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MIDDLE EAST AND NORTH AFRICA HEALTH POLICY FORUM

UNFPA

A Framework for Sexual and Reproductive Health Integration in Primary Health Care of the Arab States

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Preface

In 2015, member states of the United Nations committed to "leaving no-one behind". Such commitment has consequences and costs that are not necessarily available in developing countries. Separately, and for decades, Sexual and Reproductive Health (SRH) services in the Arab region have been provided in silos, with high fragmentation and cost to the different health systems and individuals. It is, therefore, necessary to identify ways to improve the efficiency and quality of healthcare provision and freeing resources to help leave no-one behind.

In 2017 and 2018, UNFPA Arab States Regional Office (ASRO) in partnership with the Middle East North Africa Health Policy Forum (MENA-HPF) launched a regional assessment of the integration of SRH services into Primary Health Care in eleven Arab countries. The exercise did not stop at the assessment stage but further built on the findings from the eleven countries to propose an integration framework that provides a sort of a road map and guidance to advancing national level integration efforts to improve efficiency and quality of healthcare provision to the most needy, minimizing costs to the health system as well as the individual.

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Introduction

In 1978, the International Conference on Primary Health Care took place in Alma-Ata. Sixteen years later, the International Conference on Population and Development (ICPD) promoted the integration of sexual and reproductive health (SRH) services within primary health care (World Health Organization, 2006). In 2005, the 60th United Nations General Assembly concluded that to achieve universal access to reproductive health care by 2015, SRH services must be delivered through primary health care (WHO, 2011). Then, in the *World Health Report 2008: Primary Health Care – Now More Than Ever*, the integration of SRH in primary health care also appeared as a basic element in the provision of comprehensive health services to lower costs and improve outcomes (WHO, 2008). The United Nations General Assembly gathered again in 2015 to consider and adopt a global development agenda for the next 15 years—a plan of action for "people, planet and prosperity" that contained the Sustainable Development Goals (SDGs) (United Nations, 2015). Since then, governments have increasingly recognized that SRH is a relevant public health issue that should be an essential component of primary health care. Most recently, in 2018, the Astana Declaration emphasized the critical role of primary health care around the world, to ensure that everyone can attain the highest possible standard of health.

Countries in the Arab Region and elsewhere have experienced many challenges in adopting integrated approaches to delivering SRH services in primary health care. In the Arab Region, assessments conducted in 2017-2018 identified the lack of a health systems approach as the main impediment to the integration of these services. The assessments were conducted by the Middle East and North Africa Health Policy Forum (MENA HPF), in partnership with the Arab States Regional Office of the United Nations Population Fund (UNFPA/ASRO), to analyse the readiness of health systems to integrate SRH in primary health care in Egypt, Jordan, Kingdom of Saudi Arabia, Morocco, Palestine, Sudan, Lebanon, Oman, Tunis and Libya (MENA HPF/ASRO 2017, 2018). The findings highlighted the need for integration to be carefully planned in relation to health systems functions.

This document presents a framework that takes a health systems approach to the integrated delivery of SRH in primary health care in the Arab Region. A health systems approach is one that understands how elements of care operate individually and in connection with each other. The proposed framework aims to remedy the fragmentation and vertical delivery of care in the health system (Ekman B, Pathmanathan I, Liljestrand J, 2008), in order to achieve universal access to SRH services in support of achieving the SDGs.

Integrated primary care adds value not only by reducing illnesses and deaths, but also by reducing inefficiencies in health care. Integration enables primary care to provide continuity of care, and high continuity means 13% fewer hospital admissions (WHO, 2018). Furthermore, according to the World Health Organization, 63% of patients value seeing someone they know and trust, most often their primary care physician (WHO, 2018).

Integration of SRH services

Integration can be defined according to the level of the health system at which it is implemented, either at the service delivery point or a higher administrative level (ATUN, 2010). Integration at the service point is understood as the integration of all, or some, specific programme activities into the package of activities provided by basic health services that include curative, preventive and health promotional activities.

The WHO describes the categories of health system functions according to six health system blocks, including governance, financing, service delivery, human resources, medical and health technology, and health information (WHO, 2012). Integration of health systems functions is defined as "a variety of managerial or operational changes to health systems to bring together inputs, delivery, management and organization of particular service functions" (Coalition, April 2012).

In terms of SRH services, integration means providing more than just basic maternal and child health care and family planning. A simplified, health systems definition of integration of SRH care in public health services is that the control of management, budgeting, funding and provision of services is situated within the ministry of health and its decentralized levels, rather than in a separate directorate with separate management and funding (Bart Criel).

Success in service delivery is usually related to the extent of integration of higher-level health systems functions (Coalition,I.W., April 2012). Such integration entails effective collaboration and coordination, comprising formal and informal productive relationships throughout the health system, and between the health system, patients and communities; adequate and appropriately skilled and incentivized health workers—with the right expertise, training and operational support for the programme; supportive institutional structures and dedicated resources; leadership in terms of political will, effective managerial oversight and organizational culture; and placing the patient at the centre of service delivery and responding holistically to their diverse needs (Watt N, 2017).

Integration of SRH services is therefore beneficial for both service recipients and health systems in terms of cross-utilization of services and continuity of care. Integrated services can attract those who might otherwise not receive SRH care at all; emphasize prevention, early intervention and harm reduction across all services; introduce cost-saving measures; and encourage more efficient, effective and equitable use of health systems (Coalition, 2012).

Why does SRH matter in primary care?

Health systems based on primary health care are generally more efficient and provide better services than those less oriented to primary health care (Starfield B. , 1998). An integrated health programme aims to manage and

deliver health services so that users receive a continuum of preventative and curative services according to their needs over time and across different levels of the health system (Kennedy CE, Spaulding AB, Brickley DB, et al, 2010). The global health community has promoted integration of services for SRH and HIV with the intent that both clients and health providers benefit from improvements in quality, efficient use of resources and lower costs. It can help maximize limited health resources and provide comprehensive, client-centred care (Warren CE, Mayhew SH, Hopkins J, 2017).

> **Integration in this context "refers to different kinds of SRH and HIV/AIDS services or operational programs that can be joined together to ensure collective outcomes. This would include referrals from one service to another. It is based on the need to offer comprehensive services"**
>
> "WHO" UNFPA, UNAIDS, 2008).

This is even more essential in resource-constrained settings and considering the current global agenda for achieving universal health coverage (Universal Health Coverage. Factsheet, 2016).

In practice, there have been different approaches or models for integration of SRH services. In some settings, new interventions have been added to existing services, and in others, separate components of care have been combined in the same delivery system through changes in the organization and coordination of care (Ekman B, Pathmanathan I, Liljestrand J, 2008; Fleischman Fleit KG, Hardee K, Agarwal K., 2002).

Although several Arab countries have undertaken health system reforms, many challenges remain for fully integrating packages of SRH and HIV care within the existing primary healthcare system. Adequate, integrated SRH services typically take a life-cycle approach and include a package of family planning and maternal and child health services and antiretroviral treatment to improve the wellbeing of people living with HIV, to prevent further transmission of the virus and to extend their lives. An integrated approach to the planning and delivery of SRH services increases the chances for achieving universal access to SRH in communities by ensuring that integrated services are more cost-effective and efficient, improving access to health care and increasing financial sustainability (Warren CE, Mayhew SH, Hopkins J, 2017). Therefore, monitoring and evaluating progress towards the provision of integrated SRH services within primary health care is essential to build a comprehensive understanding of the challenges and opportunities for improvement.

Challenges

Table 1 summarizes cross-cutting issues facing the different countries in the region.

Table 1. General Challenging Areas for Integration of SRH into PHC

Policy level	Health sector level	Service delivery level
Insufficient political commitment and support. Insufficient financial support. Ineffective coordination between different stakeholders. Vertical programming. Need for community involvement and participation.	Lack of training programmes and supervision. lack of unified health information system.	Resistance towards integration (lack of understanding of the concept). Lack of continuous care, weak referral and follow-up. Disadvantaged and vulnerable groups (e.g., internally displaced populations, refugees). Missing services.

The SRH assessments of selected member countries showed the following challenges across the region:

- The sustainability of services is limited because of workforce constraints. SRH-trained health care professionals are needed, especially midwives, nurses and general practitioners, as well as qualified program managers. Health care professionals are unevenly distributed, concentrating mainly in the big cities.
- Specific national and regional guidelines are required, in addition to continuous education and training programs. Current training is not designed to broaden skills on components of SRH care.
- Health personnel shortages and inadequate training in the provision of integrated services increases the staff workload, and consequently generates high turnover of personnel.
- Vertical, donor-dependent programming has not been consistent with mainstreaming and integration of SRH care.
- Spurring the interest of the growing private sector in SRH is challenging. There is also a lack of information on rates of use and the quality of private-sector services.
- Coordination between the private and public sectors, including universities, is also needed with regards to service availability, monitoring and access. Duplication of services across different institutions has consequences in terms of coverage and quality.
- Training in integrated health systems is needed, combined with an official SRH service package and an integrated health informatio n and referral system.
- Health information systems are deficient. Primary care data is not connected to the records of hospitals or other SRH services.

- Insufficient physical space along with intermittent war, conflict and occupation are a constant threat to the accessibility and quality of services. Space limitations affect the privacy and confidentiality of services.
- Services are mostly focused on maternal and child health and family planning but are missing other SRH services.
- Political commitment is lacking to prioritize the integration of SRH/HIV services strategically and financially.
- The availability of medicines and supplies is inconsistent, and equipment is limited. Stock-outs and shortages in family planning supplies are common due to funding disruptions and low government funding.
- The emphasis on curative health care and continuous referrals from the first and second levels of care to tertiary care reduces efficiency and increases costs.

Framework for Integration of Sexual and Reproductive Health Services in Primary Health Care in the Arab States

Vision

Strengthen primary care through the integration of sexual and reproductive health (SRH) services, in order to achieve universal health coverage, leaving no one behind and in agreement with Sustainable Development Goal 3.7:

Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Integrating SRH services in primary health care in the Arab States region will be challenging because most countries have not achieved universal health coverage.

Goal

To strengthen SRH services in the Arab States region by integrating service delivery within primary care in the context of universal health coverage.

Objectives

To address the challenges facing Arab States, the objectives of integrating services and systems include the following:

- Improve integrated SRH responses at the policy, systems, facility and community levels.
- Improve institutional capacity, organization and management, and system development for the integration of SRH services.
- Improve and maximize access to quality comprehensive, essential SRH services in primary care facilities within the framework of PHC.

Guiding principles

The framework for the integration of SRH services in primary care is based on the following principles:

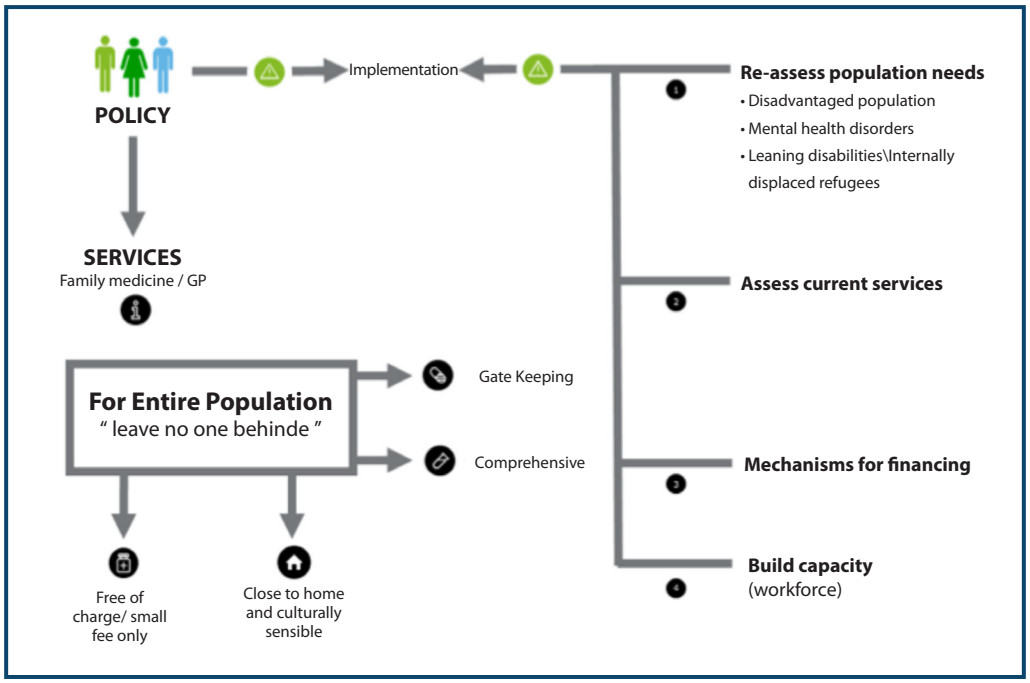
- Stewardship, leadership and governance
- Cultural sensitivity
- Confidentiality and privacy
- Efficiency
- Universal access to quality, affordable and comprehensive SRH services
- Needs met
- Reach all, "leave no one behind"
- Targeted community-based and patient-centred, evidence-based approaches
- Reduced inequalities
- Involvement, participation, coordination and partnerships: Consider health-related determinants and partnerships with clearly defined roles and responsibilities.

Enablers and pillars (Framework)

Successful SRH service implementation relies on all stakeholders, including governments, investors and communities, sharing an interest in integrated services . Once interest exists, public involvement will be necessary to shape policy that attends to the population's actual needs and is likely to be adopted. As illustrated in figure 1, the integration of SRH in primary care requires:

- Capacity building: Have enough workforce and infrastructure at the primary care level.
- Affordability: Reduce or subsidize the cost of services at the point of delivery, using different sustained financing mechanisms Such as insurance or pooled funding.
- Comprehensiveness and cultural sensitivity: Services must address all aspects of SRH for all age groups including youth and older persons, while taking into account the culture of the place where they are delivered. This is based on identifying core program elements and service delivery arrangements that should be identified based on evidence and priority setting by decision makers and relevant stakeholders.
- Conducive policy environment: Policy is generated within an enabling environment (figure 1) that supports SRH service integration in primary health care.
- Public, private and society coordination: Different health providers must be aware of the services delivered and to whom, to aid in effective referrals. Both sectors must work towards common societal goals.
- Data collection: Gather information for decision-making based on monitoring and evaluation and promote the use of information technology.

Figure 1: Enablers to SRH Services Integration



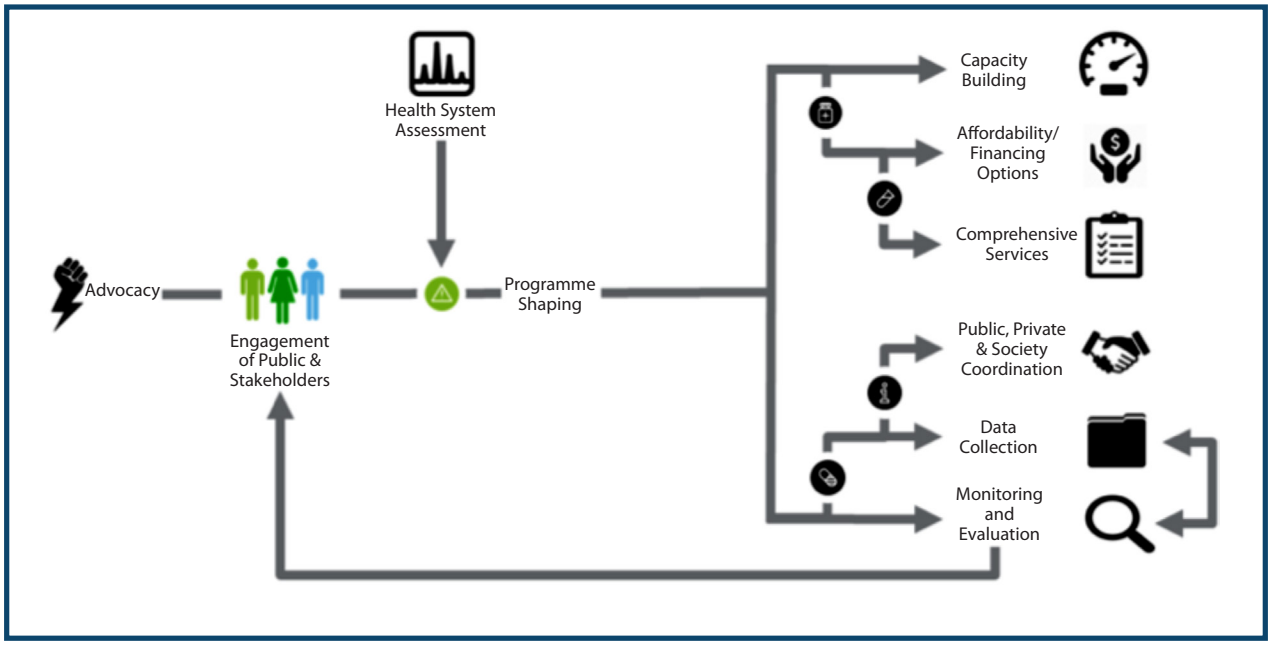
Actions

Policies and regulations should address actual population's needs based on the latest evidence. National policies, strategies and guidelines should take into account the most vulnerable and high-need groups such as youth, older persons, individuals with mental health disorders, learning disabilities or chronic diseases, and internally displaced persons or refugees (see figure 2). The latter is a current and growing challenge in the region. Other vulnerable groups include immune-compromised individuals (those living with HIV/AIDS) and people who suffer violence. After reviewing needs, the current services are likely to be revised and tailored to fit those needs.

It is inevitable that this will generate new costs, requiring mechanisms for sustained financing. New investments, as well as the re-allocation of existing resources, will be needed to prioritize SRH within a sustainable system that ensures continuity of care.

Globally, there is a crisis in the health workforce. Budgeting must ensure wages and schemes that retain healthcare staff. Avoiding high specialty salaries and providing the majority of services through primary health care also reduces human resource costs.

Figure 2: Services and Implementation



Following the above objectives for integration of SRH services, this framework consists of actions to be delivered at the policy, systems and facility levels, described below.

Policy Level

At the policy level, interventions are focused on **"Creating improved, integrated, SRH responses at policy, systems, facility and community levels"** by:

a) Creating a supportive political environment;

b) Integrating systems and ensuring sustainability; and

c) Coordinating different stakeholders, including the community.

Prioritize strategies

Identify targets

Identify measuring indicators

a) Creating a supportive political environment

Integration of SRH services will not be possible and enduring without political support and commitment. National governments and other stakeholders are uniquely equipped to set priorities and guarantee the health of their populations. Advocates can obtain policy-level support and commitment for the delivery of integrated SRH services by highlighting to policy-makers the benefits and challenges of this approach compared with existing service delivery approaches for SRH services. New, evidence-based research and policy briefs may be used to assist with this advocacy process. A committee or working group focused on engaging strong and influential partners within the health ministry and other relevant ministries and sectors will best serve as a leadership mechanism to this end. Sectors worth engaging include political groups associated with women's affairs, finance, education, planning and development; key NGOs; UN and other international development partners; medical professional associations; and civil society representatives. These partners should be recruited as potential "champions" to advocate within their own organizations. Gaining support from the media, religious groups and academics is also valuable in generating a supportive policy environment.

Creating a supportive political environment will be achieved through the following activities:

- Establish a leadership mechanism (committee/working group) for advocacy purposes and raise the awareness of policy-makers to prioritize the integration of SRH/HIV services strategically and financially, using evidence-based research.

b) Integrate systems and ensure sustainability

Achieving integrated services requires careful mapping and planning to identify the needs of clients and communities; the quality, accessibility and affordability of existing services; the training and logistical requirements of expanding the mix of services; and existing resource constraints. Providing integrated health services that respond to population needs will inevitably generate new costs, and therefore mechanisms for sustained financing will be required. New investment and/or re-allocation of existing resources will be needed to prioritize SRH in order to achieve a sustainable system that ensures continuity

of care. Budgeting must ensure wages and schemes that retain healthcare staff. To support meeting these needs, integration of services requires the development of national-level health policies that define the core group of services and call for their integrated delivery.

Policies and regulations should address actual population's needs based on the latest evidence. National policies, strategies and guidelines should take into account the most vulnerable and high-need groups such as youth, older persons, individuals with mental health disorders, learning disabilities or chronic diseases, and internally displaced persons or refugees .

Integration of SRH services also requires developing policies concerning financing and payment for health services, procurement and distribution of essential medicines through an efficient logistics system, as well as planning and management processes related to human resources (i.e., staffing patterns, remuneration and motivation, training and supervision).

Integration of systems will be achieved through the following activities:

- Develop policies that address integration and provision of a comprehensive package of services based on context, needs and capacities.
- Develop policies to support the integration of reproductive health commodities, human resources (staffing pattern and norms and training, multidisciplinary team approach, team composition, multitasking of existing HR, CPD, retention and motivation), health information and financing mechanisms in PHC.
- Revise/develop new policies that support access to integrated SRH services for vulnerable groups, especially adolescents, youth, migrant populations, people with disabilities, and older persons.
- Plan and allocate for the needed finances and develop a resource mobilization strategy, including an integrated budgeting process.

c) Coordinate different stakeholders, including the community

At the national development planning level, integration involves linkages between SRH policy and health sector planning and similar planning processes taking place in and across other sectors, such as education, agriculture, youth, women's affairs, environment and finance.

At the health sector level, the responsibility for policy and programme development, implementation and evaluation may rest with different managers or departments. In this context, integration is achieved through effective communication and collaboration aimed at ensuring that necessary linkages are established at all levels of service delivery. SRH policies and programmes also need to be strongly linked to planning and policy development in other sectors, as effective linkages can lead to synergies in the provision of services and thus improved health outcomes.

Once policy choices are made about which providers will offer which services, governments must determine where and how such services will be delivered throughout the health system, in collaboration with private-sector health care providers, NGOs and representatives of civil society.

Coordination of stakeholders will be achieved through the following activities:

- Develop guidelines and mechanisms for inter-programmatic coordination and collaboration.
- Develop strategies, guidelines and protocols that support the linkages and integration of SRH comprehensive services at all levels.
- Develop effective coordination mechanisms to engage different stakeholders (private sector, civil society organizations, the community and academia).

Systems level

At the systems level, interventions should be focused on improving institutional capacity, organization and management, and system development through "improving performance and motivating the health workforce"; "strengthening the health information system (including monitoring and evaluation)"; and "strengthening quality and accreditation and referral systems" for SRH service integration.

As SRH services are integrated within the broader healthcare system, the provision of all services will become more complex. Therefore, both technical and managerial capabilities of service providers must be increased simultaneously. That is, supervisors need to expand the range of their technical knowledge and skills, and logistics and information systems need to become more complex. In addition, clear referral pathways should be established between services so that care can be integrated around the needs of the individual. To ensure that services are high quality, quality assurance mechanisms should be developed and implemented, including those that involve professional associations and other public organizations to increase public accountability via civil society.

This will be achieved through the following system level integration activities:

- Provide integrated training for PHC workers (midwives, nurses, general practitioners) to broaden their skills in the components of SRH care and the provision of integrated services.
- Plan for the needed infrastructure and human resources (numbers and capacities) and commodities.
- Develop strategies, including facilitative supervision for health workers.
- Strengthen the health information system, including supervision and monitoring and evaluation, to incorporate integration of services delivery.
- Establish clear referral and follow-up processes.
- Establish quality assurance mechanisms.

Facility level

At the facility level, interventions are focused on **"Improving and maximizing access to quality comprehensive, essential SRH services in PHC facilities within the framework of PHC."**

Because SRH problems disproportionately affect the poor, women and youth, the health system should place priority on developing effective services to meet the needs of these groups. Each country must decide which services to deliver and how, based on current circumstances, while aiming for the entire package. This requires assessing current services, identifying the comprehensive package needed and integrating services and referrals along the life cycle. Service recipients and providers at the community level should be involved in assessing current services and the population's needs.

People may use different "entry points" or specific types of services, but they should be offered a full range of SRH services to meet their needs. At the facility level, SRH services—from the client's perspective—are best delivered at the same time in the same location ("one-stop shopping"). In order to achieve this, the family medicine or general practice venues act as the first point of contact with the health service, being gatekeepers within the health system and ensuring proper allocation of resources. The optimal use of services will depend on their comprehensiveness, closeness to home, cultural sensitivity, free or low-cost at the point of delivery and a strong referral system.

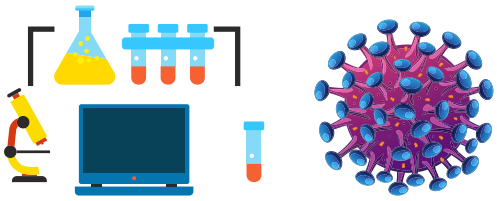
Improving the availability of and access to SRH services can be achieved through private-public partnerships and other mechanisms for contracting with the private sector for the provision of health services, since some sexual and reproductive health services, such as STI care, are often obtained predominantly from private providers. In order to ensure services of high quality, quality assurance mechanisms should be implemented.

Facility-level integration will be achieved through the following activities:

- Define the SRH comprehensive package and delivery model.
- Fill gaps in the provision of SRH services.
- Introduce unified service delivery guidelines that take into account internally displaced populations and other vulnerable groups.
- Introduce quality assurance mechanisms.

Country level

Every national government is responsible for following international human rights standards, including those that pertain to health. They should commit to ensuring the well-being of their populations and to work towards improving policy and service delivery in accordance with the evidence available.



The SRH provided through primary care must ensure that no one is left behind. In order to achieve this, the family medicine or general practice venues act as the first contact point with the health service, being gatekeepers within the health system and ensuring proper allocation of resources. The optimal use of services will depend on their comprehensiveness, closeness to home, culturally sensitivity; free or low-cost at the point of delivery and a strong referral system. The latter requires an assessment of existing services, identification of the needed comprehensive package as well as service integration and referral along the life cycle.

Table 2: Framework for Integration of Sexual and Reproductive Health Services in Primary Health Care in the Arab States

	Results/ key activities
Goal:	To strengthen sexual and reproductive health service delivery in the Arab States region by integrating services delivery within primary care in the context of universal health care.
Objective 1:	To create improved, integrated SRH responses at the policy, systems, facility and community levels
A/C 1.1	Establish leadership mechanism (committee/working group) for advocacy purposes and raising the awareness of policy makers to prioritize the integration of SRH/HIV services strategically and financially through the use of evidence-based research.
Integrate systems and ensure sustainability	
A/C 1.2	Develop policies that address integration and provision of comprehensive package of services based on context, needs and capacities.
A/C 1.3	Develop policies to support the integration of reproductive health commodities, human resources (staffing pattern and norms, multidisciplinary team approach, team composition, multitasking of existing HR, CPD, retention and motivation), health information and financing mechanisms in PHC
A/C 1.4	Revise/develop new policies that support access to integrated SRH services for vulnerable groups, especially adolescents, youth, migrant populations and people with disabilities, and the young and elderly.
A/C 1.5	Plan and allocate for the needed finances and develop a resource mobilization strategy including integrated budgeting process.

Coordinate the different stakeholders including the community	
A/C 1.5	Develop guidelines and mechanisms for inter-programmatic coordination and collaboration.
A/C 1.6	Develop strategies, guidelines and protocols that support the linkages and integration of SRH comprehensive services at all levels.
A/C 1.7	Develop effective coordination mechanisms to engage different stakeholders (private sector, civil society organizations, the community, academia)
Objective 2:	Improve institutional capacity, organization and management, and system development for the integration of SRH services.
A/C 2.1	Provide integrated training for PHC workers (midwives, nurses, general practitioners) to broaden their skills in SRH components and the provision of integrated services.
A/C 2.2	Plan for the needed infrastructure and human resources (numbers and capacities) and commodities.
A/C 2.3	Develop strategies, including facilitative supervision for health workers.
A/C 2.4	Strengthen the health information system, including supervision and monitoring and evaluation, to incorporate integration of services delivery.
A/C 2.5	Establish clear referral and follow-up processes.
A/C 2.6	Establish quality assurance mechanisms.
Objective 3:	To improve and maximize access to quality, comprehensive, essential SRH services in PHC facilities within the framework of PHC.
A/C 3.1	Define the SRH comprehensive package and delivery model.
A/C 3.2	Fill gaps in the provision of SRH services.
A/C 4.3	Introduce unified service delivery guidelines that take into account internally displaced populations and other vulnerable groups.
A/C 4.5	Introduce quality assurance mechanisms.

All the above levels require adequate governance, which refers to the responsibility, whether undertaken by the government, a market/sector or a network, to ensure universal health coverage to nationals and migrants. In order to warrant the latter, many countries in the region must deal with brain drain and loss of medical expertise due to poor working conditions and the frustrations of health workers operating within inefficient health systems, in addition to other challenges.

Governance involves ensuring the existence of policy frameworks that address these issues through accountability, partnerships, advocacy, intelligence, participation, consensus, regulation and transparency (Barbazza E, Tello J E, 2014). Advocacy is key for governance and can be achieved by relying on evidence-based research and taking advantage of different points of intersection and relationships between stakeholders. Finally, sustainability will be an outcome of good governance.

UNFPA, NGOs and Communities' Roles and Responsibilities

UNFPA

UNFPA's mission is to ensure that every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. To achieve this, it supports three areas of action: empowering individuals and governments, advocating for action and promoting partnerships. This includes providing educational support, training, monitoring, mobilizing resources and expertise, advocating directly with government officials or in public forums, and encouraging partnerships and dialogue on programming and policies.

NGOs

NGOs influence policy development and dialogue by commissioning and disseminating high quality, original policy-relevant research and analysis; building national and regional capacity for sound, relevant, independent policy research and analysis; and facilitating networking and the exchange of ideas and experiences among stakeholders. They can act as a regional think tank and advocacy centre for health policies. The MENA HPF is well positioned to support the ongoing regional efforts to build more responsive, equitable, and universal health systems in the region.

Communities

At the community level, service recipients and providers should be involved in assessing population needs and current services. To generate a conducive policy environment, it is valuable to gain support from the media, religious groups and academics.

Services to be delivered

Based on the assessment carried out by MENA HPF, the UNFPA Essential Package of SRH services , and the advisors' recommendations, the following services should be included or modified within existing services in order to offer a comprehensive package and to enable the provision of supplementary essential services at suggested intersection points. The main gaps that have been identified appear in **bold**:

Table 3. Suggested SRH Services to be Included in the PHC package

	Services	Integrated responses (points of intersection)	Measurement (including but not limited to)
Infancy	Post-natal care (including vaccination) Breast feeding	Maternal visits	Neonatal mortality rate Under-five mortality rate
Childhood	Counselling: gender-based violence (GBV)	Child development assessment Vaccination School enrolment	Number of girls and number of boys subjected to GBV
Adolescence (10-19) and reproductive age (15-49)	STIs/HIV, family planning (including pre-marital, and preconception advice), **gender-based violence** Condom provision to men and women **Screenings**: **STI/RTI**, antenatal syphilis, **HIV**, HBV and HCV, breast cancer, **cervical cancer**, TB, malnutrition, genetic disorders Treatment of gestational hypertension and pre-eclampsia	Vaccination Any health consultation is an opportunity; special focus if urinary tract infection, prenuptial, antenatal or fertility advice, etc. University enrolment	% of men and women who have correct comprehensive knowledge of STIs/HIV prevention Proportion of women aged 15-49 who have undergone female genital mutilation or other form of GBV Incidence/prevalence of STI infections Prevalence of anaemia in pregnant women % of pregnant women who made at least 4 antenatal care visits in PHC Prevalence of post-abortion complications

Adolescence (10-19) and reproductive age (15-49)	**Post-abortion care** Variety of contraceptive methods available (short and long-term options including **injectables**), **emergency contraception** and **prevention of unsafe abortion** Smoking cessation Fertility (infertility diagnosis and risk screening for men and women)		% of women with unsafe abortion who have been properly managed Maternal mortality and morbidity ratios % of PHC facilities providing at least 3 modern family planning methods, including emergency contraception Contraceptive prevalence rate Rate of smoking cessation after confirmation of pregnancy % of patients who receive fertility services when requested
Adulthood	Counselling: STIs/ HIV, **gender-based violence** Condom provision to men and women **Screenings**: **STI/ RTI**, **HIV**, HBV and HCV, breast cancer, **cervical cancer**, prostate cancer, TB Perimenopausal and menopause care	Vaccination General consultations	Number of new HIV infections per 1,000 population Existence of policy on cervical and breast cancer screening Screening prevalence among utilizers % with mother to baby transmission % of newborns to infected mothers receiving proper management % of women who receive treatment of menopause-related symptoms when required

Throughout life cycle	Risk assessments (questionnaires or physical examination) Antiretroviral therapy and referrals **Health workforce training on SRHS including a clear referral network** Mental health screening and referral; psychosocial support Clinical management of rape as GBV.	Vaccination General consultation	Number of new HIV infections per 1,000 population Number of primary care physicians per 1,000 population % of health service delivery points providing necessary medical and psychological services for women with FGM % of cases of rape that receive clinical attention when needed

When going to a PHC unit for a general consultation, family planning, HIV, psycho-social support and other SRH-related services should be available at the same place, on the same day for:

- **The general population;**
- **Refugees and internally displaced persons;**
- **People living with HIV; and**
- **People with disabilities or mental health disorders.**

Once a consensus is reached, these services must be integrated within existing services and institutionalized in public policies and strategies for integration.

Monitoring and Evaluation

First, researchers must evaluate if the necessary actions (see page 5) for implementing the framework have been set. Qualitatively, the following conditions are to be verified:

At the policy level:

- A supportive political environment has been created.
- A budget has been allocated.
- The different stakeholders including the community are involved.

At the health system level:

- A SRH comprehensive package and delivery model has been decided.
- A training programs has been created.
- A supervising entity exists.
- There is a unified health information system.

At the service delivery level:

- There is awareness of the concept of integration of SRH in primary health care.
- Clear referral and follow-up processes have been established.
- Unified guidelines have been introduced.
- A regulation exists for the distribution of the health workforce.

At later stages, those conducting monitoring and evaluation will collect relevant data focusing on the implementation of suggested interventions at the policy, system and facility levels and outcome indicators. An integrative monitoring and evaluation strategy must be developed based on the SDG targets and may assess different areas as follows:

Inputs: % of government expenditure towards SRH; Number of PHC facilities with functioning basic SRH services; Number of trained PHC workforce in SRH services; Number of primary care physicians per 1,000 population; % of PHC facilities providing at least three modern family planning methods; Existence of a policy on cervical cancer screening; Existence of a policy on breast cancer screening.

Process: % of facilities providing integrated SRH services, including youth services; % of facilities with proper referral mechanisms.

Outputs: % of pregnant women who made at least four antenatal care visits in PHC; % of pregnant women attending PHC tested for antenatal syphilis, HIV, TB, malnutrition; % of women of reproductive age attending PHC tested for STI/RTIs, HIV, TB, malnutrition; % of pregnant women who received tetanus vaccination.

Outcomes: Contraceptive prevalence rate; % of live births with low birth weight; prevalence of anaemia in pregnant women; % of women reporting to have undergone

FGM disaggregated by age groups (only for: Djibouti, Egypt, Somalia, Sudan and Yemen); % of health service delivery points providing necessary medical and psychological services for women with FGM (only for: Djibouti, Egypt, Somalia, Sudan and Yemen); % of women aged 15–49 screened for cervical cancer during the past five years; % of young men and women aged 15–24 or "at risk" groups who have correct comprehensive knowledge of HIV prevention ; % of youth served with needed SRH services;

Impact: Maternal mortality ratio (MMR); adolescent birth rate; neonatal mortality rate; perinatal mortality rate; total fertility rate, etc.

Despite quantitative indicators, we must not forget that the final users should also have a voice in the monitoring of the service, especially regarding accessibility (affordability, comprehensiveness, cultural sensibility, closeness to home) and quality. For the latter, qualitative research could also be useful.

Operationalization to Implementation

Overall, no change will be possible and enduring without political support and commitment. Governments and stakeholders are in a privileged position to set priorities for guaranteeing the health of their populations. Once support and commitment are gained from high-level decision-makers, the following should be undertaken:

a) Undertaking a health needs assessment for SRH in all Arab States countries is needed (desktop exercise). Rawaf's Ten Steps for Health Needs Assessment is a simple and good guide to use:

   1. Profile your population.
   2. Measure the extent of use and misuse of drugs.
   3. Calculate the expected number of cases (incidence/prevalence).
   4. Collect and analyse routine data on service utilization (current and trends).
   5. Calculate the unmet needs or excessive service provision.
   6. Segment your population into different strata (population segmentation).
   7. Review the current evidence on the effectiveness of intervention(s).
   8. Measure your population's perceptions and expectations.
   9. Seek the opinions of professionals about the size of the problems, best practices and service delivery.
   10. Project the type and size of the action programs and services necessary to deal with the identified problems. (Rawaf S, Marshall F, 1999)

b) Determine the capacity of primary care in each of these countries, including doctors, nurses, midwives, social and community workers. Table 3 shows the projected number of family physicians required by 2030 per country based on three physicians per 10,000 population (Organization, Regional Committee for the Eastern Mediterranean Region Resolution. Scaling up family practice: progressing towards universal health coverage, 2016). An optimistic number is six physicians per 10,000, meaning a doubling of the projections in table 4. The countries are grouped based on population health outcomes, health system performance and level of health expenditure, as follows:

Group1) Countries with progressed socioeconomic development over the last four decades, supported by high income;

Group 2) Countries with extensive public health service delivery infrastructure but that face resource constraints, largely middle-income; and

Group 3) Countries with major constraints in improving population health outcomes due to insufficient resources for health, political instability, and conflicts.

Table 4: Density of family physicians per 1,000 populations in Arab countries (Organization, Regional Committee for the Eastern Mediterranean Region Resolution. Scaling up family practice: progressing towards universal health coverage, 2016)

Projection of family physician production to 2030 in group 1 countries

country	Annual physician (output (2015	Family physician working at Ministry of Health primary health (care facilities (2015	Family physician/ (10.000 (2015	Cumulative trained family physicians with current annual increase	Family physicians working at Ministry of Health primary health care facilities	Family physicians/ 10.000	Recommended increase/ year to reach 3 family physicians/ (%) 10.000	Cumulative trained family physicians with recommended (%)increase	Family physicians working at Ministry of Health primary health care facilities	Family physician/ 10.000
			With current annual increase by 2030				With recommended annual increase by 2030			
Bahrain	22	288	1.84	330	558	3.40	0	330	558	3.40
Kuwait	35	194	0.64	525	719	1.49	10	1223	1417	2.93
Oman	20	143	0.4	300	443	0.90	17	1313	1456	2.96
Qatar	12	139	0.64	180	319	1.16	15	657	796	2.88
Saudi Arabia	140	600	0.25	2100	2700	0.76	20	12.102	12.702	3.56
United Arab Emirattes	10	36	0.05	150	186	0.15	36	3767	3803	3.08
Subtotal	**239**	**1340**	**0.31**	**3585**	**4925**	**0.79**	**19**	**19.392**	**20.732**	**3.34**

Projection of family physician production to 2030 in group 2 countries

country	Annual physician (output (2015	Family physician working at Ministry of Health primary health (care facilities (2015	Family physician/ (10.000 (2015	cumulative trained family physicians with current annual increase	Family physicians working at Ministry of Health primary health care facilities	Family physicians/ 10.000	Recommended increase/ year to reach 3 family physicians/ (%) 10.000	cumulative trained family physicians with recommended (%)increase	Family physicians working at Ministry of Health primary health care facilities	Family physician/ 10.000
			With current annual increase by 2030				With recommended annual increase by 2030			
Egypt	180	256	0.05	2700	2956	0.29	29	35.701	35.957	3.51
Iran (Islamic (Republic of	810	0	0.10	12.150	12.150	1.33	10	28.309	28.309	3.10
Iraq	120	833	0.27	1800	2633	0.52	25	16.453	17.286	3.39
Jordan	35	221	0.33	525	746	0.80	19	260	2981	3.19
Lebanon	27	19	0.09	405	424	0.82	16	1618	1637	3.17
Libya	10	100	0.17	150	250	0.34	30	2175	2275	3.05
Morocco	50	0	0.01	750	750	0.19	31	11.921	11.921	3.04
Palestine	4	18	0.05	60	78	0.12	39	1977	1995	3.11
Syrian Arab Republic	20	201	0.10	300	501	0.17	38	9033	9234	3.08
Tunisia	80	150	0.20	1200	1350	1.07	13	3654	3804	3.03
Subtotal	**1336**	**1798**	**0.11**	**20.040**	**21.838**	**0.62**	**30**	**113.601**	**115.399**	**3.25**

Projection of family physician production to 2030 in group 3 countries

country	Annual physician output ((2015	Family physician working at Ministry of Health primary health care (facilities (2015	Family physician/ 10.000 ((2015	cumulative trained family physicians with current annual increase	Family physicians working at Ministry of Health primary health care facilities	Family physicians/ 10.000	Recommended increase/ year to reach 3 family (%) physicians/ 10.000	cumulative trained family physicians with recommended (%)increase	Family physicians working at Ministry of Health primary health care facilities	Family physician/ 10.000
			2030 With current annual increase by				With recommended annual increase by 2030			
Afghanistan	6	20	0.01	90	110	0.30	55	12.092	12.112	2.78
Djibouti	0	0	0.00	0	0	0.00	0	0	0	0.00
Pakistan	4	18	0.00	60	78	0.00	82	70.686	70.704	3.05
Somalia	0	0	0.00	0	0	0.00	0	0	0	0.00
Sudan	435	46	0.13	6525	6571	1.19	10	15203	15249	2.77
Yemen	0	3	0.00	0	3	0.00	0	0	3	0.00
Subtotal	**445**	**87**	**0.02**	**6675**	**6762**	**0.18**	**50**	**9.981**	**98.068**	**2.57**

c) Identify the best strategies to bridge the identified gaps (e.g., though resource shifting, capacity building, and retraining the current workforce) and the models of service delivery (e.g., integrated services; dedicated clinics within PC; evening clinics (access); and specialized additional resources).

d) Operationalize these strategies.

e) Define clear measurement and monitoring indicators:

- Monitoring and evaluation
- Possible scorecard

f) Costing and long-term benefits

The integration of SRH services in PHC has emerged as a necessary element in the provision of comprehensive health services to lower costs and improve outcomes (World Health Organization, 2008). Integrated health services will benefit both providers and patients. These benefits include:

- Improving the quality of the services;
- Reducing duplication and costs;
- Optimizing the use of resources; and
- Providing a more comprehensive health care (Warren CE, Mayhew SH, Hopkins J, 2017; Sweeney S, Obure C, Terris - Prestholt F, et al, 2014).

Moreover, the delivery of a well-planned service can improve uptake of SRH services, thus ensuring cost-effectiveness, efficiency, improved universal access to health care and financial sustainability (Warren CE, Mayhew SH, Hopkins J, 2017).

g) Public engagement and involvement: Governments need to take SRH issues seriously and invest enough resources to reach young people with the right messages and appropriate services.

Social marketing should include the following actions:

- Target health promotion messages appropriate to age and gender.
- Review school curricula to ensure that SRH is part and parcel of the learning process.
- Ensure services are accessible with choice and confidentiality.
- Engage young people in service development and planning.

h) Establishing a think tank

The purpose of a think tank is to bridge the gap between policy and practice. It should help develop independent, social policy that is informed by the public and practitioners – a balance between public engagement and direct influence.

Think tanks thrive on ideas. But, because of their independence, they need to be run well, from effective communication to management to fundraising. Their leaders should put energy where research does not traditionally put energy. Members should be versed in public policy, yet able to combine empirical and analytical skills. Successful think tanks are also built on member trust. Trust is the cornerstone of an independent, non-partisan and secular think tank.

An executive council whose members head each area of interest sets an internal, transparent, standard operating procedure of checks and balances, and it allows all members to remain loyal to the organization's principles and mission. Members must also bring with them good networks in their field of expertise.

- Articulate a results-driven mission.
- Focus on two to three policy issues.
- Begin with flexible money – but not too much.
- A think tank is its people; give great people freedom and responsibility.
- Need a big idea.
- Share ideas and leadership.
- Don't plan – be prepared to react to policy.
- Partner with people, not organizations.
- Ask tough questions.
- Keep the work dynamic, even fun, and celebrate successes.
- Good researchers are the backbone (a few senior associates with young and relatively inexpensive research assistants). Young researchers may not stay long but will work hard and are skilled in digital tools.
- Setting up a think tank takes time; expect to commit five years to make an impact.
- Publish an annual report.

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