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Assessment of Sexual and Reproductive Health Integration in Selected Arab Countries

Regional Report

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

UNFPA

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In this study, the Middle East and North Africa Health Policy Forum (MENA HPF), in partnership with the UNFPA/ Arab States Regional Office (ASRO), seeks to address sexual and reproductive health in the Arab states as a priority in health development and advocacy in the post-2015 period. This exercise is intended to provide policymakers and stakeholders in the Arab states with insight about the current status of integration of sexual and reproductive health (SRH) in primary health care services as a priority for achievement of SRH –SDGs.

This report was written by Dr. Tamar Kabakian-Khasholian (Associate Professor, Health Promotion and Community Health Department , AUB) and Dr. Ahmed Ali (Postdoctoral Fellow, AUB). We gratefully acknowledge the input of the authors of the six national reports on which this report is based in the respective countries of focus: in Egypt, Dr. Atef Al Shitany; in Jordan, Dr. Maha AlSaheb; in Morocco, Dr. Radouane Belouali and Dr. Safowan Mowafak; in Kingdom of Saudi Arabia, Dr. Fawzia Habib, and Dr. Khawater Bahkali; in Palestine, Ms. Nadira Sansour; in Sudan, Dr. Nefissa El Bedri.

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ACRONYMS AND ABBREVIATIONS

BEmONC	Basic emergency obstetric and newborn care
CEmONC	Comprehensive emergency obstetric and newborn care
CPR	Contraceptive prevalence rate
HIV/AIDS	Human Immunodeficiency virus/acquired immunodeficiency syndrome
ICPD	International Conference on Population and Development
IUD	Intrauterine device
KSA	Kingdom of Saudi Arabia
MDG	Millennium Development Goal
MMR	Maternal mortality rate
NGO	Nongovernmental organization
OB/GYN	Obstetrician/ Gynecologist
PHC	Primary health care
PMTCT	Prevention of mother-to-child transmission of HIV
RTI	Reproductive Tract Infections
SDG	Sustainable Development Goal
SRH	Sexual and reproductive health
STD	Sexually transmitted disease
STI	Sexually transmittable infection
TFR	Total fertility rate
UHC	Universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East

EXECUTIVE SUMMARY

Integrated sexual and reproductive health (SRH) services, delivered effectively and efficiently, are pre-requisites for universal access to SRH services. Integration strategies aim to improve efficiency, increase access to health services, improve clients' satisfaction with care and improve health status. Several challenges are associated with adopting integrated approaches, however, at the strategic and operational levels.

The Arab States Region consists of countries with widely diverse income levels, cultural norms, and political and health systems. Despite the health sector reforms undertaken in many Arab countries, continuous political unrest and armed conflict put additional burdens on health care systems already suffering from fragmentation and poor quality of care.

The Middle East and North Africa Health Policy Forum, under collaborative agreement with the Arab States Regional Office (ASRO) of the United Nations Population Fund (UNFPA), undertook this assessment to develop a comprehensive overview of SRH integration in public health systems in Arab countries. This exercise intends to support the prioritization of SRH in health development and advocacy efforts in Arab countries. It aims to describe health systems' readiness to integrate SRH, family planning and HIV services within primary health care in six selected Arab countries—Egypt, Jordan, Kingdom of Saudi Arabia (KSA), Morocco, Palestine and Sudan.

The country consultants collected data from published country reports, UN agency reports and stakeholder interviews, using an assessment tool provided by the regional consultant. They presented their findings based on triangulation of the data collected, and made country-specific recommendations in separate reports. This report synthesizes the findings from the country reports and draws recommendations relevant for the region as a whole.

The six countries included in this assessment are characterized by complex healthcare systems, consisting of the governmental and/or public, private and civil society sectors. Primary health care is prominent in these healthcare systems; however, it suffers from fragmentation, poor infrastructure and donor-driven agendas.

The ministries of health and health authorities at the central/federal, regional and district levels manage and oversee SRH programing and service provision. They work in collaboration with several UN agencies. The UN Relief Work Agency plays a major role in providing services to Palestinian refugees in Jordan and Palestine. The UN High Commissioner for Refugees and UNFPA address the SRH needs of populations affected by conflict in Syria and Sudan. Civil society organizations provide SRH services in Egypt, Palestine, Jordan and Morocco. In addition, Egypt and Jordan have a large private sector. SRH programs and services are heavily reliant on government funding in these countries. Ministries of health also rely on UN and international donor agencies.

These countries have physician-dominated health care systems. Midwives only constitute a large proportion of the SRH workforce in Sudan and, to a lesser extent, in Morocco. Community health workers are present in Egypt, Palestine and Sudan. Shortages of physicians and poor geographic distribution of specialists are common challenges in the provision of SRH services.

Family planning is integrated into maternal and child health services in all six countries. Palestine integrates family planning in all other SRH services. HIV-related services are well integrated in other SRH services in Morocco, but only in antenatal care in Sudan and through 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. Specific projects have made efforts to offer integrated services, such as the Family Health Model in Egypt, UNRWA services in Palestine and the HIV/SRH linkages program in Sudan. The evaluations of these pilot programs showed gaps in implementation, and effective scaling-up has not yet been accomplished.

The country reports identified a large array of challenges at the strategic, operational and service delivery levels, starting with the lack of a common, clear vision at the highest levels of health leadership regarding the integration of SRH services. As a result, there is a lack of political, technical and operational guidance for the integration process, and insufficient political commitment and resources for integration efforts.

Newly developed national strategies on SRH and HIV in these countries provide important opportunities for drafting operational plans and guidelines for integrated services. System reforms, whether at the operational level, as in Egypt, or at the central organizational level, as in Morocco, create opportunities for more integrated SRH services. In addition, the new national agendas focusing on the SDGs present opportunities to develop country-specific targets for which integration of SRH is necessary.

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

Integration is a process of change that requires consolidating efforts at the political, administrative and technical levels. When reforming systems, it will be necessary to strengthen linkages and close gaps in SRH services before embarking on new integration efforts, and to take the time to introduce change in increments, with input from many stakeholders. At the operational levels, referral pathways need to be established or renewed, and entry points for integrated services need to be identified; they might differ depending on the national context.

SRH integration projects that have shown the potential to improve health outcomes, such as the Family Health Model in Palestine, Jordan, and Egypt, should be scaled up. Major investments will also be needed in the health workforce—to retrain, reorient and motivate personnel to work as a team providing integrated services.

I. BACKGROUND

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Since the International Conference on Population and Development (ICPD) in 1994, the global community has promoted the provision of comprehensive and integrated SRH services. The essential service package that originated at the ICPD conference, consisting of integrated and universally accessible SRH services, comprehensive sexuality education for adolescents and implementation of policies to protect SRH rights (UN, 1994), remains relevant today.

Universal access to SRH requires the delivery of an essential package of the following services:

- contraceptive services, including a full array of modern and long-lasting methods, and emergency contraception;
- safe abortion care and the treatment of complications from unsafe abortion;
- maternal health care, including antenatal care, skilled attendance at birth, emergency obstetric care, postnatal and newborn care;
- prevention, diagnosis and treatment of sexually transmitted infections, HIV/AIDS, cancers of the reproductive system, infertility and other sexual and reproductive disorders.

The Millennium Development Goals (MDGs), launched in 2000 and concluded in 2015 (UNDP, 2015), contained key components of the ICPD Program of Action, including a target calling for universal access to sexual and reproductive health care. Recently, the Sustainable Development Goals (SDGs), which guide the global developmental agenda through 2030, repeated the call for universal access to SRH services. Target 3.7 under SDG 3 states: "By 2030, ensure universal access to sexual and reproductive health care services, including family planning, information, and education, and the integration of reproductive health into national strategies and programs"

Integrated SRH services, delivered effectively and efficiently, are pre-requisites for universal access to SRH services. Integration of SRH services in the public health system in primary health care settings means that people who are seeking information or health care for a specific sexual or reproductive health issue have their other needs met simultaneously, preferably at the same time in the same location, but otherwise by effective referral. Integration of services does not necessarily dictate that all SRH services are provided together in one site, but it requires that health care providers have the skills to provide the appropriate basic package of care and are knowledgeable about the processes for referrals. This process should be supported by a health system that provides for human, material and financial resources and by an environment that considers the prevailing social and cultural norms (WHO, 2006). Integration should therefore be viewed as a continuum, as services are usually integrated to varying extents, ranging from referrals to fully integrated services in the same facility (Atun et al, 2010).

Integration strategies aim to improve efficiency, increase access to health services, improve satisfaction with care and improve health status (Dudley & Garner, 2011). At the health systems level, integration of SRH in public health services refers the management, funding and provision of services to the health authorities and their decentralized levels rather than having a separate entity with separate management and funding for each specific program. At the service delivery level, integration of SRH services means providing more than the basic maternal and child health care and family planning, such as services for sexually transmitted infections, HIV/AIDS, infertility, abortion care, reproductive cancers and menopause-related health issues (Berer, 2003).

In practice, there have been different approaches for integrating SRH services. In some settings, new interventions have been added to existing services, and in others, separate components of care have been combined through changes in the organization and coordination of care (Ekman, 2008; Fleischman et al, 2002). Given the heavy burden of infant and maternal mortality, STIs, HIV/AIDS and other reproductive health problems, especially in low- and middle-income countries, the integration of an essential SRH package meeting the country's most pressing needs is deemed a more promising alternative towards enhancing reproductive health. Making SRH services available only through vertical programs and the private sector is deemed insufficient to promote equity in access and utilization of reproductive health services. Therefore, integrating SRH services into mainstream, existing primary health care makes the services more accessible for non-traditional users of family planning services such as men and adolescents (Warren et al, 2017). Studies evaluating horizontal or vertical systems of service delivery confirm that integration improves the efficiency and the quality of care; however, in contexts with weak public health systems, vertical programs can be effective in delivering targeted lifesaving interventions (Dudley & Garner, 2011).

More specifically, some evidence supports improving the efficiency of services with integrated models of family planning; however, there is not enough evidence that integration improves health outcomes (Dudley & Garner, 2011). Linking SRH and HIV services in family planning clinics is considered beneficial in improving health and behavioral outcomes (WHO, UNFPA, UNAIDS, IPPF, and UCSF, 2009). More research is needed examining strategies for integrating services for specific population groups, such as adolescents, men, sex workers and people living with HIV (Warren et al, 2017), and the cost-effectiveness and cost-efficiency of integrated services in different settings (Dudley & Garner, 2011). There is also a large gap in our understanding of the most effective pathways for integrated services and mechanisms necessary to strengthen linkages between different forms of primary health care services (Briggs & Garner 2006).

Several challenges are associated with adopting integrated approaches. A lack of resources (financial, human, and technological) and absence of political commitment contributes to one dimension of this problem. The process of integration may also overwhelm the front-line health practitioners who must provide multiple SRH services (Sweeney et al, 2014). It requires training individual providers in several core competencies, and/or having multiple providers with different skills clustered in each service site (Dudley & Garner 2011). Given the lack of rigorous monitoring and evaluation of integrated primary health care services, it is difficult to learn more about the implementation challenges faced in each context.

Progress toward providing universal health care requires changing how health systems interact with communities and clients, and incorporating integration as a core principle in service delivery (Warren et al, 2017). This includes infrastructure, equipment, commodities, and a skilled health workforce at all levels, and especially at the community and first level of care. Moreover, efforts to implement integration need to be assessed within the broader context of human resource planning to ensure that neither staff nor clients are negatively affected by integration policy, and that providers' concerns are addressed (Mutemwa et al, 2013; Mayhew et al, 2016.)

Moreover, although integrated physical structures, equipment, supplies and trained staff are all important, they do not guarantee that clients will receive integrated services (Mayhew et al. 2016). Motivated staff must initiate more than one service, or a client must demand more than one service, during a consultation. Building a health-sector workforce with the agency and authority to work flexibly to make decisions, communicate effectively within and across services, and share workloads as part of a team is critical to sustainable programs of integrated SRH-HIV care (Warren et al, 2017).

Arab countries represent a large diversity in income levels, cultural norms, political and health systems. Despite the health sector reforms that have been undertaken, continuous political unrest, armed conflict and the resulting humanitarian crises hinder access to SRH services and overwhelm the health care systems. These problems compound the existing challenges of poor quality care, fragmented systems and the rising conservatism in some Arab countries that are restricting budgets and shifting priorities away from reproductive health issues. Nevertheless, concerted efforts in the region have led to important progress in reproductive health, such as the reduction in maternal mortality in Egypt, Tunisia and Morocco. These efforts continue building consensus and shaping agendas for integrating comprehensive SRH services in the health benefits package of each country working toward universal health coverage (UNFPA 2014).

2. CURRENT PROJECT

As a regional think tank and policy research hub, the Middle East and North Africa (MENA) Health Policy Forum is contributing to the improvement of SRH in the Arab region. It provides evidence-based solutions relevant to the region by supporting policy dialogue at the national and regional level. Within this capacity, the MENA Health Policy Forum under a cooperation agreement with the United Nations Population Fund (UNFPA) undertook an assessment exercise to develop a comprehensive overview of the situation of SRH integration in public health systems in Arab countries. This exercise is intended to address the prioritization of SRH in health development and advocacy efforts in Arab countries.

This exercise describes health system readiness to integrate SRH, family planning, and HIV services within PHC systems in six selected Arab countries. The specific objectives are to:

- Assess the gaps in the delivery of SRH, family planning, and HIV packages in PHC services.
- Assess the implications of national and health care policies in facilitating or hindering the integration of SRH and HIV services within PHC systems.
- Identify the efforts, strategies, and opportunities for the provision of integrated SRH and HIV services.
- Identify the challenges for the provision of integrated SRH and HIV services within PHC systems.

For the purpose of this report, a country assessment took place in each of Egypt, Jordan, Kingdom of Saudi Arabia (KSA), Morocco, Palestine, and Sudan. The regional consultant developed tools to guide the country assessments and a guidance document for reporting. The country consultants based their assessments on desk reviews of published country reports, different UN agency reports, and stakeholder interviews. They presented their findings based on triangulation of data and raised country-specific recommendations in separate reports.

This regional report compiles the information from all six country reports and draws recommendations relevant at the regional level. It does not aim to provide an evaluation of the impact of integration on health outcomes in these countries nor does it assess quality of care. In general, the report presents the current situation in the six countries in terms of SRH services and programs, then discusses opportunities for integration. This report will be presented and discussed during a regional meeting organized by the MENA Health Policy Forum.

3. CURRENT SITUATION IN THE SELECTED COUNTRIES

3.1 The Primary Health Care Systems

The six countries included in this assessment are characterized by their complex health care systems, which consist of the government and/or public, private, and civil society sectors. PHC is prominent in their health care systems. The ministries of health and health authorities in these countries govern a network of PHC centers and act as the main provider of services in KSA and Morocco, with varying roles for civil society, nongovernmental organizations (NGOs), and the private sector in Jordan, Palestine, Egypt, and Sudan. UNRWA (United Nations Relief and Works Agency for Palestine Refugees in the Near East) also plays a major role in provision of services to Palestinian refugees in Jordan and in Palestine.

Although the health care systems in the six countries are mostly hierarchical and centralized in nature, the ministries of health in these countries regulate and govern the health sector and have invested in PHC throughout the years. For example, Egypt, Sudan, and Jordan made efforts to have regional and/or rural coverage of PHC centers. Most PHC centers provide general basic services for the public, yet examples exist of different kinds of centers with specific scopes. For instance, Egypt and Sudan have PHC centers directed toward family health and Egypt has specific maternal and child health centers. Morocco is the only country in this assessment that has designated PHC centers in the form of youth health spaces.

Despite efforts to improve coverage of the PHC system in most of these countries, many suffer from fragmentation, poor infrastructure, and donor-driven agendas, as reported in Palestine, and Sudan. In general, there is recognition of the need to focus on improving coverage and quality of services and reaching pockets of social disparities in populations.

3.2 National Reproductive Health Programs

Since the 1960s and 1970s population policy has been considered a main component of economic and social development programs in these countries, specifically in Jordan, Morocco, and Egypt. These programs focused on decreasing total fertility rates (TFRs) through the provision of family planning services at the PHC level and minimizing social barriers to increase acceptability and use. With the adoption of the ICPD Program of Action in the mid-1990s and later with the MDGs, national programs supported by UN agencies in some instances targeted the coverage and quality of family planning and maternal and child health programs. In the recent SDG era and in line with the new global developmental agenda, national strategies, such as in the case of Jordan, Morocco, and Sudan, are highlighting multisectoral collaboration, integration, and strengthening of the linkages and referral systems. Challenges remain in the coverage of remote rural areas and of socioeconomically disadvantaged populations.

Maternal and child health national programs started with the Safe Motherhood Initiative, with all six countries integrating family planning services; later with the MDGs,

these programs included HIV testing during pregnancy in certain countries. The main aim was to achieve the MDG target of the expected reduction in maternal mortality. Sudan and Egypt experienced a substantial reduction in the maternal mortality rate (MMR) during the two preceding decades. However, both countries face wide regional disparities in this regard. Morocco has achieved the MMR MDG target. This success is the result of efforts put toward decentralization of services, provision and strengthening of emergency obstetric care, support for collaboration between different sectors, and improved quality of care. National programs or action plans are currently in place in Morocco and Sudan to further improve their maternal health outcomes.

HIV/AIDS is considered to have a low prevalence in all of the reviewed countries except Sudan, where its priority among youth is acknowledged. HIV/AIDS national programs are predominantly designed and provided as vertical programs and rely heavily on donor assistance, which creates challenges with sustainability, as demonstrated by the experience with the Global Fund in Palestine and Sudan. Most of the national programs target populations at risk (sex workers, men who have sex with men, and injection drug users). Both Morocco and Sudan have recent national plans responding to the UNAIDS (Joint United Nations Programme on HIV/AIDS) "zero new HIV infections, zero discrimination and zero AIDS-related deaths" initiative.

All national strategies and plans developed throughout the years were aligned with the PHC approach. Recently these are also heavily influenced by the focus on UHC. Nonetheless, gaps remain between national health strategies or plans and service delivery processes.

3.3 Sexual and Reproductive Health Indicators

The six selected countries show a variation in the TFR, from the lowest rates of 2.2 children per woman in Morocco and 2.3 in KSA, to the highest rates of 4.1 and 5.3 in Palestine and Sudan, respectively. The contraceptive prevalence rate (CPR) is highest in Morocco (67.4 percent) followed by Jordan and Egypt, and lowest in KSA (28.2 percent) and Sudan (12.1 percent), where the unmet need is also substantial (26.6 percent). The low CPR coupled with the low TFR in KSA suggests that contraception is used for spacing rather than limiting. Oral contraceptives and intrauterine devices (IUDs) are the most commonly used methods of contraception in these countries, in addition to withdrawal specifically in Jordan and Sudan. The high desired number of children reflects the pro-natalist cultures in these countries (Table 1).

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

Indicator	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Total fertility rate (TFR)	3.5[1]	3.38[2]	2.2[3]	4.1[4]	2.4[5]	5.2[6]
Contraceptive prevalence rate (CPR)	59%[1]	61%[7]	67.4%[8]	57.2%[9]	28.2%[5]	12.1%[6]
Prevalence of infertility in women	NA	NA	5%[10]	NA	NA	NA
Unmet need for family planning	13%[1]	12%[7]	10.9%[8]	10.9%[9]	NA	26.6%[6]
Unintended births	16%[1]	NA	27.6%[8]	NA	NA	NA
Method mix						
IUD	30%[1]	21%[7]	4.3%[12]	59.3%[11]	18%[5]	0.6%[12]
Pills	16%[1]	8%[7]	49.6%[12]	18.1%[11]	62%[5]	4.8%[12]
Injectables	9%[1]	1%[7]	-	-	1%	0.1%[12]
Female sterilization	1%[1]	2%[7]	3%[12]	-	3%[5]	0.9%[12]
Withdrawal	-	14%[7]	3.9%[12]	-	1%[5]	3.4%[12]
Condoms	-	8%[7]	1.2%[12]	12.7%	-	0.1%[12]
Traditional methods	2%[1]	19	2%[12]	5%	4%	-
Breastfeeding	-	1.3	-	-	10%[5]	-
Others	-	0.2%	4.2%[12]	9.9%	3%[5]	2.3%[12]
Desire for additional children	77%[1]	76%[7]	43.5%[8]	NA	NA	NA

1. EDHS (2014).
2. Ministry of Health Statistical report, Jordan (2016).
3. Healthy numbers in 2015, Ministry of Health, Morocco (2016).
4. Palestine 2030, UNFPA (2017).
5. Ministry of Health indicators 2016, GAStat (2016).
6. MICS (2014).
7. JPFHS (2012).
8. National Population and Family Health Survey 2011 (2012).
9. PCBS (2014).
10. 3C studies: To see, or not to see: that is the question! Infertility in the Maghreb: Statistical aspect 3c studies - Marketing, media and opinion study institute (2017).
11. Family Planning 2020, State of Palestine (2016).
12. UN – Economic and Social Affairs, Trends in contraceptive use worldwide (2015).

Despite the fact that all six countries witnessed a decline in maternal mortality during the last decades, wide variation exists in their MMRs, ranging from a high of 216 deaths per 100,000 live births in Sudan to a low of 12 in KSA. The same trend is observed in the perinatal mortality rate. All countries have universal coverage of antenatal care and birth with skilled health personnel, except Morocco and Sudan, the latter having only 30 percent antenatal care coverage (Table 2).

Table 2: Maternal and newborn health indicators

Indicator	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Maternal mortality rate (MMR)	49[13]	19.1[14]	72.6[15]	23.1[16]	12[17]	216[18]
Antenatal care coverage	93.3%[19]	99%[20]	77.1%[21]	99.2%[22]	98%[23]	30%[18]
Percent of births attended by skilled health personnel	90.7%[19]	100%[20]	72.7%[21]	99.20%[22]	98%	77.50%[18]
Availability of basic essential obstetric care	NA	3.6[24]	174[25]	8.4[26]	NA	211[18]
Availability of comprehensive essential obstetric care	NA	3.1[24]	83[25]	8.4[26]	NA	211[18]
Prevalence of anemia in women	25%[19]	23.7%[27]	32,3%[28]	NA	NA	NA
Perinatal Mortality Rate (PMR)	15[13]	17	28.5[21]	11[29]	2.74[17]	60[30]
Low birth weight prevalence	16.5%[19]	8.6%[14]	3.3%[31]	8.3%[32]	8.4%[33]	32.3%[34]

13. Statistical yearbook 2017– Vital Statistics: 3-4 Maternal, Neonatal & Infant Mortality Rates (1988 - 2016).
14. Ministry of Health Statistical report, Jordan (2016).
15. Ministry of Health website, Morocco (2016).
16. Ministry of Health, Palestine (2014).
17. Ministry of Health indicators (2016).
18. UNFPA – FMOH Sudan - SRH Survey (2016).
19. EDHS (2014).
20. JPFHS (2012).
21. National Population and Family Health Survey (2011).
22. National Reproductive Health Strategy and Action Plan, MOH, 2014-2016.
23. WHO (2015).
24. Ministry of Health Statistical Report, Jordan (2016).
25. Resource assessment system, needs and monitoring of obstetric and neonatal emergency care (2011).
26. Annual Health Report, Palestine. PHIC (2015).
27. Ministry of Health website, Jordan (2016).
28. World Bank (2011).
29. WHO (2007).
30. SHHS (2010).
31. Health in numbers in 2015, Ministry of Health, Morocco (2016).
32. PCBS (2009).
33. GAStat (2014).
34. MICS (2014).

HIV/AIDS prevalence is considered to be low in these countries, although few data are available in this regard. This is also reflected in the low prevalence among pregnant women reported from Morocco and Sudan. Morocco also reports efforts in improving knowledge about HIV/AIDS in its population through its national strategic plan, resulting in a 44.7 percent knowledge level. Female genital cutting is highly prevalent in both Egypt and Sudan (Table 3).

Table 3: HIV, STIs, and other indicators

Indicator	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Positive syphilis serology prevalence in pregnant women	NA	NA	0.73%[35]	NA	NA	NA
Reported incidence of urethritis in men	NA	NA	0.62%[35]	1.2%[36]	NA	NA
HIV prevalence among pregnant women	NA	NA	0.1%[35]	NA	NA	2%
Knowledge of HIV-related prevention practices	26.1%[37]	13%[38]	44.09%[35]	7.7%[39]	NA	NA
Reported prevalence of women with female genital cutting	93.10%[40]	NA	NA	NA	NA	86.6%[41]

3.4 Essential SRH Services Offered at PHC Facilities

The current status of the reproductive, family planning, and maternal and newborn health infrastructure and services in the six countries is summarized in Table 4 and as follows:

- While most facilities in all of the countries provide family planning services, it is worth noting that Sudan does so in slightly over one-third of its family health centers and units. Most of the countries provide family planning methods, counseling, and information, yet provision of emergency contraception is lacking. Egypt, Jordan, and KSA do not provide emergency contraception in any of their public health care facilities.

35. Implementation of the Political Declaration on HIV/AIDS (2015).
36. Annual Health Report, Palestine. PHIC (2015).
37. EDHS (2014). Knowledge of HIV preventive methods: for women aged 15–59, 26.1 percent, and for men 40.5 percent for two methods.
38. JPFHS (2012).
39. PCBS (2014).
40. EDHS (2014).
41. MICS (2014).

- Most of the countries do not have designated facilities for youth-friendly services, except for KSA and Morocco. The latter has 32 youth health spaces designated specifically for that purpose. Minor efforts in this regard were conducted in Egypt and Palestine but were not scaled up.
- The situation for HIV/AIDS-related services shows variation among countries. Morocco provides comprehensive services that include: (i) prevention and management of mother-to-child transmission of HIV/AIDS; (ii) HIV testing and counseling; and (iii) HIV/AIDS treatment. KSA provides the above services at the secondary and tertiary care levels whereas Jordan provides only testing, counselling, and treatment in specialized clinics at the central level. Palestine provides information on prevention and management of HIV/AIDS in all of its facilities, but without providing HIV counseling and testing or treatment. Sudan provides HIV counseling and testing through its family health centers. In Egypt, counselling and testing is provided in 27 Voluntary Counseling and Testing centers (VCTs) distributed across the country, where 9 of these centers are mobile. HIV/AIDS treatment is provided in 15 Fever Hospitals that also offer prevention and management of mother-to-child transmission of HIV/AIDS. Egypt is currently piloting the integration of prevention of mother-to-child transmission of HIV (PMTCT) in nine Maternal Child Health centers.
- In all six countries, antenatal care is part of the PHC package. On the other hand, facilities that are designated to carry out deliveries are primarily hospitals. Only a portion of PHC centers are designated for that purpose in Morocco (550 out of 2,792). The same applies to family health centers (875 out of 1,930) and units (250 out of 1,882) in Sudan.
- Basic Emergency Obstetric and Neonatal Care (BEmONC) is provided mainly in hospitals in the six countries, with the exception of the PHC centers in Morocco and Sudan – mentioned in the previous point – and the 19 advanced PHC centers in Palestine. The provision of Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) through PHC centers is virtually nonexistent. In all countries, CEmONC is provided in hospitals and similar facilities. It is worth noting that PHC centers in Jordan and KSA do not provide either CEmONC or BEmONC.
- All countries provide neonatal and child care in their public health care facilities whether they are specialized centers, hospitals, or different types of PHC centers.
- Prevention of unsafe abortion and post-abortion care are provided only in Morocco and Sudan. Abortion services are restricted by law in all of these countries.
- In contrast to antenatal and postnatal care and family planning services, other reproductive health conditions such as cervical and breast cancer screening and prevention and management of gender-based violence and sexual health conditions are not universally available at PHC facilities.

Table 4: Essential SRH services offered at PHC facilities

Services	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Family planning	Yes	Yes	Yes	Yes	Yes	Yes
Antenatal care	Yes	Yes	Yes	Yes	Yes	Yes
Labor and delivery	-	-	Yes	-	.	Yes
Postnatal care	Yes	Yes	Yes	Yes	Yes	Yes
Newborn and child health	Yes	Yes	Yes	Yes	Yes	Yes
Prevention of unsafe abortion and post-abortion care	-	-	Yes	-	-	Yes
Emergency contraception	-	-	Yes	Yes	-	Yes
STI/RTI screening, diagnosis, and treatment	-	Yes	Yes	Yes	-	Yes
Cervical cancer screening	-	.	Yes	Yes	-	-
Breast cancer screening	Yes	Yes[42]	Yes	Yes	-	-
Prevention and management of gender-based violence	-	Yes[43]	Yes	Yes	-	-

In summary, Morocco seems to be a unique example, as it provides the majority of the mentioned services in all public health care facilities. KSA is similar in some aspects. The other countries share some common gaps with respect to services provided. Emergency contraception and youth-friendly services are lacking in most of the countries. Many services provided at public health care facilities are lacking at the PHC level, such as carrying out deliveries and providing CEmONC and to some extent BEmONC. Gaps in provision of HIV/AIDS-related services and neonatal and child care are also apparent, but with some variations among countries in terms of the service provided and of the providing facility.

The review of the country assessments identified a set of common challenges faced and gaps in the provision of SRH services. The complexities of social norms, prevailing poverty, and political dynamics hinder the design and provision of services targeting the most vulnerable population groups, namely youth, unmarried women, and pregnant adolescents. The restrictive types of services targeting women and children at the PHC level also exclude men. In general, the concept of sexual health is

42 Diagnosis and treatment only.
43 Management only.

not well incorporated in the components of the service packages provided. A clear gap exists in the provision of services targeting STDs. In addition, gaps arise in the organization of existing services, demonstrated by poor coordination between different sectors of the health care system as well as by the quality of care, resulting in deficient effectiveness and efficiency of services.

3.4.1 Status of Family Planning Services Offered at PHC Facilities

Contraceptive methods that are mostly available in PHC centers in these six countries include oral contraceptive pills, injectables, IUDs, and to a lesser extent, implants and male condoms. The exception is KSA, where the only method offered at PHC centers is the oral contraceptive pill. Female sterilization is offered in PHC centers run by the health authority in Sudan and referrals to secondary and tertiary care levels are made in Jordan for the same purpose. Emergency contraceptive pills are not offered in Jordan, Egypt, and KSA. Contraceptive supply gaps are reported mainly for implants and emergency contraceptive pills (Table 5).

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

	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Family planning services offered at PHC facilities						
Contraception provision	Yes	Yes	Yes	Yes	Yes	Yes
Counseling	Yes	Yes	Yes	Yes	Yes	Yes
Health education	Yes	Yes	Yes	Yes	Yes	Yes
Emergency contraception	-	-	Yes	Yes	-	Yes
Other, specify:	-	Yes [44]	-	-	-	-
Family planning methods offered at PHC facilities						
Oral contraceptive pills	Yes	Yes	Yes	Yes	Yes	Yes
Implants	Yes	Yes	-	-	-	Yes
Injectables	Yes	Yes	Yes	Yes	-	Yes
IUDs	Yes	Yes	Yes	Yes	-	Yes
Male condoms	Yes	Yes	Yes	-	-	Yes
Female condoms	-	-	-	-	-	-
Male sterilization	-	-	-	-	-	-
Female sterilization	-	-	-	-	-	Yes
Emergency contraceptive pills	-	-	Yes	Yes	-	Yes
Diaphragms	-	-	-	-	-	-
Foam/gel	-	-	-	-	-	-
Cycle beads	-	-	-	-	-	-
Lactational Amenorrhea Method (LAM)	Yes	Yes	-	-	-	-
Other, specify:	-	-	-	-	-	-
Family planning methods that suffer mostly from supply delays or lack of resources to ensure availability						
Oral contraceptive pills	-	-	-	-	-	Yes
Implants	Yes	Yes	Yes	-	-	Yes
Injectables	-	-	-	Yes	-	-
IUDs	-	-	Yes	.	-	-
Male condoms	-	-	-	-	-	-
Female condoms	-	-	-	-	-	-
Male sterilization	-	-	-	-	-	-
Female sterilization	-	-	-	-	-	-
Emergency contraceptive pills	-	-	Yes	-	-	-
Diaphragms	-	-	-	-	-	-
Foam/gel	-	-	-	-	-	-
Cycle beads	-	-	-	-	-	-
Lactational Amenorrhea Method (LAM)	-	-	-	-	-	-

44 Referral for tubal ligation.

3.4.2 Status of HIV-Related Services Offered at PHC Facilities

HIV-related services are quite restrictive in PHC centers in these countries and are mainly provided through vertical programs and/or specialized clinics. HIV counselling and testing at the level of PHC centers is offered in Morocco and in Egypt as part of a pilot project in some centers. PMTCT is adopted in Morocco and Sudan. Prevention information and services are also lacking except in Palestine and through a pilot project in Egypt (Table 6).

Table 6: Status of HIV-related services offered at PHC facilities

Service	Egypt[45]	Jordan	Morocco	Palestine	KSA	Sudan[46]
HIV counseling and testing	Yes	-	Yes	-	-	-
PMTCT (at a minimum: access to antiretroviral drugs to prevent vertical transmission and for treatment of mothers)	Yes	-	Yes	-	-	Yes
TB screening	-	-	-[47]	Yes	Yes	Yes
Prophylaxis and treatment of people living with HIV (PLHIV) (Opportunistic Infections (OIs) and HIV)	-	-	-[48]	-	-	Yes
Treatment for opportunistic infections	-	-	Yes	Yes	-	-
Male circumcision	-	-	Yes	.	-	-
STI screening, diagnosis, and treatment	-	-	Yes	Yes	-	-
Anti-retroviral therapy (ART)	-	-	-[49]	-	-	Yes
Condom provision	Yes	-	Yes	Yes	-	-
Psychosocial support (positive health, dignity, and prevention)	-	-	Yes	-	Yes	Yes
HIV prevention information and services for general population	Yes	-	-	Yes	-	-
Specific HIV information and services for key populations (Injection drug users, men who have sex with men, sex workers)	-	-	Yes	-	-	-

45 As a pilot project in some PHC centers.
46 Services scattered in ministry of health, UNFPA, and UNAIDS centers.
47 Offered in specialized clinics.
48 Offered at reference hospital.
49 Offered at reference hospital.

3.4.3 The Minimum Benefits Package for Reproductive, Family Planning, and Maternal and Newborn Health Services

As shown in Table 7, all six countries reported having a minimum guaranteed benefits package for reproductive, family planning, and maternal and newborn health. In general, services related to STIs and HIV are rarely included in these packages. Abortion care follows the legal framework of each country. Family planning is not part of the minimum benefits package of care in KSA.

Table 7: Status of the minimum benefits package for SRH services

	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Does your country have a minimum guaranteed benefits package for SRH?	Yes	Yes	Yes	Yes	Yes	Yes
Core pre-pregnancy interventions included in the minimum guaranteed benefits package						
Family planning (advice, hormonal and barrier methods)	Yes	Yes	Yes	Yes	-	Yes
Family planning (surgical methods)	-	Yes	-	Yes	-	Yes
Prevention and management of STIs and HIV	Yes	Yes[50]	-	Yes	Yes	Yes
Folic acid fortification/ supplementation to prevent neural tube defects	Yes	Yes	-	Yes	Yes	Yes
Core antenatal interventions included in the minimum guaranteed benefits package						
Iron and folic acid supplementation	Yes	Yes	Yes	Yes	Yes	Yes
Tetanus vaccination	Yes	Yes	Yes	Yes	Yes	Yes
Prevention and management of STIs and HIV, including with antiretroviral medicines	-	Yes[51]	Yes	-	Yes	-
Calcium supplementation to prevent hypertension (high blood pressure)	Yes	Yes	-	Yes	Yes	Yes

50 HIV is not included.
51 HIV prevention, antiretroviral medicines are not included.

	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Interventions for cessation of smoking	Yes	-	Yes	Yes	Yes	-
Screening for and treatment of syphilis	-	-	Yes	-	Yes	Yes
Low-dose aspirin to prevent pre-eclampsia	Yes	Yes		Yes	Yes	Yes
Antihypertensive drugs (to treat high blood pressure)	Yes	Yes	Yes	Yes	Yes	Yes
Magnesium sulphate for eclampsia	Yes	Yes	Yes	Yes	Yes	Yes
Antibiotics for preterm prelabor rupture of membranes	Yes	Yes	Yes	Yes	Yes	Yes
Corticosteroids to prevent respiratory distress syndrome in preterm babies	Yes	Yes	Yes	Yes	Yes	Yes
Safe abortion (in certain conditions)	-	-[52]	-[53]	-	-	Yes
Post-abortion care	Yes	Yes	Yes	-	Yes	Yes
Reduce malpresentation at term with External Cephalic Version	-	Yes	-	Yes	-	-
Induction of labor to manage prelabor rupture of membranes at term (initiate labor)	Yes	Yes	Yes	Yes	Yes	Yes
Core childbirth interventions included in the minimum guaranteed benefits package						
Prophylactic uterotonics to prevent postpartum hemorrhage (excessive bleeding after birth)	Yes	Yes	Yes	Yes	Yes	Yes
Manage postpartum hemorrhage using uterine massage and uterotonics	Yes	Yes	Yes	Yes	Yes	Yes
Social support during childbirth	-	-	Yes	Yes	Yes	-

52 Only if mother's health is at risk for medical reasons.
53 In many cases, until now the abortion is illegal in Morocco.

	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Active management of third stage of labor (to deliver the placenta) to prevent postpartum hemorrhage (as above plus controlled cord traction)	Yes	Yes	Yes	Yes	Yes	Yes
Management of postpartum hemorrhage (as above plus manual removal of placenta)	Yes	Yes	Yes	Yes	Yes	Yes
Screen and manage HIV (if not already tested)	Yes	-	Yes	-	-	-
Caesarean section for maternal/fetal indication (to save the life of the mother/baby)	Yes	Yes	Yes	Yes	Yes	Yes
Prophylactic antibiotic for caesarean section	Yes	Yes	Yes	Yes	Yes	Yes
Induction of labor for prolonged pregnancy (initiate labor)	Yes	Yes	Yes	Yes	Yes	Yes
Management of postpartum hemorrhage (as above plus surgical procedures)	Yes	Yes	Yes	Yes	Yes	Yes
Core postnatal (mother) interventions included in the minimum guaranteed benefits package						
Family planning advice and contraceptives	Yes	Yes	Yes	Yes	Yes	Yes
Nutrition counselling	Yes	Yes	Yes	Yes	Yes	-
Screen for and initiate or continue antiretroviral therapy for HIV	-	-[54]	Yes	Yes	Yes	Yes
Treat maternal anemia	Yes	Yes	Yes	Yes	Yes	Yes
Detect and manage postpartum sepsis (serious infections after birth)	Yes	Yes	Yes	Yes	Yes	Yes
Core postnatal (newborn) interventions included in the minimum guaranteed benefits package						
Immediate thermal care (to keep the baby warm)	Yes	Yes	Yes	Yes	Yes	Yes
Initiation of early breastfeeding (within the first hour)	Yes	-[55]	Yes	Yes	Yes	Yes

54 At-risk groups and known cases are referred to the related department at the level of health governorates.
55 There are five breastfeeding-friendly hospitals. The initiative is now being reinitiated by the Ministry of Health.

	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Hygienic cord and skin care	Yes	Yes	Yes	Yes	Yes	Yes
Neonatal resuscitation with bag and mask (by professional health workers for babies who do not breathe at birth)	Yes	Yes	Yes	Yes	Yes	Yes
Kangaroo mother care for preterm (premature) and less than 2000-g babies	Yes	Yes	Yes[56]	Yes	-	-
Extra support for feeding small and preterm babies	Yes	Yes	Yes	Yes	Yes	Yes
Management of newborns with jaundice ("yellow" newborns)	Yes	Yes	Yes	Yes	Yes	Yes
Initiate prophylactic antiretroviral therapy for babies exposed to HIV	Yes	Yes	Yes	Yes	Yes	Yes
Presumptive antibiotic therapy for newborns at risk of bacterial infection	Yes	Yes	Yes	Yes	Yes	Yes
Use of surfactant (respiratory medication) to prevent respiratory distress syndrome in preterm babies	Yes	Yes	Yes	-	Yes	Yes
Continuous positive airway pressure (CPAP) to manage babies with respiratory distress syndrome	Yes	Yes	Yes	Yes	Yes	Yes

56 One unit at health center at Rabat.

3.5 Key Players and Funding for SRH Programs and Services

The ministries of health and health authorities at central/federal, regional, and district levels are the main stakeholders involved in SRH programing and service provision. In all six countries, close collaboration occurs between governmental departments and UN agencies (UNFPA, UNAIDS, UNICEF). The role of UNRWA is major in the provision of services to Palestinian refugees in Jordan and in Palestine as is the role of the United Nations High Commissioner for Refugees (UNHCR) and UNFPA in addressing SRH needs of populations affected by the conflict in Syria and Sudan. UN agencies provide technical and financial assistance to governments, NGOs, and sometimes the private sector.

Civil society, represented by NGOs, is an important stakeholder mainly for SRH service provision in Egypt, Palestine, Jordan, and Morocco. NGOs play an active role in filling the gaps in service provision through their health care centers and often through outreach services such as mobile clinics in rural areas in Jordan. They are also heavily involved in working with key populations such as sex workers, injecting drug users, and men who have sex with men, and in raising awareness about SRH issues.

Egypt, Palestine, and Jordan also have a large private sector. This sector's role is in service provision and is often unregulated, contributing to inefficiency in the system. A good example of such a situation is portrayed in Palestine and Egypt. Pharmacies have a growing role in the private sector through the delivery of family planning commodities in both urban and rural areas.

Religious authorities have a continuous role in shaping people's belief system and have been partnered in certain SRH programs such as family planning initiatives. The continuous engagement in open dialogue with these authorities remains important for the success of SRH policies and programs.

SRH programs and services are heavily reliant on government funding in these countries. Ministries of health also rely on UN and international donor agencies in the implementation of specific programs, something that threatens disruption in services with the discontinuation of support (for example, HIV/AIDS programs supported by the Global Fund in Morocco, Sudan, and Palestine and family planning initiatives supported by UNFPA). It is to be noted here that government funding for primary health services is usually less than that allocated for secondary and tertiary care. Moreover, ministry of health budgets are often divided between independently operated vertical SRH programs, creating further competition for already scarce resources.

3.6 SRH Workforce

In general, these countries have a physician-dominated health care system. Midwives constitute a large proportion of the SRH workforce only in Sudan and to a lesser extent in Morocco. Jordan has a newly established midwifery program with 20 students currently enrolled. Midwives, auxiliary midwives, and auxiliary nurse-midwives are not part of the workforce in KSA. Egypt's situation is similar, with some roles only for nurse-midwives. Community health workers are present in Egypt, Palestine, and Sudan (Table 8).

High school degrees were reported as the minimum requirement to be trained as a midwife, auxiliary midwife, and nurse-midwife in all countries offering academic training in these professions, which require three to four years to complete. A prior university degree or a high school degree is required to enter medical schools in these countries, depending on the local educational system. As followed in all educational models, the training of physicians takes around six to seven years, and specializations in obstetrics and gynecology require an additional four to five years.

An obvious lack of complementarity arises in the division of tasks between general physicians, obstetrician/gynecologists (OB/GYNs), and the midwifery cadre. Physicians and specialists bear the majority of responsibilities, with minimal exclusive roles given to midwifery personnel. An exception to this is Sudan, where midwives are given more roles than in other countries in this assessment. Jordan is the only country with some task divisions among its cadre that might reflect certain efforts toward complementarity. In general, the emphasis is more on clinical tasks than on other aspects of care, such as cross-cultural communication and promotion of shared responsibility with women, families, and the community in all these countries.

Tasks relating to labor and birth care are shared between general physicians, OB/GYNs, and midwives in all six countries except Egypt, where these tasks are the responsibility of physicians only. Providing HIV treatment and care is exclusively recognized as physicians' responsibility in Egypt, Jordan, and Sudan, whereas in KSA, HIV counselling is not listed as a responsibility for any group in the cadre. It is only in Morocco that everyone in the cadre is involved in provision of HIV services. Family planning services in terms of counselling and provision of contraception are among the responsibilities of only physicians in KSA. The situation is not that different in Egypt, as additional cadre other than physicians are only involved in counseling, either as a core responsibility of community health workers or as a minimal role of nurse-midwives in postpartum family planning advice. In contrast, the health care cadre other than physicians are responsible for providing contraception in Morocco. Every member of the health care workforce is engaged in the provision of family planning-related services in Jordan and Sudan.

Sudan is the only country with a large number of trained midwives working in the public health care system. These midwives share all the responsibilities of providing SRH services, very few roles are exclusive to them. These include the vital roles of promotion of family planning, cross-cultural communication with beneficiaries, education of women and their families/supporter in self-care, and promotion of shared responsibility with women, their families, and communities, leaving most of the clinical or other psychosocial roles to be covered primarily by physicians and, to a lesser extent, the rest of the cadre.

Countries reported workforce-related challenges encountered in the provision of SRH services, mainly related to lack of capacity-building opportunities and shortage of staff time, in addition to maldistribution of qualified staff between rural and urban regions and "brain drain." Shortages in certain cadres are evident, namely of midwives and nurses. Low wages in the public sector are a major contributing factor for dual practice among physicians, a persistent problem encountered in countries with a major private sector, such as Egypt.

Table 8: SRH workforce and cadre

	Country	Midwives	Auxiliary midwives	Nurse-midwives	Auxiliary nurse-midwives	Physicians (general)	Physicians (OB/GYN)	Community Health Worker	Counselors for HIV/AIDS
The minimum entry requirements to train as this cadre	Egypt[57]	-	-	S or U	-	U	U	S	S or U
	Jordan[58]	S	S	S	S	S	S	S	S
	Morocco	S[59]	-	S[3]	NA	S[3]	U[60]	-	-
	Palestine	S	S	S	-	S	S	S	-
	KSA	S	S	S	S	U	U	U	U
	Sudan	S	S	S	S	U	U	S	U
Years of study required to qualify as this cadre	Egypt	-	-	3-5 years[61]	-	6 years [62]	8-9 years[63]	3 years[64]	2-5 years
	Jordan	4 years	3 years	4 years	2 years	7 years	11 years	-[65]	-
	Morocco	3 years	-	3 years	2 years	7 years	12 years	-	-
	Palestine	4 years	2 years	4-6 years	NA	7 years	11 years	2 years	-
	KSA	NA	NA	NA	NA	6 years	11 years	10 years	8 years
	Sudan	15 months	2 years	4 years	NA	6 years	12 years	9 months	4 years
Number of workers in this cadre currently engaged in providing RMNH (including FP and HIV) services	Egypt	-	-	3,186 17,144 (nurses)[66]	-	71,900	6,512	14,000	200
	Jordan	20[67]	Public hospitals: 5,699 PHC: 742	Public hospitals: 32,301 PHC: 652	Public hospitals: 32,301 PHC: 652	Public hospitals: 2,129 PHC: 728	PHC: 51	48	1
	Morocco	1600	-	3,503	2,340	3,105	273	-	-
	Palestine	357	NA	NA	-	1,406	290	300	-
	KSA	*Total number of nurses is 172,483				12,332	3,614	2,640	89
	Sudan	19,596	NA	NA	NA	NA	NA	NA	NA

57 Egypt does not have in its cadre midwives, auxiliary midwives, or auxiliary nurse-midwives, but rather has nurses and nurse specialists. Nurses qualify after either 3 or 5 years of education and training after preparatory school, estimated at 98,123 and 4,686 nurses, respectively. Nurse specialists qualify after 4 years of education and training in a university degree and are estimated at 12,458 nurse specialists.

58 In Jordan, the auxiliary nurse-midwive cadre is referred to as registered nurse (RN), and includes associate midwives who completed the required additional one year of qualification for RN, and who continue to work as midwives but are reported as RNs. Additionally, there is another cadre, assistant nurse, that work under supervision mainly in PHC.

59 Scientific baccalaureate; entrance examination.

60 Internship or residency contest.

61 Plus 21 weeks of specialized training.

62 Plus 10 weeks for preservice training and 5 days of specialized practical training on family planning.

63 Plus 3 days advanced course on family planning standards.

64 Plus 1 week for basic family planning service delivery and counselling training.

65 Pre- and on-the-job training.

66 Nurse-midwives: 3,186; Nurses: 4,686 (5 years secondary school), 98,123 (3 years secondary school); total numbers not only those who work in SRH.

67 Currently enrolled as this is a newly established program.

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

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, and UNAIDS 2008), and was used accordingly in the assessments done in the six selected countries.

Historically, reproductive health services offered in these countries consisted of family planning programs and antenatal care. Following ICPD in 1994, family planning was integrated in maternal and child health services like in the cases of Egypt and Jordan. Vertical programs continued to dominate the health sector, some of which were donor-driven. During the last decade, efforts toward integration were made through specific projects such as the Family Health Model in Egypt and in UNRWA services in Palestine and Jordan and the HIV/SRH linkages program in Sudan. The evaluation of these pilot programs showed gaps in implementation and effective scaling-up has not yet been accomplished. It is important to acknowledge that recent national strategies in these countries are favoring integration of SRH services, but implementation challenges in both human and financial resources are envisaged.

At the policy level, none of the six countries selected for this assessment have national policies that specifically address SRH integration into PHC systems. Table 9 shows the array of different strategies, plans, or programs that introduce some form of integration in these countries.

Table 9: Strategies, plans, programs, or guidelines addressing SRH and HIV/AIDS integration

Country	Strategies, plans, programs or guidelines
Egypt	Family Health Model Pilot study on integration of prevention of mother-to-child transmission of HIV/AIDS and ante-natal care
Jordan	Ministry of Health – Inter-referral system within PHC 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
KSA	Ministry of Health – Strategic Plan
Sudan	National Health Strategy SRH and HIV Integration Guidelines

At the service delivery level, family planning is integrated in maternal and child health services in all the selected countries except for Morocco and only during postnatal care in Egypt. Palestine has a good integration of family planning in all other SRH services. HIV-related services are well integrated in other SRH services in Morocco and only in antenatal care in Sudan and through 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 followed in Morocco and Egypt.

These services are mainly offered to married women and only to a small group of men who accompany their partners to the PHC center (Table 10).

Table 10: Status of integration of family planning and HIV services in the current PHC system

	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Currently, the way PHC is organized in the country, are family planning services offered through the following SRH services?						
Antenatal care	-	Yes	-	Yes	Yes	Yes
Postnatal care	Yes[68]	Yes	-	Yes	Yes	Yes
Newborn and child health	-	- Yes	-	Yes	Yes	Yes
Prevention of unsafe abortion and post-abortion care	-	-	Yes	Yes	-	Yes
Emergency contraception	-	-	-	Yes	-	-
STI/RTI screening, diagnosis, and treatment	-	Yes[69]	-	Yes	-	Yes
Cervical cancer screening	-	-	Yes	Yes	-	-
Prevention and management of gender-based violence	-	-	Yes	Yes	-	-
Currently, the way PHC is organized in the country, are HIV services offered as part of the following SRH services?						
Family planning	-	-	Yes	-	-	-
Antenatal care	Yes[70]	-	Yes	-	-	Yes
Labor and delivery	-	-	Yes	-	-	-
Postnatal care	-	-	Yes	-	-	-
Newborn and child health	-	-	Yes	-	-	-

68 Counseling on contraceptives is provided during postnatal home visits.
69 STI/RTI diagnosis and treatment only.
70 In some selected sites as part a pilot project.

	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Prevention of unsafe abortion and post-abortion care	-	-	Yes	-	-	-
Emergency contraception	-	-	Yes	-	-	-
STI/RTI screening, diagnosis, and treatment	-	-	Yes	-	-	-
Cervical cancer screening	-	-	Yes	-	-	-
Prevention and management of gender-based violence	-	-	Yes	-	-	-
If yes, specify which HIV services are integrated specifically:						
HIV counselling and testing	Yes	-	Yes	-	-	Yes
PMTCT (at a minimum: access to antiretroviral drugs to prevent vertical transmission and for treatment of mothers)	Yes	-	Yes	-	-	Yes
TB screening	-	-	-	-	-	-
Prophylaxis and treatment of PLHIV (OIs and HIV)	Yes[71]	-	-	-	-	-
Treatment for opportunistic infections	Yes[71]	-	Yes	-	-	-
Male circumcision	-	-	Yes	-	-	-
STI screening, diagnosis, and treatment	-	-	Yes	-	-	-
Anti-retroviral therapy (ART)	Yes[71]	-	-	-	-	-
Condom provision	Yes[71]	-	Yes	-	-	Yes
Psychosocial support (positive health, dignity, and prevention)	Yes[71]	-	Yes	-	-	-
HIV prevention information and services for general population	Yes[71]	-	Yes	-	-	-
Specific HIV information and services for key populations (IDUs, MSM, SW)	-	-	Yes	-	-	-

71 These services are provided only to HIV-positive women through an active referral system at specialized hospitals.

	Egypt	Jordan	Morocco	Palestine	KSA	Sudan
Currently, the way SRH services are offered in the country, how are family planning and HIV services provided?						
Provided at the same location by the same health care worker on the same day	-	Yes	-	Yes	-	Yes
Provided at the same location by the same health care worker on a different day	-	-	Yes	Yes	-	Yes
Provided at the same location by a different health care worker on the same day	-	Yes	Yes	Yes	-	Yes
Provided at the same location by a different health care worker on a different day	-	-	-	Yes	-	Yes
Referred to a different service delivery point within the same facility	Yes	Yes	-	Yes	-	Yes
Referred to a different facility	Yes	Yes	-	Yes	Yes	-
Are there SRH, family planning, and HIV services provided to the following population groups at the PHC facilities in the country?						
General population	-	Yes	-	Yes		Yes
Women	Yes	Yes[72]	Yes	Yes		Yes
Men	-	Yes[73]	-	Yes		Yes
Children	-	-	-	Yes		-
Young people	-	Yes[74]	-	Yes		-
People living with HIV	-	-	-	-		-
Sex workers	-	-	-	-		-
Men who have sex with men	-	-	-	-		-
People who inject drugs	-	-	-	Yes		-
People living with disability	-	Yes	-	Yes		-
Other, specify:						

72 Married women only.
73 Usually through the wife or when he comes with wife.
74 SRH services only.

5. LESSONS LEARNED

A number of efforts have been made toward SRH integration whether through national programs or pilot projects in Egypt, Palestine, Sudan, and Morocco. These either aimed at integrating family planning and maternal child health services, as in Egypt, or integrating HIV-related services in provision of reproductive health care, as in Sudan and Morocco. The Family Health Model in UNRWA clinics in Palestine provides a successful approach in the region for providing integrated care at the PHC level.

Several issues noted through the different experiences shared in the country reports can serve as lessons learned to inform future endeavors in this regard:

- Building partnerships with civil society organizations has been an important asset in reaching key populations of interest regarding HIV/AIDS programs and services. These organizations have a large potential to access grassroots communities and therefore are an important partner leading these tasks in HIV programs.
- Recent funding opportunities in SRH from donor agencies favor integration approaches, thus providing a means to spearhead integrative efforts.
- Thorough assessment of the needs and preferences of beneficiaries is essential to inform program design and development. Ongoing monitoring is also a must. Their lack was identified as a key factor in the failure of implementation of previous integrated programs.
- Vertical programs have created multiple units and departments within the central health authorities. Any efforts toward the development of integrated programs need to allow for integration of program management within the existing structure of the system and to avoid replication of the same situation.
- National policies supporting integration cannot be materialized into action for change unless there is a timely effort to develop implementation plans.
- The health care cadre currently delivering SRH services in these countries are mainly trained to provide family planning and maternal child health services rather than HIV-related services.
- A mix between vertical and integrated programs could be a model that fits the needs in certain settings, especially considering that some vertical programs were quite successful in the past.
- When planning for integration efforts and programs, it is necessary to consider funding limits from governments and avoid dependency on external funds with time limits.
- 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. This can serve as a model to be replicated elsewhere in the region, or scaled-up in Palestine, Jordan and Egypt.

6. CHALLENGES FOR SRH INTEGRATION

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This section presents the challenges brought forward in the country reports. Some major country-level challenges are highlighted first, followed by challenges that cross-cut the six countries. It presents a synthesis of issues identified at the country level with an effort to highlight overarching aspects of relevance to most countries participating in this exercise. The challenges discussed below need to be considered within the wider geopolitical context of these countries.

6.1 Country-specific Challenges

6.1.1 Egypt

Following the ICPD in 1994, Egypt developed ambitious health plans that were not matched by the existing financial or human resources. Previous integration efforts also suffered from being confined to vertical, sponsor-dependent programming, a design that was not integration friendly. Without sustainability plans, service implementation, coverage and continuity have suffered. The recent increase in fertility rates reflects a loss of momentum in the family planning program, which was one of the early components of SRH programming in Egypt.

Lack of awareness and orientation of decision makers with appropriate forecasting in health expenditure, and programs' costing, in addition to utilization of solutions that are not evidence-based, coupled with the lack of an efficient central information system, might all impede proper prioritization and implementation of integration efforts. For instance, the current line specified in the budget of the Population and Family Planning sector does not reflect the anticipated need for expansion in the use of long-acting contraceptives.

While the Ministry of Health and Population's (MOHP) National Information Center for Health and Population generates monthly reports on maternal and child health and family planning services performance indicators, other surveillance and data gathering and information systems are either: (i) weak, such as STD surveillance; (ii) not communicating with other vertical programs, such as the maternal morbidity and mortality risks analysis that is confined to the Department of Motherhood and not shared with other sectors of the MOHP or outside it; or (iii) not optimized, as in the case of the Logistics Management Information System (LMIS), another vertical information program that lacks reporting of commodities' status. This gap in reporting and communication of information is a challenge for informed decision making.

Although the PHC system in Egypt provides considerably extensive coverage and reach, its current status needs attention in terms of maintenance and/or renovations, and it lacks essential staff such as drivers and janitorial staff. The anticipated increase in the population would add burden on the existing facilities and subsequently act as a challenge for integration efforts.

Women, especially the young married, have limited access to family planning services and information. This is further exacerbated by the some lack of commitment of service providers to provide sufficient consultation and counseling. Unsatisfactory interaction at the service delivery level deprives beneficiaries from the opportunity for empowerment and exercising their

reproductive rights. Other groups that might lack equitable access to services include slum dwellers, currently estimated at 15 million, a population that has been proven to be hard to reach, in addition to residents of Upper Egypt, especially those residing in rural areas.

The role of the private sector in providing SRH services is increasing. Private sector facilities and clinics provide antenatal care, family planning services, and management of STDs. Yet information is lacking in terms of utilization rates and the extent of the quality of services provided. This might impede the opportunity for collaboration and coordination between state- and private sector-operated services to increase availability and access.

6.1.2 Jordan

Current routine data collected at PHCs are not linked to data collected at hospitals. Furthermore, SRH services are not reflected in the data collected at any of the health system levels. Another challenge is that the collected data are only quantitative in nature. The lack of qualitative data limits further interpretations and hinders the capture of issues not reflected in quantitative measurements.

Regionalization of services in terms of policies and implementation might support integration efforts. Yet as previous efforts for regionalization have failed, restarting a new trial poses a strong challenge.

At the facility level, lack of appropriate space poses issues with provision of quality of care in terms of respect for privacy for youth, unmarried women, and men.

6.1.3 Morocco

The system is inefficient given the multiplicity of programs at the Ministries of Health and Population and lack of coordination between the management of different departments. The implementation process for programs developed at the central level does not allow much room for flexibility and does not encourage participation from all levels of the system.

The lack of an integrated health information system is yet another important challenge facing the workforce, which suffers from shortages, especially of nurses and general practitioners.

6.1.4 Palestine

The population of Palestine, estimated at 4.7 million in 2015, will reach 6.9 million in 2030 and 9.5 million in 2050. This imposes challenges for provision of SRH and HIV services in the future. Health personnel numbers should increase to match the expected increase in services utilization due to population growth.

The multitude of service providers is another challenge. Public, private, and nongovernmental sectors all provide PHC, leading to fragmentation of services, duplication of effort, and competing agendas. Lack of information about the private sector adds to the challenges.

The current referral system reform focuses on secondary and tertiary health care and ignores SRH at the PHC level. This will necessitate extension of the referral system reform in the future.

At the facility level, the lack of space and deficiencies in health care providers' encounters with beneficiaries pose issues related to quality of care.

The prevailing war and occupation is a continuous source of challenge for service provision in terms of access as well as impeding efforts for change.

6.1.5 KSA

Reproductive health is still considered a controversial concept and is rather substituted with maternal and child health. This allows sexual health services to be overlooked, and excludes men and youth, especially the unmarried. Furthermore, misperceptions among health care providers, lack of adequate attention from researchers and legislators, and the conflicting nature of SRH issues with societal norms all result in the neglect of reproductive health across development plans and uncertainty regarding investments in SRH services, therefore limiting opportunities for integration of SRH services .

The Ministry of Health has no control over the health workforce that operates under other existing health institutions (National Guard, the military and the security forces hospitals, university hospitals, health insurance companies, and private sector organizations). This results in duplication of effort, competition for health care providers, and disparities in the coverage and quality of services.

As the country is moving toward privatization of health services, a considerable challenge for integration efforts exists in the low interest of private sector organizations in provision of SRH and RMNH services.

A standardized data collection system for health indicators and social determinants of health is lacking. Data will enable follow-up across different services and health care facilities.

The lack of midwives and midwifery schools in the country restricts the SRH workforce, as do the capacity-building needs of the existing cadre.

6.1.6 Sudan

HIV integration policies and programs considered integration of HIV testing within different reproductive health services. However, family planning services are not provided for unmarried youth. Therefore, this limits their access to HIV testing in addition to family planning services. While some legislation might facilitate HIV interventions (such as the Women's Protection Law and the anti-discrimination provisions under the Labor Act), other laws (such as the Public Order General Act, Shari'aa laws, and laws criminalizing sex work and men who have sex with men) hinder HIV programs' expansion, condom distribution, and work with and for key populations.

The scope of provided services is inconsistent. For example, anti-retroviral therapy (ART), condoms, nutrition, health education, rape management, vaccination, and awareness-raising on female genital mutilation are not part of the services provided by some facilities. Even services such as maternal and neonatal services are missing from some facilities. This heterogonous nature of provided services

could hinder the future provision of integrated basic and comprehensive packages.

Furthermore, service providers lack commitment to fulfilling the needs of beneficiaries in terms of proper counseling during clinical encounters, which results in unsatisfactory interactions. The lack of physical space and use of inappropriate locations limits the privacy, care, and comfort of beneficiaries.

Generally, a gap exists in reach and coverage of internally displaced populations. Integration and delivery of SRH and HIV services suffer additional challenges in humanitarian settings such as in Darfur states. Despite continuous action from the humanitarian sector, HIV services are not integrated. The current response is favorable as the five Darfur-based AIDS programs adopted integration of HIV services at PHC level. The prevailing unrest, however, is a continuous source of challenge for service provision.


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6.2 Overarching Challenges

6.2.1 At the Strategic Level

LACK OF A CLEAR VISION

One of the most obvious challenges is the lack of a clear common vision regarding integration of SRH services within the highest levels of the health leadership cadre and stakeholders, especially decision makers at the ministries of health. This translates into a lack of consensus on the SRH services that need to be integrated. Despite the perceived understanding and acceptance of the concept of integration, much confusion persists about its operationalization, which affects implementation. The prevailing understanding was not translated into a common vision that is built on consensus or that is propagated along the different hierarchies of operational and administrative staff all the way to service providers at the different service delivery points. This also hinders the political, technical, and operational guidance for the integration processes. It contributes to creating an environment that allows for a more sporadic effort of integration in the current existing health systems, and hinders coordination and communication among different stakeholders inside health ministries, and between ministries and other concerned government or public institutions.

LACK OF POLITICAL WILL, COMMITMENT, AND SUPPORT

Given the lack of national integration-specific policies or operational strategies, current integration efforts may be stalled. This could also come as a consequence of

a deficient commitment to the relevant policies or current strategic plans. This situation may arise due to the lack of clear vision within the leadership and the lack of action plans that are realistic, built on consensus, and take into account the adverse impact on different sectors while proceeding with integration. Furthermore, it might be perceived that integration of SRH services in current health systems raises concerns regarding a wider health reform, dragging additional burden and fatigue due to its complications.

LIMITED FINANCIAL SUPPORT

Integration is a costly process. The coverage of integration-related costs faces increasing difficulty due to limited resources and economic strains, low health shares in national budgets, accumulated debt, and the dependency on external funding that is becoming more intermittent and rather disrupted or discontinued. These factors limit possible financing and resource allocation.

LACK OF COORDINATION BETWEEN DIFFERENT STAKEHOLDERS

There are multiple players with sometimes competing agendas, resulting in duplication of effort and inefficiency in the system. The role played by the private sector and NGOs is large in the provision of SRH services in these countries. This is coupled with the lack of information generated for monitoring and evaluation purposes from these sectors. Within the governmental structures, recognition of the role of other sectors such as education, environment, and labor is not considered at the strategic and programmatic levels. Integration of SRH services also requires the amalgamation of separate supervisory systems in the same health ministry into one integrated system.

LACK OF UNIFIED QUALITY STANDARDS AND OPERATIONAL AND TECHNICAL GUIDELINES

Programs running without technical guidelines are extremely challenging to monitor and evaluate. The multiplicity of vertically designed and implemented programs that are not necessarily evidence-based creates an additional challenge for operational and quality performance reviews.

6.2.2 At the Organizational Level

VERTICAL PROGRAMMING, CENTRAL ADMINISTRATION, AND MULTIPLICITY OF OPERATIONS

The current available SRH services are fragmented and provided within vertical programs that are usually centrally administered at their respective departments at the ministry level. These programs usually operate independently, and vary in terms of resources and strengths. This organizational model hinders coordination and the establishment of linkages between different departments and sectors inside health ministries, and negatively influences the efforts of integration of SRH services.

In such situations, it is harder to track financial and performance data for cross-departmental SRH services and operations. This is also mirrored in functions related to

quality and training and other management functions that are fragmented between departments without linkage or connection, making it harder to assess training needs, and duplicating follow-up, monitoring, and supervision efforts. This burdens management staff at the central level and exhausts service providers, who are subjected to multiple inputs and requests from different supervisors representing different departments at the same service delivery point. This also results in gaps in supervision and follow-up for certain tasks.

LACK OF AUTONOMY

The rigidity of the current PHC system model makes autonomous management and administration difficult at service facility, district, or regional levels in terms of setting objectives, planning, and implementation. This contributes to the burden discussed in the previous challenges.

RESISTANCE TOWARD INTEGRATION AND LACK OF CHANGE CULTURE

It is understandable that integration could face resistance as it necessitates increasing the technical and managerial capabilities of service providers and associated personnel, managers, and supervisors to match the changes occurring in the service delivery system during the integration process. The lack of clear roles and motivation, comprehensive training in addition to anticipated work overload, task shifting, change of routine, and the added complexity of operations are all barriers toward integration. Lack of clear communication and desensitization from leadership or consultation with the workforce is a contributing factor.

LACK OF COMPLETE AND COMPREHENSIVE UNIFIED DATA FOR FOLLOW-UP, MONITORING, AND EVALUATION

The current models of routine data collection do not provide comprehensive datasets with accurate and complete information needed for monitoring and evaluation. Moreover, data routinely collected at the PHC service delivery levels are not linked to secondary and tertiary care centers. Linkages to the private sector and NGOs are also lacking. Multiple reporting sources create a challenge for collecting and analyzing data.

INTEGRATION-ASSOCIATED DEVELOPMENTS

There are many processes that require actions that include the development of: (i) new systems, such as an integrated health information system to support accurate data management and effective tracking; (ii) new job profiles, with adapted responsibilities and competencies that enable effective performance of the integrated services; and (iii) an integrated curriculum for training of service providers and management staff. These are examples of complex actions that would require high-level commitment and investment and would consume a considerable amount of time.

6.2.3 At the Service Delivery Level

LACK OF RESOURCES AND TRAINED SERVICE PROVIDERS

Shortages of space, pharmaceutical products, health commodities and service

providers are major challenges facing integration efforts. The PHC workforce suffers from rapid turnover as retention of trained personnel is low, further challenging the sustainability of services.

LOW CAPACITY OF SERVICE PROVIDERS AND SUPERVISORS TO PROVIDE INTEGRATED HEALTH SERVICES

The new job profiles would require additional skills and competencies. In the current situation, health care providers would require capacity building using developed training curricula on SRH integrated services, and any other associated processes.

PRIORITIZATION OF CLINICAL SERVICES

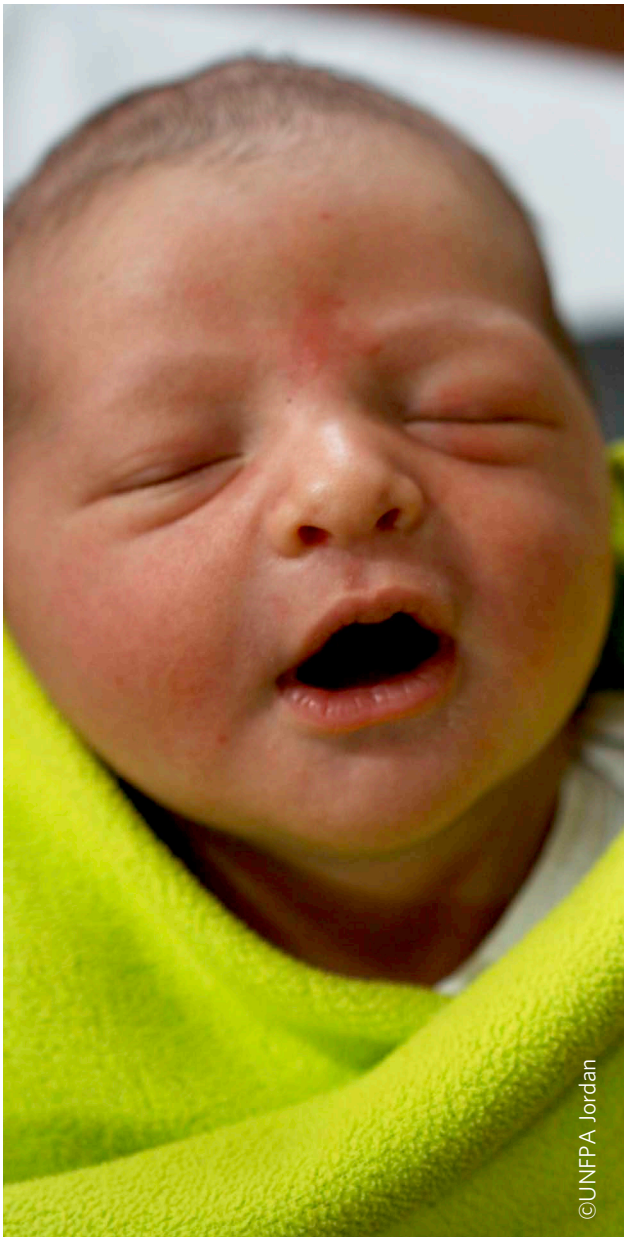
The current focus is more toward clinical services that support the biomedical model and disregard the psychosocial component of health, which might lower the chances for integration of services such as counseling in family planning, HIV, and STI prevention, management, and support for sexual and gender-based violence subjects, or other health and social relevant issues.

LACK OF CONTINUUM OF CARE AND WEAK REFERRAL AND FOLLOW-UP

The lack of clear linkages between different departments that offer SRH services makes it harder to establish efficient referral systems at the vertical or horizontal level. In addition, the lack of integrated information systems that allow tracking of and follow-up on clients makes it harder to ensure quality and continuous service.

POLITICAL UNREST AND CONFLICT

The prevailing conflict in the region creates inequities in access to and use of health care services and is responsible for the generation of new forms of vulnerabilities within these populations. A large number of internally displaced populations reside in Palestine and Sudan, and Jordan is host to a substantial number of Syrian refugees. This overburdens these countries' health care systems by stretching already scarce resources, and challenges health care providers in catering to culturally diverse populations.



7. OPPORTUNITIES FOR SRH INTEGRATION

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System reforms – whether at the level of the health care system as in Egypt or at the level of organization of structures of ministry of health as anticipated in Morocco – create an environment conducive for change, with opportunities for better-integrated SRH services. The newly developed national strategies provide an opportunity to draft operational plans and guidelines for integrated services (Table 9). In this regard, the new national agendas focusing on SDGs present important opportunities to develop country-specific targets where integration of SRH is considered as a necessary approach in achieving set targets.

At the operational level, a few existing programs can serve as building blocks for piloting SRH integrated service provision: the Family Health Model in Egypt and Morocco and the SRH HIV integration program in Sudan and Egypt (Table 9). Lessons learned from the implementation of these programs can inform the readiness of the system, the needed resources, as well as the feasibility and acceptability in their contexts. The focus on SRH integration in the global agenda may assist in funding these pilot projects, which provide important knowledge on contextualized integration strategies and facilitate their successful scale-up.

The growing partnership with the private sector and the strong engagement of civil society witnessed in more than one country, both at the strategic and operational levels, are important assets that need to be used in favor of advocating for and implementing integrated services. This might require having clear guidance for integration of SRH services in sectors not governed by government.

8. RECOMMENDATIONS

Integration is seen on a continuum rather than as opposite extremes in service organization and provision. It is a process of change that requires consolidation of efforts at the political, administrative, and technical levels. Below are a set of recommendations that arise from the identified challenges and opportunities as well as from the country-specific recommendations.

8.1 At the Policy and Programmatic Levels

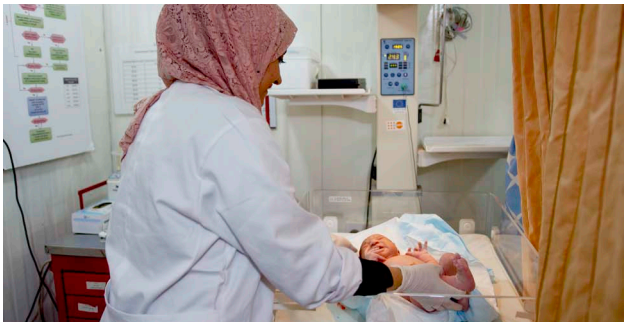
- *Advocate for SRH integration by bringing forward global evidence together with local experience.* This includes raising the importance among policy makers of providing SRH and HIV-related services to unmarried women and youth. It is critical to ensure commitment and political will for integration before planning and implementation of programs. This role can be endorsed by professional associations at the country and regional level, academicians, civil society advocates, and other agencies with SRH on their agenda.
- *Develop strategic plans for SRH integration based on national health strategies with defined indicators and outcomes.* These plans will further operationalize integration concepts brought forward in national strategies and enhance implementation possibilities. Using the opportunity provided through the SDG agenda to set targets that have integration in their core is recommended.
- *Foster partnerships with different stakeholders and at various phases of planning, implementation, and evaluation.* This will enhance an inclusive environment, reduce competition, and pave the way for future effective collaborations. In this regard, it is recommended to develop country level think tanks or coordination bodies with representation from various stakeholders.
- *Mobilize local communities for implementation of programs, especially in view of the efforts put toward decentralization of services.* Creating a social need for and acceptance of integrated SRH services can only maximize the benefits of such efforts. Reaching out to civil society organizations that have access and acceptance among the most marginalized groups of the population is recommended for this purpose.
- *Facilitate human resource development to address rapid turnover of the workforce.* Curriculum development for academic and professional training is needed based on the anticipated changes in the health care system. In this regard, it is timely for Arab countries to invest in midwives and in midwifery schools as well as to support their role in SRH services. This has the potential to reduce overmedicalization of care and improve quality of care.
- *Institutionalize existing programs to ensure their sustainability.*

8.2 At the System Level

- *Strengthen linkages and close gaps* in SRH services before embarking on new integration efforts. For example, review lessons learned from the Family Health Model and integration of PMTCT to strengthen the provision of these services. Address policy considerations and resources at the operational level to ensure the success of these initiatives before scaling up.
- *Invest time and effort to introduce change in increments.* Participatory approaches engaging all stakeholders are necessary. This will help create an environment where change will be gradually accepted. The establishment of coordinating bodies is recommended for this purpose.
- *Support strong leadership and governance by providing the tools necessary for proper management.* These include health information systems, funding, quality monitoring tools and systems, and development of guidelines and protocols that are culturally sensitive and context-specific. Collaboration with academia and professional bodies can facilitate the development of these tools and systems.
- *Introduce rigorous monitoring and evaluation processes within existing systems to improve understanding of gaps and system-level failures, and within newly developed programs for continuous process evaluation and planning.* Continuous quality monitoring is part of this process.

8.3 At the Operational Level

- *Strengthen referral pathways or establish new ones that protect users from social stigmatization and address the inefficient or ineffective referral systems already in place.* A prerequisite for this is data generated through evaluation of existing referral mechanisms.
- *Find appropriate opportunities to use as entry points for introducing integrated services.* These entry points can be identified based on the priority agendas in each country and the current readiness of its health care system at the targeted level of integrated service delivery.
- *Scale up SRH integration projects that have 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 the projects are extremely informative for such initiatives.
- *Invest in the SRH workforce to facilitate the integration process through capacity building, revision of roles and job descriptions, and development of job aids.* In addition, it will be important to support leaderships that foster teamwork, prioritize accountability, and provide motivation.



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