teams) and experts from international organizations were trained on how to reorient SPAs 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 to integrate equity into health strategies, programmes and activities (2)*.

A platform was provided for technical guidance and sharing methods and approaches to review how SPAs related to MDGs 4 and 5 address health equity.

This multicounty training process supports the exchange and validation of country experiences towards reorienting SPAs.

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.

Conclusions

The multicountry training led to some general conclusions.

The training process for integrating equity into health SPAs and its methodology are transferable, but need to be adapted to each context.

This process was 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.

Lessons learnt

After the evaluation of the process, participants shared the main lessons learnt.

The review working teams valued what was learnt 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 health ministry 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 approach and the social determinants of health 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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