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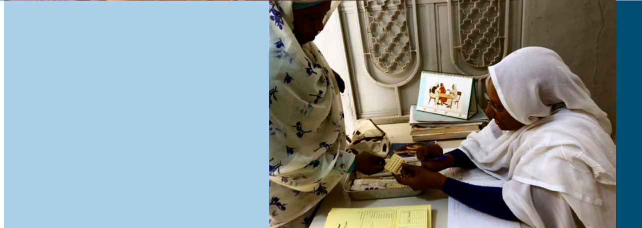
MIDDLE EAST AND NORTH AFRICA HEALTH POLICY FORUM

Integration of sexual and reproductive health services into primary health care in the Arab states region:

Assessment of eleven Arab countries



Policy Brief

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For decades, the Arab States have emphasized maternal health care, child health, and family planning in primary health care, reflecting the priorities governments have placed on these issues. Strategies or policies to guide the integration of a full package of sexual and reproductive health (SRH) services, including family planning and HIV/AIDS, have been largely absent. This brief uses assessments of the situation in 11 Arab countries to describe the challenges of integrating such care at the primary health care level, and it then makes recommendations for moving forward.

Defining integration

In many Arab countries, sexual and reproductive health programs such as family planning, maternal health care, and HIV/AIDS services are typically managed separately from the national health care system, and in many instances as semi-autonomous entities. Yet, for more than 20 years, the global health community has promoted universal access to integrated SRH services.[1,2] This service package should include family planning; maternal and newborn health care; clinical management of sexual and gender-based violence; post-abortion care; and prevention and management of HIV, other sexually transmitted infections, cancers of the reproductive system, and infertility.[3]

Integration refers to joining together different kinds of SRH and HIV/AIDS services or operational programs to offer more comprehensive services and improve outcomes.[4] It means that people seeking information or health care for a specific SRH concern can have their other needs met simultaneously—preferably at the same time, in the same location, or otherwise through referral.[5]

Integrated SRH services can have several benefits. Whereas vertical programs can be effective in delivering lifesaving interventions in countries with weak health systems, integrated care can be more efficient and can improve service utilization, especially when the different service components target the same population.[6,7] Linking HIV/AIDS-related and family planning services, for example, has been shown to improve health and behavioral outcomes in specific populations.[8] Integrating SRH services into the existing primary health care system also makes them more accessible to non-traditional users of family planning services, such as men and adolescents.[9]

Assessment of Arab countries

The Arab States Regional Office of the United Nations Population Fund (UNFPA ASRO), in partnership with the Middle East and North Africa Health Policy Forum (MENA HPF), undertook assessments of the readiness of health care systems in the region to integrate SRH services into the public sector at the primary health care level. The assessments were completed in 11 Arab countries over two phases. The first phase, in 2017, consisted of assessments in Egypt, Jordan, the Kingdom of Saudi Arabia (KSA), Morocco, Palestine and Sudan, and the second phase included Lebanon, Libya, Oman, Tunisia, and the United Arab Emirates (UAE), and was completed in 2018.[10]

This brief synthesizes the results of these country assessments. Consultants from each country reviewed reports from national and international organizations and interviewed individuals representing key stakeholders in the respective countries. Highlights of the regional synthesis reports—especially the common challenges faced by these diverse countries—are presented here.

Primary health care systems

The health care systems of the countries under review are characterized by their complexity, consisting of a mix of public, private and civil society providers. Whereas the private sector dominates in the UAE and Lebanon, the public sector plays a leading role in Egypt, Sudan, Libya and Tunisia. In Oman, the public sector provides all primary health care free of charge at public health facilities. Civil society organizations provide SRH services in Egypt, Jordan, Lebanon, Morocco, Palestine and Sudan. In addition, Egypt, Jordan and Lebanon have a large private health sector.

The governments of all 11 countries have made efforts towards achieving universal health coverage. Countries like Egypt, Libya and Tunisia have invested heavily in primary health care with the aim of attaining universal coverage. The UAE has introduced a mandatory scheme for private health insurance and is undertaking efforts to provide health care in the northern emirates, following the models of Dubai and Abu Dhabi. In Lebanon, nongovernmental organizations dominate service delivery, but the public sector has made reforms to regain its leadership position in the country's unregulated and fragmented health system.

Access to quality services is far from universal in the Arab region, however. The political unrest that has occurred since 2011 in several countries has worsened the disparities between the urban and rural populations in access to and use of health services, and between better-off and impoverished groups in urban areas. In Lebanon, humanitarian aid following the Syrian crisis has created a health subsystem that targets specific groups with specific health services, contributing to further fragmentation of the system.

Sexual and reproductive health programs

Sexual and reproductive health programs in the reviewed countries (all but Oman) are mainly delivered vertically—that is, as stand-alone, separately administered services—which have resulted in fragmented planning and implementation. The most common of these programs are maternal and newborn health, and family planning. In addition, these countries have national HIV/AIDS programs that have been conceived and implemented as vertical programs.

Antenatal, postnatal, neonatal and children's health care are the main SRH services within primary health care in the countries under review. Essential services required to complement and supplement an SRH service package, such as screening services for reproductive cancers and sexually transmitted infections, are available in primary health care facilities in eight countries. Services for preventing and responding to gender-based violence are offered at the primary health care level in just over 50% of the countries.

Integrated family planning and HIV/AIDs services

In most countries, integration of family planning within SRH care at the primary health care level is delivered within the SRH services already available (except for Libya), where only a form of counseling is provided, without provision of contraceptive methods. However, in many instances, not all age groups are included. Oman started its birth spacing program in 1994, and since then contraceptive methods have been available at primary health care centers. Services targeting gender-based violence are offered only in Tunisia and the UAE, and mainly through humanitarian aid programs in Lebanon.

The comprehensive integration of HIV/AIDS into SRH services at primary health care is variable among the countries that were reviewed. Morocco, Oman, Tunisia and UAE have integrated HIV services within the provided SRH services. In Egypt, the integration of HIV services into antenatal care provided at primary health care facilities was limited to some selected sites as part of a pilot project.

In terms of having a continuum of SRH service provision at the same primary health care delivery point, most of the integrated family planning or HIV services in Sudan, Morocco and Oman are provided within the same facilities, with minimum referral.

Funding and personnel for SRH

The public sector is responsible for primary health care in these countries, but funding is reported to be insufficient in most (all but Oman), as state budgets allocate more for curative services than for primary care. Some governments therefore rely on bilateral donors such as the European Union (EU), the World Bank, and other international agencies. The unsustainability of these funding sources poses a potential challenge to the strategic development of programs that support universal health coverage.

Most of the Arab countries face major human resources challenges related to the uneven distribution of personnel, shortages of nurses and midwives, and low competence of health care workers in SRH care. Additionally, the humanitarian crises in Libya and in Lebanon have created the need for a specific set of competencies, thereby making it harder to provide continuous education or capacity building tailored specifically for SRH.

Physicians provide SRH services in most countries under review particularly when it comes to family planning and HIV services. In Oman, family and community health workers also provide SRH services. In Tunisia, by contrast, midwives have an essential role as front-line health care providers that gives them the potential to extend their roles within community settings, providing much needed personalized care on issues that are often ignored. In Palestine, Saudi Arabia and Libya, midwives' responsibilities are limited to care during pregnancy, labor and postpartum. In others, there are efforts to establish or promote midwifery. At the time of the study, Jordan was enrolling its first cohort of midwifery students.

The Nursing and Midwifery Council in UAE and the Lebanese Order of Midwives (LOM) have also promoted the role of midwives in SRH. Since the LOM was established in 2014, the capacities of midwives have increased, particularly in family planning counseling, and their visibility in society has been enhanced. The production of this policy brief is

very timely in that it acknowledges the critical role that nurses and midwives play in improving the integration of SRH care into PHC, especially that the World Health Assembly has declared the year 2020 as the year of nurse and midwife.

Strategic challenges facing SRH integration

Absent unified vision

One of the most prominent challenges to integrating SRH services is the absence of a clear common vision regarding integration at the highest levels of health leadership, especially decision-makers at the ministries of health. Although a broad understanding and acceptance of the concept of integration exists, there is much confusion about how to operationalize it. The prevailing understanding has not been translated into a common vision built on consensus; nor has it spread through the hierarchies of operational and administrative staff, all the way to service providers. There is therefore a lack of political, technical and operational guidance for the integration processes. This also contributes to an environment in which sporadic integration efforts are made, without coordination and communication inside the health ministries, between ministries and with other concerned institutions.

Weak commitment and support

The lack of national policies or operational strategies on integration has led to a stalling of integration efforts. A consensus needs to be built that considers the adverse impacts on different sectors while proceeding with integration. However, some may perceive that integrating SRH services into the existing health systems raises concerns about wider health reforms, creating an additional layer of complication and fatigue due to the complexity of these reforms.

Insufficient financial support

Integration is a costly process and therefore is constrained by limited resources, weak national economies, low health spending in government budgets, accumulated debt, and dependence on external funding that has become intermittent, disrupted or discontinued.

Ineffective coordination mechanisms between different stakeholders

There are multiple players in the health system, sometimes with competing agendas, resulting in a duplication of efforts and other inefficiencies. Integration of SRH services requires combining separate supervisory systems in the same health ministry into one integrated system. The private sector and civil society organizations play large roles in providing SRH services in these countries, but little information is generated from these sectors for monitoring and evaluation.

Organizational and operational challenges

Multiplicity of governing authorities with vertical programming

The oversight, delivery, and follow-up of SRH services are often carried out by different entities within the same governmental body/ministry, or they are located in different ministries. These departments and entities plan separately for service delivery and compete for resources. Rather than considering opportunities for integration, each program operates independently.

Inadequate operational standards and technical guidance

Inadequate operational plans or frameworks to support service integration have prompted many partial efforts that lack uniformity and comprehensiveness. Furthermore, the need for evidence-based tools, training protocols, and clinical practice guidelines is mandatory to deliver a standard quality of integrated services.

Lack of autonomy

The highly centralized administration of health services in many of the countries under review has resulted in rigidity and inefficiency in responding to local and regional operational needs.

Low quality of services

Service coverage is often limited in rural, remote, and underdeveloped regions. In addition, access

may be further reduced by a lack of equipment, medicine, commodities, or human resources. Other problems include long waiting times and limited consultation periods. Interpersonal communication issues and the social stigma surrounding, for example, HIV/AIDS, can limit the quality of services provided and clients' satisfaction, especially for the populations most at risk. Other quality issues include a lack of continuity of care, weak referrals, and—more importantly—a lack of accountability mechanisms.

Shortage of qualified and motivated health care professionals

Health care providers are often distributed inequitably, with shortages of midwives, nurses, and specialty physicians, especially in rural or underdeveloped areas. In addition, health care providers in many under-resourced facilities suffer from work overload, which decreases their satisfaction and may increase their resistance to performing additional tasks relevant to the integration of SRH and HIV services. Poor working conditions can also drive qualified personnel to the private sector, thereby adding to the burden on the existing cadre.

Ineffective integration-specific training and service guidelines

Integrated SRH and HIV services require additional skills and competencies that much of the current workforce has not acquired, either because of deficient continuing education programs or because of the absence of integration-specific training. Insufficient training could lower the quality of integrated services or could deter integration efforts until the necessary changes occur.

Ineffective continuum of care, weak referral and follow-up

The weak linkages between the different departments that offer SRH services make it hard to support effective and efficient linkages and coordinated referral systems. This also requires strong, integrated information systems—which are generally lacking at present—to allow proper planning, monitoring and follow-up.

Opportunities for SRH integration

Despite these challenges, opportunities for SRH integration are available to all countries in the region, especially given recent reforms and the newly developed health strategies aiming to achieve universal health coverage. There are now windows of opportunity to prioritize and reposition SRH within primary health care while ensuring attention to quality, satisfaction, and acceptability of services. Health system reforms can create opportunities for better-integrated SRH services. Newly developed national strategies in some countries provide an opportunity for drafting operational plans and guidelines for integrated services. The new national agendas focusing on the Sustainable Development Goals (SDGs) also present opportunities to develop country-specific targets for which integration of SRH is considered necessary.

Several conditions in the region described below are conducive to integrated approaches to SRH care.

A wide network of primary care facilities

An expanding network of primary health care infrastructure and human resources presents an opportunity for integrating SRH and HIV services, provided that facilities can be rehabilitated and maintained. Egypt has a range of primary health care centers that are distributed widely across the country, allowing for full coverage. In Lebanon, the health system has been resilient in the face of many challenges and has adapted to change, sustained its services, and even expanded coverage. Currently, the country has a wide network of primary health care centers, and its Health Strategic Plan is committed to an integrated system in the public sector. Furthermore, in response to the Syrian refugee crisis, the Ministry of Public Health developed and implemented a near continuum of services through the cooperation of different service providers—public, private, and civil society. Such examples prove that complex services such as SRH, including HIV services, can be successfully integrated within primary health care centers.

Examples of national strategies and programmes integrating SRH and HIV/AIDS

Country	Strategies, plans, programs or guidelines
Egypt	• The new Health Insurance Act and Family Health Model • Pilot study on integration of prevention of mother-to-child transmission of HIV/AIDS and antenatal care
Jordan	• MoH: Inter-referral system within primary health care • UNRWA-Family Health Team
Oman	• All SRH components are integrated into primary health care activities; thus, utilization of both human and financial resources and infrastructure and supplies is optimized.
Morocco	• National Strategic Plan for HIV/AIDS • Family Health Model • National Plan to Reduce Maternal and Neonatal Mortality and Morbidity • National Reproductive Health Strategy
Palestine	• National Reproductive Health Strategy • Family Health Team
Saudi Arabia	• MoH Strategic Plan
Sudan	• National Health Strategy • SRH and HIV integration guidelines

(MoH = Ministry of Health; UNRWA = UN Relief Work Agency for Palestine Refugees in the Near East)

Increasingly positive attitudes towards SRH integration

Countries in the region have a growing record of advocacy for SRH. In Egypt, Ministry of Health and its partner agencies for decades have shown increasing acceptance of SRH, which has allowed the development of quality SRH programs, guidelines, and trainings. Similarly, the efforts of health authorities and women's organizations in the UAE are receiving more support, and while there are still challenges, there is now more acceptance within the government of the discussion of SRH policies and programs.

In Libya, national and international partners are increasingly active and there is growing work on SRH issues, which could create opportunities for advocacy and implementation of integrated SRH services. The country also has a new Reproductive, Maternal, Newborn, Child and Adolescent Health Strategic Plan for 2019–2023, providing the opportunity to introduce a comprehensive approach for SRH integration at the primary health care level.

Recent actions to address shortages in qualified personnel

In Lebanon, the Ministry of Public Health supports establishing a career path for nurses, and the training of new nurses at the Lebanese University. The anticipated increase in nurses should reduce the gaps between supply and demand for health care.

In Egypt, the new academic track in family medicine presents an opportunity to reposition reproductive, maternal, newborn, and child health as part of a broader SRH approach that includes HIV prevention and treatment. The resulting changes have significantly improved service quality.

Recommendations

Integrating programs can be difficult, but it has to be seen as an investments which is necessary in order to improve the efficiency and quality of services. The following recommendations address the challenges and build on the opportunities identified in the country assessments:

At the policy level

- Develop/contextualize and apply a unified definition of the package of SRH and HIV services based on human rights, transparency, accessibility, and sustainability. Such a defi-

nition would ensure that all relevant policies, strategies, and operational plans—including trainings and service protocols—are guided by the same vision and geared towards the same objectives.

- Advocate for and ensure stronger political commitment and good governance with respect to integrated service delivery. Evidence-based practices and lessons learned at the national and regional levels are vital sources of information that could show the potential positive effects of integrating services at the primary health care level, and could be used for advocacy, networking, and planning. Evidence should also be used to make the case that SRH is central for development efforts and for achieving the Sustainable Development Goals.

- Develop or reform national policies, strategies, and operational plans based on the following concepts:
  - Services that are client-centered and protect and fulfill human rights.
  - Evidence-based service approaches adapted to the national and local contexts.
  - A continuum of care across primary health care and in existing programs; for example, maternal and child health programs, national AIDS programs, and family planning.
  - Emphasis on reaching vulnerable and hard-to-reach groups with the aim of reducing health disparities.
  - Emphasis on quality of care.
  - Development and use of national-level indicators—with subnational disaggregation—for SRH integration and accurate data collection mechanisms.
  - Compliance with international health regulations and the Sustainable Development Goals.

- Strengthen coordination and accountability-mechanisms within and between sectors to facilitate information-sharing, follow-up, and evaluation, and to reduce waste due to misallocation of resources and duplication of services. Because the incentives for coordination are often lacking and competition for resources is pervasive, the involvement of civil society in observational bodies or as part of societal dialogue are potential options.

- Increase partnerships and improve collaboration among different stakeholders: public and private sectors, international organizations and agencies, community-based organizations and citizens. Stronger alliances could bolster efforts to obtain funding, mobilize resources, improve accountability, and maximize reach to vulnerable groups.

At the organizational and operational levels

- Develop unified, coordinated health information systems using electronic records and providing the necessary infrastructure and training for data management. These information systems would provide the data required for needs assessment, follow-up, evaluation, and forecasting of future resource needs. A major motivational campaign will be needed to educate health providers about the importance of this exercise, and data must also be disseminated to the public at large.

- Shift from physician-centric care and assign more responsibilities to qualified midwives, nurses, social workers, and counselors. Such task shifting requires new job descriptions, specialized professional training, and university education programs to develop a professional cadre whose training is based on the defined SRH and HIV services package. Well-trained midwives have also proven effective in providing SRH care in the region. Market-responsive education, and training programs should be introduced.

- Develop SRH and HIV integration-related training curricula that aim to increase health care providers' skills, competencies, positive attitudes, respect, and empathy with special attention to the needs of younger populations.

- Ensure availability of essential commodities, equipment and medicines. Promote essential drug lists that include low-cost and effective products, such as contraceptives, rather than higher cost pharmaceuticals.

Political commitment has proven to be a key factor in the countries that have already integrated SRH

into primary health care, and it will be key to creating the enabling environment to achieve successful and sustainable integration elsewhere. It could be the driving force to prioritize SRH integration and to develop relevant policies, provide guidance, and establish partnerships among various stakeholders. The commitment to universal and integrated SRH care must come not only from health ministries, however. Economic, finance, and other development-related agencies must also be brought on board to support these services as essential to attaining the nation's social and economic development goals.

Synthesis and drafting:

Lori Ashford (independent consultant).
Dr. Maha El Rabbat (MENA HPF).

Review:

Dr. Shible Sahbani (UNFPA/ASRO).

Dr. Mohamed Afifi (UNFPA/ASRO).

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