

UNFPA Arab States Regional Office Position Paper

Sexual and Reproductive Health:

A Core Component of Universal Health Coverage

The United Nations is working with governments, civil society organizations, and other partners around the world to define the next set of goals that will follow the Millennium Development Goals (MDGs), which end in 2015. The new goals will focus on ending extreme poverty, promoting sustainable development, and reaching excluded groups, with the aim to “leave no one behind”.⁽¹⁾ The goals are expected to include one related to health, the content of which is still being negotiated. One proposal is universal health coverage (UHC), which is reached when everyone is able to obtain good quality health services when they need them without experiencing financial hardship.^(2,3) It is seen as fundamental to improving equity in health and human development because it emphasizes reaching the poorest and most marginalized people who usually face the greatest health risks and need more services.⁽⁴⁾

Sexual and reproductive health is a critical part of the health and wellbeing of women, men, and families, affecting people from childhood to old age. It was first defined and became a universal goal in the report of the 1994 International Conference on Population and Development (ICPD).⁽⁵⁾ The recent 20th anniversary review, called ICPD Beyond 2014, which included a regional conference for the Arab States, emphasized the need for a sustained commitment to universal access to sexual and reproductive health care.⁽⁶⁾ Essential packages of interventions have been identified and continue to be refined. Yet, it is also a contested and highly politicized topic in many countries, and has often been neglected in global health policies, including the MDGs. Universal access to reproductive health, including family planning, came as a late addition to Goal 5 (to improve maternal health), and therefore did not garner as much political commitment as other goals and targets.

In this context, UNFPA's Arab States Regional Office convened a regional consultation to discuss the place of sexual and reproductive health in the new health agenda, and particularly in universal health coverage. Another motivation for the consultation was to ensure that countries' experiences on the ground inform the global health agenda. The meeting was held in Sharm-el-Sheikh, Egypt, on February 12-13, 2014, and included representatives from ministries of health and UNFPA from 13 countries: Algeria, Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, Oman, Palestine, Somalia, Sudan, Tunisia, and Yemen. Colleagues from the World Health Organization, the National Population Council of Egypt, and UNFPA headquarters in New York also participated. This position paper builds on the findings of the consultation.

The Regional Context

The Arab States region represents a diverse group of countries with different income levels, cultures, and political systems. The countries have had disparate rates of progress on the MDGs, with some countries, such as Egypt, Tunisia, and Morocco achieving a marked reduction in maternal mortality in the past 20 years and others, such as Somalia and Yemen, lagging far behind. Throughout the region, the expansion of family planning services has been slower than required to reach the MDG target 5B, to reduce unmet need for contraception. All countries in the region have large youth populations, also referred to as a “youth bulge”. Recent political uprisings have triggered instability and migration within countries and across borders. The migrants are especially vulnerable to ill-health and require a specialized approach to health service delivery. But political unrest in many countries, marked by frequent turnover of ministers of health, has hampered efforts to expand access to reproductive health services - for the general population as well as migrants. The rising conservatism of new governments in some countries, accompanied by budget constraints and flagging economies, has shifted priorities away from sexual and reproductive health. On the other hand, while health policymakers shied away from discussing sexual and reproductive health in the past, the humanitarian crises has forced governments to acknowledge its importance, including services to prevent and mitigate rape and other forms of gender-based violence in camps for refugees and internally displaced persons.

Health Service Challenges

Meeting participants discussed a range of challenges that their countries face in efforts to expand access to sexual and reproductive health services. Many of these challenges are also obstacles to achieving universal health coverage.

Weak services in rural areas. Representatives from Tunisia, Algeria, and Iraq noted that poor quality of care is a major roadblock to improving health, especially in rural regions. Many of the deficiencies are related to weak governance and accountability in decentralized health systems where local governments are unable to guarantee high quality care. Representatives from Lebanon, Sudan, and Morocco also echoed concerns about subnational disparities in access to services.

Ongoing conflict. Service provision remains weak in countries facing protracted conflict, such as in Libya. Yemen had been

making strong progress between 1990 and 2010, but the health sector collapsed in the revolution of 2011. Somalia is struggling to serve a largely nomadic population.

Traditional mores. Family planning programmes are slow to expand where social mores continue to favor large families, such as in Jordan. In Yemen, continued high rates of early marriage and a low level of female enrolment in secondary schools of 31 percent⁽⁷⁾ undermine efforts to promote reproductive health. Somalia and Sudan have low levels of demand for and use of contraception because of cultural and traditional barriers to family planning.

Challenges of more developed health systems. Palestine and Lebanon, states with many health providers, face challenges with over-provision of specialist care, particularly caesarean sections, which can impose health risks for women and financial burdens on families. Strengthening primary care is a priority in both countries. Oman, a Gulf state that has already experienced large declines in fertility and in maternal and child mortality, has begun to shift attention away from reproductive health to non-communicable diseases.

Gap between policies and implementation. Egyptian participants highlighted the gap between strong policies on sexual and reproductive health and weak implementation, particularly in rural areas. One area of concern is the lack of regulation of private health providers who provide unnecessary specialized care and are not accountable to the government regarding quality of care.

The political transition in the region is both a challenge and an opportunity to reconsider national health strategies. Social exclusion of the poor, youth, and religious and ethnic minorities was a major motivation for the uprisings, and consequently people have a greater demand for well-functioning services that reach the poor and vulnerable. As a result, six of the countries in the meeting (Algeria, Egypt, Iraq, Lebanon, Tunisia, and Yemen) have embarked on reforms of their health systems and/or health financing strategies (see box on page 3).

Recommended Actions for Including Sexual and Reproductive Health in Universal Health Coverage

The Sharm-el-Sheikh consultation informed two sets of recommendations. The first set deals with policies and implementation of universal health coverage and the second includes proposed indicators for monitoring sexual and reproductive health services within universal health coverage. These recommendations are consistent with UNFPA's recent proposals for the Post-2015 Development Agenda.⁽⁸⁾ They also build on the recommendations of the 'ICPD Beyond 2014' global and regional consultations and the report of the United Nations Secretary General on ICPD Beyond 2014, which emphasized making sexual and reproductive health a priority for the health sector and ensuring that everyone has access to quality, affordable services.

1. Secure high-level political commitment for universal health coverage that includes sexual and reproductive health services.

Sufficient funding for a UHC benefit package that includes sexual and reproductive health services will be required to ensure both universal access and financial protection. Experiences from countries that have pursued UHC show that greater

government financing of health will be essential: High-level political commitment in Morocco led to an increase in health-sector budgets, which contributed to a large decline in maternal mortality. Additionally, seven countries participated in the Dubai regional conference on maternal and newborn health organized by WHO, UNFPA, and UNICEF in 2013, which led to the Dubai Declaration to accelerate progress towards achieving MDGs 4 and 5, including family planning.⁽⁹⁾ This declaration highlighted the need to strengthen health systems and mobilize domestic and international resources to establish sustainable financing mechanisms. Budget increases for health will involve difficult trade-offs, and therefore articulating the economic and intrinsic value of improved health to decision-makers will be crucial.

2. Make sexual and reproductive health services and commodities an integral part of the UHC benefit package.

In addition to traditional sexual and reproductive health services, such as antenatal care, skilled attendance at delivery, emergency obstetric and newborn care, postnatal care, family planning, and addressing sexually transmitted infections and HIV, countries should also include the following:

- preventing and responding to gender-based violence;
- adolescent reproductive health education and services;
- detection and treatment of breast cancer;
- prevention, detection, and treatment of cervical cancer (including HPV vaccination); and
- ensuring availability of a larger mix of acceptable modern contraceptives.

These services should be made available at the appropriate level of the health system, from the community level to tertiary hospitals.

3. Start with the vulnerable.

The unmet need for health services, including those related to sexual and reproductive health, is highest among the poor and in rural populations. National household surveys clearly document wealth-based inequities in access to care in Arab States.⁽¹⁰⁾ Adolescents, particularly girls, are often unable to access reproductive health care because of providers' bias and other forms of discrimination, even when they are married, leading to high adolescent birth rates. All efforts to implement UHC should begin with reaching these populations and use disaggregated data to identify needs and monitor progress. Since most countries will not be able to afford the full set of desired services, services targeting the most vulnerable women throughout the continuum of reproductive health care should be prioritized.

4. Strengthen capacity for subnational implementation.

Most countries in the region, including Morocco, Somalia, Sudan, and Tunisia, have decentralized health systems, with regional and local autonomy over health budget allocation and implementation. One reason for the gap between policies and implementation is insufficient collaboration between the central ministries and local governments who are charged with health

Examples of Recent Health System and Financing Reforms in the Arab States Region

- Algeria's basic health care package requires patient cost-sharing. The government is launching a review of all health policies and may pursue financing reform. Additional funds for health may come from taxes and oil revenues.
- Egypt provides primary care services, including sexual and reproductive health, free of charge in all government primary health care facilities. Meanwhile, out-of-pocket spending is an estimated 70 percent of total health spending. The new constitution includes a right to health for all and allocates an annual percentage increase in the budget for social sectors including health, education, and research.
- In Iraq, reproductive health services are free in public facilities, but out-of-pocket financing is very high as poor quality drives people to seek private care. The government is embarking on a health policy review to reduce the financial burden and promote access.
- Lebanon's primary care system levies user charges and is disconnected from secondary care. A reform is underway to explore ways to provide free primary care to all.
- In Tunisia, social insurance covers health care for 70 percent of the population; the government finances the poorest 20 percent; and 10 percent have no insurance. The government is re-examining its health financing strategy to improve coverage.
- Yemen's government passed a law mandating health insurance for government employees and their families. This is seen as a first step toward a broader expansion of insurance.

service delivery. A related concern is that when service packages are developed at a decentralized level, particularly in rural regions, the voices and the concerns of women are frequently excluded. Ministries of health should develop stronger ties to their local counterparts to ensure the whole population receives the universal benefit package. Experiences in other regions have shown that even in decentralized systems, the central government has an important role to play in setting minimum standards and ensuring local programmes are socially inclusive.⁽¹¹⁾

5. Pursue innovative solutions to reach rural communities.

As in many parts of the world, dramatic disparities exist between the health services available in urban and rural communities in the region. Finding innovative ways to connect rural dwellers with the full continuum of care will be crucial to reduce inequities. For example, Oman has successfully implemented a referral system for obstetric emergencies that guarantees rapid transport of women from rural clinics to hospitals with surgical capacity. Libya and Morocco have used mobile clinics to reach rural women who live far from health facilities. Morocco has also equipped midwives in the villages with mobile phones and provided a national emergency phone number to facilitate transport of women with obstetric complications.

6. Focus on quality - not just access.

When services are reliable and of high quality, people are more likely to consistently use them. Conversely, people's trust in health care will be diminished if health workers are absent, commodities are stocked out, and health workers treat people with disdain. Careful attention must be paid to how the benefit package is delivered, not only what it contains. One constraint to quality services is the shortage of health workers in the region. Sudan, for example, is suffering from emigration of qualified health professionals. Morocco, Libya, Somalia, and Yemen are among the Arab countries facing shortages of health workers,

and others, such as Egypt, need to increase the number of female providers to encourage service use. Including and recognizing community health workers as part of the health workforce and shifting tasks from physicians to competent non-physicians will be essential to increase access to services, particularly in rural areas. Working with and regulating the private sector will be essential to avoid over-provision of lucrative, but unnecessary services, such as elective caesarean sections.

7. Communicate the value of sexual and reproductive health and universal coverage to the population.

If people are to support universal health coverage, including the provision of sexual and reproductive health services, they must be convinced of its value. Public support makes it easier for governments to increase tax-based financing for health, and it is critical for sustaining the political momentum for universal coverage. Health advocates and ministries of health alike need to clearly communicate the importance of investing in health, and to build demand for underused but high-impact health services. For example, the ministry of health of Algeria has been working with religious leaders in local communities to encourage women to deliver in health facilities. Broad population support is more critical than ever given that post-revolution governments are striving to be more responsive to the needs of communities than their predecessors.

8. Collaborate with other sectors.

Health professionals and advocates must also collaborate with partners in other sectors to address the social determinants of health, such as education, nutrition, and gender inequality, particularly where these have a direct effect on access and utilization of reproductive health services. Special attention should be paid to providing reproductive health services in humanitarian settings to reduce gender-based violence and ensure that women deliver their babies safely and have access to contraceptives.

Recommended Indicators to Monitor Universal Coverage:

Recently, the WHO and World Bank proposed targets and indicators to monitor progress on universal health coverage,⁽¹²⁾ and invited each country to compile a list of indicators for services related to the MDGs as well as chronic conditions and injuries. Sexual and reproductive health services span both categories of services. Representatives in the regional consultation propose the following sexual and reproductive health-related indicators:

- 1. Health system function** (figures to be shown in the aggregate, regionally disaggregated, and for facilities serving most disadvantaged)
 - Percent of health facilities providing the appropriate set of sexual and reproductive health services. This includes at a minimum: antenatal care, postnatal care, skilled attendance at delivery, HIV services, and family planning.
 - Percent of total health expenditure spent on sexual and reproductive health.
- 2. Coverage** (aggregate, for the poorest 40%, rural/urban, and subnational)

Indicators previously included in MDG5:

- Proportion of births attended by skilled health personnel
- Antenatal care coverage (at least one visit, at least four visits)
- Contraceptive prevalence rate
- Unmet need for family planning

New indicators:

- Proportion of births delivered via caesarean section
 - HPV vaccine coverage
 - Proportion of women with cervical cancer screening
- 3. Health outcomes** (aggregate, poorest 40%, rural/urban, and subnational)
 - Adolescent birth rate
 - Maternal mortality ratio
 - Five-year survival rate for breast cancer

Conclusion: Shared Challenges, Common Goals

There is no contradiction between sexual and reproductive health and universal health coverage. Indeed, the two areas share the core aims of providing universal coverage of effective health services while ensuring that families do not suffer financially from using them. As such, integrating strong and comprehensive sexual and reproductive health services in the benefit package

will strengthen the value of universal health coverage to the population, while supporting the ultimate goal of reaching the highest attainable standard of health for all. Each country will need to select interventions based on its demographic and health profile, its current progress on sexual and reproductive health goals, and its ability to sustainably finance the delivery of the services.

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