



Integration of sexual and reproductive health services in the provision of primary health care in the Arab States: status and a way forward

Tamar Kabakian-Khasholian ^a, Harumi Quezada-Yamamoto,^b Ahmed Ali,^c Shible Sahbani ^d, Mohamed Afifi,^e Salman Rawaf,^f Maha El Rabbat^g

a Associate Professor, Department of Health Promotion and Community Health, Faculty of Health Sciences, American University of Beirut, Beirut, Lebanon. *Correspondence:* tk00@aub.edu.lb

b Research Assistant, Department of Primary Care & Public Health, School of Public Health, Faculty of Medicine, WHO Collaborating Centre, Imperial College London, London, UK

c Postdoctoral Research Fellow, Department of Health Promotion and Community Health, Faculty of Health Sciences, American University of Beirut, Beirut, Lebanon

d Reproductive Health Regional Adviser, Arab States Regional Office, United Nations Population Fund, Cairo, Egypt

e Reproductive Health Programme Specialist, Arab States Regional Office, United Nations Population Fund, Cairo, Egypt

f Professor, Department of Primary Care & Public Health, School of Public Health, Faculty of Medicine, WHO Collaborating Centre, Imperial College London, London, UK

g Executive Director, Middle East North Africa Health Policy Forum, Cairo, Egypt

Abstract: *Different approaches are used for integration of sexual and reproductive health (SRH) services at the primary health care (PHC) level, aiming at providing comprehensive services leaving no one behind. This paper aims to assess gaps in the delivery of SRH in PHC services, identifying challenges and proposing action towards universal health coverage in Arab countries. The United Nations Population Fund, Arab States Regional Office (UNFPA/ASRO), in partnership with Middle East and North Africa Health Policy Forum (HPF), launched an assessment of integration of SRH into PHC in 11 Arab countries in 2017–2018. Desk reviews were conducted, using published program reports and national statistics. Data from country reports were compiled to present a regional assessment, challenges and recommendations. SRH services are partially integrated in PHC. Family planning is part of PHC in all countries except Libya, where only counselling is provided. Only Morocco, Tunisia and Oman provide comprehensive HIV services at PHC level. Jordan, Libya and Saudi Arabia rely mainly on referral to other facilities, while most of the integrated family planning or HIV services in Sudan, Morocco and Oman are provided within the same facilities. Action is required at the policy, organisational and operational levels. Prioritisation of services can guide the development of essential packages of SRH care. Developing the skills of the PHC workforce in SRH services and the adoption of the family medicine/general practice model can ensure proper allocation of resources. A presented regional integration framework needs further efforts for addressing the actions entailed. DOI: 10.1080/26410397.2020.1773693*

Keywords: sexual and reproductive health, Arab States, integration, universal health coverage, primary health care

Introduction

The International Conference on Population and Development (ICPD) in 1994 marked a global movement towards the provision of comprehensive and integrated sexual and reproductive health

(SRH) services for universally accessible health care. Nowadays, this movement continues to be promoted under SDG 3 target 3.7: “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”.¹ Service integration, including effective and efficient SRH delivery, is at the heart of successful implementation to support SDG 3.

Integration “*can be understood as joining operational programs to ensure effective outcomes through many modalities; multi-tasked providers, referral, ‘one-stop shop’, services under one roof ...*”.² In practice, there have been different approaches to integration of SRH services. In some settings, it has been translated as the addition of new interventions to already existing services, and in others as the amalgamation of separate components of care into the same delivery system through changes in the organisation and coordination of care.^{3,4} To ensure adequate integration and efficient service delivery at primary health care (PHC) level, health systems require strengthening of their human, material and financial resources. Nevertheless, these elements do not work alone; they call for an environment that considers the prevailing socio-cultural norms when determining the appropriate package of care.⁵ An integrated health system is potentially cost-effective, helps maximise the use of limited health resources and provides a more comprehensive care for the users.⁶ Yet, it should be understood that service integration alone cannot guarantee achieving integrated care and improving health outcomes.⁷

Guidelines provided by the WHO, UNAIDS, UNFPA and others, are available to support the inclusion of comprehensive SRH services into primary health care to ensure equity, accessibility, acceptability and cultural sensitivity.^{8,9} Several challenges are associated with adopting integrated approaches. Lack of resources (financial, human, and technological) and absence of political commitment contribute to one dimension of this problem. The process of integration may also overwhelm the front-line health practitioners who must provide multiple SRH services.¹⁰ It requires training individual providers in several core competencies, and/or having multiple providers with different skills clustered in each service site.⁹ Given the lack of rigorous monitoring and evaluation of integrated primary health care services in the literature, it is difficult to learn more about the implementation challenges faced in each context.

Arab countries represent a wide diversity in income levels, cultural norms and political systems. Most of the health care systems in this region

are complex, characterised by a mix of public and private providers. PHC in these healthcare systems suffers from fragmentation, weak infrastructure and donor-driven agendas, especially in conflict-settings. Despite the health sector reforms that have been undertaken and the improved health outcomes, continuous political unrest, armed conflict and the resulting humanitarian crises hinder access to SRH services and overwhelm health care systems while shifting priorities away from reproductive health issues. However, concerted efforts in the region have led to important progress, building consensus and shaping agendas for integrating comprehensive SRH services in the primary care of each country, advancing along the path towards universal health coverage.¹¹

This paper presents an overview of the situation of SRH integration in the public primary health care system in 11 Arab countries. It specifically aims at assessing the gaps in the delivery of SRH in primary health care services; identifying the challenges; and proposing action in Arab countries towards more integrative SRH services for universal health coverage.

Methods

In partnership with the Middle East and North Africa Health Policy Forum (MENA-HPF), United Nations Population Fund, Arab States Regional Office (UNFPA/ASRO) launched an assessment of integration of SRH into PHC in 11 countries in 2017–2018. The selected countries represented the diversity of geographical distribution, economic level and culture in Arab countries. For this study, a team of experts developed a guiding document and adapted tools^{12–14} for performing country-level assessments. Teams in each country, comprising two or three experts in the field of SRH from academia or civil society, prepared the country reports. The country teams used the guiding documents and adapted tools to conduct desk reviews and the synthesis of literature and data.

Desk reviews consisted of identification of program reports, most recent national statistics, and documents available through the health authorities and published literature, with the aim of providing a description of the country’s health care system, key SRH indicators, statistics on the use of primary health care services and SRH service delivery. The majority of the resources needed to complete the country reports consisted of Ministry of Health statistical reports, statistics yearbooks

and national strategy reports, as well as country program reports from UN agencies and specialised programs. The source of each national statistic was noted in the tables and all identified references used were cited in the reports. In four countries only, informal interviews were conducted with key personnel in government institutions and international agencies to complement the desk review and fill gaps in available information, with 4–5 informants in each country. These interviews provided context and validation for the researchers' interpretation of the findings and development of recommendations at the country level. Triangulation of these data was carried out to prepare country reports consisting of narrative interpretation of challenges as well as tabulated information using the adapted tools. Data from country reports were compiled to present a regional assessment. The preliminary national and regional syntheses were discussed in two regional expert group meetings in November 2017 and December 2019. During these meetings, the findings were presented for validation, and discussions of challenges and recommendations took place in small groups as well as in plenary. All individuals involved in the planning and implementation of the project in the 11 countries attended these meetings, in addition to experts from MENA-HPF and UNFPA/ASRO.

This work was completed in 11 Arab countries in two phases. The first phase consisted of assessments done in Egypt, Jordan, Kingdom of Saudi Arabia (KSA), Morocco, Palestine and Sudan in 2017 and the second phase included Lebanon, Libya, Oman, Tunisia, and the United Arab Emirates (UAE) and was completed in 2018.

Results

Total fertility rates (TFR) vary largely among these countries, from the lowest in Lebanon (1.7) to the highest in Sudan (5.2). These rates reflect the variation in contraceptive prevalence. Oral contraceptives, IUDs and withdrawal are the most commonly used methods of contraception in the studied nations. Abortion care and emergency contraception are only provided in PHC in five countries. Unmet need for family planning is substantial in Libya (40.2%) where contraception is mainly available in the private sector and for birth spacing. Although contraceptive prevalence rate is 57.2% in Palestine, unmet need is believed to be high among the poorest of the population, which

might explain the high TFR. There is no data available on male sterilisation. Female sterilisation is reported only for five countries and ranges from 0.9% in Sudan to 3% in Morocco and KSA. These are not offered at the PHC level. A wide variation exists in maternal mortality rates (MMR), ranging from 216 maternal deaths per 100,000 births in Sudan to 6 per 100,000 births in the UAE. Despite concentrated efforts over the last decades, the MMR remains relatively high in Tunisia. This is attributed to limited access to services in certain regions of the country. There is universal coverage of antenatal and skilled attendance at birth in these countries with the exception of Libya, Morocco, and Sudan (Table 1).

The only SRH services provided within PHC in all eleven countries are antenatal and postnatal care, in addition to neonatal and child health care. Services such as screening for sexually transmitted infections and breast cancer services are available at the PHC level in eight countries. Cervical cancer screening, and gender-based violence prevention and/or management are only delivered as part of PHC in six countries. Abortion care is only legal in Tunisia and is provided through specialised services at the PHC level. Post-abortion care and emergency contraception are not commonly provided in PHC, except in four countries. Family planning is included in PHC in all countries, except in Libya, where only a form of counselling is provided, without provision of contraception. HIV/AIDS prevalence is considered low and comprehensive HIV services appear to be lacking. In fact, only Morocco and Oman provide comprehensive HIV services at PHC level. Even in the case of condom provision, counselling and testing, which are basic HIV services, these are delivered only by six countries out of the eleven (Table 2).

Among the eleven Arab countries included in this assessment, only Morocco and Oman provide the vast majority of essential SRH services at the PHC level, closely followed by Tunisia, Palestine and UAE. Other countries such as Egypt, Libya and Saudi Arabia, provide a package of services that includes antenatal, postnatal, neonatal and child health care (Table 2).

With regard to the integration of family planning and HIV services within SRH care at the PHC level, family planning is delivered within the already available SRH services of antenatal, postnatal, newborn and child health care, except in Egypt, Libya and Morocco. Oman, Palestine,

Table 1. Selected demographic and family planning indicators in the eleven countries

Indicator	Egypt	Jordan	Lebanon	Libya	Morocco	Oman	Palestine	KSA	Sudan	Tunisia	UAE
Total Fertility Rate (TFR) (2017)	3.2 ^a	2.8 ^a	1.7 ^a	2.2 ^a	2.5 ^a	2.9 ^a	4.1 ^b	2.5 ^a	5.2 ^c	2.2 ^a	1.7 ^a
Contraceptive Prevalence Rate	59% ^d	61% ^e	53.6% ^f	27.7% ^a	67.4% ^g	24.4% ^h	57.2% ⁱ	28.2% ^j	12.1% ^c	64.4% ^k	48.1% ^l
Maternal Mortality Ratio (MMR)	49 ^m	19.1 ⁿ	15 ^o	9 ^p	72.6 ^q	20.2% ^r	23.1 ^s	12 ^j	216 ^c	62 ^t	6 ^t
Antenatal care coverage	93.3% ^d	99% ^e	96% ^u	66.3% ^v	77.1% ^g	99.6% ^w	98% ^t	97% ^a	79.1% ^c	85.1% ^k	100% ^t
Percentage of births attended by skilled health personnel	90.7% ^d	100% ^e	98% ^u	98.9 ^p	72.7% ^g	99.6% ^w	98% ^t	98% ^a	77.5% ^c	98.6% ^k	100% ^t

^a World Bank Open Data. Retrieved July 1st 2019

^b Palestine 2030, UNFPA (2017)

^c MICS (2014)

^d EDHS (2014)

^e JPFHS (2012)

^f United Nations 2016 UNFPA, UNPD, MDG database <http://unstats.un.org>

^g National Population and Family Health Survey (2011)

^h National Center for statistics and information, Data portal (2010), <https://data.gov.om/bhncikg/reproductive-health?tsId=1003830>

ⁱ PCBS (2014), <http://www.pCBS.gov.ps/default.aspx#>

^j Ministry of Health indicators (2016)

^k MICS 4 2011/2012

^l UN DESA Contraceptive Global Trends 2015

^m MOHP Press release, Egypt (2016)

ⁿ Ministry of Health Statistical report, Jordan (2016)

^o WHO 2015-2017

^p UN IGME 2015

^q Ministry of Health website, Morocco (2016)

^r Annual Health Report 2017, Chapter 2, Ministry of Health, Oman <https://www.moh.gov.om/documents/274609/2607839/66الفصل+الثاني/b98f72-1978-f517-e75c-6da0375899ad>

^s Ministry of Health, Palestine (2014)

^t WHO Global Observatory 2015

^u UNICEF Global Database/PAPFAM 2004

^v Libya PAPFAM 2014

^w Annual Health Report 2017, Chapter 8, Ministry of Health, Oman, <https://www.moh.gov.om/documents/274609/2607839/الفصل+الثامن/c242d408-74a9-51be-6830-fb25ac386ff0>

Tunisia, Lebanon and the UAE have integrated family planning services beyond the maternal health ones. As for the integration of HIV services into PHC, Saudi Arabia, Libya, Jordan, Oman and Palestine do not have integrated HIV services. There is minimal integration of HIV services in antenatal care in Sudan and Egypt; however, comprehensive services are provided elsewhere. Only Morocco, Tunisia and UAE have integrated HIV services within the already available SRH services. Morocco is the only country that provides comprehensive integrated HIV services, with referral only needed in the case of a few of the services. Tunisia and UAE follow closely, while Egypt has a wide range of integrated HIV services provided in the form of a “pilot”, relying more on referral, and yet to be scaled up (Table 3).

In terms of having a continuum of SRH services at PHC level, Jordan, Libya and Saudi Arabia rely mainly on referral to other facilities, while most of the integrated family planning or HIV services in Sudan, Morocco, Palestine, Tunisia, UAE and Oman, are provided mainly within the same facilities, with minimal referral (Table 3).

In general, SRH provision is physician-centric, where family planning and HIV services are mostly provided by general practitioners, gynecologists, and obstetricians. Some responsibilities are shared with other health cadres, but are more related to care during pregnancy, labour and the postpartum period, and to a lesser extent to family planning. Midwives’ and nurses’ responsibilities in terms of HIV services are limited, as most services are exclusively provided by physicians. In some

Table 2. Essential sexual and reproductive health (SRH) services provided at primary health care (PHC) in 11 Arab countries

Services	Egypt	Jordan	Lebanon	Libya	Morocco	Oman	Palestine	KSA	Sudan	Tunisia	UAE
<i>Family planning</i>	●	●	●		●	● ^a	●	●	●	●	●
<i>Antenatal care</i>	●	●	●	●	●	●	●	●	●	●	●
<i>Labor and delivery</i>				●	●				●		
<i>Postnatal care</i>	●	●	●	●	●	●	●	●	●	●	●
<i>Newborn and child health</i>	●	●	●	●	●	●	●	●	●	●	●
<i>Prevention of unsafe abortion and post-abortion care</i>					●	●			●	● ^b	●
<i>Emergency contraception</i>	● ^c				●		●		●	● ^d	
<i>STIs/RTIs screening, diagnosis and treatment</i>		●	●		●	●	●		●	●	●
<i>Cervical cancer screening</i>			●		●	●	●			●	●
<i>Breast cancer screening</i>	●	● ^e	●		●	●	●			●	●
<i>Prevention and management of gender-based violence</i>		● ^f	● ^g		●		●			●	●

Table 2. Continued												
	Family Planning Services offered at PHC facilities											
Services	Egypt	Jordan	Lebanon	Libya	Morocco	Oman	Palestine	KSA	Sudan	Tunisia	UAE	
<i>Contraception provision</i>	●	●	<i>Information is not available</i>		●	●	●	●	●	●	●	
<i>Counselling</i>	●	●		●	●	●	●	●	●	●	●	
<i>Health education</i>	●	●			●	●	●	●	●	●	●	
<i>Emergency contraception</i>	●				●	●	●		●	●		
	HIV services offered at PHC facilities											
Services	Egypt	Jordan	Lebanon	Libya	Morocco	Oman	Palestine	KSA	Sudan	Tunisia	UAE	
<i>HIV counselling and testing</i>	●		<i>Information is not available</i>		●	●			● ^h	●	●	
<i>PMTCT (at minimum, access to anti-retroviral drugs)</i>	●				●	●			● ^h			
<i>TB screening</i>						● ^h	●	●	●	● ^h	●	●
<i>STI screening, diagnosis and treatment</i>		● ⁱ				●	●	●		●		
<i>Prophylaxis and treatment of PLHIV (OIs and HIV)</i>						● ^h	●					
<i>Treatment for opportunistic infections</i>						●	●	●			●	
<i>ART</i>						● ^h	●				●	●
<i>Male circumcision</i>						●						
<i>Condom provision</i>	●	●				●	●	●		● ^h	●	
<i>Psycho-social support (positive health, dignity, and prevention)</i>						●	●		●			●

Table 2. Continued										
HIV prevention information and services for general population	●				●	●			●	●
HIV prevention information and services for key populations				●	●				●	
<p>^a Referred to as birth spacing in the public sector ^b Medical abortion, and screening for cervical and breast cancers are provided in the National Office for Family and Population (ONFP), Ministry of Public Health ^c Emergency contraceptives provided in some PHC facilities ^d Available but not promoted ^e Diagnosis and treatment services ^f Management only ^g Programmes that are funded through the Humanitarian Aid Agency ^h Services provided as part of specific programs or at specialised centres ⁱ Diagnosis and treatment only</p>										

countries, like Egypt, there is no midwifery workforce. In Palestine, Saudi Arabia and Libya, midwives’ responsibilities are limited to care during pregnancy, labour and postpartum. In other countries, there are efforts to establish or promote midwifery. At the time of the study, Jordan was enrolling its first cohort of midwifery students. The UAE and Lebanon are advocating for better recognition of midwives as a part of the SRH workforce.

On the other hand, Sudan, Tunisia, Morocco and Oman have a well-established midwifery cadre that acts as front-line SRH providers. In these countries, they have shared responsibilities with nurses and physicians that ensure provision of SRH, including family planning and HIV services, at PHC level. The heavy reliance on physicians, along with the medicalisation of services, leads to minimal attention to the socio-cultural aspects of SRH and in some cases to tasks not being assigned to any member of the SRH workforce. This is the case in Egypt and Libya, where HIV counselling, prevention, treatment and management are not recognised responsibilities of the SRH workforce. A similar situation applies to provision of emergency contraception in Tunisia and Jordan.

Discussion

The governments of the 11 Arab countries presented in this paper recognise the importance of integrated approaches in primary health care and are making efforts towards achieving universal health coverage. These countries have diverse PHC systems consisting of governmental, public, private and civil society sectors which are mostly organised in a hierarchical and centralised manner. Although several Arab countries have undertaken health system reforms, there is a long way to go for the full integration of SRH (including HIV packages) within the existing PHC systems. Challenges to achieving integration, as shown in our findings, emanate from underlying factors such as armed conflicts and political unrest, as well as medicalisation, workforce sustainability and lack of cultural sensitivity. For example, Oman, a high-income country, seems to be leading the way through their public health system. Nevertheless, there are still gaps due to aspects related to cultural sensitivity regarding prevention of unsafe abortion and provision of emergency contraception. In Sudan, a low-income country that has suffered from conflict, there seems to be a vicious circle between unmet need for family planning, total fertility rate and high maternal mortality,

Services	Egypt	Jordan	Lebanon	Libya	Morocco	Oman	Palestine	KSA	Sudan	Tunisia	UAE
<i>Antenatal care</i>		•	•			•	•	•	•	•	•
<i>Postnatal care</i>	• ^a	•	•	•		•	•	•	•	•	•
<i>Newborn and child health</i>		•	•			•	•	•	•		•
<i>Prevention of unsafe abortion and post-abortion care</i>					•	•	•		•	•	•
<i>Emergency contraception</i>			•			•	•			• ^b	
<i>STI/RTI screening, diagnosis and treatment</i>		• ^c	•			•	•		•	•	•
<i>Cervical cancer screening</i>			•		•	•	•		• ^d	•	•
<i>Prevention and management of gender-based violence</i>			•		•		•		• ^d	•	•

^a Counseling on contraceptives is provided during postnatal home visits
^b Available but not promoted
^c STI/RTI diagnosis and treatment only.
^d Services provided in certain non-governmental centres

that needs to be broken. National HIV/AIDS programs in most of these countries are designed vertically. Despite the prioritisation of this issue among high risk populations, such as youth in Sudan, HIV/AIDS programs rely heavily on donor assistance, which threatens their sustainability.

Integrated planning and delivery of SRH services would advance universal access to SRH in communities, as integrated services are more cost-effective and efficient, improve access to health care, and increase financial sustainability.¹⁵ Therefore, monitoring and evaluation of progress towards the provision of integrated SRH services within primary health care is essential to build a broad picture, suggest a comprehensive package and better address the challenges while detecting opportunities for improvement.

Achieving integrated services for UHC requires careful mapping and planning to identify the

needs of individuals and communities; the quality, accessibility and affordability of existing services; the training and logistical requirements of expanding the mix of services; and prevailing resource constraints.

Diverse challenges exist in the Arab States that, in order to be addressed, require action at different levels: at the policy level, a unified definition is needed for the package of SRH services, based on the principles of human rights, transparency, accessibility, and sustainability. This will ensure that all strategies follow the same vision. After reaching regional consensus, each country can advocate for evidence-based, stronger political commitment and good governance with respect to integrated services, not only from health ministries but also from economic, finance, and other development-related agencies. These stakeholders have a duty to ensure the development and use of national-level

Table 3. Continued

Status of integration of HIV services in SRH care provided at PHC											
Services	Egypt	Jordan	Lebanon	Libya	Morocco	Oman	Palestine	KSA	Sudan	Tunisia	UAE
<i>Family planning</i>			•		•					•	•
<i>Antenatal care</i>	• ^a		•		•				•	•	•
<i>Labor and delivery</i>					•					•	•
<i>Postnatal care</i>	•		•		•					•	•
<i>Newborn and child health</i>			•		•						
<i>Prevention unsafe abortion & post-abortion care</i>					•					•	•
<i>Emergency contraception</i>					•						•
<i>STI/RTI screening, diagnosis and treatment</i>			•		•					•	•
<i>Cervical cancer screening</i>					•						•
<i>Prevention and management of gender-based violence</i>				± ^b	•				•*		•
Scope of HIV integrated services											
Services	Egypt	Jordan	Lebanon	Libya	Morocco	Oman	Palestine	KSA	Sudan	Tunisia	UAE
<i>HIV counselling and testing</i>	•		•		•				•	•	•
<i>PMTCT</i>	•		•		•				•		
<i>TB screening</i>					±					•	•
<i>Prophylaxis and treatment of PLHIV</i>	• ^c				±				•*		
<i>Treatment for opportunistic infections</i>	• ^d				•						
<i>Male circumcision</i>					•					•	
<i>STI screening, diagnosis and treatment</i>					•					•	•

ART	• ^d				±			•*		
Condom provision	• ^d				•			•	•	
Psycho-social support	• ^d				•			•*		•
Services for public population	• ^d				•				•	•
Services for key populations					•				• ^d	

^a In some selected sites as part a pilot project.
^b ± Services provided are provided at hospitals or other specialised centres
^c * These services are provided only to positive women through active referral system at specialised hospitals
^d More efficient in CSOs in comparison to public structures

indicators and data collection mechanisms. National policies, strategies, and operational plans should guarantee a continuum of care across PHC and in existing programs especially in Jordan, Libya and Saudi Arabia.

At the organisational and operational levels, SRH services in PHC must rely on the whole range of primary care workforce including not only physicians but also midwives, nurses, social workers, and counsellors. In order to increase healthcare providers’ skills, competencies, positive attitudes, respect, and empathy, gender and sexual health content should be included in professional training and university education programs in each country and added to job descriptions. There is a need to embed systems of routine monitoring and evaluation at the PHC programmatic and service levels.

The SRH services provided through primary care must ensure that no one is left behind. Each country has to decide which services to prioritise, based on current economic, cultural and political circumstances as well as its population needs¹⁶ but aiming for comprehensive coverage of an essential package. In order to achieve this, the adoption and implementation of the family medicine or general practice approach will provide venues to act as the first contact point with the health service, being gatekeepers within the health system and ensuring proper allocation of resources.

A framework to guide and unify strategies within the region has been developed, following a regional meeting where the findings from this assessment were discussed. This framework has a

health systems approach, with a view to ensuring sustainability. It highlights the need for the coordination of the different stakeholders including the community. Moreover, it identifies the enablers to SRH services integration, such as capacity building, affordability and resilience of health systems, cultural sensitivity, having a conducive policy environment and the collaboration of public and private health sectors. In addition, it provides guidance for service planning and implementation. The framework highlights the importance of feedback from the public and stakeholders as well as assessment of population and health care service needs to inform financing. Further efforts are required for putting such frameworks into action in the Arab countries.

Despite the wealth of information used for this assessment, we acknowledge the limitations of relying on national reports and routinely collected information, resulting in lack of data on within-country disparities, as well as information related to gender- and age-specific differentials with regard to certain indicators. Future research should address barriers faced by specific population groups, such as youth’s access to age-appropriate SRH services within PHC.

Conclusion

While some Arab nations have attempted health system reforms, there is still work to be done for the full integration of SRH within current PHC services. Action is required at the policy, organisational and operational levels. SRH services provided through PHC must ensure that no one

Table 3. Continued

Continuum of family planning and HIV services within SRH Care offered at PHC											
Services	Egypt	Jordan	Lebanon	Libya	Morocco	Oman	Palestine	KSA	Sudan	Tunisia	UAE
<i>At the same location by the same healthcare worker on the same day</i>		●*	●			●	●		●	●	
<i>At the same location by the same healthcare worker on a different day</i>					●		●		●		
<i>At the same location by a different healthcare worker on the same day</i>					●		●		●	●	●
<i>At the same location by a different healthcare worker on a different day</i>							●		●		
<i>Referred within the same facility</i>	●						●		●		●
<i>Referred to a different facility</i>	●	●**		●			●	●	●***	● ^a	●
^a Testing services and anti-retroviral therapies * Family planning only ** HIV *** These services are provided at certain hospitals and specialised centres.											

is left behind. Prioritisation of services can guide the development of essential packages of SRH care. The adoption and implementation of the family medicine/general practice approach will allow the first contact point to be at the level of primary health care, as gatekeeper within the health system, and ensure proper allocation of resources. This model can be supported by the development of competence among the various members of the primary health care workforce to engage them in the provision of SRH services. Further efforts are required for implementing frameworks regarding this aim in the Arab countries.

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ORCID

Tamar Kabakian-Khasholian  <http://orcid.org/0000-0001-5098-5483>
Shible Sahbani  <http://orcid.org/0000-0002-1350-2486>

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Résumé

Différentes approches sont utilisées pour intégrer les services de santé sexuelle et reproductive (SSR) au niveau des soins de santé primaires (SSP), dans le but de fournir des services complets qui ne

Resumen

Diferentes enfoques son utilizados para integrar los servicios de salud sexual y reproductiva (SSR) en el primer nivel de atención (PNA), con el fin de proporcionar servicios integrales y no dejar

laissent personne de côté. Cet article vise à évaluer les lacunes des services de soins de santé sexuelle et reproductive dans les services de SSP, en identifiant les obstacles et en proposant des mesures en vue d'atteindre une couverture santé universelle dans les pays arabes. Le Bureau régional pour les États arabes du Programme des Nations Unies pour la population (FNUAP), en partenariat avec le Forum sur les politiques en matière de santé au Moyen-Orient et en Afrique du Nord (HPF), a lancé une évaluation de l'intégration de la SSR dans les SSP dans 11 pays arabes en 2017–2018. Des études documentaires ont été réalisées à l'aide de rapports de programmes publiés et de statistiques nationales. Les données issues de rapports de pays ont été rassemblées pour présenter une évaluation régionale, les obstacles et des recommandations. Les services de SSR sont partiellement intégrés dans les SSP. La planification familiale fait partie des SSP dans tous les pays, à l'exception de la Libye où seuls des conseils sont prodigués. Seuls le Maroc, la Tunisie et Oman fournissent des services complets en matière de VIH au niveau des SSP. La Jordanie, la Libye et l'Arabie saoudite comptent principalement sur l'aiguillage vers d'autres centres, alors que la plupart des services intégrés de planification familiale ou de VIH au Soudan, au Maroc et à Oman sont assurés dans les mêmes centres. Des mesures sont requises aux niveaux politiques, organisationnels et opérationnels. La priorisation des services peut guider la mise au point de paniers essentiels de soins de SSR. Développer les compétences des personnels des SSP dans les services de SSR et adopter le modèle du généraliste /médecin de famille peut garantir une allocation suffisante de ressources. Le cadre d'intégration régionale présenté requiert des efforts supplémentaires pour aborder les mesures qu'il impose.

a nadie atrás. Este artículo tiene como objetivo evaluar las brechas en la prestación de SSR en el PNA, identificar los retos y proponer medidas para lograr cobertura médica universal en los países árabes. El Fondo de Población de las Naciones Unidas – Oficina Regional de los Estados Árabes (UNFPA/ASRO), en colaboración con el Foro de Políticas Sanitarias del Oriente Medio y África Septentrional (HPF), lanzaron una evaluación de la integración de SSR en el PNA en 11 países árabes en 2017–2018. Se realizaron investigaciones bibliográficas, utilizando informes de programas publicados y estadísticas nacionales. Los datos de los informes de país fueron compilados para presentar una evaluación regional, retos y recomendaciones. Los servicios de SSR son integrados parcialmente en el PNA. La planificación familiar es parte del PNA en todos los países salvo Libia, donde solo se brinda consejería. Marruecos, Túnez y Omán son los únicos países donde se proporcionan servicios integrales de VIH en el PNA. Jordán, Libia y Arabia Saudí dependen principalmente de referencias a otras unidades de salud, mientras que la mayoría de los servicios integrados de planificación familiar o VIH en Sudán, Marruecos y Omán son proporcionados en las mismas unidades de salud. Se necesita acción a nivel político, organizacional y operativo. La priorización de los servicios puede guiar la creación de paquetes esenciales de servicios de SSR. El desarrollo de las habilidades de la fuerza laboral en el PNA para la prestación de servicios de SSR y la adopción del modelo de medicina familiar/general pueden asegurar la asignación correspondiente de los recursos. El marco de integración regional presentado necesita mayores esfuerzos para abordar las acciones implicadas.