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

UNFPA

Integration of Sexual and Reproductive Health Services in the Arab States Region: A Six-Country Assessment

Policy Brief

Integration of health services can improve efficiency in the health system, increase people's access to a range of basic and essential health services, improve clients' satisfaction with care, and improve health outcomes.[1] Countries in the Arab States Region and elsewhere have experienced many challenges in adopting integrated approaches, however. These challenges can be overcome by learning the lessons of previous integration efforts and taking advantage of new opportunities for integration, as described in this brief.

1 Dudley L, Garner P. Strategies for integrating primary health services in low- and middle-income countries at the point of delivery (Review). *Cochrane Database of Systematic Reviews* 2011, Issue 7. Art. No.: CD003318. DOI: 10.1002/14651858.CD003318.pub3

WHAT DOES INTEGRATION MEAN?

For more than 20 years, the global health community has promoted universal access to integrated sexual and reproductive health (SRH) services,[2,3] which should include family planning; maternal and new born 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. Universal access implies that all who need the services can obtain them through the primary healthcare system.[4] The recently adopted Sustainable Development Goals (SDGs), which guide the global developmental agenda through 2030, include two targets (3.7 and 5.6) calling for universal access to sexual and reproductive health care and the integration of reproductive health into national strategies and programs.

Integration of SRH services and primary health care means that people who are seeking information or health care for a specific sexual or reproductive health concern can have their other needs met simultaneously—preferably at the same time in the same location, or otherwise by effective referral.[5] Integration of services does not necessarily dictate that all SRH services be provided in one site, but healthcare providers must have the skills to provide a basic package of care and be knowledgeable about processes for referrals. Service integration should be supported by a health system that provides for human, material and financial resources and that considers the prevailing social and cultural norms.[6]

2 United Nations. Report of the International Conference on Population and Development. Cairo, 5–13 September, 1994 (A/CONF.171/13).

3 United Nations. Sustainable Development Goals post-2015. Available at: https://sustainabledevelopment.un.org/post2015/summit

4 UNFPA Arab States Regional Office Position Paper. Sexual and reproductive health: a core component of universal health coverage. 2014. Available at: http://arabstates.unfpa.org/en/publications/position-paper-sexual-and-reproductive-health-arab-states

5 Warren, C. E., Mayhew, S. H., & Hopkins, J. The Current Status of Research on the Integration of Sexual and Reproductive Health and HIV Services. *Studies in Family Planning* 2017, 48(2):91-105.

6 WHO. Integrating sexual and reproductive health-care services. Policy brief 2. Implementing the global reproductive health strategy. 2006.

ASSESSMENT OF SIX ARAB STATES

The Middle East and North Africa Health Policy Forum, in partnership with the Arab States Regional Office of the United Nations Population Fund (UNFPA), undertook a comprehensive assessment of SRH integration in public health systems in six Arab countries. Its objective was to analyse the readiness of health systems to integrate SRH, including family planning and HIV services, with primary health care in six selected Arab countries—Egypt, Jordan, Kingdom of Saudi Arabia (KSA), Morocco, Palestine, and Sudan.

The research team analysed data from published country reports, UN agency reports, and stakeholder interviews, using a specifically designed assessment tool. Based on triangulation of the data collected, they presented their findings and made country-specific recommendations. The synthesis report, highlighted here, compiled the findings from the country reports and drew recommendations relevant for the region.

FINDINGS: SRH SERVICES IN THE SIX COUNTRIES

The six countries included in this assessment are characterized by complex healthcare systems, consisting of public (governmental), private, and civil society sectors. Primary health care is prominent in these health systems; however, these systems suffer from fragmentation, weak infrastructure and donor—driven agendas.

Health authorities at the central, regional and district levels manage and oversee SRH programmes and services. They also collaborate with several UN agencies. For example, the UN Relief Work Agency (UNRWA) plays a major role in providing services to Palestinian refugees in Jordan and Palestine, while the UN High Commissioner for Refugees and UNFPA addresses the SRH needs of populations affected by conflict, e.g., in Syria and Sudan. Civil society organizations provide SRH services in Egypt, Jordan, Morocco, Palestine, and Sudan. In addition, Egypt and Jordan have a large private sector. SRH programmes and services rely heavily on government funding in these countries.

In terms of services provided (Table 1), Morocco is unique in offering most SRH services in all its public health facilities, although implementation and quality vary widely. The other countries have gaps in common such as lack of prevention and management of HIV/STIs, reproductive cancers, and gender-based violence, which are provided at other levels of care. Emergency contraception and youth-friendly services are also lacking in most of the countries. Some public health facilities lack comprehensive emergency obstetric and new born care, which are provided at other levels of care.

The assessments revealed common challenges these countries face in providing SRH services. Social norms, poverty, and political dynamics often prevent services from reaching the most vulnerable population groups—namely youth, unmarried women and pregnant adolescents. Moreover, the services targeting women and children at the primary healthcare level exclude men and youth. In general, sexual health services are not well incorporated in the services provided, and few services address sexually transmitted infections. In addition, existing services are not well organized; there is poor coordination between different parts of the healthcare system, resulting in ineffective and inefficient services.

Table 1: Essential SRH Services Offered at Primary Healthcare Facilities

Services	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Family planning	✓	✓	✓	✓	✓	✓
Antenatal care	✓	✓	✓	✓	✓	✓
Labour and delivery			✓			✓
Postnatal care	✓	✓	✓	✓	✓	✓
Newborn and child health	✓	✓	✓	✓	✓	✓
Prevention of unsafe abortion and post-abortion care			✓			✓
Emergency contraception	✓a		✓	✓		✓
STI/RTI screening, diagnosis and treatment		✓	✓	✓		✓
Cervical cancer screening			✓	✓		
Breast cancer screening	✓	✓b	✓	✓		
Prevention and management of gender-based violence		✓c	✓	✓		

a. private facilities only

a. diagnosis and treatment only

b. management only

Source: Assessment of Sexual and Reproductive Health Integration in Selected Arab Countries: Regional Report. Cairo: MENA Health Policy Forum and UNFPA Arab States Regional Office, 2017.

Family planning is integrated with maternal and child health care in all six countries (Table 2). Palestine integrates family planning with all other SRH services. HIV-related services are well integrated in other SRH services in Morocco, but only in antenatal care in Sudan and in a pilot project in Egypt. Referral to a different facility to receive family planning and HIV-related services is the norm in Jordan and KSA. Referral within the same facility is common in Egypt and Morocco.

Egypt, Palestine, Sudan and Morocco have made efforts to integrate SRH services through either national programmes or pilot projects. In Egypt, programmes have integrated family planning and maternal child health services; in Sudan and Morocco, programmes have aimed to integrate HIV-related services with reproductive health care. In Morocco, a referral centre for reproductive health in the regions integrates a range of services including family planning; STI screening, diagnosis and treatment; and cervical and breast cancer screening.

The Family Health Model in UNRWA clinics in Palestine and Jordan offers a successful example of providing integrated care at the primary healthcare level. In this model, family health teams provide comprehensive primary health care based on holistic care of the entire family. The model emphasizes long-term provider-patient relationships, ensuring that services are client-centred, comprehensive and continuous. Moreover, the family health team helps address cross-cutting issues that impact health, such as diet and physical activity, education, gender-based violence, child protection, poverty, and community development.

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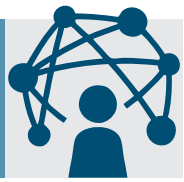
Table 2: Integration of Family Planning and HIV Services in Primary Health Systems

	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Services offering family planning						
Antenatal care	✓	✓	✓	✓	✓	✓
Postnatal care	✓a	✓		✓	✓	✓
Newborn and child health	✓a	✓		✓	✓	✓
Prevention of unsafe abortion and post-abortion care			✓	✓		✓
Emergency contraception				✓		
STI/RTI screening, diagnosis and treatment		✓b		✓		✓
Cervical cancer screening			✓	✓		
Prevention and management of gender-based violence			✓	✓		
Services offering HIV prevention and management						
Family planning			✓			
Antenatal care	✓c		✓			✓
Labour 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			✓			
Way in which family planning and HIV services are linked						
Provided at the same location by the same health-care worker on the same day		✓		✓		✓
Provided at the same location by the same health-care worker on a different day			✓	✓		✓
Provided at the same location by a different health-care worker on the same day		✓	✓	✓		✓
Provided at the same location by a different health-care worker on a different day				✓		✓
Referred to a different service delivery point within the same facility	✓d	✓		✓		✓
Referred to a different facility	✓e	✓		✓	✓	
Populations receiving SRH, family planning, and HIV services at PHC facilities						
General population	✓	✓		✓		✓
Women	✓	✓f	✓	✓		✓
Men		✓g		✓		✓
Children		-		✓		
Young people		✓h		✓		
People living with HIV						
Sex workers						
Men who have sex with men						
People who inject drugs				✓		
People living with disability		✓		✓		

a Counseling on contraceptives is provided during postnatal home visits
b STI/RTI diagnosis and treatment only
c In some selected sites as part a pilot project.
d for family planning services
e for HIV services
f married women only
g usually through the wife or when comes with wife
h SRH services only

Source: Assessment of Sexual and Reproductive Health Integration in Selected Arab Countries: Regional Report. Cairo: MENA Health Policy Forum and UNFPA Arab States Regional Office, 2017.

LESSONS LEARNED FROM INTEGRATION EFFORTS



Many of the issues documented in the country reports serve as lessons for future integration efforts. First, vertical programmes throughout the region have created multiple units and departments within the central health ministries. Any efforts to develop integrated programmes must therefore integrate management to avoid replicating the same situation. A mix between vertical and integrated programmes could be a model that fits the needs in certain settings, especially considering that some vertical programmes, such as antenatal care and child immunization, were successful in the past.

Second, building partnerships with civil society organizations has been important for reaching key populations with HIV/AIDS programmes and services. These organizations have great potential to access grass-roots communities, and therefore are important assets in HIV programmes and in communities in need of SRH services.

Third, a thorough assessment of the needs and preferences of beneficiaries is essential for designing and developing programmes. Ongoing monitoring is also a must. The failure to do so was identified as a key factor in the failure of previous integrated programmes.

Finally, the healthcare providers currently delivering SRH services in these countries are primarily trained to provide family planning and maternal child health services, rather than HIV-related services.

Much can be learned from the Family Health Model in UNRWA clinics in Palestine. This model was successful in terms of improving users' and providers' satisfaction and quality of care. It can be replicated elsewhere in the region, or scaled-up in Palestine, Jordan and Egypt.

COUNTRY-SPECIFIC CHALLENGES

The country assessments highlighted country-specific challenges as well as those that cut across the region. Country-specific challenges, described below, should be considered within the wider geopolitical context of each country.

EGYPT

Since the mid-1990s, Egypt has developed ambitious health plans that include integration efforts, but their sustainability has been challenged by human resource constraints. Also, previous integration efforts suffered because of vertical, donor-dependent programming—a design that did not lend itself to integration.

The private sector's role in providing SRH services is increasing. Private sector clinics provide antenatal care, family planning services and management of sexually transmitted infections. Yet, information is lacking on utilization rates and service quality, which hinders coordination between the public and private sectors to improve service availability and access.

JORDAN

The routine service data collected in primary health centres are not linked to those collected in hospitals, and sexual health services are not recorded at any level. Moreover, the data collected is only quantitative, which limits interpretation and analysis of issues. In facilities, the shortage of space makes it difficult to provide good quality care that respects privacy and confidentiality, which is particularly important for youth, men and unmarried women.

The decentralization and regionalisation of services could support integration in terms of priority-setting and implementation planning. Yet, as previous efforts for regionalisation have

failed, starting a new trial poses serious challenges, especially in building the technical capacity of local management teams.

MOROCCO

The Moroccan health system suffers from multiplicity of programmes at the ministries of health and population, and the lack of coordination among different departments within the ministry of health. The process of programme implementation at the central level does not allow much room for flexibility and does not encourage staff participation and autonomy at all levels of the system. Another important challenge is the lack of an integrated information system for the health workforce, which suffers from shortages of nurses and general practitioners.

PALESTINE

Palestine has a multitude of service providers—public, private, and non-governmental organizations—providing primary health care, leading to uncoordinated care, duplication of efforts, and competing agendas.

Current reforms in the referral system focus on secondary and tertiary health care but ignore SRH in PHC; thus, referral-system reforms must expand in the future to include PHC. In facilities, the shortage of space and deficiencies in communication between healthcare providers and clients impede good quality care. Finally, war and occupation impede reform efforts and pose a continuous challenge in terms of people's access to services.

SAUDI ARABIA

Reproductive health services are still not comprehensive in the kingdom; they consist mainly of maternal and child health, with very few sexual health services.

The Ministry of Health has little control of the health workforce that operates under other institutions, such as the national guard, military hospitals, university hospitals, and private sector organizations. This results in duplication of efforts and causes disparities in the coverage and quality of services. As the country moves toward privatization of health services, a considerable challenge for integration efforts is to spur the interest of private sector organizations in providing sexual, reproductive, maternal and new born health services.

SUDAN

HIV policies and programmes have integrated HIV testing within different reproductive health services. However, family planning services are not provided to unmarried youth, which also limits their access to HIV testing. The scope of services provided is inconsistent. Some facilities, for example, do not provide antiretroviral therapy, condoms, nutrition, health education, rape management, vaccination and/or awareness raising on female genital mutilation. Even maternal and new born health care is missing in some facilities. Furthermore, service providers lack the commitment to meet clients' counselling needs, resulting in unsatisfactory interactions. The lack of physical space and inappropriate locations limit client's privacy, care and comfort.

Integrating SRH and HIV services is complex and challenging in humanitarian settings, such as in Darfur. In a positive development, five Darfur AIDS programmes integrated HIV services in primary health care.

OVERARCHING CHALLENGES

Insufficient political commitment and support

One of the most prominent challenges to integrating SRH services is insufficient commitment and support at the highest levels of health leadership, especially among decision-makers at the ministries of health. Even though the concept of integration is broadly understood and accepted, 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. Thus, technical and operational guidance for the integration processes is largely missing. This also contributes to an environment in which sporadic integration efforts are made without coordination or communication inside the health ministries, among ministries or among other concerned institutions.

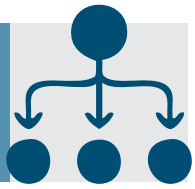
Insufficient financial support

Integration is constrained by limited resources, the low share of health in national budgets, and somehow the dependence on external funding that has become intermittent or disrupted.

Ineffective coordination between different stakeholders

There are multiple players in the health system with sometimes competing agendas, resulting in duplication of efforts and inefficiency. 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.

SOME ORGANIZATIONAL CHALLENGES



Vertical programming, central administration, and multiplicity of operations

Current SRH services are typically provided within vertical programmes administered in their respective departments at the health ministry. This organizational model hinders coordination between the different departments inside health ministries and makes it hard to track financial and performance data for cross-departmental SRH services and operations. Functions related to quality, training and other management issues are also fragmented across departments. The need to supervise, follow-up, assess training needs, and monitor services overwhelms managerial staff at the central level and exhausts service providers, who are subjected to multiple instructions and requests from supervisors from different departments. It also results in gaps in supervision and follow-up for certain tasks.

Resistance toward integration

Service integration can understandably face resistance, as it requires increasing the technical and managerial capabilities of service providers, supervisors and other personnel commensurate with the changes occurring in the health system. Barriers to integration include a lack of clear roles, motivation, and training; the anticipated work overload; task shifting; change of routine; and the added complexity of operations. Lack of clear communication or consultation with the workforce and insensitivity from leadership are contributing factors.

Intensive efforts associated with integration

Developing new systems, such as integrated health information systems, new job profiles with different responsibilities and training requirements, and an integrated curriculum for training service providers and management staff are complex actions. They

require high-level commitment and investment, and they consume a considerable amount of time.

Lack of continuum of care, weak referral and follow up

The lack of clear linkages between the different departments that offer SRH services makes it hard to establish efficient referral systems, whether vertical or horizontal. In addition, integrated information systems are lacking that would allow for tracking and follow-up of clients, making it hard to ensure quality and continuous care.

OPPORTUNITIES FOR SRH INTEGRATION

Health system reforms can create opportunities for better integrated SRH services. Newly developed national strategies in all six countries provide an opportunity for drafting operational plans and guidelines for integrated services (Table 3). The new national agendas focusing on the SDGs also present opportunities to develop country-specific targets for which integration of SRH is considered necessary.

Table 3: National strategies and programmes integrating SRH and HIV/AIDS

Country	Strategies, plans, programmes 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 ante-natal care
Jordan	MoH: Inter-referral system within primary health care UNRWA-Family Health Team
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

Source: Assessment of Sexual and Reproductive Health Integration in Selected Arab Countries: Regional Report. Cairo: MENA Health Policy Forum and UNFPA Arab States Regional Office, 2017.

A few existing programmes can serve as building blocks for piloting integrated SRH services: the Family Health Model in Egypt and Morocco, and the SRH and HIV integration programme in Sudan and Egypt. Lessons from these programmes can help others assess feasibility and acceptability in different contexts, and plan and allocate resources. The global community's focus on SRH integration could be helpful for mobilizing funds for pilot projects of locally adapted integration strategies, and for scaling them up.

Growing partnerships with the private sector, along with the strong engagement of civil society witnessed in several countries, are important assets that could work in favour of advocating for and implementing integrated services. Fully engaging these partners might require having clear guidance for integrating SRH services in the non-governmental sectors.

RECOMMENDATIONS

Integration occurs on a continuum rather than as opposite extremes in service organization and provision.[7] It is a process of change that requires consolidating efforts at the political, administrative and technical levels. The following are recommendations arising from the common challenges and opportunities identified in this report, as well as from the country-specific recommendations.

At the policy level:

- Advocate for SRH integration by combining global evidence and local experiences. This includes raising awareness among policymakers on the importance and urgency of providing SRH and HIV-related services to unmarried women and youth.
- To facilitate advocacy and planning, solicit national studies and analyses to estimate efficiency gains from integration, creating evidence showing where best the return on investment lies.
- Ensure political commitment for integration before planning and implementing programmes. It is useful to gain endorsement from national and regional professional associations, academicians, civil society advocates and other agencies whose agendas include SRH. A consensus should be built that takes into consideration the adverse impacts on different sectors while proceeding with integration.
- Develop strategic plans for SRH integration with defined indicators and outcomes, to make the integration concepts outlined in national strategies more concrete and help make implementation possible. Use the opportunity provided through the SDG agenda to set targets that have integration at their core, such as integrating family planning with antenatal and postnatal care to reduce maternal deaths.
- Forge partnerships with different stakeholders and at various phases of planning, implementation and evaluation, to foster an inclusive environment, reduce competition and pave the way for future collaboration. One way to accomplish this is to develop country-level think tanks or coordination bodies with representatives from various health-related organizations.

7 Atun R, de Jongh T, Secci F, et al. A systematic review of the evidence on integration of targeted health interventions into health systems. *Health Policy and Planning* 2010, 25: 1-14.

At the programmatic level:

- In view of decentralization, mobilize local communities to implement integrated programmes. Creating a social need for and acceptance of integrated SRH services can only enhance the benefits of such efforts. Reaching out to civil society organizations that work with the most marginalized groups will also strengthen these efforts.
- Strengthen linkages and close gaps in SRH services before embarking on new integration efforts. Review lessons, for example, from the Family Health Model and integration of prevention of mother-to-child transmission of HIV.
- Identify the services that will be entry points for integrated care. These may vary depending on the priority agenda in each country and the readiness of its health system.
- Introduce change in increments. Participatory approaches are necessary that engage all stakeholders, creating an environment in which change will be gradually accepted. Coordinating bodies can also be useful for this purpose.
- Support good governance by providing management tools such as health information systems, quality monitoring tools and systems, and guidelines and protocols that are culturally sensitive and context-specific. These tools can be developed through collaboration with academia and professional bodies.

At the operational level:

- Train the SRH workforce to provide integrated services, revise roles and job descriptions, and develop job-aids. In addition, support leaders that foster teamwork, make accountability a priority, and motivate staff.
- Strengthen referral pathways or establish new ones that protect users of SRH services from social stigma. Address the ineffective referral systems already in place based on data from evaluations.
- Scale up SRH integration projects that have shown the potential to improve health outcomes, such as the Family Health Model in Palestine, Jordan and Egypt. Implementation challenges faced in the pilot phases of these projects are extremely informative.

Integration involves changing mindsets as much as organizational structures and budgets. Health systems providing integrated SRH care need a workforce that has the flexibility to make decisions, communicate within and across services, and share workloads as part of a team.[8] Motivated staff should initiate more than one service during a consultation, and clients should expect multiple services when they seek SRH care.

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8 Warren, C. E., Mayhew, S. H., & Hopkins, J. The Current Status of Research on the Integration of Sexual and Reproductive Health and HIV Services. *Studies in Family Planning* 2017, 48(2):91-105.