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Research Article

Readiness to meet Sexual and Reproductive Health-related Sustainable Development Goals in selected Arab countries

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Abstract

This study on countries' readiness for achieving the Sexual and Reproductive Health related Sustainable Development Goals was conducted in four selected Arab countries: Egypt, Jordan, Morocco, and Kingdom of Saudi Arabia. The assessment found some common challenges to achieving SRH-related SDGs' targets, including fragmentation of health care systems, limitations in the SRH services provided and the populations reached, shortcomings in the health workforce, and disparities in health outcomes among different segments of the population.

The research makes recommendations for overcoming these and other challenges that need to be contextualized according to each country specificities. They should include reprioritizing public spending to respond to SRH challenges, developing innovative solutions to improve health equity, creating a stronger role for civil society in monitoring and evaluating health service delivery, developing better health information systems, and making better use of technology to improve sexual and reproductive health. Examples include: midwifery workforce, family planning programming and reproductive health security, and generation of data for equity analysis to inform targeted programming and interventions.

Introduction

In 2015, world leaders adopted the Sustainable Development Goals (SDGs) as part of a broad agenda focusing on poverty eradication, inclusive and equitable development, environmental protection, and social development. Of the 17 goals to be achieved by 2030, two relate closely to Sexual and Reproductive Health (SRH), highlighting its importance for economic and social development. Goal 3 aims to ensure healthy lives and promote wellbeing for all, and Goal 5 calls for gender equality and the empowerment of women and girls. Under each goal, countries must meet specified targets by 2030 - several of which require universal access to SRH services and fulfillment of reproductive rights.

To achieve Goal 3, the international community called for (among other things) ensuring universal access to SRH services to reduce maternal death and disability, improve the provision of family planning services and information and education about SRH, and integrate reproductive health into national and regional strategies, policies, and programs. SRH services should be provided as part of Universal Health Coverage (UHC), so that all people have access, without discrimination and regardless of ability to pay, to a nationally determined package of health care

and essential medicines.

Goal 5, to achieve gender equality, includes a target calling for the elimination of harmful practices against women, such as child, early and forced marriage and female genital mutilation. Another target under this goal also calls for ensuring "universal access to sexual and reproductive health and reproductive rights."

Also, Goal 10 calls for reducing inequality within and between countries. This is relevant for SRH because achieving health targets at the national level is not enough; some population subgroups might exceed targets while others lag far behind. Potential disparities could exist according to wealth, gender, geography, marital status, and/or disability or displacement status. Monitoring disparities is essential for achieving the SDGs, which calls for countries to "leave no one behind."

In the Arab States region, universal access to SRH remains an unmet goal. Most countries have adopted national strategies and plans consistent with international agreements that established SRH goals-notably the 1994 International Conference on Population and Development and the Millennium Development Goals. However, some SRH components have not been implemented because of inadequate funding and weaknesses in health systems, among other reasons. Many obstacles to gender equality and women's empowerment persist, including socio- cultural norms, unequal power relationships between men and women, and limiting legal environments.

Having experienced major political, economic, and social transitions in recent years, the Arab States now stand at a crossroads between maintaining and building on what has been achieved and reforming what requires change. Many challenges confronting the region as a whole create obstacles for making comprehensive SRH services universally available. Although the region has made progress overall in improving health outcomes, differences and inequalities in achievement are evident between and within countries. In some countries, health systems are strained to respond to the needs of large numbers of forcibly displaced people due to conflict. Women and girls make up a large share of these populations, and they face heightened sexual and reproductive health risks in fragile and unstable settings.

Methodology

To assess readiness for achieving the SRH-related targets of the SDGs (shown in Table 1) by 2030, a team of experts in each of the four countries used standardized data-collection tools developed by the Middle East and North Africa/Health Policy Forum (MENA/ HPF) and the United Nations Population Fund/ Arab States Regional Office (UNFPA/ASRO) to assess the readiness of health systems to achieve the SRH SDGs targets.

Goal/ Target	Indicator
Goal 3. Ensure healthy lives and promote well-being for all	
Target 3.1: Reduce the global maternal mortality ratio to less than 70 per 100,000 live births.	3.1.1 Maternal mortality ratio
	3.1.2 Proportion of births attended by skilled health personnel
Target 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age	3.2.1 Under-five mortality rate
	3.2.2 Neonatal mortality rate
Target 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and other communicable diseases.	3.3.1 Number of new HIV infections per 1,000 uninfected
Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs.	3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods
	3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group
Target 3.8: Achieve universal health coverage, including financial risk protection	3.8.1 Coverage of essential health services (service capacity and access to reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases)
Goal 5. Achieve gender equality and empower all women and girls	

Target 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.	5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
	5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
Target 5.3: Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.	5.3.1 Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18
	5.3.2 Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting
Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights.	5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
	5.6.2 Number of countries with laws and regulations that guarantee women aged 15-49 access to SRH care, information and services

Table 1: Goals, Targets, and Indicators for SRH-related SDGs.

The tool includes five modules to cover different aspects related to the readiness of the health system for provision of sexual and reproductive health services in the country including the health services, the health workforce, health equity, and information gaps.

Module A	**Country profile & baseline assessment of targets**
	Module A.1 Country profile
	Module A.2 Health policies
	Module A.3 Baseline indicators
	Module A.4 Major sources of health and population data
	Module A.5 Data coverage
Module B	**Accessibility & coverage of health system**
	Module B.1 Minimum benefits package
	Module B.2 Infrastructure and planning models
	Module B.3 Norms for coverage
	Module B.4 Overall assessment of coverage
Module C	**Health workforce availability**
	Module C.1 Availability of workforce
	Module C.2 Roles and responsibility
	Module C.3 Education and capacity building
	Module C.4 Overall assessment of workforce
Module D	Health equity
Module E	Information gap analysis

The teams assessed countries' readiness to provide reproductive, maternal, newborn and child health care; to achieve Universal Health Coverage (UHC); and to address Gender Based Violence (GBV), pinpointing the most significant challenges facing each country.

Data was Collected through Various Channels Including:

The literature review of the most recent documents, scientific articles, policy documents, sectoral strategies, surveys, health information system, Interviews and meetings with the main stakeholders including government and non-government partners. Analysis of international databases (DHS, PAPFAM, MICS…), reports, and other sources.

The level of SRH services needed in each country was estimated by using United Nations projections of estimated numbers of births and numbers of women of reproductive age by 2030, according to different fertility scenarios.

After reviewing the evidence, the teams ranked the SDG targets according to the level of challenge each country faces in achieving them by 2030. The ranking exercise was repeated for three dimensions of health: health system accessibility and coverage, the health workforce, and health equity.

The results of each country team's assessment were compiled in a scorecard format to present a regional perspective on the most pressing health service gaps and challenges. (Table 2).

Target	Sub-target	Egypt	Jordan	Morocco	KSA
3.1	Antenatal care	2	2	5	4
	Obstetric care	4	3	7	3
3.2	Newborn care	6	3	7	4
	Immunization	1	1	1	0
	Child preventative and curative care	3	2	2	2
3.3	Prevention of mother-to-child transmission of HIV	6	5	4	7
	HIV counselling and testing	7	7	5	8
	HIV treatment	5	4	3	5
	HIV care and support	6	6	6	9
	Sexually transmitted infections control	7	7	5	10
3.7	Providing modern family planning methods	1	1	1	1
	Family planning counselling	5	2	1	4
	Information on sexual and reproductive health available for dissemination	7	3	5	0
	Adolescent health	8	7	9	6
3.8	Achieve universal health coverage of essential services	8	4	9	2
5.2	Eliminate physical, sexual or psychological violence by intimate partner	7	7	9	-
	Eliminate sexual violence by persons other than partner	7	6	9	-
5.3	Eliminate child, early and forced marriage	6	8	10	10
	Eliminate female genital cutting	6	NA	NA	NA
5.6	Enabling women to make own informed decisions regarding sexual relations, contraceptive use and reproductive health care.	5	-	4	5
Cut-off scores for low, medium and high challenge		1-4 5-6 7-10	1-3 4-6 7-8	1-3 4-6 7-10	0-2 3-6 7-10
Notes: Challenges are ranked from 0 to 10, with "0" reflecting the lowest challenge and "10" reflecting the highest. Red refers to most challenging; yellow refers to somewhat challenging; white refers to least challenging; NA refers to not applicable. The cut-off scores by country differ to standardize the results.					

Table 2: Health service challenges to achieving SRH-related SDG targets by 2030, ranked according to priority, by country. (**Source):** Based on M. Osman et al., Readiness Analysis to Meet Sexual and Reproductive Health-Related Sustainable Development Goals in Selected Arab Countries, Cairo,

Egypt: Middle East and North Africa Health Policy Forum, 2017.

Findings / Results

Reproductive, maternal, newborn, and child healthcare services are relatively well developed in these countries. By 2030, all four countries are expected to achieve - at the national level - target 3.1 (reduce the global maternal mortality ratio to 70 per 100,000) and target 3.2 (reduce neonatal mortality to no more than 12 per 1,000 live births and under-5 mortalities to no more than 25 per 1,000 live births).

All four countries face challenges in responding to HIV and AIDS (target 3.3). While they have national strategic plans on HIV/AIDS, prevention and treatment are still not fully integrated in the SRH service package. Greater attention is needed in the areas of prevention of mother-to-child transmission of HIV, HIV counselling and voluntary testing services, and control of sexually transmitted infections.

Regarding universal access to SRH services (target 3.7), the assessment found that satisfying needs for modern family planning methods and counseling are achievable by 2030.

On the other hand, adolescent health, as expressed by the age - specific fertility rate among teenagers, represents a challenge in these countries. High birth rates among adolescents compound the problem of having large, youthful populations, putting countries on a path of continued, rapid population growth.

The ability to achieve UHC (target 3.8) varies among countries. Achieving UHC entails financial risk protection (protecting households from financial hardship due to health expenses); access to quality essential SRH care services; and access to safe, effective, quality, and affordable essential medicines and vaccines for all. Using data on general health insurance as a substitute measure for SRH- related insurance coverage, the teams found that the target may be achievable in Kingdom of Saudi Arabia and to a lesser extent in Jordan, but it will be highly challenging in Egypt and Morocco.

Regarding eliminating all forms of violence against all women and girls (target 5.2), eliminating domestic and sexual violence against women presents a serious challenge in all four countries. Eliminating child, early, and forced marriage is highly challenging in Kingdom of Saudi Arabia and Morocco and somewhat challenging in Egypt. In Jordan, this issue is highly challenging among refugees and asylum seekers. Female genital cutting continues to be a challenge in Egypt; it is generally not practiced in the other three countries.

Health System Accessibility and Coverage

All four countries have a defined, minimum benefits package for reproductive, maternal, newborn, and child health services. The services are delivered mainly through the health ministries' networks of primary health care facilities and hospitals. To varying degrees, nongovernmental organizations, private sector providers, and military facilities also provide services.

Available data from 2011–2016 reveal high coverage of key services in the countries under study. For example, in Egypt, 90 percent of pregnant women made at least one antenatal visit, and 83 percent made at least four follow-up visits [1]. In Jordan, nearly all births are attended by skilled health personnel [2]. In Morocco, the proportion of births attended by skilled health personnel is reported to be 74 percent [3]. Nearly all births in Kingdom of Saudi Arabia are attended by skilled health personnel (99 percent) [4].

Some services are lacking or poorly implemented in all four countries, however. Examples include surgical methods of family planning (i.e., female and male sterilization), post- abortion care, voluntary testing and management of HIV, preventive antiretroviral therapy for babies exposed to HIV, and the use of surfactant to prevent respiratory distress syndrome in preterm babies.

All four countries face common health system challenges-namely fragmentation, a lack of integrated care that leads to ineffectiveness and inefficiency, along with unregulated private and nongovernmental service providers, wide disparities and inequities in health, and a weakness in health-system governance.

Health Workforce Readiness

The assessment revealed that health workforce challenges are closely correlated with health service challenges, and thus align closely with the results shown in (Table 2). The health workforce needs strengthening in all four countries, although the specific challenges vary (Table 3).

Challenge	Egypt	Jordan	Morocco	Saudi Arabia
Lack of or ineffective human resources strategic planning				
Notable mal-distribution of health care workers, or inequitable distribution				
Ineffective retention policies and high staff turnover				
Poor remuneration of staff and dual practice due to poor incentives in the public sector				
Centralized decision making in human resources management				
Chronic absenteeism				
Poor quality and comprehensiveness of the education and training of medical and para-medical staff as well as pre- and in-service training				
Weak human resources information system, especially for the private sector				
Limited practice of family medicine specialty				
The absence of the Higher Health Council role in drawing up health education policy				

Table 3: Scorecard of health workforce challenges by country.

Note: Red refers to highly challenging issues, yellow refers to issues that are somewhat challenging, and white refers to issues that do not present a challenge.

Source: M. Osman et al., Readiness Analysis to Meet Sexual and Reproductive Health-Related Sustainable Development Goals in Selected Arab Countries, Cairo, Egypt: Middle East and North Africa Health Policy Forum, 2017.

Shortages may exist in the numbers of workers or specialties available, in the distribution of workers across areas of need, a lack of quality training in SRH, or all of these. The emigration of skilled workers (the "brain-drain") also exacerbates these problems. Moreover, increased numbers of women of childbearing age (due to population growth) will put additional pressure on health systems, making reforms in the primary health care workforce even more urgent.

The current skill mix of Egypt's health workforce may not adequately respond to increasing health care demands [5,6]. Thus, innovative approaches are needed to make the best use of the current workforce. For example, in Upper Egypt, where physicians are scarce, experienced nursing staff could perform basic medical procedures once they receive the appropriate training [7]. Workforce incentives should also be sought; for example, the use of performance-based payments to providers has proven successful in improving quality of care.

Investing in human resources for health is a strategic necessity in Jordan to attain quality health care services and contribute to social welfare and development. Drafting and implementing a short- and long-term human resources plan is essential, with an emphasis on expanding academic and vocational training for key specialties such as midwifery, nursing, and family medicine [8].

Morocco must make greater efforts to redistribute the number of public service staff, reduce gender inequalities, devolve administrative functions, and improve performance. The extension of some hospital care exacerbates Morocco's deficit in human resources, currently estimated at more than 6,000 physicians and over 9,000 nurses.

Equity in Health Outcomes

Large disparities in health outcomes among different segments of society are a major challenge in all four countries-even in areas where progress can be seen nationally, such as declining maternal and infant mortality. The inequity problem is multifaceted and relates to the lack of a clear vision and planning, health workforce shortages, lack of resources, and/or inappropriate governance. It is also related to external factors such as forced in-migration, as in the case of Jordan.

For many health outcomes, a significant gap exists between affluent and marginalized groups of people. In some cases, the risk of death among the marginalized group is double that of the affluent group. This applies to infant mortality in Egypt when comparing the richest 20 percent and poorest 20 percent [1], and to maternal mortality in Morocco when comparing urban areas to rural areas.

Data describing inequality in health outcomes are scarce. However, women and adolescent girls belonging to marginalized subpopulations, including forced migrants, would certainly be most affected because of early marriage, illiteracy, lack of information, and lack of empowerment. They are the first victims of unwanted pregnancies, abortions, violence, and HIV/AIDS, and they may have little or no health coverage or ability to pay for healthcare.

Equity in adolescent health is a challenge in all four countries due to early marriage and childbearing among some population subgroups. Jordan and Kingdom of Saudi Arabia are both highly challenged in achieving equity in relation to HIV prevention, counseling, and treatment, while Egypt and Morocco are highly challenged to achieve universal coverage of essential health services.

Closing Information Gaps

The country assessments identified information gaps that must be bridged to enable governments to monitor and evaluate SRH-related SDG achievements regularly. The absence or irregularity of household-based health surveys is a serious challenge. Surveys such as Demographic and Health Surveys (DHS), the Pan Arab Family Health Survey (PAPFAM), and Multiple Indicator Cluster Surveys (MICS) need to be conducted, and they should be modified to collect data on populations that are currently missed, such as unmarried women and adolescents. In addition, data must be collected and analyzed in a way that allows for disaggregation to the lowest administrative units.

A paradigm shift must be introduced to collect data on topics considered taboo, such as HIV/AIDS and violence against women. In addition, health registries must be built, and the data used to inform decision-makers and to develop evidence-based policies.

National health information systems need strengthening to ensure quality, consistency, and inclusion of the private sector and other public institutions that provide health services e.g. military, police, universities, insurance. Health information systems must have the capability to collect and disseminate national health data and indicators for monitoring progress toward health goals.

Recommendations

The results of this assessment are relevant for countries with similar health systems or similar political, economic, and health challenges. Achieving the 2030 SDGs depends to a large extent on health system strengthening, particularly improving human resource capacities and the availability and accessibility of quality services.

Urgent and comprehensive reforms must be made to address fragmentation and resulting inefficiencies in health systems, and wide disparities in health service management, financing, and provision. A related challenge is the shift toward privatization of health services without a clear vision on how to achieve public health goals. This process could reduce the chances of achieving equitable health services and outcomes within countries.

Working toward UHC is crucial to overcoming the current shortcomings facing health systems in the region today. Policymakers should:

Form a clear vision and roadmap for a stepwise approach to UHC, setting priorities based on evidence and giving special attention to the most vulnerable populations.

Guarantee access to an essential package of services that includes SRH, under a financing system that ensures financial risk protection and reduces out-of- pocket spending. Social health insurance is one strategy for improving service coverage, equity, and quality. Expand geographical coverage of services, focusing on remote and underserved areas.

Invest in primary health care and strengthen the role of family physicians in providing accessible, comprehensive, continuing, and personalized care, with referrals to specialists as needed.

Develop partnerships with the private sector and support complementarity between the public and private sectors to achieve national health goals. Non-governmental and private health care providers must be regulated to ensure they are compliant with health ministries' national policies, standards and guidelines.

Plan for the health workforce based on existing and projected needs; increase the size and strengthen the skill mix of the workforce to provide better quality SRH care.

Explore a strategy of contracting out the needed health workforce from existing NGOs or private providers in remote areas, or in areas where gender-specific or specialized providers are lacking. Existing legislation could be revised to accommodate innovative options to compensate for the lack of or mal-distribution of health manpower.

Develop regional and community-level SRH indicators that measure disparities in SRH outcomes based on residence, education, geographic region, gender, wealth, ethnic group, displacement status, and disability. Performance indicators should also be developed to monitor health disparities as outcomes themselves.

Amend and review existing laws and policies to ensure that all population categories, regardless of their legal status, have access to quality SRH information and services.

Conclusion

A wide range of strategies and action plans are needed to meet the SRH-related targets of the SDGs, and to ensure

that "no one is left behind." Interventions should be country-specific, and they should include reprioritizing public spending to respond to SRH challenges, developing innovative solutions to improve health equity, creating a stronger role for civil society in monitoring and evaluating health service delivery, developing better health information systems, and making better use of technology to improve sexual and reproductive health. Examples include: midwifery workforce, family planning programming and reproductive health security, and generation of data for equity analysis to inform targeted programming and interventions.

References

1. Ministry of Health and Population [Egypt]: El-Zanaty and Associates [Egypt] and ICF International 2015 Egypt Demographic and Health Survey (2014) Cairo, Egypt and Rockville, Maryland, Ministry of Health and Population and ICF International, USA.

2. (2013) Department of Statistics [Jordan] and ICF International: Jordan Population and Family Health Survey 2012. Calverton, Maryland, Department of Statistics and ICF International, USA.

3. (2011) Moroccan Ministry of Health: National Survey of Population and Family Health 2011, Pan-Arab Project for Family Health (PAPFAM).

4. Al-Ansary, Lubna (2016) Assessment of the Health System Readiness for Achieving Sustainable Development Goals Related to Sexual and Reproductive Health in the Kingdom of Saudi Arabia: Cairo, Egypt: Middle East and North Africa Health Policy Forum / United Nations Population Fund.

5. (2016) Central Agency for Public Mobilization and Statistics (CAP-MAS), Egypt in Numbers.

6. (2016) WHO: Health service delivery.

7. (2015) World Bank: A Roadmap to Achieve Social Justice in Health Care in Egypt, DC: World Bank, Washington.

8. Aqel, Ibrahim (2016) Assessment of the Health System Readiness for Achieving Sustainable Development Goals Related to Sexual and Reproductive Health in the Kingdom of Saudi Arabia. Cairo, Egypt: Middle East and North Africa Health Policy Forum/United Nations Population Fund.