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Assessment of Sexual and Reproductive Health Services Integration in Selected Arab Countries: Phase II

Regional Report

منتدى السياسات الصحية في الشرق الأوسط وشمال افريقيا
MIDDLE EAST AND NORTH AFRICA HEALTH POLICY FORUM

UNFPA
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PREFACE

In this report, the United Nations Population Fund (UNFPA) Arab States Regional Office (ASRO) and its collaborative partner, the Middle East and North Africa Health Policy Forum (MENA HPF) build on the sexual and reproductive health (SRH) integration assessment tool that was – developed by both partners - and used for a similar analysis in 2017 in six Arab countries. This year, five more countries are added to the initiative and it is intended to provide policymakers and stakeholders in the Arab states with insight about the current status of integration of SRH in primary health care services as a priority for the achievement of SRH –SDGs. The outcome of the expanded analysis will inform the development of an integration-enhancing framework that will optimistically be adopted by the different countries to advance SRH integration into PHC at the national and sub-national levels.

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ACRONYMS AND ABBREVIATIONS

BEmONC	Basic emergency obstetric and newborn care
CEmONC	Comprehensive emergency obstetric and newborn care
CSO	Civil society organization
HIV/AIDS	Human Immunodeficiency virus/acquired immunodeficiency syndrome
ICPD	International Conference on Population and Development
IUD	Intrauterine device
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MoPH	Ministry of Public Health
MOSA	Ministry of Social Affairs
NGO	Non-governmental organization
PHC	Primary health care
PHCUs	Primary Health Care Units
PMTCT	Prevention of mother-to-child transmission of HIV/AIDS
RH	Reproductive Health
RMNCH	Reproductive Maternal Neonatal Child Health
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
STI	Sexually transmittable infections
TB	Tuberculoses
UAE	United Arab Emirates
UN	United Nations
UNFPA	United Nations Population Fund

EXECUTIVE SUMMARY

Under a partnership agreement with United Nations Population Fund /Arab States Regional Office (UNFPA/ASRO) and the Middle East North Africa Health Policy Forum (MENA HPF) has engaged in preparing a comprehensive overview of the situation of Sexual and Reproductive Health (SRH) integration in primary health care systems in Arab countries. An earlier assessment of the situation of SRH integration in six selected Arab countries (Egypt, Morocco, Kingdom of Saudi Arabia, Palestine, Sudan and Jordan) revealed the absence of organized and strategic approaches for integrative models and the dominance of vertical programs. This current analysis complements that first assessment presenting the situation of SRH integration in five other Arab countries, namely Tunisia, Lebanon, United Arab Emirates (UAE), Libya and Oman. These five countries differ substantially in terms of infrastructure for health, policy and health system focus and management. In other words, the report describes five different systems and will endeavor to identify common positive and negative points which could benefit from a regional or multi-country analysis and policy recommendations. It should be noted that Lebanon and Libya, have witnessed additional challenges due to humanitarian crisis. This is reflected in a decreased capacity to address the needs of the people today.

The analysis reveals that data on SRH outcomes and health care system indicators as well as on workforce distribution is largely missing in these countries. The available information indicates the absence of integrative models for SRH service delivery in the primary health care systems in four countries out of the five reviewed.

The health care systems in these countries are characterized by centralization, fragmentation and inequities in access. Some also have a dominant private sector with limited jurisdiction of the state over private facilities. This situation is exacerbated by political unrest and the refugee crisis in the region. Vertical family planning and safe motherhood programs have historically improved health outcomes in Tunisia. All five countries have National AIDS Programs and following ICPD 1994, SRH components such as screening for reproductive cancers and for STIs were included in primary health care services in Lebanon, Oman and Tunisia. Family planning services are highly deficient in Libya and UAE following cultural and social norms favoring large families.

In terms of SRH indicators, contraceptive prevalence is low in Libya where a substantial proportion of the population has reported unmet needs as well as preference for larger families. Similar low levels of contraceptive prevalence are found in Oman. All five countries have successfully reduced their maternal mortality rates, although the rate remains relatively high in Tunisia despite concentrated efforts spent during the last decades. Maternal health services are provided at the primary health care level in the five countries, however Libya suffers from misdistribution of obstetric care facilities for childbirth mainly in rural areas. Libya is also the only country among the five not pro-

viding family planning services at the primary health care level and Tunisia is the only one with the full range of abortion services provided at PHCUs (Primary Health Care Units) given the fact that it is the only Arab country that has legalized abortion since 1973.

Data on contraceptive methods are only available from Tunisia and the UAE. Whereas oral contraceptive pills, IUDs, injectables and male condoms are offered in primary health care centers in Tunisia, there are deficiencies in the availability of the emergency contraceptive pill. This latter is also banned in the UAE. Tunisia and Oman provide HIV/AIDS-related services at the PHC level. Only Libya and Tunisia reported having a minimum guaranteed benefits package for reproductive, family planning, maternal and newborn health.

Libya, Oman and Tunisia, although substantially different in terms of structures and policies, have a stronger public health system than what is found to function in Lebanon and the UAE. NGOs are main stakeholders in the delivery of PHC in Lebanon. Funding for PHC is not substantial in these countries and state budgets are mainly allocated for curative services rather than for the PHC system. With the exception of Oman, there is heavy reliance on bilateral funding. The care is delivered through physicians in all these countries except in Tunisia where midwives have an essential role both at the facility and community levels in the provision of SRH services.

HIV/AIDS services such as counselling are provided through family planning, abortion/post-abortion care and maternal health services in Tunisia and UAE. There are also different modalities of offering services, ranging from referral to a different facility as in Libya, to referral to a different health care provider within the same facility as in Tunisia and the UAE.

A number of challenges are identified at the strategic level such as limited political commitment and integration strategies and policies as well as non-sustainable financing approaches and lack of coordination between stakeholders. At the organizational level, challenges pertain to the multiplicity of vertical programs, lack of operational guidelines and centralization of services. At the operations level, these are summarized in deficiencies in quality of care, shortage in the workforce and absence of capacity building opportunities. Despite these challenges, some opportunities are discussed. These pertain to the use of PHC networks, building on the efforts for change based on global agendas and some local efforts for capacity building of the health care workforce. Some specific recommendations are made to address these challenges and use the identified opportunities.

I. BACKGROUND

Reproductive health programs, including family planning and HIV/AIDS, are typically delivered vertically and in many instances as semi-autonomous entities parallel to the national health care systems in Arab countries. An earlier assessment of the extent of integration of Sexual Reproductive Health (SRH) services within the primary health care system in six selected Arab countries point to the absence of an integrative approach in these settings (UNFPA ASRO/ MENA HPF 2017). In contrast, some Arab countries such as Egypt, Morocco and Tunisia, have established and maintained strong vertical family planning and/or safe motherhood programs that have effectively improved the reproductive health outcomes of their populations.

Following the ICDP 1994 program of action, a global call to provide integrated SRH services through the primary health care systems was made (UN 1994). Many Arab countries have undergone some forms of health care system reforms to assimilate global trends, however many of these countries face challenges related to political unrest, armed conflict, influx of refugees and competing resources, which impede the implementation of global SRH agendas. The current Sustainable Development Goals (SDGs) global agenda prioritizes universal health coverage and highlights the important role of primary health care. A specific objective under SDG 3 addresses universal health coverage for sexual and reproductive health care services and the integration of these services into national strategies and programs (UN 2015). Recent strategies and programs in Arab countries are mostly in line with this global agenda.

Essential packages for integrated SRH services need to consider the integration of family planning services into maternal and newborn health care and the integration of prevention and treatment of STI, RTI and HIV/AIDS into primary health care (UNFPA, Population Council 2010). Integration is defined as "the 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). Therefore, there could be several models for integration where all SRH services are not necessarily provided together however, these would be accessible through effective referral systems. Integration therefore could be looked at as a continuum ranging from a fully integrated system to integration of different SRH components to varying levels (Atun et al 2010).

The implementation modalities of large integration programs are not well studied and might create threats for health systems, especially those functioning within fragile environments. It is usually easier to perform integration of front-line services; however, these might be ineffective without the necessary changes in policies, financing mechanisms, management structures and the necessary capacity building

of health care providers. The integration process therefore needs to be supported by adequate provision of human, financial and material resources with much considerations given to the social and cultural norms of the context (WHO 2006).

There are a number of benefits attributed to a system of integrated SRH services. Whereas in contexts of weak health care systems, vertical programs are effective in improving access to lifesaving interventions, integrated models of care are believed to be more efficient (Dudley and Garner 2011). In general, it is argued that integration of SRH will improve utilization of services especially when the target population of the different integrated components of the service are the same (Berer, 2003). In this regard, linking HIV/AIDS related and family planning services has shown to improve health and behavioral outcomes in specific populations (WHO, UNFPA, UNAIDS, IPPF, UCSF 2009). The integration of 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 (Warren et al 2017). In general, there is scarce evidence on the effectiveness of SRH integrated models of care in improving health outcomes (Dudley and Garner 2011) and in the effective implementation of such models that can strengthen the primary health care systems in different contexts (Briggs and Garner 2006).

The various health care systems in Arab countries are a reflection of the diverse income levels and socio-cultural context characterizing these countries. Given some minor efforts in endorsing and implementing integration agendas in SRH services in these countries, it is important to have a comprehensive analysis of the situation and draw recommendations that can be used for shaping policies and practices for integrative models of SRH services in the region.

II. CURRENT REPORT

For the conceptualization and the implementation of this analysis, UNFPA/ASRO has partnered with the MENA Health Policy Forum, a regional think tank and policy research hub that aims to provide evidence-based solutions, create and support dialogue at the national and regional levels. This resulted in the development of a process for the preparation of comprehensive overview of the situation of SRH integration in primary health care systems in Arab countries. The first assessments were conducted in 2017 focusing on six Arab countries: Egypt, Jordan, Kingdom of Saudi Arabia, Morocco, Palestine and Sudan. A regional report was prepared presenting the information gathered from the six countries and building on reported experiences to draw recommendations. This current report presents the result of the second phase of assessments conducted in five other Arab countries, namely: Lebanon, Libya, Tunisia, Oman and the United Arab Emirates (UAE).

This report aims at describing the health care system status of integrating SRH services, specifically family planning and HIV/AIDS related services, into the public health care system at the primary health care level in these five countries. The specific objectives are:

1. To assess the gaps in the delivery of SRH, family planning and HIV/AIDS service packages in PHC services.
2. To assess the implications of national health care policies in facilitating or hindering the integration of SRH and HIV/AIDS services within PHC systems.
3. To identify efforts, strategies and opportunities for the provision of integrated SRH and HIV/AIDS services.
4. To identify the challenges for the provision of integrated SRH and HIV/AIDS services within PHC systems.

Assessments were conducted in each of the five selected countries based on guidance documents for assessment and reporting developed during the first phase of this analysis. Country consultants reviewed national reports published by governmental, UN agencies or NGOs in addition to conducting interviews with targeted key informants representing stakeholders in their respective countries. Findings and recommendations were presented in country reports based on triangulation of data.

This regional report synthesizes the information from the five country reports and draws recommendations relevant at the regional level. It does not aim at providing an evaluation of the impact of integration on health outcomes in these countries nor it assesses the quality of care. The report aims at presenting a situation analysis of the current status of SRH services in these countries, identifying opportunities in each context and drawing relevant recommendations. This report was presented and discussed during a regional meeting organized by the UNFPA Arab States Regional Office/ MENA Health Policy Forum before finalization.

III. CURRENT SITUATION IN THE SELECTED COUNTRIES

1. The primary health care system in the selected countries

The health care systems of the five selected Arab countries consist of a mix of public and private sectors with varying levels of dominance of one sector over the other in each country. Whereas fragmented health care systems with a dominant private sector is characteristic of the systems of UAE and Lebanon, the public sector plays a leading role in Libya, Oman and Tunisia. The provision of primary health care therefore through the central government or the district health authorities is the norm in Oman, Libya and Tunisia whereas the non-governmental organizations are major partners of the Ministry of Public Health in Lebanon in the provision of health through primary health care centers.

Investments in establishing and providing primary health care started since the 1980s in Libya and Tunisia and the 1990's in Oman, with the aim of reaching universal health coverage. Historically, vertical maternal and child health as well as family planning programs were developed over time. In addition to introducing a mandatory private health insurance scheme, the UAE is currently undertaking efforts to provide health care for its populations in the northern emirates following the models in Dubai and Abu Dhabi. The public sector in Lebanon has undergone series of reforms during the last decade and is aspiring to regain its leadership position within the fragmented health care system in the country. The Lebanese Ministry of Public Health has invested largely in programs aiming for the health coverage of vulnerable groups having universal health coverage as the main objective of the national health strategy. In Oman, high level strategic planning has served in establishing a network of 184 primary health care centers in the country where reproductive health care services are provided.

Political unrest since 2011 in Libya and Tunisia worsened the existing social disparities in access and use of health care services, something that has created inequities between the urban and rural populations as well as urban poverty pockets. In Lebanon, the humanitarian aid in the form of health care following the Syrian crisis has created a sub-health system targeting specific groups of the population with specific health care packages and thus contributed to the further fragmentation of the system.

Despite challenges faced by fragmentation, centralization and inequitable access to services, there is recognition of the importance of integrated approaches in the delivery of primary health care and some efforts are put towards universal health coverage in all countries considered in this report.

2. Overview of the sexual reproductive health programs in the selected countries

SRH programs in these five countries are delivered vertically and there is high level of fragmentation in terms of planning and implementation. These vertical programs and initiatives mostly target maternal neonatal health and family planning. All five countries have national HIV/AIDS programs since the mid or late 1980s-1990s that are also conceived and implemented as vertical programs. Oman has been successful in integrating SRH services within the maternal and child health programs of primary health care centers throughout the country.

There has been concentrated efforts throughout the last decades to reduce maternal mortality in these countries, demonstrated for example by the establishment of national perinatal program in Tunisia and the national maternal neonatal mortality committee in Lebanon that entails mandatory reporting from hospitals and conducts detailed analysis of the reported cases. In this regard, the public health care systems in the four countries focus invariably on antenatal and postnatal care.

Following the ICPD in 1994 and the new focus on Reproductive Health, components related to reproductive cancers, youth friendly services, STI/HIV/AIDS prevention and management were introduced within the maternal neonatal and family planning packages at the primary health care level in Tunisia and Oman. Similar efforts were done in Lebanon through a number of reproductive health programs introduced by UN agencies with partnership with MoPH and implemented through the Lebanese PHC network. Lately in response to the humanitarian crisis and influx of refugees in the country, programs and services addressing gender based violence are introduced through programs sponsored by UN agencies. Despite their abundance, these programs are implemented with minimal or no coordination between the different agencies thus creating further fragmentation in the system rather than contributing towards integration.

Tunisia has a strong family planning program established since the 1960s and strengthened through the legalization of abortion since 1973. In contrast, family planning services are highly deficient in Libya and UAE due to the absence of prioritization of the issue by subsequent governments. Although family planning is provided through antenatal care and premarital screening packages in the UAE, there are major deficiencies in the commodities supported by lack of social norms and population policies favoring the use of contraception.

The lately developed Reproductive Maternal Neonatal Child health (RMNCAH) strategy (2019-2023) in Libya and the proposed Strategic Development Plan in Tunisia can provide opportunities for the design and implementation of tailored approaches for the delivery of integrated SRH within the primary health care systems in these countries.

3. Sexual and reproductive health indicators

There is limited data on basic indicators for family planning available from Lebanon and UAE due to the lack of national statistics or recent national large scale surveys in these countries. Based on the available data shown in Table 1, the highest fertility rate among the five

countries is observed in Libya (3.4), followed by Oman (2.6), Tunisia (2.1), and with similar below replacement level rates in UAE and Lebanon (1.7). The contraceptive prevalence rate is highest in Tunisia (62.5%) followed by Lebanon, UAE and Oman. The reported contraceptive prevalence rate from Libya is quite low (27.7%) with also a substantial percentage of unmet needs (40.2%) pointing to the lack of family planning programs or provision of integrated services within the health care system of the country. This is paralleled with a considerable proportion (35.4%) of the population reporting desire for more children something that highlights social preferences for large families. Although contraceptive prevalence is low in Oman (24.4%), the reported unmet need from one study is also low (25%).[1]

Tunisia is the only country among the five having information on the types of contraceptive methods used among its population. IUDs, pills and traditional methods seem to be the prevalent methods used in the country (Table 1).

Table 2 describes the maternal and newborn health indicators in the five countries. Oman, Libya, UAE and Lebanon have low maternal mortality rates as a result of concentrated national efforts to improve antenatal coverage and skilled birth attendants in these countries. Despite the 35% reduction achieved between 1994 and 2010, Tunisia's MMR is still at 62 maternal deaths per 100,000 livebirths. This stabilization in the maternal mortality rate comes as a result of the wide regional disparities in service infrastructure despite of national efforts aiming for further improvements. Antenatal coverage is universal in Lebanon, Oman, Tunisia and the UAE, however it is reported to amount to only 66.3% in Libya. In Lebanon, the high rates of antenatal care use among the Lebanese is not mirrored by the situation among Syrian refugees. All five countries however have achieved excellent coverage of skilled attendance at birth.

No data is reported on HIV/AIDS prevalence among pregnant women from all five countries (Table 3). The prevalence of syphilis is reported to be very low (1.6%) and knowledge of HIV/AIDS-related prevention practices is 70% in Libya.

1 Data extracted from country reports in 2018 and referenced in Table 1.

Table 1: Selected demographic and family planning indicators in the five countries

Indicator	Lebanon	Libya	Tunisia	UAE	Oman
Total Fertility Rate (TFR)	1.7[1]	3.4[2]	2.1[3]	1.7[4]	2.6[11]
Contraceptive Prevalence Rate (CPR)	53.6%[5]	27.7%[2]	64.4%[3]	48.1%[6]	24.4%[11]
Prevalence of Infertility in Women	-	7.4%[7]	15%[8]	3.8%[9*]	0.81%[11]
Unmet need for family planning	-	40.2%[2]	10.5%[10]	-	25%[12]
Unintended births	-	-		-	-
Desire for additional children	-	35.4%[2]	-	-	-
Method mix	-			-	-
IUD	-	-	27%[10]	-	-
Pills	-	8.2%[2]	20.3%[10]	-	-
Injectables	-	-	1.1%[10]	-	-
F.Sterilization	-	-	3.3%[10]	-	-
Withdrawal	-	-	0.5%[10]	-	-
Condom	-	-	1.25[10]	-	-
Traditional methods	-	-	12.5%[10]	-	-
Breastfeeding	-	-	-	-	-
Others	-	-	11%[10**]	-	-

1. World Bank Open Data 2016
2. PAPFAM 2014
3. MICS 4 2011-2012
4. World Bank Open Data 2016
5. United Nations 2016 UNFPA, UNPD, MDG database http://unstats.un.org
6. UN DESA Contraceptive Global Trends 2015
7. PAPFAM 2007
8. According to MH-ONFP Data 15% of couples had infertility
9. Mascarenhas MN, Flaxman SR, Boerma T, Vanderpoel S, Stevens GA (2012) National, Regional, and Global Trends in Infertility Prevalence Since 1990: A Systematic Analysis of 277 Health Surveys. PLOS Medicine 9(12): e1001356. https://doi.org/10.1371/journal.pmed.1001356 **Estimates of primary infertility among women aged 20-44 yrs is 2%. Secondary infertility is estimated at 1.8% among same age group*
10. UN DESA Contraceptive Global Trends 2015. ***Calculated from estimates of using implants, diaphragms, periodic abstention, and others*
11. Sultanate of Oman, Department of Health Information and Statistics, 2018
12. Al Riyami A, Afifi M, Mabry RM. (2004) Women's Autonomy, Education and Employment in Oman and their Influence on Contraceptive Use. *Reproductive Health Matters,* 12**,** 144-154.

Table 2: Maternal and newborn health indicators

Indicator	Lebanon	Libya	Tunisia	UAE	Oman
Maternal Mortality Ratio (MMR)	15[11]	9[12]	62[13]	6[14]	20.2[24]
Antenatal care coverage	96%[15]	66.3%[16]	85.1%[17]	100%[18]	99.6%[24]
Percent of births attended by skilled health personnel	98%[19]	98.9%[12]	98.6%[17]	100% [18]	99.1%[24]
Availability of basic essential obstetric care	-	52.6[20]	-	-	-
Availability of comprehensive essential obstetric care	-	44.3[20]	-	-	-
Prevalence of anemia in women	-	28.4%[21]	36.7%[21]	28%[22]	26.8%[24]
Perinatal Mortality Rate (PMR)	-	-	-	-	-
Low birth weight prevalence	-	6.7[23]	6.9[17]	-	-

11. WHO 2015-2017
12. UN IGME 2015
13. WHO Global Observatory 2015
14. WHO Global Observatory 2015
15. UNICEF global database/ PAPFAM 2004
16. PAPFAM 2014
17. MICS 4 2011/2012
18. WHO Global Observatory 2015
19. UNICEF global database/PAPCHILD 1996
20. SARA 2 2017
21. World Bank 2016
22. World Bank 2016
23. BSC Vital Statistics Annual Report 2011
24. Sultanate of Oman, Department of Health information and Statistics, Ministry of Health, 2017.

Table 3: HIV/AIDS, STI and other indicators

Indicator	Lebanon	Libya	Tunisia	UAE	Oman
Positive syphilis serology prevalence in pregnant women	-	1.6[24]	-	0.1[25]	-
Reported incidence of urethritis in men	-	-	-	-	1/10,000[27]
HIV/AIDS prevalence among pregnant women	-	-	-	-	0[27]
Knowledge of HIV/AIDS-related prevention practices	-	70%[26]	-	-	90%[28]

24. PAPFAM 2014
25. WHO Global Observatory 2017
26. PAPFAM 2007
27. Sultanate of Oman, Department of Information and Statistics, 2017
28. Al-Jabri AA et al (2014) Knowledge, attitudes and intended behaviours towards HIV/AIDS testing and self-protection: a survey of Omani pregnant women. *Eastern Mediterranean health journal* 20**,** 614.

4. Essential SRH services offered at the PHC facilities

Antenatal, postnatal, newborn and child health services are provided at the primary health care level in the five countries. Libya is the only country among the five that does not provide family planning services at all primary health care level facilities (Table 4). Only few of these centers in Libya offer a restricted range of contraceptives and family planning counseling aimed specifically towards birth spacing. Also in Libya, 17 primary health care facilities in remote areas conduct vaginal deliveries and only one of them offers Basic Emergency Obstetric Care (BEmONC). Childbirth takes place in hospitals in Lebanon, Tunisia, Oman and the UAE. Many of the secondary level facilities in these countries provide BEmONC and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) services.

Tunisia is the only Arab country having legalized abortion since 1973. Access to abortion services is provided free of charge in public facilities in the country. Recent reports indicate changes in providers' attitudes leading to denial of access to safe abortion services as a consequence of lack of clear government commitment and a socio cultural transition with the political changing environment in the country. Services targeting prevention of unsafe abortion and post-abortion care are provided at the primary health care level in Oman and UAE but not in Libya and Lebanon. STI and reproductive cancer screening services are available in primary health care facilities in Lebanon, Oman and UAE. Services targeting gender based violence are offered at the primary health care level in Tunisia and UAE and mainly through humanitarian aid programs in Lebanon (Table 4).

a. Status of the family planning services offered at the PHC facilities

Data on family planning commodities is available from Tunisia, Oman and the UAE (Table 5). Family planning services offered at the PHC level include counselling, education and provision of contraceptives. Emergency contraception is approved for use in the public sector in Tunisia but not promoted. It is worth mentioning that the emergency contraceptive pill is banned in the UAE but offered in Oman.

b. Status of HIV/AIDS-related services offered at PHC facilities

Tunisia, Oman and Lebanon report on the provision of HIV/AIDS-related services at the PHC level. The package offered includes HIV/AIDS counselling and testing, TB screening, STI screening, diagnosis and treatment, condom provision and provision of information on HIV/AIDS prevention to the general population.

c. The minimum benefits package for reproductive, family planning, maternal and newborn health services

Libya and Tunisia reported having a minimum guaranteed benefits package for reproductive, family planning, maternal and newborn health. Family planning services are deficient in the care package reported by Libya. Oman does not have a specific minimum benefits package however its components are offered at the primary health care level (Table 6).

Table 4: Essential SRH services offered at PHC facilities

Services	Lebanon	Libya	Tunisia	UAE	Oman
Family planning	✓	-	✓	✓	✓
Antenatal care	✓	✓	✓	✓	✓
Labor and delivery	-	✓	-		
Postnatal care	✓	✓	✓	✓	✓
Newborn and child health	✓	✓	✓	✓	✓
Prevention of unsafe abortion and post-abortion care	-	-	✓[27]	✓	✓
Emergency contraception	-	-	✓[28]		
STI/RTI screening, diagnosis and treatment	✓	-	✓	✓	✓
Cervical cancer screening	✓	-	✓[28]	✓	✓
Breast cancer screening	✓	-	✓[28]	✓	✓
Prevention and management of gender-based violence	✓[29]	-	✓	✓	

27. Medical abortion, Cervical and Breast cancer screening services are available in ONFP centers
28. Available but not promoted
29. Programs funded through Humanitarian Aid Agency

© UNFPA Morocco

Table 5: Status of family planning services offered at PHC facilities

	Lebanon	Libya	Tunisia	UAE	Oman
Family planning services offered at PHC facilities					
Contraception provision	-	-	✓	✓	✓
Counselling	-	✓	✓	✓	✓
Health education	-	-	✓	✓	✓
Emergency contraception	-	-	✓[30]	-	✓
Other, Specify:	-	-	✓[31]	-	
Family planning methods offered at PHC facilities					
Oral contraceptive pills	-	-	✓	✓	-
Implants	-	-	✓	-	-
Injectables	-	-	✓	-	-
IUD	-	-	✓	✓	-
Male condom	-	-	✓	✓	-
Female condom	-	-	-	✓	-
Male sterilization	-	-	-	-	-
Female sterilization	-	-	-	-	-
Emergency contraceptive pill	-	-	✓[32]	✓	-
Diaphragm	-	-	-	-	-
Foam/jel	-	-	✓[33]	✓	-
Cycle beads	-	-	✓	-	-
LAM counseling	-	-	✓	✓	-
Other, specify:	-	-	-	-	-
Family planning methods that suffer mostly from supply delays or lack of resources to ensure availability					
Oral contraceptive pills	-	-	✓	-	-
Implants	-	-	✓	-	-
Injectables	-	-	-	-	-
IUD	-	-	✓	-	-
Male condom	-	-	✓	-	-
Female condom	-	-		-	-
Male sterilization	-	-		-	-
Female sterilization	-	-		-	-
Emergency contraceptive pill	-	-	✓	-	-
Diaphragm	-	-		-	-
Foam/jell	-	-		-	-

30. Theoretically available but not in practice
31. Abortion, gender-based violence and , youth friendly services are available in specific facilities of ONFP
32. Available but not promoted
33. Spermicides

Table 6: Status of the minimum benefits package for SRH services.

	Lebanon	Libya	Tunisia	UAE	Oman
Does your country have a minimum guaranteed benefits package for SRH?	NO	YES	YES	NO	NO
Core pre-pregnancy interventions included in the minimum guaranteed benefits package					
Family planning (advice, hormonal and barrier methods)		-	✓		
Family planning (surgical methods)		-	✓		
Prevention and management of sexually transmitted infections and HIV/AIDS		-	✓		
Folic acid fortification/ supplementation to prevent neural tube defects		✓	✓		
Core antenatal interventions included in the minimum guaranteed benefits package					
Iron and folic acid supplementation		✓	✓		
Tetanus vaccination		-	✓		
Prevention and management of sexually transmitted infections and HIV/AIDS, including with antiretroviral medicines		✓	✓[30]		
Calcium supplementation to prevent hypertension (high blood pressure)		✓	✓		
Interventions for cessation of smoking		-	✓		
Screening for and treatment of syphilis		-	✓		
Low dose aspirin to prevent pre-eclampsia		✓	✓		
Antihypertensive drugs (to treat high blood pressure)		✓	✓		
Magnesium sulphate for eclampsia		-	✓		
Antibiotics for preterm prelabour rupture of membranes		✓	✓		
Corticosteroids to prevent respiratory distress syndrome in preterm babies		✓	✓		
Safe abortion (in certain conditions)		-	✓		
Post abortion care		✓	✓		
Reduce malpresentation at term with External Cephalic Version		-	✓		
Induction of labour to manage prelabour rupture of membranes at term (initiate labour)		✓	✓		

	Lebanon	Libya	Tunisia	UAE	Oman
Core childbirth interventions included in the minimum guaranteed benefits package					
Prophylactic uterotonics to prevent postpartum haemorrhage (excessive bleeding after birth)		✓	✓		
Manage postpartum haemorrhage using uterine massage and uterotonics		✓	✓		
Social support during childbirth		-	✓		
Active management of third stage of labour (to deliver the placenta) to prevent postpartum haemorrhage (as above plus controlled cord traction)		✓	✓		
Management of postpartum haemorrhage (as above plus manual removal of placenta)		✓	✓		
Screen and manage HIV/AIDS (if not already tested)		✓	✓		
Caesarean section for maternal/foetal indication (to save the life of the mother/baby)		✓	✓		
Prophylactic antibiotic for caesarean section		✓	✓		
Induction of labour for prolonged pregnancy (initiate labour)		✓	✓		
Management of postpartum haemorrhage(as above plus surgical procedures)		✓	✓		
Core postnatal (mother) interventions included in the minimum guaranteed benefits package					
Family planning advice and contraceptives		-	✓		
Nutrition counselling		✓	✓		
Screen for and initiate or continue antiretroviral therapy for HIV/AIDS		✓	✓		
Treat maternal anaemia		✓	✓		
Detect and manage postpartum sepsis (serious infections after birth)		✓	✓		
Core postnatal (newborn) interventions included in the minimum guaranteed benefits package					
Immediate thermal care (to keep the baby warm)		✓	✓		

	Lebanon	Libya	Tunisia	UAE	Oman
Initiation of early breastfeeding (within the first hour)		✓	✓		
Hygienic cord and skin care		✓	✓		
Neonatal resuscitation with bag and mask (by professional health workers for babies who do not breathe at birth)		✓	✓		
Kangaroo mother care for preterm (premature) and for less than 2000g babies		-	-		
Extra support for feeding small and preterm babies		✓	✓		
Management of newborns with jaundice ("yellow" newborns)		✓	✓		
Initiate prophylactic antiretroviral therapy for babies exposed to HIV/AIDS		✓	✓[34]		
Presumptive antibiotic therapy for newborns at risk of bacterial infection		✓	✓		
Use of surfactant (respiratory medication) to prevent respiratory distress syndrome in preterm babies		✓	✓		
Continuous positive airway pressure (CPAP) to manage babies with respiratory distress syndrome		✓	✓		

34. Services are provided but via referral to special sites

5. Key players and funding for SRH programs and services

The provision of primary health care is through the public sector in these countries despite the primary role played by the private sector in UAE and Lebanon for example. The ministries of health at the central level have several departments and units that target SRH components in all countries under study in this report, except for Oman where all reproductive health services are provided by the maternal and child health department of the Ministry of Health. In Tunisia and Libya there are also well developed regional or district levels of governance through health authorities, in addition to specific vertical programs such as the National AIDS Programs or the National Office of the Family and Population, a semi-autonomous public entity in Tunisia.

The role of international development partners is similar in the five countries in terms of bringing parallel programs targeting different SRH objectives. These programs are implemented through the health authorities in their majority

or in some instances through partnership with civil society. There is a strong presence of civil society through NGO operated primary health care centers in Lebanon for example or through strong advocacy groups like in the case of Tunisia. Despite the important contribution to the provision of primary health care, the work of local and international NGOs is fragmented and conducted in a competitive manner.

Private sector has a leading role in the provision of secondary and tertiary care in most of these countries. Unfortunately, not much is known about the contribution of this sector to the provision of primary health care however, it is believed that these services are provided in an ad hoc manner through an unregulated process. In addition to private health care facilities, third party payers play an important role in the health care system in UAE and in Lebanon which is implemented in partnership with the government to insure universal health care coverage of its populations.

The primary health care level is funded through the state budget in the five countries. For example, Lebanon's health bill is inflated with the burden of covering curative services in the absence of alternative health care schemes to insure universal health coverage. Governments therefore rely heavily on bilateral donors such as the EU, World Bank and other international agencies. Humanitarian aid during the last few years in Lebanon is also reported to be insufficient to meet the needs of the already burdened health care system. The sustainability of funds is a threat that can have major consequences on the strategic development of programs that will support universal health coverage.

6. SRH workforce

Not much data is available from Lebanon and the UAE to describe the workforce responsible for providing SRH services at the primary health care level. Tunisia is the only country among the five that has a well developed role for the midwives at the primary health care level where they assume the role of front line health care providers. In the other four countries, physicians rather than midwives play that role. Some efforts have been put over the last decade in advocating for the role of midwifery, such as the work done by the Nursing and Midwifery Council in UAE and the Lebanese Order of Midwives.

There are major challenges facing human resources in these countries pertaining to mal-distribution, shortage of some necessary cadres mainly nurses and midwives and competence of health care workers in SRH care. The humanitarian crises in Libya and in Lebanon have also created the need for a specific set of competencies among health care workers, which accentuated the absence of continuous education requirements or tailored capacity building initiatives.

In Libya, tasks are mostly physician-centric. Many of the tasks that could be carried out by nurses or midwives seem as being exclusive responsibilities of obstetricians, gynecologists and general physicians. Physicians carry out most of clinical diagnostics and management tasks, but also those related to counseling and education in an exclusive manner. For example, tasks related to promotion of family planning, assisting pregnant women and their families in making a plan for birth, educating women and their families, supporting self-care, and promotion of shared responsibility with women, their families and the communities are not included

in midwives' or nurses' responsibilities. These tasks are only supposed to be performed by physicians. In fact, midwives only carry out a limited set of tasks that is related to intrapartum and postnatal care. These include identifying the onset of labor, identifying delayed progress in labor and taking appropriate action, and managing a vaginal birth. This in addition to immediate postnatal tasks such as providing postnatal care to women and their newborn infants, and assisting women and their newborns in initiating and establishing exclusive breastfeeding. The scope of these tasks are not exclusive and shared with nurses and physicians, and they seem to be carried out during intrapartum care, minimizing in role within community settings or the different PHC centers.

On the other hand, Tunisia has an established cadre of midwives with clear and sometimes exclusive responsibilities. Not only are they engaged in education, counseling, provision of contraception and reporting of activities, but they also share in most of the clinical management tasks. The following summarizes their tasks:

- Performing vaginal examination, identifying the onset of labor, managing a vaginal delivery, and the active management of the third stage of labor.
- Identifying maternal and fetal distress and taking appropriate actions.
- Assessing the newborn at birth and giving immediate care, and identifying any life threatening conditions in the newborn and taking essential life-saving measures.
- Providing post-abortion care under physician's supervision.

Furthermore, they exclusively assist pregnant women and their families in making a plan for birth, and educating women in self-care during pregnancy, childbirth and the postnatal period. These tasks give them the potential to extend their roles within community settings, especially in the antenatal period, providing much needed personalized care on issues that are often ignored.


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IV. STATUS OF INTEGRATION OF SRH AND HIV/AIDS SERVICES IN THE CURRENT PHC SYSTEMS

SRH services are not well integrated within the PHC systems in the countries considered in this report with the exception of Oman. SRH programs in their majority run in a vertical manner and there are no strategies or health care policies that would govern or guide an integration process. Ad hoc integration of SRH services is encountered in the PHC systems in Lebanon and Tunisia. In these countries, the emphasis put on promoting and monitoring safe motherhood, child health and family planning at the PHC level demonstrates priorities of governments for a long period of time. Oman offers integrated family planning services in the primary health care facilities.

Tunisia has a strong family planning program that has been running vertically with a semi-autonomous governance since the 1970s. Although this program was effective in improving contraceptive use and reducing fertility and maternal mortality, it remains a standalone approach. Another example of a vertical program is the National AIDS Program in Libya that regulates the services offered in only two hospitals in the country.

Following the ICPD in 1994, governments have made efforts to bring family planning into maternal health services, something reflected in services offered in UAE and Tunisia and to a lesser extent in Libya, however no such efforts were made in these countries to extend this integration to child health services. Family planning services are also provided during abortion/post-abortion care, gender-based violence and reproductive cancer screening services in Tunisia and the UAE.

HIV/AIDS services such as counselling, TB and STI screening and prevention information sharing are provided through family planning, post-abortion care and maternal health services in Tunisia and UAE in addition to abortion services in Tunisia. There are also different modalities of offering services, whereas referral to a different facility is the norm in Libya, referral to a different health care provider within the same facility is followed in Tunisia and the UAE. SRH services are offered to all population groups in Tunisia and Lebanon including migrants and refugees (Table 7).

The provision of these family planning or HIV/AIDS services within other packages of SRH services as reported in UAE and Tunisia does not necessarily indicate an integrated approach in the provision of these services. No such claims can be made in the absence of national programs and strategies that should outline short and long term objectives and serve as the platform for the development of implementation plans. The new RMNCAH strategic plan 2019-2023 in Libya is one such opportunity for the introduction of a comprehensive approach for SRH integration in the primary health care level.

Table 7: Status of integration of FP and HIV/AIDS services in the current PHC system

	Lebanon	Libya	Tunisia[35]	UAE	Oman
Currently, the way PHC is organized in the country, are family planning services offered through the following SRH services?					
Antenatal care	✓	-	✓	✓	✓
Postnatal care	✓	✓	✓	✓	✓
Newborn and child health	✓	-	-	✓	✓
Prevention of unsafe abortion and post-abortion care		-	✓	✓	✓
Emergency contraception	✓	-	-[36]	-	✓
STI/RTI screening, diagnosis and treatment	✓	-	✓	✓	✓
Cervical cancer screening	✓	-	✓	✓	✓
Prevention and management of gender-based violence	✓	-	✓	✓	
Currently, the way PHC is organized in the country, are HIV/AIDS services offered as part of the following SRH services?					
Family planning	✓	-	✓	✓	-
Antenatal care	✓	-	✓	✓	-
Labor and delivery		-	✓	✓	-
Postnatal care	✓	-	✓	✓	-
Newborn and child health	✓	-	-	-	-
Prevention of unsafe abortion and post-abortion care		-	✓	✓	-
Emergency contraception		-	-	✓	-
STI/RTI screening, diagnosis and treatment	✓	-	✓	✓	-
Cervical cancer screening		-	-	✓	-
Prevention and management of gender-based violence		-[37]	-	✓	-
If yes, specify which HIV/AIDS services are integrated specifically:					
HIV/AIDS counselling and testing	✓	-	✓	✓	-

	Lebanon	Libya	Tunisia[35]	UAE	Oman
PMTCT (at a minimum: access to antiretroviral drugs to prevent vertical transmission and for treatment of mothers)	✓	-	-	-	-
TB screening		-	✓	✓	-
Prophylaxis and treatment of PLHIV (OIs and HIV/AIDS)		-	-	-	-
Treatment for opportunistic infections		-	-	-	-
STI screening, diagnosis and treatment		-	✓	✓	-
ART		-	-	-	-
Condom provision		-	✓	-	-
Psycho-social support (positive health, dignity and prevention)		-	-	✓	-
HIV/AIDS prevention information and services for general population		-	✓	✓	-
Currently, the way SRH services are offered in the country, how are family planning and HIV/AIDS services provided?					
Provided at the same location by the same healthcare worker on the same day	✓	-	✓		-
Provided at the same location by the same healthcare worker on a different day		-	-		-
Provided at the same location by a different healthcare worker on the same day		-	✓	✓	-
Provided at the same location by a different healthcare worker on a different day		-	-		-
Referred to a different service delivery point within the same facility		-	-	✓	-
Referred to a different facility		✓	✓[38]	✓	-

	Lebanon	Libya	Tunisia[35]	UAE	Oman
Are there SRH, FP and HIV/AIDS services provided to the following population groups at the PHC facilities in the country?					
General population	✓	-	✓	✓	-
Women	✓	✓	✓	✓	-
Men	✓	-	✓	✓	-
Children	✓	-	✓	✓	-
Young people	✓	✓	✓	✓	-
People living with HIV/AIDS	✓	-	✓	✓	-
Sex workers	✓	-	✓	-	-
People who inject drugs	✓	-	✓	✓	-
People living with disability	✓	-	✓	✓	-
Other, specify:	Migrants and refugees	-	Migrants	-	-

35. Family planning services are also available within medical and surgical abortion services, and youth friendly services in ONFP centers.
36. Available in theory: not available nor promoted in practice
37. Only at Hospitals
38. Testing services and antiretroviral therapies

V. LESSONS LEARNED

In the absence of organized efforts and clear strategies for integrating SRH into the PHC systems in four out of five countries reviewed, some lessons can be learned from the development and the implementation of SRH programs in these systems including vertical ones such as the family planning or the National AIDS Programs. These are discussed below:

- Incorporation of a new SRH component into an existing program has shown to be successful in some contexts. For example, in Tunisia, the success of the family planning program is a result of the strong political will that mobilized resources to reach specific targets. It was thus possible later on to add maternal, neonatal and child health components to the already solid family planning program to reach some form of integration between these SRH components. Similarly, the recent efforts of integrating Prevention of Mother-to-Child Transmission (PMTCT) services into the existing SRH services is building on the long established infrastructure of maternal health services in the country.

- The strong political will and strategic development made it possible for Oman to integrate most reproductive health services within maternal and child health services at the primary health care level.

- The recent global agendas of donors that prioritize integrative approaches might entice the political commitment to change the organization of services towards more horizontal than vertical programming. In this regard, capacity building for the delivery of integrated services are being implemented in certain contexts such as in Lebanon in response to donor agendas. These efforts however need to be consolidated in a national strategy and plan for SRH integration.

- The minimal integration of family planning services into maternal health and other SRH packages is encouraging. Experiences from Libya highlight the need for capacity building of the health personnel before further integration is envisaged.

VI. CHALLENGES FOR SRH INTEGRATION

1. Challenges at the strategic level

a. Insufficiency in the clarity and uniformity of visions, policies and strategies in respect to integration of SRH services into primary health care

The absence of clear written policies and strategies in respect to primary healthcare, sexual and reproductive health services, and the lack of consensus on operational definitions and strategies for integrating these services are all factors that hindered the provision of high coverage and quality comprehensive services.

In UAE, addressing SRH issues as priorities is taking momentum, yet it is still challenging due to the add cultural sensitivity attached to SRH issues. This was reflected at the levels of policies and service delivery programs. In Lebanon, the lack of commitment to prioritize SRH integration drove back the efforts of integration, as the lack of a clear and transparent operation strategies made it more difficult for coordination, resource distribution or training of healthcare professionals. In Libya, this absence may have aggravated the lack of care continuum, the overlap between the services or the lack of coordination. As for Tunisia, the lack of clear medium- and long-term vision and policies with clear objectives or components has definitely made it harder for assigning roles and responsibilities in terms of oversight, financing, implementation, monitoring or evaluation. Therefore, integration was done for separate components.

The lack of clear policies has its implications as it drives or facilitates other challenges on the organizational and operational levels. These include lack of coordination and autonomy, lack of consensus on operational strategies and training needs, in addition to duplication of efforts.

b. Insufficient political commitment

Integration programs are proven difficult, yet they are necessary. Insufficient political commitment could be due to a different array of challenges economical, political, social, or even in terms of lack of technical capacities. The anticipated resulting burden from integration, low financial capacity, an already burdened primary healthcare and the weakened health systems, in addition to previous unsuccessful attempts are often cited as reasons for weak political support. Furthermore, prioritizing curative services, or public health services other than SRH/HIV/AIDS services are contributing factors that could clarify the inadequate national level commitments.

There is no denying that political will and commitment are necessary as they would act as the driving forces to prioritize SRH/HIV/AIDS integration efforts in order to develop relevant policies, provide guidance, establish partnerships and communicate

with the different stakeholders. This has implications in terms of enabling the environment to achieve successful and sustainable integration. Oman serves as a good example for integration of SRH services in primary health care. Services are planned to be governed by two departments at the level of the Ministry of Health (maternal and child health component is run by the Department of Family and Community Health, while the HIV/AIDS component is run by the Communicable Diseases Department). All SRH components are integrated as primary health care products and activities as part of the 9th five year plan of action including considerations of human and financial resources, infrastructure and supplies.

c. Lack of clear coordination mechanisms between and within ministries, and between governmental bodies and other stakeholders.

With multiple authorities and stakeholders, the lack of clear coordination mechanisms affects the process of sharing information, establishing pathways for referral and continuum of care, mapping and distribution of resources, in addition to communication of expectations, roles and responsibilities.

Lack of coordination facilitates the overlap and duplication of efforts thus wasting much needed resources. This appears as more integration efforts are geared up towards family planning components, without being uniform across SRH components or PHC services, and often are ignoring HIV services. Moreover, management operations including implementation and evaluation suffer in the absence of necessary levels of coordination, inside and outside the concerned governmental body. This also affects partnerships and communication with key actors and stakeholders. Current examples of coordination and partnerships are not scaled up, unified or sustained.

d. Limited financial sustainability

Investment in integration of SRH/HIV/AIDS services would have a variety of positive outcomes on individual, population and system levels, yet limited financial support continues to be a major challenge that limits the extent and the quality of integration processes. Lack of financial support is anticipated due to the current state of economic burden in the region. The support from funding sources is rather intermittent, and there is lack of certainty in respect to availability of financial resources, which may have increased the competition between the different key service operators, such as NGOs, over resources.

2. Challenges at the organizational level

a. Multiplicity of governance and leadership authorities with vertical programming

In different cases, the oversight, delivery and follow up on SRH services are carried out by different separate governmental entities that are within the same governmental body/ministry or are located in different ministries.

For instance, two different departments that are in two different ministries manage SRH services in Lebanon. The first is the Department of Primary Health Care that acts under the Directorate of Preventive Medicine in MoPH. This is in addition to the RH unit in MoSA which is the unit concerned with the SRH in general. The two departments in the two ministries plan separately for service delivery, and compete for resources. Furthermore, within the MoPH, two different divisions manage SRH programs. One manages the safe motherhood and child health program and the other manages the RH program. Unfortunately, rather than considering different opportunities for integration at the different levels, each program operates independently.

As for Tunisia, and while the Family Planning program is under the lead of National Bureau for Family and Population (ONFPA), the delivery of services is performed through the ONFP centers and the Department of Basic Health Services (DSSB) structures. While both deliver the same SRH services' components, each has a separate information system, training framework, different reporting channels at the regional level.

This multiplicity has further fragmented the services and their related management operations. Furthermore, it did not help decentralization of the services, as they are still carried out via vertical programming. It confuses an already weak governance system with limited inter- or intra-sectorial coordination, and it further fragmented the governmental leadership, often with uneven performances from the concerned authorities.

b. Lack of operational standards and technical guidance

The current existing organizational models within the existing health systems are not integration friendly. The lack of operational plans or frameworks to support integration between the different sectors and services prompted separate ad-hoc efforts that was partial, uninform and far from being comprehensive. Furthermore, the lack of clarity in the existing plans, and the absence of integration specific optional tools, training protocols and clinical practice guidelines make it difficult to deliver a standard quality integrated evidence-based services.

c. Lack of autonomy

Restriction of autonomous and flexible roles at the regional level, in addition to having vertical programs, and centralized administration result in difficulty, rigidity and inefficiency in responding to local or regional operational needs.

3. Challenges at the operational level

a. Low quality of service

Geographical coverage could be limited in rural, remote or underdeveloped regions. Realized access could be further lowered in an already burdened PHC system due to lack of equipment, medicine, commodities or human resources. Other factors include increased waiting times, and limited consultation periods. Interpersonal communi-

cation issues and stigma against SRH or HIV/AIDS limit the satisfaction of the clients, and suggest lower quality of the provided services especially for most at risk populations. Additional issues include lack of continuum of care, weak referral, and more importantly, lack of accountability mechanisms.

b. Shortage in qualified and motivated healthcare professionals

This shortage often refers to multiple problems. Firstly, there are often inequitable distribution of healthcare providers, and shortages in midwives, nurses, or specialty physicians especially in rural or underdeveloped areas. Secondly, healthcare providers in many under-resourced facilities and centers suffer from work overload, which decrease their satisfaction, and may increase their resistance to performing additional tasks relevant to integration of SRH HIV/AIDS services. High turnover rates, and driving qualified personnel to private practices are increasing shortage and adding the burden exerted on the existing cadre and lower retention rates.

c. Lack of integration specific training programs and service guidelines

Integration services would require additional skills and competencies related to carrying out of SRH/HIV/AIDS services. The current cadre probably lacks such skills either due to deficient continuing education programs, or due to the absence of integration-specific training programs. This has its implications where services provided would be of lower quality, or it could even deter integration efforts until necessary changes occur.

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VII. OPPORTUNITIES FOR SRH INTEGRATION

1. A wide network of Primary health care units (PHCUs) that are open for integrated services

Libya has an expanding network of Primary health care units (PHCUs) in terms of infrastructure, and human resources. While this presents an opportunity for maximizing benefits when SRH and HIV/AIDS services are integrated, yet it is challenged by the needs of rehabilitation and maintenance for many of these PHCUs.

In Lebanon, the opportunity is more pronounced. The Lebanese healthcare system has been resilient to many challenges including civil conflicts, the Israeli war, and current refugee crisis. It adapted to these changes, and was able to sustain its services and expand its coverage. Currently, Lebanon has an existing wide network of PHC centers and it is working to ensure universal health coverage. Furthermore, the Health Strategic Plan is committed to a public integrated system. This has occurred in the country 's response within mental health services as they were integrated in PHC centers. Furthermore, as a response for the Syrian refugee crisis, the MoPH managed to adopt an integrative approach developing and implementing a near continuum of services via the cooperation of different service provides; public, private and civil society. Such examples prove the potential ability to integrate complex services such SRH and HIV/AIDS services within PHCUs in this country.

2. An enabled political environment with increasing positive social change towards SRH

In Libya, there is an increased activity from national and international partners and growing work on SRH issues which could open opportunities for advocating and implementing the integration of SRH services. Similarly, efforts in the UAE by health authorities, and women's organizations are receiving more support, and while it still is more challenging, there is more acceptance within the government to discuss SRH policies and programs.

Lebanon has a growing record of advocacy for SRH, through MoPH and partner agencies, this was reflected in an increasing social change towards acceptance of SRH and allowed for developing quality SRH programs, guidelines, and trainings. The environment is relatively more facilitating to provide comprehensive and integrated SRH services for the public and the vulnerable and the marginalized groups. This poses an increased opportunity due to the active key actors, international partners, civil society and outreach programs that could improve the linkage between HIV/AIDS and SRH services, to further prompt integration efforts in PHCUs.

Tunisia, it has a growing recognition of the right to health and social protection, and is committed to achieve the Sustainable Development Goals (SDGs) through using rights

based approaches, life-cycle programs, and inter-sectoral coordination. Furthermore, the recently approved comprehensive law on violence against women has ensured the rights to access health services within user-friendly facilities. These events show that there is a window of opportunity to prioritize and reposition a comprehensive strategy for RMNCH within primary healthcare, while ensuring its attention to quality, satisfaction, and acceptability of services while responding to social justice, human rights and gender equity calls.

3. Acknowledgment of shortage in qualified human resources and start of action

In Lebanon, MoPH encouraged establishing career paths for nurses and the training of new nurses, which is done by the Lebanese University. Anticipated increase in nurses is believed to reduce the gaps between supply and demand, including those created by the integration of SRH and HIV/AIDS services. As for Tunisia, the new academic Family Medicine training track has an opportunity to approach SRH and HIV/AIDS integration via the suggested repositioning of RMNCH. Therefore, it could create a cascade of actions involving mentoring, training to support a new cadre of qualified and motivated physicians.

Healthcare providers' lack of empathy, negative attitudes and presence of stigma are persistent challenges. They are factors that could contribute to inequity in access to SRH services. In that regard, a CSO in Tunisia has successfully implemented the Value Clarification Program, which is a self-evaluation program that aimed at transforming attitude to support women choices for contraception, abortion and protection from violence. Resulting changes were significant for improvement of service quality. Therefore, the program and similar programs could be investigated for further scaling up.

4. A global approach towards decentralization of services

Initiated by the 2014 Constitution in Tunisia, the global approach to decentralization, the implementation of the second phase of the Societal Dialogue, and the increasing political commitment to decentralization are all factors that could open the door for the Ministry of Health to allow for autonomy and services at the different levels. This could allow more independence at the regional levels for the design, contextualization, implementation and evaluation of programs and could alleviate fragmentation of the services to allow better linkages for integrated SRH services within a flexible and responsive PHC system.

VIII. RECOMMENDATIONS

1. At policy level

- Advocating for and ensuring stronger political commitment and good governance with respect to integrated service delivery. This should reflect on the development of needed policies and strategic plans, sustaining financial commitments, and fostering needed partnerships at the different levels of action. Furthermore, this political commitment should recognize building capacities of financial and human resources as priorities for the successful integration.

- Evidence based practices, cost effectiveness studies, and lessons learned at the national and regional levels could be vital sources of information that could show the potential positive outcomes of services integration at PHC, and should be used for the purpose of advocacy, networking and planning. Framing SRH services integration into the dialogues of social and economic development, human rights and gender equality, achievement of SDGs or at the level of achieving Universal Health Coverage can initiate or enhance the needed dialogues for political commitment and prioritization of SRH services integration.

- Development or modification of integration country-specific policies, strategies and operational plans. These should consider the following concepts:
  - Adoption of user-centric and human rights-based approaches.
  - To be based on evidence and get adapted according to national, local and humanitarian contexts.
  - Achieve continuum of care within the same facility and at different facilities across PHCUs and at the existing programs; e.g. Maternal and Child Health programs, National AIDS Programs, Family Planning, and Youth Friendly Centers.
  - Complement the existing policies, strategies and programs and ensure alignment.
  - Consider vulnerable groups and out of reach areas, and aim at reducing disparities.
  - Stress on quality of services.
  - Develop SRH integration-related national level indicators, and ensure accurate data collection mechanisms.
  - Compliance with international health regulations, and SDGs

- Developing a unified definition of SRH and HIV/AIDS package of services. This will ensure that relevant policies, strategies, and operational plans, including trainings and guidelines, are all guided by the same vision, and geared towards the same objectives.

- Establishing coordination mechanisms for intra- and inter-sectoral collaboration and resource management and mobilization. This would facilitate sharing of information, follow up and evaluation. It would reduce waste in terms of misallocation of resources, or overlap of services. Political support, motivation, and agreement on roles and responsibilities in respect to coordination functions could facilitate its sustainability and protect from experiencing system weakness. Community involvement could ensure higher levels of accountability within the coordination mechanisms.

- Increasing partnerships and effective engagement between the different stakeholders; public and private sectors, international organizations and agencies, community-based organizations and citizens. This would facilitate development of innovative financial solutions to increase funding, mobilization of resources, enhancing of accountability mechanisms, and community participation to maximize reach to vulnerable groups.

2. At the organizational level

- Development of supporting health information systems and electronic records. This includes the development of unified coordinated information management systems and providing the needed training for data management and infrastructure. Integration-related health information systems would provide the data required for needs assessment, follow up on the developed national indicators, evaluation of services, and forcasting for future needs in terms of resources. This data would have a vital role in informing decision makers, allocation of resources, and prioritizing of actions. A major motivational campaign among healthcare providers to understand the importance of this exercise is needed. Furthermore data must be disseminated to the public at large.

- Strengthening organizational systems through:

  - Development of specific pathways for horizontal integration, establishing links at different services levels, and ensuring effective referral and continuum of care.
  - Decentralization of services and increasing of autonomy.
  - Ensuring programs' financial, operational and institutional sustainability.
  - Development of a clear monitoring and evaluation framework.
  - Increasing organizational competency through the development of SRH integration operational guidelines and protocols, in addition to providing necessary trainings.
  - Development of proper integrated logistics and commodities management systems.
  - Adoption of efficient strategies for recruitment, motivation and retention of qualified healthcare providers to decrease shortage in SRH cadre.

3. At the operational level

- Task shifting from a physician-centric service delivery to assign more responsibilities

for the assisting cadre, including nurses, midwives, social workers, and counselors. This may require new job descriptions, specific professional training or university education programs to create and develop professional cadre that is based on the SRH and HIV/AIDS services package definition.

- Development and implementation of SRH and HIV/AIDS integration-related training curricula to increase health care providers' skills, competencies, positive attitudes, respect and empathy.
- Ensuring availability of needed commodities, equipment and medicines.
- Ensuring feedback mechanisms from clients to evaluate services' quality and their satisfaction. Communication of these findings to ensure corresponding measures at the organizational and system levels for accountability and continuous improvement of the services' quality.
- Presenting community-based care, socio-behavioral programs, and outreach in the communities.

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