



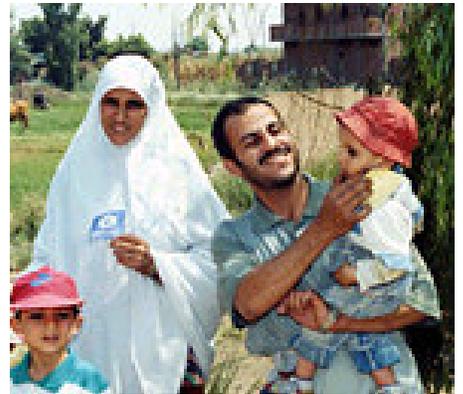
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# Integration of Family Planning / Reproductive Health and Maternal and Child Health Services: Missed Opportunities and Challenges

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November 2003

Project funded by United States Agency for International Development





The CATALYST Consortium is a global reproductive health activity initiated in September 2000 by the Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development (USAID). The Consortium is a partnership of five organizations: the Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), Meridian Group International, Inc., Pathfinder International and PROFAMILIA/Colombia.



This publication was made possible through support provided by the Office of Population and Health, United States Agency for International Development, under the terms of the contract No. HRN-A-00-00-00003-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the United States Agency for International Development.

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## Abbreviations

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ANC	Antenatal Care
BBP	Basic Benefit Package
BCC	Behavior Change Communications
CQI	Continuous Quality Improvement
CYP	Couple Years Protection
FGC	Female Genital Cutting
FP	Family Planning
GOE	Government of Egypt
HIS	Health Information System
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IUD	Intrauterine Device
MCH	Maternal and Child Health
MOHP	Ministry of Health and Population
MIS	Management Information System
NGO	Non Governmental Organization
PAC	Post Abortion Care
RTI	Reproductive Tract Infections
RH	Reproductive Health
RHU	Rural Health Unit
STI	Sexually Transmitted Infections
USAID	United States Agency for International Development



## 1. Executive Summary

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Despite existing challenges, family planning (FP), reproductive health (RH)<sup>1</sup> and maternal and child health (MCH) activities in Egypt have attained significant success since the 1980s. This success includes a reduction in the total fertility rate (average number of children per woman) from 5.3 in 1980 to 3.5 in 2000; an increase in the contraceptive prevalence rate from 24% in 1980 to 56% in 2000; a decline in the infant mortality rate from 63/1000 live births in 1995 to 44/1000 in 2000; and a noteworthy decline in maternal mortality of more than 50 percent, from 174/100,000 in 1992/3 to 84/100,000 in 2000.<sup>2</sup>

Issues that continue to challenge the service delivery system include:

- Satisfying not only the family planning and mother and child health care needs of clients, but their reproductive health care needs, as well;
- Providing quality contraceptive services to women who would want to use these services but are not currently using contraception;
- Further improving infant and child health care indicators, despite significant gains.
- Improving service quality and user knowledge to increase contraceptive effectiveness and consumer satisfaction with their chosen method;
- Further decreasing the total fertility rate, which as only experienced a slight decline from 3.6 in 1995 to 3.5 in 2000.<sup>3</sup>
- Further decreasing the maternal mortality rate;
- Improving access to and the quality of information available to policy makers concerning important demographic and health issues related to population and family planning programming;
- Tailoring services to meet the specific requirements of important subgroups, such as rural women living in Upper Egypt; young women, and women with few or no children; and
- Assuring the long-term sustainability of quality services.

An analysis of current FP and MCH service delivery and organization suggests that within the current management structure of vertical programs, it would be difficult to better meet the full range of client health needs and improve the efficiency and effectiveness of service delivery.

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<sup>1</sup> In Egypt, RH is taken to mean services like counseling for menopausal problems, premarital counseling, counseling for female genital cutting, screening and treatment of reproductive tract infections, screening and referral for suspicion of cervix cancer and breast cancer.

<sup>2</sup> Egyptian Ministry of Health 2002.

<sup>3</sup> Egypt Demographic Health Survey 2002.



Vertical programming relies on the provision of separate programs that cater to the unique goals of FP and MCH as distinct programs; each with its own training curricula, staffing patterns, information systems, supervisory tools and a top-down management approach.

Experience from other nations indicates that integrated services lead to better fulfillment of client needs by providing an integrated package of FP, RH and MCH services through one provider, at one service delivery point. Integrated services also reach more clients by using all opportunities for service delivery, requiring fewer provider-client contacts. The following missed opportunities can be readily identified at rural health units and MCH centers.

- Women in the postpartum period, who receive follow-up care at the MCH clinic, must visit the FP clinic to receive contraceptive counseling and service.
- Women who come for FP or ANC are not asked about the vaccination status of their children.
- Women who come for ANC or vaccination are not always asked about their plans for FP use after the delivery.
- Women who visit for FP services or ANC are not asked about signs or symptoms of reproductive tract infections (RTIs). If they are asked, they need to be referred for treatment.
- Women who visit for FP or MCH services are not screened for genital cancer, breast cancer or even informed about screening possibilities.
- Infertile couples are not asked about their exposure to RTIs or asked about signs or symptoms.
- Many women who deliver are not offered immediate postpartum intrauterine devices (IUDs).
- Women are not informed about the risks of Female Genital Cutting (FGC) during clinic visits.
- Many women in the waiting room of MCH clinics do not receive BCC material or information about RH or FP, nor do those who are in the waiting room for RH clinic receive BCC for MCH.
- Women in need of post abortion care do not receive FP counseling.
- Women with serious medical conditions, which medically qualify them for tubal ligation, are not informed or offered the services.

In our analysis, integration describes a range of options that includes integration at the point of service (service and essential drug packages, training curricula, staffing patterns, information systems, supervisory tools and performance management incentives), local administrative (supervisory and program budget), and national (policy) levels. While some problems related to efficiency and effectiveness can be attributed to the management of the current service delivery system, such as the application of CQI methods and supervising the implementation of the clinical guide, the majority is attributable to the vertical non-integrated

status of FP, RH and MCH services. Integrated services can thus help to overcome the issues currently challenging the health system in Egypt.

On balance integration as an opportunity to strengthen existing FP, RH and MCH services and operationalize an expanded holistic reproductive health approach in Egypt is highly desirable. Political commitment to integration is a must for the success of such a program. This commitment is evident in the recent signing of a Memorandum of Understanding between MOHP/FP, MOHP/MCH, USAID, John Snow, Inc. (JSI), and the CATALYST Consortium/TAHSEEN Project. The Memorandum describes the steps to be taken towards integration as well as a plan of action. TAHSEEN is committed to the implementation of this plan. At the time of writing considerable progress has been made.





## 2. Introduction and Background

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Over the past two decades, and especially since the International Conference on Population and Development (ICPD) Plan of Action was issued in 1994 the integration of FP, RH and MCH services has jumped to the forefront of the reproductive health activists' agenda and received considerable attention in the international family planning community. The argument for integration is based on improved reproductive and child health care delivery through MCH and FP/RH/service provider collaboration at all levels (local, district, governorate and central) and with other community, national, and international organizations whether governmental or non-governmental (NGO). Such collaboration would facilitate the sharing of expertise to evaluate and problem solve. Integration advocates proclaim the advantages of an integrated versus vertical organization of FP/RH and MCH services to be:

- Broader cultural acceptability of family planning when presented as a MCH services component;
- Greater access to medical personnel trained in delivering comprehensive MCH services;
- Improved service delivery efficiency;
- Reduced costs for clients and the service delivery system;<sup>4</sup>
- Improved ability of health care providers to make a more comprehensive assessment of women's reproductive health needs, and finally, and most important,
- Improved health outcomes for clients.

In Egypt, the case for integration has been on the policy and program agenda for some time. An MOHP strategy paper approved in May 2003 illustrates a degree of political commitment towards integration of FP/RH and MCH services in its family health approach with its integrated holistic philosophy.<sup>5</sup> The Ministry's commitment to integration was further demonstrated at model centers in Kalyubeya, Fayoum, Minia and Ismailia, where CQI techniques and improved cross referral trials were considered as bold steps in the piloting of integration and quality improvement.

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<sup>4</sup> G. D. Ness, *Existing Patterns of Integrated Programmes Their Strengths and Weaknesses*, United Nations Economic and Social Commission for Asia and the Pacific, Asian Population Studies Series no. 51. New York: United Nations, 1979. 44-45.

<sup>5</sup> Cairo, Egypt, Ministry of Health and Population, *The D4 Document: Health Sector Reform*, approved May 2003.



Do current attempts and efforts as represented by the newly developed model centers provide an adequate basis for assessing integration? Do they meet client FP, RH and MCH needs? Do they offer the prospect of improving service efficiency and effectiveness? Before attempting to provide an answer, we need to define what is meant by integration.

### 3. Defining Integration

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Ideally, integration results in services that are more responsive to client needs through the provision of an integrated package of FP, RH and MCH services through one provider, at one point of delivery. In our analysis, integration describes a range of options that includes integration at the point of service (service and essential drug packages, training curricula, staffing patterns, information systems, supervisory tools and performance management incentives), local administrative (supervisory and program budget), and national (policy) levels. Many countries, including Egypt, are grappling to operationalize the integration of FP, RH and MCH services and apply the ICPD Plan for Action. While considerable progress has been made in placing reproductive health on Egypt's national health agenda and having the issue included in a policy dialogue at the highest levels within the MOHP, integration means different things to different people and different stakeholders. Even internationally different meanings and understandings of integration exist.

Therefore, it is not surprising that the term “integration” is surrounded by a certain sense of controversy within the Egyptian context, despite general agreement on its necessity. At the central levels, ministry and governorate, integration is generally understood to cover a broad spectrum from the availability of FP, RH and MCH services with efficient cross referral, to the provision of a comprehensive package of essential services with a constellation of methods, techniques and services that contribute to reproductive health and well-being through the prevention and solution of reproductive health problems.

At the peripheral level, health unit and center, integration is understood to imply either the addition of family planning-specific activities (not the holistic reproductive health services) to MCH services or vice versa; or a “supermarket approach” where the health unit or health center provides a variety of FP, RH and MCH services, though not necessarily in the same station or room.

Learning from the experience of other nations, integration is better conceived as a process responsive to unique contexts. No template for integration can universally be applied. Integration is neither a matter of all or nothing nor does it mean that specialized staff no longer have an important role to play. Ideally the integration of FP/RH and MCH means a more responsive and effective system, better equipped to address local health issues and the social needs of women and children whether related to maternal health, female genital mutilation, cervical cancer screening, delivery by trained and skilled birth attendants, emergency obstetric interventions, or sexually transmitted infections (STI) counseling, prevention and treatment. It describes a range of options, including integration at the national, local administrative, and service delivery levels. Each level will have its own issues concerning integration such as the reorganization of supervisory roles and program budgeting at the local administrative level and service integration to link of provider functions at the service delivery point, and administrative integration where relevant opportunities exist.

In summary the ultimate goal of integration is improved child and reproductive health for women, men and children throughout Egypt. Improved services are merely a means to the



end of improved health services for all. For the purpose of the current integration activities, which focus on the service provision level, all concerned have agreed that integration means the provision of all necessary services by one provider to the client, in one visit.

**Table 1. Selected FP/RH and MCH Integration Issues at Various Administrative and Service Levels<sup>6</sup>**

<p style="text-align: center;"><b>National/Policy Level</b></p>	<ul style="list-style-type: none"> <li>• Integration mechanisms and organizational arrangements to strengthen policy and set realistic timeframe for program implementation</li> </ul>
<p style="text-align: center;"><b>Inter-ministerial Level</b></p> <p style="text-align: center;">National Council for Women and Children</p> <p style="text-align: center;">National Population Council</p> <p style="text-align: center;">Ministry of Higher Education and Supreme Council for Universities</p>	<ul style="list-style-type: none"> <li>• Linkage of roles across agencies through joint activities</li> <li>• Agency coordination for FP/RH/MCH services affecting children and adolescents such as domestic violence, sex education, FGC and empowerment of women</li> </ul>
<p style="text-align: center;"><b>Governorate and District Levels</b></p>	<ul style="list-style-type: none"> <li>• Integration of administrative functions including staff interaction or consolidation, training systems (pre-service training), streamlining of record systems, salary arrangements, incentives, etc.</li> <li>• Reorganization of local administrative supervisory roles, client record systems and program budgets</li> </ul>
<p style="text-align: center;"><b>Service Level</b></p>	<ul style="list-style-type: none"> <li>• Linkage of provider functions at service delivery point</li> <li>• Modification of staff roles, job descriptions, time allocation, and referral requirements</li> <li>• Definition of a Basic Package of Essential FP/RH/MCH services</li> </ul>

<sup>6</sup> Adapted from Hardee, K. and Yount, KM “Delivering Reproductive Health Promises through Integrated Services, Family Health International 2003.

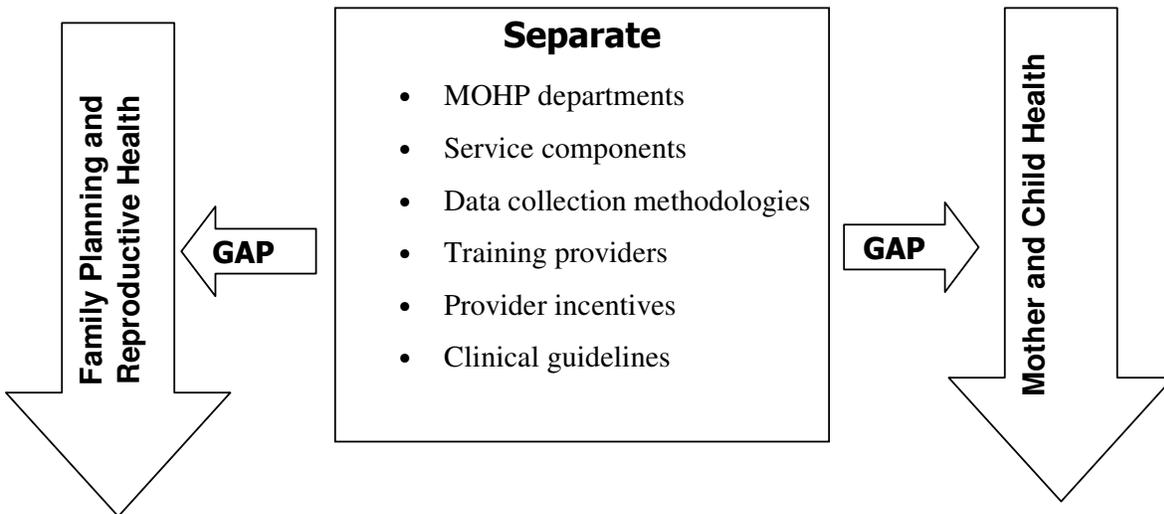
## 4. Current Situation

Through applied efforts the MOHP and other stakeholders have successfully attained and maintained an increased contraceptive prevalence rate using a vertical approach to family planning with a demographic imperative. Similar success has been achieved in the field of infant and child health care using the same vertical approach. Maternal health care has significantly improved as well.

In order to understand the evolution of the current FP and MCH service delivery systems it is important to revisit the 1960s and 1970s when primary health care in Egypt was provided through nearly 4000 health units nationwide that promoted a comprehensive set of services through accessible and affordable basic health units. Referral to a more limited number of secondary and tertiary facilities took place as required. Donor attention to specific service delivery systems and client groups, and logistic, managerial and financial dilemmas, necessitated the birth of specialized management structures. Over time these became mirrored in specialized services to clients, necessitating clients to seek care from various providers on different days at different sites (or the same site) in order to meet all their health needs.

With increased attention on population growth issues as well as MCH, separate services were established to address related objectives and goals. These services have been managed through separate top-down management systems or vertical programs, with different training curricula and staffing patterns, information systems, supervisory tools, performance management standards, incentives and service and essential drug packages.

**Figure 1. Effects of Vertical Programming**



Characteristically, separate MCH and FP systems at the central level necessitated the development of distinct management information systems, clinical guidelines, quality improvement systems, human resource planning and training allocations, and curricula for physician training. See figure 1. At the peripheral or operational level, whether district or governorate, the MCH or FP programs have separate staff for each program and use different supervisory tools. At the facility level, vertical programming means separate approaches to infrastructure, human resource development and service reform and impacts many operational aspects from integration, standard equipment and performance management, to counseling strategies, clinical guidelines, and essential drug packages.

After the ICPD in 1994, the international community added provisions for reproductive health services to the overriding demographic mandate of full service (RH and MCH) during a single visit. This means the availability of all services at all times. In practice, integration has come to mean adding new activities to the existing services. In the vast majority of Egyptian health units and centers, FP and MCH provided the pre-existing infrastructure to which RH management was added. The influence of a pre-existing service infrastructure is obvious in the orientation of the application for FP services, where most of the medical history questions were related to FP services.

## 5. Opportunities and Rationale for Integration

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Integration of FP, RH and MCH services falls in line with health sector reforms recently announced by the Minister of Health. The fundamental philosophy behind reform at the primary level is the delivery of a basic benefits package through family medicine. The integration of existing vertical programs is in complete alignment with ministerial strategic directions. The latest review within the Ministry of Health of the D4 document<sup>7</sup> and its adoption puts integration as one of the Ministry's reform strategies. The D4 document explicitly mentions that family medicine is the means by which services will be provided at the primary care level. This entails one basic benefits package that covers MCH and FP/RH services, with one set of clinical guidelines and one essential drug list. Based upon that package an integrated system can take shape.

Although integration can be seen as a dilution of resources, and staff time and energy, it should rightly be seen as an opportunity to strengthen existing FP/RH and MCH services. Given the potential range of service elements that could be included through an integration of FP/RH and MCH, the most probable result would be high quality and locally responsive reproductive services that empower clients to fulfill their reproductive health goals in a healthy manner. To this end, Hardee et al, mentioned two basic rationales for integration<sup>8</sup>:

- Better meeting client needs; and
- Improved efficiency and effectiveness of service delivery.

### Better Meeting Clients Needs

From a client's perspective, an integrated FP/RH and MCH service delivery system would simplify the care of clients with reproductive and child health care needs. They would be at a disadvantage if only provided with antenatal and delivery care without comprehensive information on family planning or the signs and symptoms of reproductive health problems, and vice versa. Through the integration of FP/RH and MCH services, it is expected that clients satisfy more of their reproductive and child health needs, with fewer visits<sup>9</sup>. Therefore, the most fundamental justification for integrated FP/RH and MCH services is the likelihood that clients will more readily and more comprehensively meet their reproductive and child health needs.

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<sup>7</sup> Cairo, Egypt, Ministry of Health and Population, *The D4 Document: Health Sector Reform*, approved May 2003.

<sup>8</sup> Hardee K, Yount KM (1995). From rhetoric to reality: delivering reproductive health promises through integrated services.

<sup>9</sup> R. Dixon-Mueller, *Women's Rights and Reproductive Choice: Rethinking the Connection*. Beyond the Numbers: A Reader on Population, Consumption, and the Environment, ed. Laurie Ann Mazur. (Washington, DC: Island Press, 1994), 227-41. and C. E. Taylor, et al., *Main Research Findings on Policy Issues*, vol 2. *Child and Maternal Health Services in Rural India: The Narangwal Experiment. Integrated Family Planning and Health Care*. Baltimore: Johns Hopkins University Press, 1983. 33-56. as quoted in: Hardee, K. and Yount, KM "Delivering Reproductive Health Promises through Integrated Services, Family Health International 2003.



There are lessons to be learned from the integration of health services in other countries and Egypt is well situated to benefit from these positive experiences. If Egypt adopts an integrated system, there are a number of opportunities and advantages to be expected at the delivery level that would otherwise be missed. These are:

### **Improved Provider Performance and Commitment to Comprehensive FP/RH and MCH Services**

- A change in providers' philosophy and sense of responsibility

Integrating FP/RH and MCH within the service delivery system at the unit and center levels would support a philosophical change in the approach to FP, RH and child health. Despite full comprehension of the interrelationship of FP, RH, and MCH issues, the physical, administrative and financial separation of the two services does not offer staff compelling motivation to include counseling or service provision for the other branch of services (be it FP or MCH). In many instances when FP physicians are questioned as to why they did not include counseling on other issues, they responded that while they were competent to do so, they sensed that other clinics would offer these services as part of their directives.

- A more responsive and better trained staff

Training for physicians, nurses, social workers and *raedat rifeyat* who supply a comprehensive FP/RH/MCH service package should be more responsive to the comprehensive reproductive health needs of clients. Currently, these providers participate in different training courses related to either FP or MCH, inhibiting a comprehensive and holistic reproductive health approach. In many instances health care providers in units and centers have either received training in only one of the two services (MCH or FP) or received this training over long periods of time, resulting in patchy rather than holistic service provision.

The presence of two different services package dictates two separate sets of curricula, standards, training modules, and guidelines. A comprehensive integrated FP/RH and MCH package would foster a standard unified strategy and guidelines to be uniformly followed by the providers.

### **Improved Quality of Comprehensive FP/RH and MCH Services for Clients**

- Increased health care personnel responsiveness to needs of children and mothers

Staff trained in both MCH and FP/RH are better prepared to anticipate and detect problems that might interfere with specific contraceptive methods, and to provide specific information and counseling. The use of uniform, coordinated, and comprehensive guidelines that are well supervised would result in better satisfying client needs and a common incentive mechanism would facilitate uniformity of better quality services.

- Better management of infrastructure, space and time

Quite simply, a wide range of physical organizational changes could be implemented in an integrated environment that would result in more efficient use of space, improved management of waiting areas and patient flow, the allocation of private space for counseling, and harmonization, not just lengthening, of opening hours. Currently, rural health units often have days reserved for specific services, ANC for primipara on Sundays, child monitoring on Mondays, vaccination on Tuesdays and Wednesdays, ANC for multipara on Thursdays, etc. Services that were previously offered on different days could be provided every day, waiting times and distances that patients travel could be reduced, and providers could better manage their time.

In addition to improvements in the use of physical space, an integration of service delivery at the health unit and center level would maximize equipment use and minimize duplication, and improve uniform practices including sterilization and disinfection. Improvement through one technical assistance program (i.e. Healthy Mother Healthy Child's renovation of the delivery rooms) would not be for one vertical system only but would benefit the entire service (i.e. for use in postpartum IUD insertions).

Removing the dire consequences of equipment breakage might help lower the physicians' fear of colleagues using and misusing their equipment or *eddah*, making the equipment more readily available for usage.

- Integrated and standardized supervision

The introduction of integrated services, performance management indicators, and quality standards will strengthen the supervisory teams' ability to ensure high quality integrated service delivery. Information collected through integrated services will provide the supervisory team with comprehensive information to improve monitoring and increase responsiveness at the district and governorate levels, through for example, a Safe Motherhood Committee. Integrated supervisory tools will also ensure uniformity of services within the unit and minimize double standards that affect quality or have a negative impact. Finally integrated supervision will decrease the total amount of time providers spend in the supervision process.

- Improved quality of provider-patient interaction

The interpersonal counseling skills that have been developed in FP and MCH programs over time would be of greater benefit and efficiency in an integrated system. At present, Egyptian staff seem to have a piecemeal approach to patient care, which can be attributed to the vertical programming. FP clients are served only for FP needs, and MCH clients only for MCH needs. Other services are not promoted. Once clients sense that providers are able to address all their needs and concerns, including those of their children, the patient-client relationship will automatically be enhanced.

Integrated training has a positive effect on both the quality of counseling and on staff commitment. Improvement has been seen in staff attitudes and performance in situations where training has emphasized an expanded vision of reproductive health and where providers are given the opportunity to enhance their skills and



responsibility levels. An integrated system permits service providers to initiate client contact earlier, prolonging FP and MCH care influences. For example, a client who receives FP method counseling early, during the prenatal period, has more time to consider and make a decision. Follow-up of patient records reveals a trend for regular MCH clinic visitation in an integrated environment that provides the opportunity for consistent provision of counseling regarding future contraceptive method choice.

A provider-patient relationship that develops over a longer period and throughout the life cycle is better established, promotes client confidence based on repeated interaction with the same provider and enhances the provider's knowledge of the client's individual needs and circumstances. A combination of intimacy and privacy between the provider and patient further fortified by regular visits provides additional opportunities for enhanced health care services.

- Enhanced client satisfaction

Communities generally perceive integrated services as more comprehensive and responsive to their needs<sup>10</sup>. Clients who receive all their health care needs in a comprehensive package are more likely to be satisfied. Studies have further confirmed that the image of health workers has been enhanced through the provision of comprehensive care package.<sup>11</sup>

Additionally, it was found that clients form a negative impression about a unit as a whole, if one of its services does not meet expected standards. Integration of services allows for uniformity in delivering high quality services and provides an opportunity to create a good impression about services as a whole.

In rural Egypt, one physician often attends to all the FP/RH and MCH needs of the client. Unless the physician and unit staff are trained to provide comprehensive FP/RH and MCH services using a unified supervisory system and defined set of services, there is a risk of not adequately performing one of the required services and negatively impacting client perceptions of all FP/RH and MCH care.

### **Integrated Information Systems Cater Better to Decision Makers' at District and Governorate Levels**

The existing vertical program model perpetuates the piecemeal gathering of information from specific FP or MCH services, whose collection formats are biased toward their specific needs. An integrated comprehensive package of FP, RH and MCH services would collect information across the entire range of services and the collection format (forms) would reflect this integration. Data collected at the service level would then permit managers and decision

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<sup>10</sup> I. Askew and N. Maggwa, *Integration Programs in East and Southern Africa* (paper presented at the Annual Meeting of the Population Association of America, Chicago, IL., April 2–4, 1998).

<sup>11</sup> J. Mukaire, *Presentation at Setting the African Agenda* (paper presented at Pathfinder International African Region Workshop on Integration of Services, Nairobi, Kenya, 1995).

makers to devise better strategies and responses at the district, governorate and central levels. Providers would be better able to manage client cases as a result of a common format encompassing the full family folder and keep in line with current health sector reforms that support a family approach. Policy makers would gain a comprehensive picture of what is happening in the field.

### **Improved RH Service's Information, Education and Communication (IEC) and Counseling Components Offer Increased Benefits**

An integrated approach will:

- Permit providers trained in an integrated comprehensive approach to develop their awareness of RH and MCH interdependence and increase their interest and responsibility for providing a variety of RH and MCH components;
- Unify the counseling strategy for integrated comprehensive and holistic services;
- Maximize staff time for counseling a greater number of clients during a single visit;
- Integrate IEC and counseling messages and strategies in order to avoid providers sending mixed messages; and
- Increase the likelihood of attracting new clientele.

Clients visiting the FP clinic postpartum are a specialized group, having been referred or encouraged to visit as part of their prenatal care. They are not representative of the population in general. When services are integrated, women visiting an MCH clinic or vaccinating their children have greater exposure to family planning messages and counseling, leading to changes in attitude and acceptability.

Also an integrated IEC and counseling approach could reach clients who were not previously counseled such as adolescents or those who attend the clinics for specific reasons. In addition, assembling a broader client group at one site will facilitate dissemination of IEC messages.

There is evidence that integrated projects motivate new client groups to try FP services. Young women attending for minor gynecological infections also benefit from service providers' efforts to influence them to know more about family planning services, and in the Egyptian context, to introduce issues related to FGC, domestic violence and women's education.

### **Increase Acceptance of FP and Introduce Changes in Contraceptive Method Mix**

Experiences from different regions worldwide provide evidence of increased demand for different contraceptive methods after integration. The experience of the Family Planning Association of Nepal is that integration of FP services into MCH services can increase the demand for different contraceptive methods.<sup>12</sup> In Honduras, when FP services were offered to

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<sup>12</sup> B. Liese, *Inter-Country Comparative Analysis of Vertical and Integrated Programmes*, World Bank, Washington, D.C., 1995. 347-360.



postpartum women, the percentage choosing family planning after delivery rose from 9% to 30%.<sup>13</sup>

Closer to home, in Egypt, after counseling by a specially trained provider the use of FP after post abortion care rose from 37% to 62% of Post Abortion Care (PAC) clients.<sup>14</sup> Similarly, in Kenya before FP counseling became part of PAC, only 7% of post abortion patients received contraceptive counseling, and only 3% obtained contraception. Afterwards, 68% of clients were counseled, and 48% received their chosen method.<sup>15</sup>

Child health services can also contribute to an increase in FP use. In Togo, by providing a few selected FP messages to mothers coming to a vaccination clinic with their children, the average number of acceptors per month increased by 54%.<sup>16</sup>

Finally, the Kenya experience, where integration began in 1992, shows clear evidence of increase in the use of other FP methods following integration. Figure 2 illustrates the changes that took place in the use of different contraceptive methods between 1991 and 1997. Average couple years protection (CYP) for IUDs, injectables and other methods increased.<sup>17</sup>

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<sup>13</sup> J.R.L. Canales, et. al., *Reproductive Health and Prenatal Care (INOPAL II: final technical report*, Population Council, Washington, D.C.: April 30, 1995), 74 p.

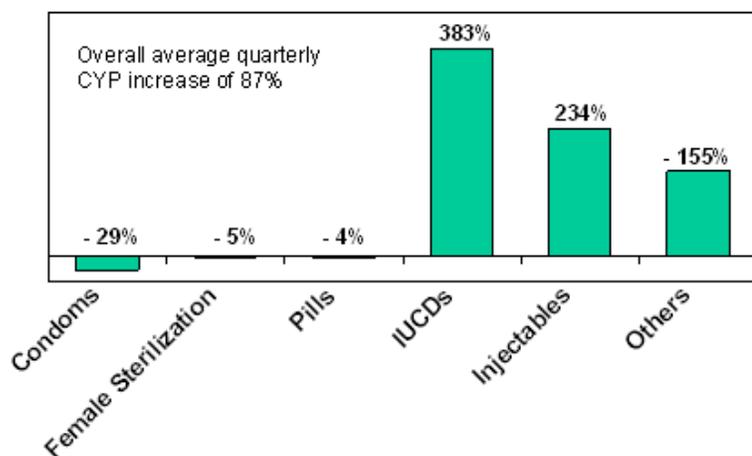
<sup>14</sup> D. Huntington, E.O. Hassan, N. Attalah, et. al., *Improving the Medical Care and Counseling of Postabortion Patients In Egypt*, *Studies in Family Planning* 26(6): 350-362. Nov./Dec. 1995.

<sup>15</sup> J. Solo and D.L. Billings, *Linkages with Treatment for Incomplete Abortions Improve Family Planning Services in Kenya*, *Operations Research Alternatives*, Washington, D.C.: Population Council, August. 1998. 3. (Available: <http://www.popcouncil.org/rhfp/alternatives/linkages.html>)

<sup>16</sup> D. Huntington and A. Aploga, *The Integration of Family Planning and Childhood Immunization Services in Togo*, *Studies in Family Planning* 25(3): 176-183. May/Jun. 1994.

<sup>17</sup> E. Lule, R. Sturgis, and S. Ladha, *Advantages and Disadvantages of Integrating Services in Sub-Saharan Africa* (paper presented at the annual meeting of Population Association of America, Chicago, Il., 1998).

**Figure 2. Changes in method use after integration (1991 – 1997)**



### Impact of Private Sector Activities

Improvements in the public sector should be mirrored in the private sector as well, as many providers are active in both sectors. Only 44.6% of general practitioners currently provide FP services in their private practice and only 17.4% of all private pediatricians provide immunizations.<sup>18</sup> This is a far cry from offering all services in one setting.

## Improving Service Efficiency and Effectiveness

### Missed Opportunities

Integration of services can improve the efficiency and effectiveness of the delivery system by reducing the number of provider-client contacts.

Currently the client has to visit different clinics if she needs comprehensive or a variety of services. The following missed opportunities can be readily identified:

1. A woman in the postpartum period, who receives following up care at the MCH clinic need to visit the FP clinic to receive contraceptive counseling and service.
2. Mothers who visit the health unit to vaccinate their children are not informed or asked about FP use.
3. Women who come for FP are not asked about the vaccination status of their children.

<sup>18</sup> National Population Council, RMU, *Promoting the Role of the Private Sector in FP/RH Services Delivery*, Atlanta: Center for Disease Control, 2002.



4. Women who come for ANC are not always asked about their plans for FP use after the delivery.
5. Women who come for ANC are not asked about the vaccination status of their children.
6. Women who visit for FP services are not asked about signs or symptoms of RTIs. If treatment is required, they should be referred for treatment.
7. Women who visit for FP or MCH services are not screened for genital cancer, breast cancer or even informed about screening possibilities.
8. Infertile couples are not asked about their exposure to RTIs nor asked about signs or symptoms.
9. Many women who deliver are not offered immediate postpartum IUDs.
10. Women are not informed about the risks and issues surrounding female genital cutting during clinic visits.
11. Many women in the waiting room of MCH clinics do not receive IEC material or information about RH; those who are in the waiting room for RH clinic receive IEC for MCH.
12. Women in need of post abortion care do not receive FP counseling.
13. Women with serious medical conditions, or in need of tubal ligation are not informed or offered these services.

Better use can be made of the birth registry as a way of reaching women, and the school age and pre-school age health insurance program also offers a way to contact clients about other services.

An integrated service would be more efficient and minimize the number of client-provider contacts while at the same time offering more complete services. Due to a streamlined FP/RH and MCH system, demands on the clients' time and energy would be minimized along with any reluctance to seek health care service. This may further increase the number of clients in the health units.

An integrated service would minimize duplication of services and resources for training, equipment, supervisory tools, quality guidelines, performance indicators and incentives. Maximizing financial and human resources eliminates waste and improves the management of FP and MCH services. Providers can be trained to perform multiple tasks that are interrelated within the context of an integrated service delivery system.

## 6. Challenges to Integration

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Advocates have supported the call for integration since 1994 in an on-going attempt to improve the quality of family planning and women's health and embrace conceptual shifts in primary health care. Existing vertical programs pose certain obstacles and challenges for advocates of integration in Egypt. If full integration for the improvement of reproductive health is envisioned, then integration must go beyond the expansion of existing services and beyond enhanced collaboration toward merged responsibility.

Although in its infancy, the newly developed MOHP models have laid the foundation for integration. A political commitment to integration of existing vertical programs is imperative for success, rather than a simple expansion of existent top down management systems. Political, financial and managerial constraints deserve consideration as well, as integration progresses. There are many challenges that could hinder the process of integration. Addressing these challenges at all different levels whether at the service delivery level, donors level or at the National level, will be necessary for a successful process of integration.<sup>19</sup>

### Service Delivery Level

#### Lack of a Fully Developed Integrated Delivery Package

There are currently two sets of service packages, an MCH package and a FP package. In order to further the integration process at the delivery level, a comprehensive integrated package needs to be developed by the MOHP. Based on the package other important elements would be integrated such as curricula, supervision tools, clinical guidelines or other service standards.

#### Two Supervisory Teams Using Different Tools at the Governorate Level

Integration will not be complete if supervisory teams from vertical programs are using different sets of indicators to measure and assess service delivery. A comprehensive perspective on provider performance should be put in place with one strong supervisory team trained in a standard set of indicators.

#### Two Standards of Quality Assurance Guidelines

In addition to the presence of two supervisory teams, two quality assurance standards currently exist for the same health unit, which would need to be integrated. For example, until recently there were two different infection control standards, reinforced respectively by the FP and MCH supervisors.

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<sup>19</sup> Hardee K, Yount KM (1995). From rhetoric to reality: delivering reproductive health promises through integrated services.



## **Different Incentive Mechanisms**

A uniform incentive mechanism is necessary for the success of integration. Maintaining the current two incentives mechanisms would distort the uniform provision of comprehensive services, with providers who receive better incentives through the MCH program expending more energy on MCH and potentially neglecting FP services and vice versa. Ideally FP/RH and MCH services could be included in the contracting system for the Health Insurance system.

## **Two Types of Information Collection Formats**

The verticalization of information collection is exemplified by the presence of many distinct record books and distinct reporting formats that overload providers and discourages a holistic approach to recording and reporting. The design of a new recording and reporting system that reflects valuable FP, RH, and MCH information is of utmost importance for the success of an integrated service delivery system. This integrated system should be supported by one integrated national MIS system for FP/RH and MCH.

## **Strengthening Management Capacity at the Unit, Center, District and Governorate Levels**

Efforts and resources should be put into strengthening the management system at the district and governorate level through the integration of financial, logistic and human resources. A failure to establish a strong management capacity at these levels may weaken integration attempts and embolden supporters of vertical programming to reestablish separate mechanisms in an aim to improve efficiency. Efforts should be made to transfer responsibility and accountability to the districts and governorates.

Concurrent with the introduction of a comprehensive and integrated RH package is the decentralization of the management process within acceptable parameters of the Egyptian political, legislative and administrative environment. A continuation of current top-down management systems (vertical programs) would hinder the integration process. Therefore, as Egypt moves toward an integrated program, vertical programs should make room for integration at the service delivery, district and governorate levels.

Finally, when two sectors integrate their activities, the end result typically has the strengths of the weaker of the two partners. For this reason, it is important to strengthen the FP and MCH departments at central level now, in anticipation of the time that they will be fully integrated.

Integration of vertical activities within each MOHP department is an initial step before integrating across MOHP departments. In this regard, the recent move by the FP sector, assisted by CATALYST Consortium/TAHSEEN Project, from a functional to a geographical supervision structure, is an impressive step forward. This shift has facilitated communication between the units and helped make the FP sector itself, a more integrated workplace. Further efforts to strengthen the two individual sectors can only help integration further down the line.

## **Staffing and Curricula**

For the integration experience to succeed the MOHP and governorates must guarantee the availability of well-trained staff at the units and eradicate all misdistribution issues. Standard guidelines for staffing patterns should be developed. National curriculum standards should be developed that maximize FP/RH and MCH integration. These should be applied in pre-service training.

## **Staff Resistance**

Staff could be resistant to the idea of integration for several reasons. Staff may be concerned that integration and provision of a comprehensive package will require more time spent per patient and increase the total number of clients visiting the clinic. Resistance resulting from these concerns could be compounded in the absence of a unified incentive mechanism. Attention to unifying the incentive system will be necessary to discourage providers from favoring the provision of certain services over others.

## **Donor Level**

If implementation of integration is to succeed, donors will have to seriously address integration within their policies as a goal. Funding of the different components of FP/RH and MCH is still implemented in a vertical fashion. Donors will have to coordinate with each other, as well as with the MOHP. Such effective collaboration between donors, or within the program of the larger donors will help the implementation of an integrated FP, RH, and MCH service delivery model.

## **National Level**

At the Ministerial level, explicit commitment to and support for integration will be needed. The MOHP leadership's vision of integration will need to be supported by clear strategies and realistic goals and activities. National leaders and other stakeholders should provide explicit and realistic goals for the phase-in of new services and geographic program expansion consistent with integration. A phased implementation of service components would allow programs time to adjust logistic and service delivery systems to accommodate program growth.

At the central level, integration has been defined as cooperation on policy development through workshops, funding arrangements and joint appointments. For successful integration the meaning, stage and level of integration should be clearly defined from the beginning at the central level and then promoted accordingly by providers.

Field support should accompany each new component so that new activities meant to serve the cause of integration, do not overburden workers and divert energy from existing tasks.





Therefore, as integration proceeds and services are added, program managers should assess the need for additional supervisors and service personnel. Equally important is the development of an integrated package of services with clear implementation guidelines capable of facilitating the integration process. Demand creation for integrated services should be supported with targeted BCC activities.





## 7. Actions

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Egypt has a unique opportunity to capitalize on the historic consensus reached at the 1994 ICPD and to expand beyond family planning to broader and more client-centered approaches to the reproductive health care needs of women and health care needs of children. CATALYST Consortium/TAHSEEN Project will assist MOHP in these efforts.

The MOHP will need to consider services currently available when developing an integrated service package. MOHP will need to monitor the implementation of FP/RH and MCH services in an integrated manner and maintain certain flexibility in making program adjustments. Careful planning, coupled with consideration of clients' needs, will facilitate the expansion of integrated services and increase women and children's access to quality health care. The list of missed opportunities can serve as a checklist for integration of services.

Political commitment to integration is vital for successful planning and implementation of integrated FP/RH and MCH programs. This commitment is evident in the signing of a Memorandum of Understanding between MOHP/FP, MOHP/MCH, USAID, JSI and CATALYST Consortium/TAHSEEN Project. The Memorandum describes the steps to be taken towards integration as well as a plan of action. An action plan was formulated and agreed upon.

### Steps Toward the Integration of FP/RH and MCH

Consensus has been reached on the meaning of integration. All partners now understand integration to mean the provision of all necessary services by one provider to the client, in one visit. The following describes the steps towards integration of FP/RH and MCH.

1. A Basic Package of Essential FP/RH/MCH Services, drafted by CATALYST Consortium/TAHSEEN Project, is finalized.
2. Integrated record systems at the district level and below will be required for successful integration. An integrated record keeping system will be designed based on the Basic Package. Changes in record keeping and reporting will minimize the record keeping burden and eliminate the need for separate reporting and evaluation systems. An integrated service delivery system will also be needed. Such a system describes client flow, referrals etc. This system will be instrumental in addressing the missed opportunities detailed in this paper.
3. Service quality standards can be defined based on the Basic Package that can then be operationalized through integrated service delivery guidelines, or clinical protocols. The guidelines will encompass all FP/RH and MCH services offered in Egypt and be based on current scientific information. Once developed, these guidelines will be disseminated to all service providers offering reproductive health services.
4. The standards will be reinforced, monitored and strengthened through an integrated supervision system. Management, training, and finance issues for this system should be resolved. An integrated checklist will be designed. The integrated supervisory team



will, in turn, inform the Safe Motherhood Committee and inform district health managers. Their information will be invaluable in the integrated district health planning. Supervision will play a key role in ensuring that health care staff is able to perform expanded duties in an integrated system. In order for supervisors to adequately supervise the new activities in an integrated setting, they too must be included in the training program. CATALYST Consortium/TAHSEEN Project is currently developing integrated supervision training courses.

5. This integrated supervision system can result in an integrated Gold Star system in which both FP/RH and MCH services are represented. CATALYST Consortium/TAHSEEN Project and JSI are providing support for the development of an integrated Gold Star system.
6. True integration cannot be achieved without integration of the incentive system. Staff from MCH and FP sectors should determine the objectives of a new integrated incentive system and the details of its implementation. CATALYST Consortium/TAHSEEN Project is working towards redefining the objectives of the incentive system and developing an integrated system. See Figure 3 for a summary.
7. Staff training is an important component in the integration process. Phased training and refresher courses will provide the means for introducing new skills and maintaining positive rapport and provider/supervisor interest in quality care. TAHSEEN will develop integrated counseling courses to further strengthen integration efforts in the clinics.
8. Personnel and staffing issues related to training, worker density and competence, staff turnover and geographic distribution should be addressed as management issues. Ways to maximize the deployment of existing staff should be explored and implemented. Integrated incentives may assist in the management of these issues.

The newly integrated systems (1-7) will be designed in 2004 and then tested in Minia Governorate within the CATALYST Consortium/TAHSEEN program. Service guidelines will be used in the entire country. CATALYST Consortium/TAHSEEN Project will work hand in hand with HM/HC in Mallawi and Mattai and with other agencies in Samalout and Minia districts to provide training and orientation to the new systems. Thus integration will be initiated simultaneously at the clinic and district levels in 2004. Further integration of training systems, management and central office staff will wait until a later phase.

Figure 3. Development of Integrated Systems in MOHP

