

# A review of family planning policies and services in WHO Eastern Mediterranean Region Member States

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## Abstract

**Background:** Family planning (FP) is a cost-effective public health and development intervention. Eastern Mediterranean Region (EMR), has one of the lowest contraceptive prevalence rate (CPR) and high unmet need for family planning.

**Aims:** The aim of this review is to assist Member States in highlighting those areas that need strengthening to improve quality of FP services in information and commodity supplies.

**Methods:** A structured questionnaire focusing on FP services was sent to 22 Member States of the WHO Eastern Mediterranean Region between August and December, 2015. Sixteen (73%) countries responded.

**Results:** Family planning services are part of the basic health benefits package and are delivered at hospitals, primary healthcare centres and outreach clinics to all women regardless of their ability to pay in the majority of Member States. In 16 Member States the family planning/birth spacing (FP/BS) counselling and FP methods are provided by general practitioner/family doctor, nurses and midwives. In many Member States the services are integrated with child health, STI and HIV services. In 16 Member States FP/BS is part of the pre- and in-service training programmes for all cadres of healthcare providers. FP/BS is actively promoted through effective social marketing of FP/BS methods in two thirds of Member States.

**Conclusions:** The findings of the survey indicate that national policies and programmes endorse FP to achieve national targets. Despite progress in many areas in FP services, many countries still struggle with weak implementation of FP programmes. There are also policy gaps for key vulnerable groups including the poor, the disabled and adolescents. This review highlighted policy and programmatic gaps required to strengthen those FP services that can help improve maternal and infant health outcomes. Special programmes for adolescents, refugees and persons with disabilities need to be streamlined and strengthened.

Keywords: family planning, contraceptive, services, Eastern Mediterranean Region

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## Introduction

Currently there are an estimated 214 million women (1) in low- and middle-income countries who want to delay or prevent pregnancy but are not using a modern method of contraception.<sup>1</sup> Family planning – especially modern methods of family planning or contraception (1) – are considered to be one of the most health-promoting and cost-effective activities in public health, with the potential to avert approximately 30% of maternal deaths and 10% of child death (2). One key pathway to better health outcomes is to reduce the high number of unintended pregnancies and unwanted births, since each pregnancy and birth carries a health risk for the mother. Particularly in areas where obstetric services are poor, maternal mortality is still high (2).

Recent global surveys estimate that 55.7 million abortions occurred worldwide each year from 2010 to 2014. Out of these, 25.1 million (45.1%) abortions each year were unsafe, with 24.3 million (97%) of these in low- and middle-income countries (3). The annual number of maternal deaths is estimated to be 303 000 in 2015, of

which 28 000 are in Eastern Mediterranean region, with a life time risk maternal death of 1 in 170, compared to 1 in 3400 in Europe (3).

Family planning has clear health benefits, principally the prevention of unintended pregnancies and reductions in maternal and infant mortality and morbidity (4). It is estimated that if all women who want to avoid a pregnancy used modern contraceptives and all pregnant women and newborns received care at the standards recommended by WHO, the benefits would be dramatic. Providing access would prevent 67 million unintended pregnancies and reduce induced abortions by 13 million. It would reduce maternal deaths by 76 000 per year, newborn deaths from 2.9 million to 660 000 per year, and HIV infections in newborns from 130 000 to 9 000 (4).

The prevalence of contraceptive use among women aged 15–49 years who were married or in a consensual union increased globally from 55% in 1990 to 64% in 2012. Unmet need – defined as the proportion of women who are married or in a union who want to stop or postpone childbearing but are not using contraception, also declined (Figure 1) (5).

It is a challenge to meet this SDG 3, target 3.7, i.e., 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 (6) in the EMR as it has the second lowest contraceptive prevalence rate CPR (48%) and second highest unmet needs of FP globally, after the Africa (Figure 1). However, regardless of the well-established FP benefits, many governments in low- and middle-income countries have made only limited investments in these programmes since priority was given to donors' interests and other areas (7) (Table 1).

An earlier survey was conducted in 2009 (8); however, due to recent changes and upheavals in several countries of the Region it was considered important to take review the existing policies and programmes in order to improve evidence-based policies for the future. Thus, the main objective of this survey was to review the FP policies, identify and map evidence-based programme practices in EMR Member States in order for their governments to design better FP strategic planning and policy.

## Methods

The survey was conducted by the WHO Regional Office for the Eastern Mediterranean (WHO/EMRO) in collaboration with WHO headquarters, country offices and national ministries of health. A descriptive study design was used to landscape the policies and implementation status of evidence-based practices in FP in EMR Member States. The tool used for the survey was a modified version of the questionnaire used in the 2009 survey in EMR for the FP status assessment (8). A total of 77 questions in the survey focused on: FP policies and guidelines present in the available health systems, integration of services, commodity security, staff competencies in FP, access to vulnerable groups, policies and strategies on family planning promotion, and programme monitoring and evaluation.

The survey was conducted between August and December 2015. The questionnaire was sent to 22 EMR Member States of which 16 responded; these were:

Afghanistan, Egypt, Iraq, Jordan, Lebanon, Morocco, Oman, Qatar, Pakistan, Palestine, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia and Yemen. Six countries did not respond; these were: Bahrain, Djibouti, Islamic Republic of Iran, Kuwait, Libya and the United Arab Emirates. The survey was completed by WHO country offices in consultation with Ministries of Health. No response to three reminders was considered as unwillingness to participate in the survey. The survey data from 16 Member States was checked for any errors before analysis. The data was entered in Microsoft excel sheet and analysed using calculated frequencies and percentages. Three researchers analyzed the questionnaires. The answers of the questionnaires were entered in the excel sheet. The numbers of "yes" and "no" answers of each topic and their proportions were calculated.

## Results

The questionnaire responses were checked by WHO/EMRO. Based on the questionnaire, we were able to analyse these responses, as presented below. Compared to previous surveys, a greater number of countries responded as shown in Table 2.

The result section is divided into seven thematic areas, as follows:

### 1. Policies, regulations and guidelines ensuring the quality of FP/BS services

All 16 Member States involved in the survey have created up-to-date minimum standards for the national regulation of health facilities to insure the safety of FP/BS services. Fifteen Member States regularly update national guidelines and protocols for FP/BS counseling and service provision that are evidence-based; only Lebanon had no guidelines for counseling although minimal counseling is included in the reproductive health service delivery guidelines. A competency-based national qualification system that certifies health workers to provide quality FP/BS counseling and services is in place in nine Member States; an effective and functional quality assurance system is in place to ensure the quality of provided

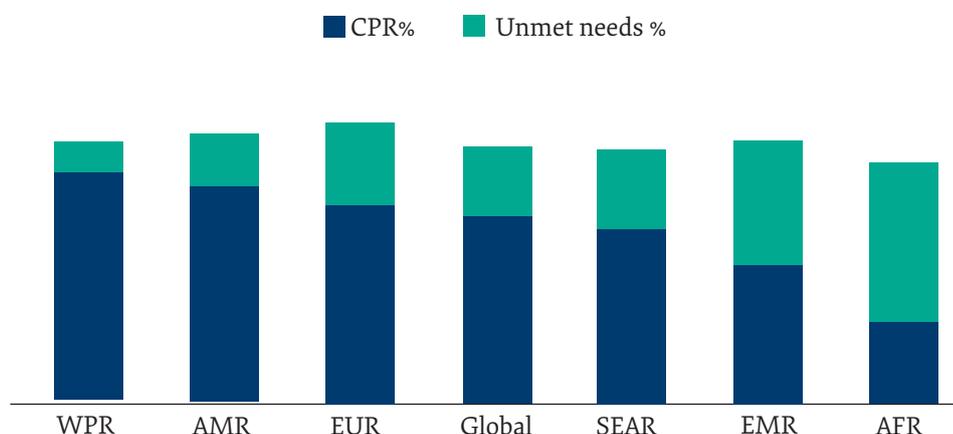


Figure 1 Contraceptive prevalence, unmet need and total demand for family planning: globally and by WHO region, 2012.

**Table 1 Eastern Mediterranean Region Member States: an overview of family planning**

Eastern Mediterranean Region Member States	Contraceptive prevalence rates (%)	Unmet need for family planning (%)
Afghanistan	21	–
Bahrain	–	–
Djibouti	19	–
Egypt	60	12
Iran (Islamic Republic of)	77	06
Iraq	53	08
Jordan	61	12
Kuwait	–	–
Lebanon	–	–
Libya	42	27
Morocco	67	11
Oman	24	56
Pakistan	35	20
Qatar	38	06
Saudi Arabia	24	–
Somalia	–	–
Sudan	09	29
Syrian Arab Republic	54	16
Tunisia	63	07
United Arab Emirates	–	–
Yemen	–	–

World health statistics 2015. [http://apps.who.int/iris/bitstream/10665/170250/1/9789240694439\\_eng.pdf?ua=1&](http://apps.who.int/iris/bitstream/10665/170250/1/9789240694439_eng.pdf?ua=1&)

FP/BS services in 11 Member States; and a supportive supervision system is in place to support service providers and improve their performance in 14 Member States at primary health care level, and 12 Member States at secondary health care level.

## 2. Integrated FP/BS services and mix of service delivery points

All 16 Member States involved in the survey have stated that FP/BS services are part of their basic health benefit package and are delivered at the primary healthcare level. All involved in the survey have stated that a mix of contraceptives is part of the country's essential drug list. Most of the Member States responded that oral pills, intra-uterine devices, male condoms, injectables and implants are the most common contraceptives. Only six Member States (Lebanon, Morocco, Oman, Qatar, Saudi Arabia and Tunisia) have responded that family planning counseling and methods are provided in preconception care. Ten Member States (Afghanistan, Egypt, Iraq, Jordan, Pakistan, Palestine, Somalia, Sudan, Syrian Arab Republic and Yemen) have responded no such services are provided in preconception care. Fourteen Member States stated that FP/BS counselling is provided by nurses. Only two Member States, Pakistan and Saudi Arabia, responded that nurses does not provide such services.

All countries provided services for surgical methods such as tubal ligation and vasectomy. Although the question was asked and emergency contraception (EC)

is present in most countries, no-one explicitly provided information on it.

## 3. Commodity security

FP/BS commodity security is ensured through effective supply chain management all over the country by 13 Member States. Only three countries (Somalia, Syrian Arab Republic and Yemen) responded ineffective FP supply chain management all over the country due to humanitarian crisis. FP/BS commodity security is ensured through data-based planning by all Member States except Somalia, and is also supported by well-functioning contraceptive logistics management information system by all Member States except Iraq, Lebanon and Somalia. The supply chain management is generally carried out by the facility staff, but not all staff is formally trained.

## 4. Well-trained staff

Pre-service and in-service training programmes exist in technical schools for midwives, nurses and female health visitors in all Member States, except in Saudi Arabia. It was also noted that 14 Member States (excluding Jordan and Somalia [only in Puntland]) responded that FP/BS is part of pre-service as well as in-service training programmes for healthcare providers (doctors, nurses, female health visitors and community health workers) in medical universities. Also 15 Member States (excluding Palestine and Somalia) responded that FP training guidelines and materials are evidence-based and are updated

**Table 2 Comparison of responses on selected variables between 2009 and 2015 by EMR Member Dates**

Selected variables	Result in 2015	Result in 2009*
FP safety regulation at Health facility $\alpha$	16/16 (100%)	16/18 (89%)
FP guidelines and protocols updated $\beta$	15/16 (94%)	13/18 (72%)
FP as basic package and delivered at Primary Health Care level	16/16 (100%)	17/18 (94%)
Mix contraceptives in essential drug list	16/16 (100%)	16/18 (89%)
FP counselling and methods in preconception care	6/16 (38%)	NA
FP counselling by nurse	14/16 (88%)	14/18 (78%)
FP effective supply chain management all over the country	13/16 (81%)	12/18 (67%)
FP pre- and in-service training programme in universities	14/15 (93%)	14/18 (78%)
Training guidelines and materials: evidence-based	14/15 (93%)	15/18 (83%)
FP special program for adolescents	8/16 (50%)	6/18 (33%)
FP special program for displaced or refugees	12/13 (92%)	9/18 (50%)
FP special program for poor/disadvantaged	10/15 (67%)	9/18 (50%)
FP promoted through Effective social marketing	10/15 (67%)	12/18 (67%)
FP promoted through community mobilization efforts	12/15 (80%)	11/18 (61%)
HMIS system collects and analyses FP data	15/16 (94%)	13/18 (72%)

\*Please note the 2009 data are taken from a previous regional survey on FP (8).

$\alpha$ : This refers to utilization of WHO MEC standards in prescription of contraceptives to clients.

regularly. Fifteen Member states excluding Syrian Arab Republic) stated that training guidelines on quality of contraceptive care standards are evidence based and updated regularly.

### 5. Special programmes for vulnerable groups

This programme primarily includes in-service training and orientation courses on the needs of adolescents and those with disabilities. Only half of Member States responded that they have FP special programme for adolescents and for those with disabilities. All Member States except Egypt (Morocco, Oman and Saudi Arabia did not reply) stated having special FP programmes for displaced populations or refugees. Ten Member States (Egypt, Lebanon, Morocco, Oman, Qatar, Pakistan, Palestine, Somalia, Syrian Arab Republic and Tunisia) stated having a FP special programme for the poor and disadvantaged. It was also interesting to note that only nine Member States had special programmes to meet the needs of rural and peri-urban and slum populations. In only 10 Member States is there a special component to meet the needs of males, which was absent in Afghanistan, Egypt, Iraq, Jordan, Oman, Sudan and Yemen.

### 6. FP/BS promotion

Ten Member States (Afghanistan, Egypt, Morocco, Oman, Qatar, Pakistan, Sudan, Syrian Arab Republic, Tunisia and Yemen) have stated that FP is promoted through effective social marketing. Community mobilization efforts was used in 12 Member States (Afghanistan, Jordan, Morocco, Oman, Qatar, Pakistan, Palestine, Somalia, Sudan, Syrian Arab Republic, Tunisia and Yemen), while community education (including a wide distribution of quality education and information materials) was the norm in Afghanistan, Egypt, Iraq, Morocco, Oman, Qatar, Palestine, Somalia, Sudan, Syrian Arab Republic, Tunisia and Yemen.

### 7. Programme planning, monitoring and evaluation

Regarding health management information system (HMIS) collection and analysis of FP data, 15 Member States (except Lebanon) responded that evidence-based indicators are selected to monitor and evaluate FP/BS programmes. Jordan remarked that the selection of evidence-based indicators to monitor and evaluate FP/BS programme were well formulated in its FP strategy 2013–2017.

### Discussion

Globally, the Eastern Mediterranean Region has the second lowest contraceptive prevalence rate (48%) and second highest unmet needs of family planning (18%) after the African Region. The EMR Member States include a broad range of countries with varying income levels, including high-income states (Bahrain, Kuwait, Oman, Saudi Arabia, Qatar, United Arab Emirates) to upper middle-income states (Islamic Republic of Iran, Iraq, Lebanon, Libya), lower middle-income states (Djibouti, Egypt, Jordan, Pakistan, Morocco, Sudan, Syrian Arab Republic, Tunisia, Yemen) to low-income economies (gross national income per capita of US\$ 1005 or less in 2016) such as Afghanistan and Somalia (8). Based on the contextual background, it is difficult to identify common factors across all countries; however, there are certain factors among lower middle and low-income countries including lack of infrastructure, stock shortages, lack of trained staff, and cost of contraceptive methods that lead to limited access among vulnerable groups. Religious belief is another common denominator for EMR countries and cultural views on family size may also vary that sometimes plays a role for the acceptance and use of contraception.

Our results noted that nine Member States (Afghanistan, Djibouti, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan and Yemen) have lower CPR

than the regional average, which needs to have priority on national agendas in order to improve the quality and access of services of FP programmes. It is also worth mentioning that unmet needs exceed 20% in 10 Member States, leading to a tremendous burden on reproductive health to achieve the SDG target of ensuring universal access to sexual and reproductive healthcare services, including FP, information and education, and the integration of reproductive health into national strategies and programmes by 2030.

Against this background, this survey will help national schemes identify strengths and weaknesses in FP programmes, while allowing comparison with regional countries regarding best practices in FP and application to improve their own programmes in the coming years. In addition, this survey identified the weaknesses in national programmes and where improvements can be made to increase quality of care and increase access for the vulnerable. It clearly shows that although national guidelines are in place, there are clear policy and programme weaknesses; for example, absence of policies for adolescents, vulnerable populations, and most importantly for men. Member States can make strides to fill these gaps and improve within the existing systems.

In Addition, competency-based national qualification systems certifying health workers to provide quality FP/BS counseling and services was also highlighted as one key issue to ensure better quality of services. National health authorities should advocate and lead the process of appraisal and prioritization for scaling up best practices in FP/BS. Based on available evidence and additional targeted research findings, a country specific action plan should be developed, and an interdisciplinary body is suggested to be established, if not already available.

Despite progress in many areas in FP services, many countries still struggle with weak or nonexistent health

information systems, which is crucial for determining and documenting progress. It was also interesting to note that despite the existence of policies, infrastructure and resources, the vital FP indicators do not provide a positive picture of EMR countries. The problem may lie in implementation of national strategies. In this regard, a well-functioning monitoring and evaluation framework will be essential to assess programme effectiveness and make recommendations for further improvements. The findings of this survey were shared with all EMR Member States in a regional meeting.

## Conclusions

The findings of the survey indicate that national policies and programmes endorse FP to achieve national targets. Despite progress in many areas in FP services, many countries still struggle with weak implementation of FP programmes. There are also policy gaps for key vulnerable groups including the poor, the disabled and adolescents. This review highlighted policy and programmatic gaps required to strengthen those FP services that can help improve maternal and infant health outcomes. Special programmes for adolescents, refugees and persons with disabilities need to be streamlined and strengthened.

**Disclaimer:** This report contains the collective views of an international group of experts, and does not necessarily represent the decisions or the stated policy of the World Health Organization.

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**Competing interests:** None declared.

## Analyse des politiques et des services de planification familiale dans les États Membres de la Région OMS de la Méditerranée orientale

### Résumé

**Contexte :** La planification familiale est une intervention de santé publique et de développement qui a un bon rapport coût-efficacité. La Région de la Méditerranée orientale affiche l'un des taux les plus faibles de prévalence de la contraception, ainsi que d'importants besoins non satisfaits en matière de planification familiale.

**Objectifs :** La présente étude avait pour objectif d'accompagner les États Membres dans l'identification des domaines qui doivent être renforcés afin d'améliorer la qualité des services de planification familiale, notamment pour ce qui a trait à l'information et à l'approvisionnement en produits.

**Méthodes :** Un questionnaire structuré se concentrant sur les services de planification familiale a été envoyé aux 22 États Membres de la Région entre août et décembre 2015. Seize pays (73 %) ont répondu.

**Résultats :** Les services de planification familiale font partie des paniers de services de santé essentiels et sont proposés dans les hôpitaux, les centres de soins de santé primaires et les cliniques de proximité à toutes les femmes, indépendamment de leur capacité de payer, dans la majorité des États Membres. Dans 16 États Membres, le conseil en planification familiale/espacement des naissances et les méthodes associées est assuré par un médecin de famille/un généraliste, des personnels infirmiers et des sages-femmes. Dans de nombreux États Membres, il est intégré aux services de santé de l'enfant, de prise en charge des infections sexuellement transmissibles et de prévention du VIH. Dans 16 États Membres, la planification familiale/l'espacement des naissances fait partie des programmes de formation initiale et

continue pour toutes les catégories des prestataires de soins. Les méthodes associées font l'objet d'une promotion active grâce à un marketing social efficace dans deux tiers des États Membres.

**Conclusions :** Les résultats de cette étude indiquent que les politiques et les programmes nationaux approuvent la planification familiale en vue d'atteindre les cibles nationales. Malgré des progrès réalisés dans différents aspects des services de planification familiale, de nombreux pays sont toujours confrontés à une faible mise en œuvre des programmes associés. Des lacunes existent également en matière de politiques pour les groupes vulnérables clés tels que les personnes démunies, les personnes handicapées et les adolescents. La présente analyse a mis en lumière des lacunes politiques et programmatiques qu'il est nécessaire de combler en vue de renforcer les services de planification familiale qui permettent d'améliorer l'état de santé des mères et des enfants. Les programmes spécifiquement destinés aux adolescents, aux réfugiés et aux personnes souffrant de handicap doivent être rationalisés et renforcés.

## استعراض سياسات وخدمات تنظيم الأسرة في الدول الأعضاء بإقليم شرق المتوسط لمنظمة الصحة العالمية

باجاوان داس شريستا، معظم علي، رامز مهاني، كريمة الغلبزوري

### الخلاصة

الخلفية: يُعدُّ تنظيم الأسرة تدخلاً فعالاً من حيث التكاليف في مجال الصحة العامة والتنمية. ويوجد في إقليم شرق المتوسط أدنى معدل انتشار لوسائل منع الحمل وأعلى احتياج لم يُلبَّى بعد لتنظيم الأسرة.

الأهداف: هدف هذا الاستعراض هو مساعدة الدول الأعضاء على إلقاء الضوء على المجالات التي تحتاج إلى تعزيز بهدف تحسين جودة خدمات تنظيم الأسرة من حيث المعلومات وإمدادات السلع.

طرق البحث: أُرسِل استبيان منظم يركز على خدمات تنظيم الأسرة إلى الدول الأعضاء الاثنى عشر والعشرين بإقليم شرق المتوسط لمنظمة الصحة العالمية في الفترة بين شهري أغسطس/ آب وديسمبر/ كانون الأول ٢٠١٥. وأجاب ستة عشر بلداً (٧٣٪) على الاستبيان.

النتائج: تُعدُّ خدمات تنظيم الأسرة جزءاً من مجموعة المزايا الصحية الأساسية، وتُقدم في المستشفيات ومراكز الرعاية الصحية الأولية وعيادات التوعية لجميع النساء بغض النظر عن قدرتهن على دفع رسوم مقابل هذه الخدمات في أغلب الدول الأعضاء. وفي ١٦ دولة عضو، تُقدم استشارات تنظيم الأسرة/ المباحة بين الولادات ووسائله بواسطة ممارس عام/ طبيب الأسرة والمرضات والقابلات. وفي العديد من الدول الأعضاء، تُدمج هذه الخدمات في خدمات صحة الأطفال وعلاج الأمراض المنقولة جنسياً وفيروس نقص المناعة البشري. وفي ١٦ دولة عضو، يُعدُّ تنظيم الأسرة/ المباحة بين الولادات جزءاً من برامج التدريب قبل الخدمة وأثنائها لجميع الكوادر التابعين لمقدمي الرعاية الصحية. ويجري تعزيز تنظيم الأسرة/ المباحة بين الولادات بنشاط من خلال التسويق الاجتماعي الفعال لوسائله في ثلثي الدول الأعضاء.

الاستنتاجات: تشير نتائج الاستطلاع إلى أن البرامج والسياسات الوطنية تعتمد تنظيم الأسرة بهدف تحقيق الغايات الوطنية. ورغم التقدم المحرز في العديد من المجالات في خدمات تنظيم الأسرة، لا تزال بعض البلدان تحاول التغلب على ضعف تنفيذ برامج تنظيم الأسرة. وتوجد أيضاً ثغرات في السياسات فيما يتعلق بالفئات الرئيسية المعرضة للخطر، بما يشمل الفقراء وذوي الإعاقة والمراهقين. ويكشف هذا الاستعراض الثغرات في السياسات والبرامج المطلوب معالجتها بهدف تعزيز خدمات تنظيم الأسرة والتي تساعد بدورها في تحسين المخرجات الصحية للأمهات والرضع. كما يجب تنظيم برامج مخصصة للبالغين واللاجئين وذوي الإعاقة وتعزيزها.

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