Original Article

Are Sexual and Reproductive Health Policies Designed for All? Vulnerable Groups in Policy Documents of Four European Countries and Their Involvement in Policy Development

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Abstract
Background: Health policies are important instruments for improving population health. However, experience suggests that policies designed for the whole population do not always benefit the most vulnerable. Participation of vulnerable groups in the policy-making process provides an opportunity for them to influence decisions related to their health, and also to exercise their rights. This paper presents the findings from a study that explored how vulnerable groups and principles of human rights are incorporated into national sexual and reproductive health (SRH) policies of 4 selected countries (Spain, Scotland, Republic of Moldova, and Ukraine). It also aimed at discussing the involvement of vulnerable groups in SRH policy development from the perspective of policy-makers.
Methods: Literature review, health policy analysis and 5 semi-structured interviews with policy-makers were carried out in this study. Content analysis of SRH policies was performed using the EquiFrame analytical framework.
Results: The study revealed that vulnerable groups and core principles of human rights are differently addressed in SRH policies within 4 studied countries. The opinions of policy-makers on the importance of mentioning vulnerable groups in policy documents and the way they ought to be mentioned varied, but they agreed that a clear definition of vulnerability, practical examples, and evidences on health status of these groups have to be included. In addition, different approaches to vulnerable group's involvement in policy development were identified during the interviews and the range of obstacles to this process was discussed by respondents.
Conclusion: Incorporation of vulnerable groups in the SRH policies and their involvement in policy development were found to be important in addressing SRH of these groups and providing an opportunity for them to advocate for equal access to healthcare and exercise their rights. Future research on this topic should include representatives of vulnerable communities which could help to build a dialogue and present the problem from multiple perspectives.
Keywords: Sexual and Reproductive Health (SRH), Health Policy, Vulnerable Groups, Participation, Policy Development, Europe

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Key Messages

Implications for policy makers

- Evidence on health status of vulnerable communities and political commitment are crucial for addressing vulnerable groups in health policies and promote their involvement in the policy development process.
- Future research on policy development process and vulnerable groups' involvement should include representatives of vulnerable communities that will help to build a dialogue and present the problem from multiple perspectives.
- Clear tools and recommendation on how to include vulnerable groups in sexual and reproductive health (SRH) policies have to be developed through collaboration of various stakeholders.
- Moreover, the concept of vulnerability has to be further discussed more in depth, and categorization of groups and populations as "vulnerable" has to be well-founded and unified, in particular in the European context.

Implications for public

The study findings showed that incorporation of vulnerable groups in the sexual and reproductive health (SRH) policies and their involvement in policy development were found to be important in addressing SRH of these groups and providing an opportunity for them to advocate for equal access to healthcare and exercise their rights.

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Background

Strong evidence exists to show the disparities in health status among different population groups and subgroups within and between countries. Populations with a higher risk of poor health outcomes and healthcare discrepancies in access to healthcare are usually considered as being vulnerable.[1] Vulnerable are often among those who are most affected by poverty, gender inequity, stigma and discrimination, harmful cultural and religious practices, lack of access to medical services, etc.[2] Moreover, there are different and complex linkages between health and human rights of vulnerable groups; for example, enjoyment of right to health is often violated because of gender, sexual orientation, age, health status, or ethnic identity, etc.[3] Frequently cited examples of vulnerable populations include ethnic minorities, rural and urban poor people, older age groups, children, women, undocumented immigrants, refugees, HIV-positive persons, people living with disabilities, and others.[1,4]

To ensure the enjoyment of the right to health for all, the United Nations Economic and Social Council imposed a duty on each state to take the required steps to certify that each person has access to health services through the adoption of national strategies and policies.[5] Health policies grounded on the values and importance of equity are more likely to result in justly distributed health services[6] which helps to move toward equalising the health outcomes of disadvantaged groups with the outcomes of their more advantaged counterparts.[7] According to the World Health Organization (WHO), this means that priority has to be afforded to vulnerable groups, as healthcare founded on equity contributes to the empowerment and social inclusion of such groups.[8] Nevertheless, policies written for the general population are not always sensitive to different types of needs of vulnerable populations and cannot claim to be concerned about the health of all the people.[9]

Health policies and participation of communities in the policy-making process are widely argued to be important instruments in improving health outcomes of the population and the performance of health systems.[10] However, few mechanisms exist to take systematically into account the needs of vulnerable groups in health policies and strategies.[11] The paper of WHO has defined participation as "*a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing, and delivering services and in taking action to achieve change.*"[12] It also emphasized that involvement of people, especially representatives of vulnerable communities, in health policy and programs development increases the possibility that their health needs are met, and that these undertakings have a higher chance of success.[12] As an example of the acceptance and support of this idea, WHO Member States in 2008 during the WHO European Ministerial Conference on Health Systems: "Health Systems for Health and Wealth" in Tallinn committed to promote shared values of equity and participation through health policies ensuring that attention is paid to the needs of vulnerable populations.[8] These principles are promoted as well in the recent WHO European health policy framework – Health 2020, where an active public participation in policy-making is encouraged and the voice of civil society is seen as essential in order to draw attention to health problems and gaps in the quality and provision of healthcare.[10]

In the last 2 decades that followed the 1994 International Conference on Population and Development (ICPD) in Cairo, reproductive and/or sexual policies and programs were developed and approved at the national level in many European countries.[13,14] The common goals of national sexual and reproductive health (SRH) policies are to improve the reproductive health of the population and to ensure opportunities for citizens to exercise their sexual and reproductive rights.[13] In 2001, the WHO Office for the European Region launched a "Regional Strategy on Sexual and Reproductive Health," encouraging member states to address problems such as adolescent pregnancy, sexual abuse, SRH needs of refugees, migrants and other vulnerable groups, in SRH policies throughout Europe.[15] This document also stressed that communities should be empowered to make decisions, plan and implement strategies which help them to achieve optimum reproductive health. However, inequities in service provision and access to SRH care still exist in many countries in the WHO European region and many population groups appear to be systematically disadvantaged.[16]

The aim of this present study is to explore how vulnerable groups and principles of human rights are incorporated into national SRH policies of 4 selected countries: Spain, Scotland, Republic of Moldova, and Ukraine which represent 2 European Union (EU) members and 2 non-EU members. Taking into account a paucity of literature that outlines and utilises analytical frameworks for the content of policies, or policy 'on the books,' a novel analytical and peer-reviewed framework – EquiFrame was developed by Mannan et al.[17,18] The framework was devised through collaboration with 100 participants drawn from relevant clinicians and practitioners, civil servants, elected government representatives, non-governmental organizations (NGOs), independent consultants, researchers, and academics, including members of different vulnerable groups. While the development and detailed application of the framework has been described in greater detail elsewhere,[17,19,20] this paper applies EquiFrame in relation to the existing SRH policies of 4 countries. This paper also aims to deeper understand the place of vulnerable groups in SRH policy documents and discuss their involvement in SRH policy development in the studied countries from the perspective of policy-makers.

Methods

The study design included a health policy analysis and semi-structured interviews with policy-makers. Data for this study was obtained from the national and international peer-reviewed and grey literature, policy documents and interviews. Data analysis consisted of 2 parts – SRH policy documents content analysis and interviews analysis. Data collection and analysis for this study were performed in January–March 2014. Health policy was defined as "*a written expression of goals for improving the health situation, the priorities among these goals, and the main directions for attaining them.*"[21] Commonly, health policies are understood as formal, written documents, rules and guidelines that present policy-makers' decisions about what actions are deemed legitimate and necessary to strengthen the health

system and improve health.[22] Other words are sometimes used to designate a policy document, such as "strategy," "action plan," or "programme," but their use does not necessarily assume differences in content, and the term "policy" does not exist in many languages.[23]

Literature Review and Content Analysis of Policies

For the content analysis of policy documents, the EquiFrame framework designed by Mannan et al[17] was used. EquiFrame evaluates the degree of commitment of health policy to 21 core concepts (CCs) of human rights and to 12 vulnerable groups, guided by the ethos of universal, equitable and accessible health services. According to the EquiFrame authors, this framework provides an approach to analysis and it can be customised to the requirements of the purpose of the analysis. For instance, vulnerable groups and CCs may be added or removed to suit specific requirements, political, cultural or other contextual interests or constraints. The number of CCs applied in the current study was reduced to 11 and they are presented in Table 1 together with key language.

At the same time, the list of vulnerable groups proposed by the framework was modified in order to adapt them to the country contexts and SRH field (Table 2). Five of the original groups proposed by the framework were preserved (young and older people, people with limited resources, people living with disabilities and ethnic minorities). Six new groups have been added after performing the literature review. The literature search spanning the international and national peer-reviewed and grey literature was carried out with the purpose of identifying these groups. Google Scholar, PubMed, POPLINE, web pages of WHO, United Nations Population Fund (UNFPA), International Planned Parenthood Federation (IPPF) and other online resources were used for the literature search. Articles and documents published in English, Spanish, Russian, and Ukrainian were included in the review. Keywords and mesh terms as "vulnerable," "marginalized," "disadvantaged," "vulnerable groups" and "sexual health," "reproductive health," "maternal health," "maternal mortality," "STI," "HIV," "abortions," "contraceptive prevalence," etc. in combination with names of

Table 1. Core Concepts Applied in the Policy Analysis

No.	Core Concept	Key Question	Key Language
1	Non-discrimination	Does the policy support the rights of vulnerable groups with equal opportunity in receiving healthcare?	Vulnerable groups are not discriminated against on the basis of their distinguishing characteristics
2	Individualized services	Does the policy support the rights of vulnerable groups with individually tailored services to meet their needs and choices?	Vulnerable groups receive appropriate, effective and understandable services
3	Participation	Does the policy support the right of vulnerable groups to participate in making of decisions that affect their lives and enhance their empowerment?	Vulnerable groups can exercise choices and influence decisions affecting their life. Such consultation may include planning, development, implementation, and evaluation
4	Integration	Does the policy promote use of mainstream services by vulnerable groups?	Vulnerable groups are not barred from participation in services that are provided for general population
5	Cultural responsiveness	Does the policy ensure that services respond to beliefs, values, gender, interpersonal styles, attitudes, cultural, ethnic, or linguistic, aspects of the person?	(1) Health facilities, goods and services must be respectful of ethical principles and culturally appropriate, ie, respectful of the culture of vulnerable groups (2) Vulnerable groups are consulted on the acceptability of the service provided
6	Capacity building	Does the policy support capacity building of health workers and of the system that they work in addressing health needs of vulnerable groups?	-
7	Prevention	Does the policy support vulnerable groups in seeking primary, secondary and tertiary prevention of health conditions?	-
8	Access (financial, physical, information, etc.)	Does the policy support vulnerable groups: physical, economic, and information access to health services?	Vulnerable groups have accessible health facilities (ie, transportation; physical structure of the facilities; affordability; and understandable information in appropriate format)
9	Privacy, confidentiality and informed choice	Does the policy address the need for information regarding vulnerable groups to be kept private and confidential?	Information regarding vulnerable groups need not to be shared among others
10	Quality	Does the policy support quality services to vulnerable groups through highlighting the need for evidence-based and professionally skilled practice?	Vulnerable groups are assured of the quality of the clinically appropriate services
11	Entitlement	Does the policy indicate how vulnerable groups may qualify for specific benefits relevant to them?	For example, people with limited resources are entitled to some services free of charge, or persons with disabilities may be entitled to respite grant

Abbreviation: CC, Core Concept.
Source: EquiFrame, Mannan et al.[17]

Table 2. List of Vulnerable Groups

No.	Vulnerable Groups Defined by EquiFrame	No.	Vulnerable Groups Adapted for the Present Study
1	Limited resources	1	Limited resources (people living in poverty)
2	Ethnic minorities	2	Ethnic minorities
3	Youth	3	Young people
4	Aged	4	Older people
5	Displaced populations	5	Migrants, asylum seekers and refugees
6	Living away from services	6	Rural population
7	Disabled	7	People living with disabilities (physical, learning/mental and sensory)
8	Suffering from chronic illness	8	LGBT
9	Mother and child mortality	9	People living with HIV
10	Women headed household	10	Sex workers
11	Children (with special needs)	11	Victims of sexual abuse, gender violence and human trafficking
12	Increased relative risk for morbidity		

Abbreviation: LGBT, lesbian, gay, bisexual, and transgender.
Source: EquiFrame, Mannan et al[17]

the countries were applied in searching engines with operators "AND," "OR."

After a new list for vulnerable groups was created and incorporated into the framework, the analysis of SRH policies was carried out. The national policy documents were searched on the web pages of Health Ministries of Scotland, Ukraine, Republic of Moldova and Spain. If the policies were missing from the official web pages, search engine Google was used to identify these policies. The combination of keywords "sexual health," "reproductive health," "policy," "strategy," "framework" with country names was applied in the search in English, Spanish, Russian and Ukrainian. Two main criteria were established for policy selection: policy had to be the most recent one, and to be produced by the Ministry of Health (MoH). Policies written in English, Spanish, Russian and Ukrainian were considered.

The analysis of policy documents consisted of 4 main steps proposed by EquiFrame:

(1) CC coverage: each policy was examined with regard to a number of CCs mentioned out of the 11. The concepts were searched, counted, and presented in percent.

(2) Vulnerable group coverage: each policy was examined with regard to a number of vulnerable groups mentioned out of the 11. The groups were identified in the policy, counted, and presented in percent.

(3) CC quality: each CC received a score within the range from 1 to 4: 1- concept only mentioned, 2- concept mentioned and explained, 3- specific policy actions identified to address the concept, 4- intention to monitor concept was expressed. This was the rating of the quality of commitment to the CC within the policy document.

Each policy was examined with respect to the number of CCs within it that was rated only as 3 or 4. This was also transferred to a percentage rate. When several references to a CC were found to be present, the highest score received was recorded as the final quality scoring.

(4) Each policy was given an overall summary ranking proposed by authors: Low, Moderate or High according to the following criteria:

- High: if the policy achieved ≥50% on all of the 3 scores above.
- Moderate: if the policy achieved ≥50% on 2

of the 3 scores above.
- Low: if the policy achieved <50% on 2 or 3 of the 3 scores above.

If a CC did not address a particular vulnerable group but referred to the total population, it was categorized as "universal." The total number and scores for mentioned CCs and vulnerable groups were calculated for each document across the 4 countries.

Semi-Structured Interviews With Policy-Makers

The second part of the methodology consisted of semi-structured interviews with policy-makers. Five interviews were conducted with key informants from 3 countries (Scotland, Republic of Moldova, and Spain). An effort was made to contact as many policy-makers as possible in different kinds of settings at the national level, such as health ministries, healthcare organizations, and research institutions. In particular, the most valuable participants were considered to be those who potentially had a role in the development of SRH policies analysed in this study. In total, 12 potential key informants were contacted via email. Ultimately, 5 interviews were carried out via Skype during February-March 2014. They were conducted in English. One researcher conducted, transcribed and documented the interviews. The interview guide was used for semi-structured interviews and it was developed with a participation of all 3 authors. The guide was tested by 2 independent colleagues from the international organization. The analysis of data began in parallel to data collection. One researcher coded the interviews, and the second researcher performed quality check of the coded transcripts. Content analysis method was used to process the resulting transcripts. The direct content analysis approach was found to be the most applicable for this study. The goal of the directed content analysis is to validate or conceptually extend a theoretical framework or theory.[24] In this study, the main goal of the interviews was to obtain additional information and amplify the health policy analysis with a deeper understanding of vulnerable groups place in SRH policy documents and in policy development processes. The analysis focused on the identification of issues as well as examples of themes such as inclusion of vulnerable communities in policy documents, opportunities

for participation in policy development, perceived barriers and facilitators to this participation, etc.

Results

The study findings are presented below in 2 parts: results of health policy analysis and main findings from interviews with policy-makers.

Health Policy Analysis

Seven SRH policy documents were identified for the purpose of this analysis. Four of them have met the established criteria and were added to the analysis. These policy documents are the most recent in the countries and differ in format, as one is a programme and 3 others are strategies. Two of the policy documents (Ukrainian and Moldavian) were designed and developed with the assistance from international organizations – WHO and UNFPA.

The first step in the policy analysis was to count and compare the frequency of references to vulnerable groups and CCs in 4 documents (Table 3 and 4).

Vulnerable Group Coverage

The most commonly mentioned group across all policies was "young people." The "sex workers," "lesbian, gay, bisexual, and transgender (LGBT)," and "ethnic minorities" groups were mentioned only in the Scottish and Spanish strategies. Meanwhile, the least mentioned group (only in one

document – the Spanish strategy) was the "migrants, refugees and asylum seekers." To summarize, the total number of groups mentioned was largest in the Spanish strategy that covered almost all of the 11 categories searched for.

Core Concept Coverage

It was noticed that in all documents, the CCs were more frequently mentioned than the vulnerable groups. The frequency of occurrence of each of the 11 CCs in the 4 documents is presented below (Table 4). Across four policies, "access" was the concept most frequently mentioned, followed by "individualized services" and "capacity building." The "access" was mentioned 64 times across all documents. It can be seen that the Spanish policy document contains the highest number of CCs, and the Ukrainian program the fewest of them. A considerable part of CCs mentioned were "universal" or referred to "vulnerable" or "socially disadvantaged" populations in general.

Core Concept Quality and Overall Summary Ranking

The next and final step was to score and rank the policies. The quality of the policy documents was assessed according to the scale proposed by the framework (Table 5). The majority of CCs were only mentioned (level 1) or mentioned and explained (level 2). All policies identified specific policy actions which address a particular concept (level 3), but only for a small number of CCs. Solely one document - the

Table 3. Frequency of Vulnerable Groups in 4 SRH policies

Vulnerable Groups	Scotland	Republic of Moldova	Ukraine	Spain
Limited resources (people living in poverty)	1	0	2	0
Young people	5	10	4	8
Older people	2	6	0	2
Rural population	1	2	1	2
People living with HIV	2	2	1	4
Victims of sexual abuse, gender violence and human trafficking	2	5	0	7
Sex workers	0	0	0	2
Ethnic minorities	0	0	0	1
Migrants, asylum seekers and refugees	0	0	0	5
People living with disabilities	2	0	2	7
LGBT	0	0	0	7
Total	15	25	10	45

Abbreviation: SRH, sexual and reproductive health; LGBT, lesbian, gay, bisexual, and transgender.

Table 4. Frequency of CCs in 4 SRH Policies

CCs	Scotland	Republic of Moldova	Ukraine	Spain
Non-discrimination	5	2	0	8
Individualized services	2	6	2	15
Participation	2	8	0	4
Integration	7	1	0	2
Cultural responsiveness	2	1	0	8
Capacity building	3	6	1	10
Prevention	2	1	3	1
Access	11	30	6	16
Privacy, confidentiality and informed choice	4	3	0	6
Quality	2	5	1	5
Entitlement	1	1	5	1
Total	41	65	17	76

Abbreviations: CC, Core Concept; SRH, sexual and reproductive health.

Table 5. Overall Assessment of SRH Policies

SRH Policies	VGs*, %	CCs, %	CC Quality, %	Overall Summary Ranking
National SRH strategy (Spain, 2010, strategy)	91	100	64	High
Respect and responsibility (Scotland, 2005, strategy)	64	100	45	Moderate
National reproductive health strategy (Republic of Moldova, 2005, strategy)	45	100	55	Moderate
Reproductive health of the nation for the period up to 2015 (Ukraine, 2004, programme)	45	55	18	Low

Abbreviations: SRH, sexual and reproductive health; VGs, vulnerable groups; CC, core concept.

Moldavian strategy – stated an intention to monitor (level 4) 3 CCs: "access," "individualized services," and "capacity building." Overall, the Spanish policy reached a high summary ranking, which in this analysis was set to ≥50 %, on any of the quality scores. Meanwhile, the Ukrainian policy scored lowest.

In general terms, Spanish and Scottish policies recognized that socio-economic, cultural and gender determining factors should be considered in addition to different situations in the different population groups. They promoted support for the populations facing discrimination due to their life circumstances or their gender, race or ethnicity, religion or faith, sexual orientation, disability or age. These 2 policies included the concept of vulnerability and made an emphasis on individual, environmental and health system factors which produce growing disparities in SRH outcomes of different populations. They justified the vulnerable groups' presence in these policies by providing evidence on their vulnerability and explaining its causes. In contrast to these 2 policies, Ukrainian and Moldavian policies operated with the concepts of "socially disadvantaged" or "vulnerable social strata" without explaining and reflecting on the meaning and applications of these terms. They acknowledged the fact that economic or social circumstances produce health inequalities and that some groups have unmet SRH needs and deserve special attention.

Findings From Interviews With Policy-Makers
After accomplishing policy analysis, five semi-structured interviews with key informants from 3 European countries (2 from Spain, 1 from Republic of Moldova, and 2 from Scotland) were conducted. Four women and one man participated in the interviews. All interviewees were directly involved in development of analysed policies. Conducted interviews supplemented the policy analysis and helped to reflect and clarify information obtained from the policies. The following themes were identified from the analysis: perceived importance of incorporation of vulnerable groups in SRH policies, the way of mentioning these populations in policy documents, importance of their involvement in policy development, and obstacles and facilitators to their participation in policy development.

Incorporation of Vulnerable Groups in Sexual and Reproductive Health Policies and the Way of Their Presentation
As results of the policy analysis demonstrated, different groups were mentioned in the policy documents. All interviewees were supportive of the idea of including particular groups in SRH policy documents. This position was substantiated by using different arguments. For instance, respondents underlined the necessity to draw attention of politicians to the health needs of vulnerable populations and the concept of

vulnerability within the country. Moreover, one interviewee commented that the absence of specific groups in the policies could result in worsening their health outcomes.

Despite the importance of mentioning vulnerable populations in policy documents, opinions of the participants regarding the way in which some groups should be mentioned in the SRH policies varied. One policy-maker shared the view which could illustrate the common attitude: "*It is important to make sure that you do not just use one phrase that says 'vulnerable groups' but you try to give some definition and examples and ensure that people see these….*" While some informants suggested that vulnerable groups should be listed exhaustively and detailed, others preferred to have a clear definition of vulnerability and expressed their concerns regarding a precise listing of population groups. Informants agreed that vulnerability should be defined and illustrated with some practical examples, but it is also important to emphasize in the policy that the proposed examples could not cover all situations. One interviewee suggested that before including particular groups in SRH policy, the benefits of including them should be assessed and evaluated, and their incorporation had to be well-founded. Besides, in 4 interviews the discussion appeared around the whole population-based approach versus mentioning particular groups. Interviewees concurred that health policies designed for the whole population were not always effective and were seen to be very traditional. One informant commented in regard to the whole population approach: "*That's fine if you can show evidence that your policy is impacting all groups and I do not think that there is any place in the world that can demonstrate that effectively.*"

Vulnerable Group's Involvement in Policy Development
The policy analysis has shown the intentions of policies to address vulnerable groups and in some cases their presence was explained by evidence on their SRH outcomes. Nevertheless, it is necessary to question whether these groups participated in the development of these policies or they were just stated without being heard. All participants assented that involvement of various communities was a necessary component in policy development. One of them suggested that vulnerable populations should be involved in the process from the beginning and participate in the design of the strategy, be asked about their standpoint regarding SRH and engaged in the development of interventions. Based on the interview analysis, the following types of participation have been identified: participation through civil organizations which represent different vulnerable populations, direct involvement of vulnerable communities, and participation through health practitioners. For instance, in the case of Spanish policy, NGOs which represented some of the vulnerable groups had been invited to be part of the technical committee which developed the strategy. Within the

committee their participation consisted in providing constant feedback on the process of strategy development, attending face-to-face meetings, and being involved in an e-health collaboration which connected all participants through internet and provided an opportunity to share comments and be involved constantly.

The approach to involve vulnerable communities used by Scottish experts and policy-makers for the analysed strategy was based on the following principle: "… *if we are reviewing something and we want feedback then it goes through formal consultation and federal organizations. But we also convene groups of interested individuals*," explained one interviewee. Two interviewees from Scotland stated that that before developing the strategy, a number of research was conducted with particular groups in order to identify their needs and their perception of SRH services, and this process is ongoing in order to revise and improve the strategy. Moreover, the committee as well as a "reference group" have been created. The reference group included representatives of various communities, young people groups, clinicians, experts, etc. who created a set of recommendations (around 90) and expressed their vision on future sexual strategy. Vulnerable groups were involved from the beginning through discussions about strategic development, open public consultations: "*Many local areas organized meetings to allow small groups of people from the community or on behalf of the communities, so like refugees, allowed them to talk openly about proposals that are going to be. So that feedback was used to develop the final strategy.*"

In case of the Republic of Moldova, the interviewee was not aware of direct involvement of vulnerable groups in the SRH strategy development. But she commented that the committee which designed the policy document constituted of specialists (healthcare workers) who directly interacted with vulnerable populations (eg, adolescents) and were aware of needs and SRH situation of different groups.

Obstacles and Facilitators to Vulnerable Groups' Participation in Policy Development

A number of hindering factors to the process of involvement of vulnerable communities in policy development were named and described by informants. Based on the obtained information, they can be divided into 3 levels: political/organizational, healthcare providers, community/individual. On the political and organizational level, the absence of political will was named by almost all interviewees as one of the main obstacles. The lack of awareness among politicians in regard to concept of vulnerability and absence of lobbying groups, which would advocate for the rights of specific populations and represent their voices, were highlighted by 2 informants. In addition, difficulties to generalize the results obtained in the process of involvement of particular groups could also hinder the process of their participation. From the technical and organizational perspectives, there were difficulties taking into account opinions of NGOs or community representatives on the national level. It led to the necessity to prioritize participants because of the technical and logistic issues, eg, size of the committee which develops policy. Difficulties to find common language between policy-makers, experts and communities were also noted.

At the level of healthcare providers, a range of obstacles was listed. As it was mentioned by a couple of informants, health professionals sometimes showed resistance to changes and lack of awareness in regard to the needs of particular groups. Prejudice and cultural barriers in regard to different groups also sometimes accompanied medical practice. On the community and individual levels, resistance to changes and lack of awareness of some populations about their SRH and available services could prevent them from participating in the decision-making process. Policy-makers also commented that they faced difficulties building a representative sample of people "… *and not having the same people coming forward all the time.*" In addition to the above mentioned barriers, more specific hindering factors for the SRH field such as difficulties which arise when people are asked to talk on private topics including sexual health, and taboos related to this field were named by interviewees.

A range of enhancing factors and recommendations was proposed by participants that could improve the process of vulnerable group's involvement in policy development. Almost all interviewees mentioned the role of political commitment and will, and the importance to draw attention of politicians to SRH issues of vulnerable populations. Another powerful mechanism mentioned by the interviewees was advocacy campaigns. Awareness could be raised by organizations representing vulnerable groups and through better use of social media. Organizations and federations could in turn play a role in capacity building and staff training in order to properly communicate with different populations. Finally, communication could be facilitated by training local community representatives. An example of cultural mediators in a number of European countries was given and the need to share experience and learn from other countries was expressed. Talking about participation with vulnerable communities and about differences that it could make was also found to be a relevant step to build a dialog with them. In addition, policy-makers agreed that the way to a greater involvement of vulnerable groups was seen to be slow and balanced based on prioritizing groups and possibilities to transfer lessons learned from some groups to others.

Discussion

This paper explored how SRH policies in 4 European countries address vulnerable groups and principles of human rights, and discussed the involvement of vulnerable populations in policy development processes. The study found that vulnerable groups were treated differently in four policy documents. The lack of explanation in the policies on how these choices were made and why these particular populations were included, does not allow for a better understanding of their place in the policies.

However, there is still no universal agreement whether separate health policies for vulnerable populations have to be in place or whether these groups have to be included and highlighted in health policy documents designed for the general population. Some authors argue that in order to enhance equal access to healthcare services for vulnerable populations, their needs have to be addressed and integrated into "mainstream" health policies.[25] These issues were touched during the interviews where opinions of key

informants on the way of addressing vulnerable groups in SRH policies varied. While some participants suggested that vulnerable groups should be listed exhaustively and detailed, others preferred to have a clear definition of vulnerability and expressed their concerns regarding a precise listing of population groups in general SRH policies. Policy-makers also highlighted that sometimes SRH policies designed for the whole population are seen to be very "traditional" and rarely equally impact different population groups. Nevertheless, they did not have a consensus on what could have been the best way to incorporate vulnerable groups in the policies. In addition, key informants underlined that before including various populations into SRH policies, evidence on their SRH needs and status has to be collected in order to justify their inclusion and assess its benefits. Following this idea, findings from policy analysis demonstrated that only 2 policies (Spanish and Scottish) tried to elaborate on factors leading to health disparities and provide evidence on health status of included vulnerable and disadvantaged populations.

The study findings also revealed that in addition to the importance of vulnerable group's incorporation in SRH policies, their participation is generally seen as a valuable component in SRH policy development process and the best guarantee for ensuring that these policies actually benefit populations and improve their health. Nevertheless, it is important to stress that sometimes health initiatives which rely on public participation place an additional burden on the already disadvantaged groups because of the costs and resources involved.[26-28] There are various barriers to participation that may affect some individuals and groups more than others, and lead to the underrepresentation of people who are facing worse SRH outcomes. For example, the participation of vulnerable groups may be limited by different constraints such as costs of travel, physical access, and lack of information. In the present study, these barriers were complemented by the informants' responses and divided into 3 levels: political/organizational, healthcare providers, and community/individual. The most mentioned obstacle during the interviews was a lack of political will which is often seen as a crucial part in policy-making process and is important in defining health priorities, and target populations. According to the literature, political will is one of the essential components for advancing public health policy, which stands together with evidence base and social strategy, including community participation in decision-making process.[29] All these components emerged during the interviewing process and were applicable in the case of vulnerable communities. In order to overcome this obstacle and to draw attention of politicians and relevant stakeholders to SRH issues of vulnerable populations, key informants proposed to implement efficient advocacy campaigns and to raise awareness by cooperating with organizations representing vulnerable groups and through better use of social media. Methodologically, this study relied primarily on health policy analysis and key informant interviews and has a range of limitations that have to be taken into account. The framework – EquiFrame used in the analysis is a very practical tool for policy-makers to screen the existing health policies and to design new policies. However, the framework was developed and applied for an analysis of health policies from low- and

middle-income countries (LMIC), in particular – African region, while the presented study concentrated on SRH policies from European countries. In order to adapt it to the study setting and also to the field of SRH, a literature review was performed including national and international literature to identify vulnerable groups. The proposed list of groups was not exhaustive and it is subject to change given the complexity and variability of definitions of vulnerable populations, concept per se and multiple country contexts. In contrast to the principles of human rights which are universal and widely acknowledged, identification and determination of vulnerable populations is a difficult task.[17,30] Moreover, it is important to keep in mind, when comparing and analysing health policies from different countries as well as creating a link between human rights and vulnerable populations, that cultural differences must be taken into account for human rights to be applicable and it is crucial for them to be compatible with these differences.[31,32] In addition, the authors of EquiFrame highlighted that the application of this framework does not side-step difficult moral and pragmatic issues about whom to include in the term 'vulnerability,' or whom to recognise as a vulnerable group.[17] Unfortunately, vulnerability cannot be measured with a single criteria or indicator, however, different authors have provided indications on how to benchmark vulnerability.[33-35]

This study gave policy-makers a chance to express their thoughts and ideas during the interviews. The main author conducted 5 interviews in 3 European countries (2 in Spain, 2 in Scotland, and 1 in Republic of Moldova); however, the number of interviews did not allow obtaining a great variety in answers. Unfortunately, the difficult and unstable situation in Ukraine influenced the possibility to get in touch with policy-makers who directly participated in the development of national SRH program and their further willingness to give interviews. At the same time, it is important to consider this study in a wider frame, together with other studies on the perceptions of vulnerable groups themselves. It will allow gaining more insights on this topic from the perspective of vulnerable communities. It is also important to acknowledge that the current paper covered only the policy development process and for the future studies it would be valuable to address all stages of the policy-making process including implementation, evaluation and monitoring.

Conclusion

Based on the findings and suggestion from the informants it is very clear that evidence on health status of vulnerable communities, political commitment and advocacy are crucial for addressing vulnerable groups in health policies and promote their involvement in the policy development process, especially in the SRH field. Quantitative data on SRH status of vulnerable populations should routinely be supplemented by qualitative information from them and advocating organizations, describing unmet needs, access to SRH services, etc. Moreover, future research on policy development process and vulnerable groups' involvement should include representatives of vulnerable communities that will help to build a dialogue and present the problem from both sides. In addition, clear tools and recommendation on how to include vulnerable groups in SRH policies and

clear definitions for these groups have to be elaborated and developed through collaboration of various stakeholders.

Authors' contributions

OI designed the study, collected and analysed data, and drafted the manuscript. TD supervised the study process, participated in the design of the study, data analysis and interpretation, reviewed and edited the manuscript. ST supervised the study process, participated in the data analysis and interpretation, reviewed and edited the manuscript.

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