Reproductive Health and Research

Policy brief

www.who.int/reproductive-health/strategy

Policy brief

World Health Organization

IMPLEMENTING THE GLOBAL REPRODUCTIVE HEALTH STRATEGY

Integrating sexual and reproductive health-care services

This policy brief is intended to give guidance to policy-makers and others engaged in planning and implementing policies and programmes in sexual and reproductive health. It elaborates on one area of action in the WHO Global Reproductive Health Strategy *(1)*, raising issues for consideration when integrating the components of sexual and reproductive health services in a broader health-care context.

The Programme of Action of the 1994 International Conference on Population and Development (ICPD) calls on countries to provide a full range of sexual and reproductive health services in an integrated manner in the context of the primary health care system. In this regard, many different definitions of integration have been proposed and various operational concepts for integration have been put forward. This brief discusses policy issues at three levels of integration: at the point of service delivery; at the health sector level; and within national development planning processes.

A sexual and reproductive health programme has five major components: maternal and newborn health; family planning; prevention of unsafe abortion; management of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), including HIV/AIDS; and promotion of sexual health. A programme needs to serve all segments of the population, including adolescents.

At the point of service delivery, integration means bringing together these components and establishing strong linkages with other health-care and related social services. The rationale for integration is to increase the effectiveness and efficiency of the health system and to meet people's needs for accessible, acceptable, convenient, client-centred comprehensive care. This should include prevention of ill-health, provision of information and counselling, screening, diagnosis and curative care and/or referral for a full range of sexual and reproductive health and other health-care needs.

Integration does not mean that all sexual and reproductive-health or other services must be provided on site, but it does require that health-care providers have the knowledge and skills to provide an appropriate basic package of services and to refer patients for other necessary services that are not provided at that site. In making decisions regarding which services to provide at any given level, policy-makers will need to consider the capacities of available health-care providers, the available equipment and supplies, and whether referral to other sites or levels of the health-care system is feasible. They will also need to take account of local social and cultural norms in making decisions about what services are provided in physical proximity by the same providers, as opposed to those that are integrated through referral mechanisms. For example, in some contexts, women may be unwilling to share a common waiting room with men or to be seen by a male health-care provider. In others, young people may be reluctant to use services intended primarily for adults and or young children, but

may be willing to use the services if special hours are established only for youth. In each context, decisions should be made in the best interest of increasing the health system's effectiveness and client satisfaction.

It is important that sexual and reproductive health services have the capacity to provide basic, quality services to individuals with different needs. For example, maternal health services need to be able to provide care or referral to other services for women with HIV/AIDS. Similarly, if special AIDS treatment services are in place, providers must be able to respond (either by providing care directly or through referral) to other sexual and reproductive health needs of women, including family planning, care of reproductive tract infections (RTIs/STIs) and cervical cancer prevention and treatment, as well as counselling on domestic abuse, nutrition and child care. People may use different "entry points" or specific types of services, but they should be offered a full range of sexual and reproductive health services to meet their needs. For example, men may initially access STI services, and women antenatal and maternal care, but both should be able to access voluntary counselling and testing for HIV, contraception, or treatment of RTIs/STIs as needed, either on site or through service linkages.

In the context of integration, policy-makers also need to consider how people's sexual and reproductive health needs change over time, in order to ensure that services are available to meet their needs throughout the life course. A woman receiving antenatal care today will in the future need delivery and postpartum care and family planning services. Service providers need the knowledge, skills and supplies to provide these services, as well as information about the woman's previous care and outcomes in order to be able to provide appropriate care. This dimension of integration over time has important implications for health information systems, particularly maintenance of client records.

At the health sector level, the responsibility for policy and programme development, implementation and evaluation may rest with different managers or departments. In this context, integration is achieved through effective communication and collaboration aimed at ensuring that necessary linkages are established at all levels of service delivery. Collaboration between different health programmes—for example, between sexual and reproductive health and other priority programmes, such as HIV/AIDS, malaria, tuberculosis or immunization—is necessary for a range of health system issues.

Sexual and reproductive health services, like other health services, require a strong functioning health system. It is critical that policies concerning financing and payment for health services, procurement and distribution of essential medicines through an efficient logistics system, as well as planning and management processes related to human resources (i.e. staffing patterns, remuneration and motivation, training and supervision) are developed so as to support the integration of sexual and reproductive health services. For example, major components of sexual and reproductive health services are preventative rather than curative in nature and thus financing, insurance and provider payment policies must ensure that availability and utilization of these services are promoted, rather than discouraged. As sexual and reproductive health problems disproportionately affect the poor, women and youth, the development of effective services to meet the needs of these groups should be a priority for the health system *(2)*. It has been demonstrated that where health systems are weak, carefully designed efforts to strengthen the availability and provision of sexual and reproductive health services can help strengthen the capacity of the entire health system.

As sexual and reproductive health services become integrated within the broader health care system, the provision of all services becomes more complex. Therefore, both technical and managerial capabilities of service providers must be increased simultaneously. For example, supervisors need to expand the range of their technical knowledge and skills, and logistics and information systems need to become more complex. Policies governing human resource development should pay particular attention to strengthening supervision and other management skills when integrating sexual and reproductive health services *(3)*.

Integration between the public and private sectors also requires attention. In many countries, use of the private health sector is increasing and some sexual and reproductive health services—STI care—are often obtained predominantly from private providers. Private–public partnerships and other mechanisms for contracting with the private sector for the provision of health services are being increasingly used to improve the availability of and access to sexual and reproductive health services *(4)*. In order to ensure services of high quality, quality assurance mechanisms should be developed and implemented, including those that involve professional associations and other public organizations in order to increase public accountability via civil society.

Integration of sexual and reproductive health with other health services is also critical in macro-health planning and resource mobilization exercises such as sector-wide approaches (SWAps) *(5)*. When the basic health goals for a SWAp are defined or when essential packages of services for financing through these mechanisms are

elaborated, it is vital that sexual and reproductive health services are adequately represented and promoted (see policy brief No.1 in this series). These exercises are often driven by priority-setting mechanisms such as the use of DALYs (disability-adjusted life years—a way of calculating the burden of disease) which have been shown to undervalue many sexual and reproductive health needs, including maternal care. Thus, there is a tendency to underemphasize sexual and reproductive health services in these processes.

At the national development planning level, integration involves linkages between sexual and reproductive health policy within health sector planning and similar planning processes taking place in and across other sectors, such as education, agriculture, youth, women's affairs, environment and finance. Sexual and reproductive health policies and programmes need to be strongly linked to planning and policy development in these sectors, as effective linkages can lead to synergies in the provision of services and thus improved health outcomes. For example, efforts to decrease gender disparities in education, economic opportunities and decision-making in households are essential in maximizing access to, and utilization of, health services by women: these measures have been shown to lead to improved health outcomes. Linkages and coordination with income-generating activities for women, community forestry projects, work-based social insurance schemes and other similar activities implemented by ministries outside of the health sector can serve both as entry points to reach women with health information and as a means of increasing their capacity to have the resources to access services and improve their own health and that of their families. Similarly, youth programmes can help support and encourage young people to access health services. Young people's need for information about their sexual and reproductive health can often be provided through schools, as well as through sports clubs or cultural groups that reach out-of-school youth.

Poverty reduction strategy papers (PRSPs) are important mechanisms in the process of macro-planning and resource mobilization *(6)*. Although poor sexual and reproductive health is a well-documented determinant of poverty, few PRSPs have yet to include sexual and reproductive health as a central part of their analysis. Health ministries need to secure their role in PRSP processes and effectively lobby for the economic benefits of investments in sexual and reproductive health. The case must be made for investments that will promote and protect sexual and reproductive health and reproductive rights, especially for women and young people.

References

1. *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets*. Geneva, World Health Organization, 2004 (Document No. WHO/RHR/04.8).
2. *World development report 2004: making services work for poor people*. Oxford, Oxford University Press for the World Bank, 2003.
3. *The world health report 2006: working together for health*. Geneva, World Health Organization, 2006.
4. Harding A. *Private participation in health services handbook*. Washington, DC, Health, Nutrition and Population Department, The World Bank, 2003.
5. *Building UNFPA/WHO capacity to work with national health development planning process in support of reproductive health: report of a technical consultation*. Geneva, World Health Organization, 2006.
6. *PRSPs. Their significance for health: second synthesis report*. Geneva, World Health Organization, 2004.

Further reading

1. Berer M. Integration of sexual and reproductive health services: a health sector policy. *Reproductive Health Matters*, 2003,11: 6–15.
2. Lush L. et al. Integrating reproductive health: myth and ideology. *Bulletin of the World Health Organization*, 1999, 77:771–777.
3. Lush, L Service integration: an overview of policy developments. *International Family Planning Perspectives*. 2002, June, 28: 71–76.
4. Integrating services. *Network*, 2004, 23 No. 3 (Family Health International).
5. de Pinho, H et al. Integration of health Services. In Sundari Ravindran TK, de Pinho H, eds. *The right reforms? Health sector reforms and sexual and reproductive health*. Johannesburg, Women's Health Project, School of Public Health, University of Witwatersrand, 2005.
6. Dehne KL et al. Integration of prevention and care of sexually transmitted infections with family planning services: what is the evidence for public health benefits? *Bulletin of the World Health Organization*, 2000, 78:628–639

For more information contact:

Peter Fajans, Dale Huntington
Department of Reproductive Health and Research
World Health Organization
Avenue Appia 20, CH-1211 Geneva 27, Switzerland
Telephone: +41 22 791 4137
Fax: +41 22 791 4189 / 4171
E-mail: fajansp@who.int
Internet address:
www.who.int/reproductive-health

© World Health Organization, 2006