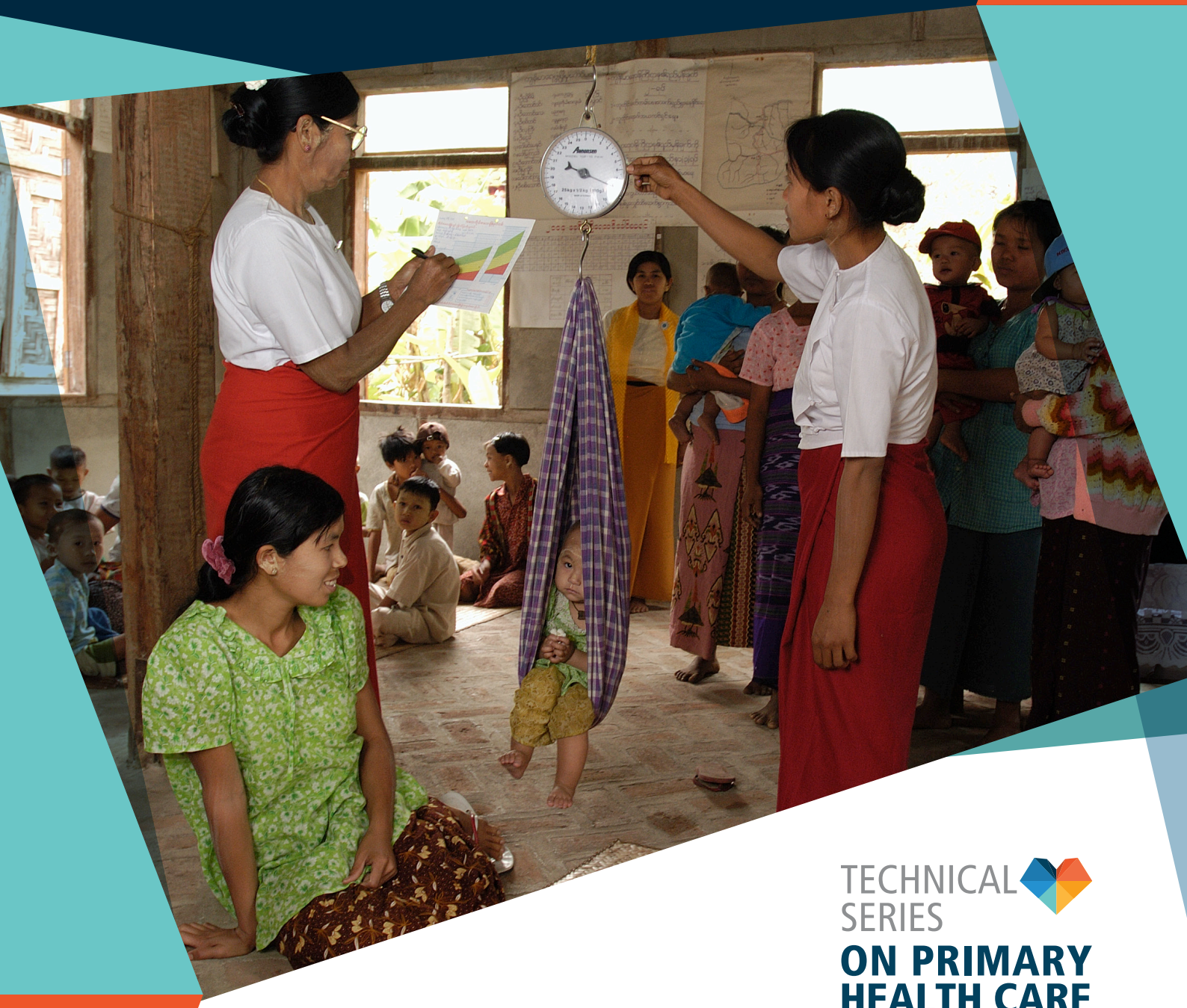
World Health Organization

Sexual, reproductive, maternal, newborn, child and adolescent health in the context of primary health care



TECHNICAL SERIES ON PRIMARY HEALTH CARE

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Changes in sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) in the past 40 years

Globally, the health and well-being of women, children and adolescents are improving faster than at any point in history, even in many of the poorest countries, as a result of commitments by governments with the support of local and global partnerships. Since 1990, maternal mortality levels have fallen by almost 44% *(1)*, and under-five mortality has declined by 58% *(2)*. More infants than ever are vaccinated, birth rates among adolescents have fallen in many parts of the world, and women around the world have gained better access to family planning. Currently, we are in an epidemiological, demographic and social transition, which has a complex inter-relationship with SRMNCAH.

- The main drivers of mortality and morbidity are moving from communicable diseases to chronic, noncommunicable conditions and mental health disorders.
- The world population is projected to grow to 11.2 billion by 2100, from its current level of 7.6 billion *(3)*. There are currently 1.2 billion adolescents aged 10–19 years, more than ever before, and this number will continue to rise slowly until 2050 *(4)*.
- Urbanization is increasing at a rapid rate, while health crises caused by conflicts, natural disasters and epidemics are becoming more frequent and extensive, especially in low- and middle-income countries. These often lead to mass migration, with its accompanying anxiety, insecurity and unsafe environments. Women, children and adolescents are particularly vulnerable as a result of their physical and psychosocial needs.

The role of primary health care in SRMNCAH

PHC has played a pivotal role in the remarkable progress seen in SRMNCAH in recent years. From the outset, maternal and child health services were the backbone of primary care. As a key component of the basic benefits package, and usually free at the point of use, pregnancy and maternity care and vaccinations have been made accessible to millions of women and children worldwide. New models of care based on outreach, and new health cadres, such as community health workers and health visitors, were introduced to bring services closer to the community. Technological innovation helped to simplify treatments delivered by community health workers and family planning clinics, expanding the range of services offered in primary care facilities. Targeted initiatives to improve social inclusion, such as adolescent-friendly health services, began to emerge.

However, while there have been positive developments, the original philosophy of PHC being centred on the person, not the disease, has sometimes been lost. Programmes have been implemented in a vertical fashion, e.g. immunization campaigns have not been coordinated with antenatal or postnatal care and services for HIV/AIDS delivered separately from other health care. This has resulted in missed opportunities to deliver effective interventions and consequently has contributed to inequity and poorer outcomes.

Ongoing and new challenges

Despite the progress in reducing maternal and child mortality, the agenda is unfinished. In 2015, an estimated 303 000 women died as a result of complications of pregnancy and childbirth *(1)*, mostly from preventable causes such as haemorrhage and hypertensive disorders *(5)*. Many more suffer longer-term consequences, such as postpartum depression, prolapse, and urinary incontinence. While global child mortality has declined dramatically, 5.4 million children under five died in 2017, mostly in low- and middle-income countries *(2, 6)*. Other age groups experienced slower reductions in mortality. Globally 2.5 million newborns died in 2017, which translates into 7000 newborn deaths a day *(2, 7)*. Most of these deaths were due to conditions associated with lack of quality care at birth or skilled care and treatment immediately after birth, including infections, asphyxia and birth trauma *(2)*. More than 3000 adolescents die every day, largely from preventable causes such as road traffic injuries, violence, HIV infection and self-harm *(4)*.

Reductions in mortality have not necessarily been translated into better health: many who survive do not thrive. An estimated 250 million children are at risk of not developing to their full potential because of stunting and extreme poverty *(8)*. An estimated 214 million women in low- and middle-income countries, who do not want to have another child, are not using a modern contraceptive method *(9)*. Half of all mental health disorders start in adolescence, and most go undetected and untreated *(10)*.

The general overall improvement masks suboptimal progress in many countries, provinces and communities. For example, stunting has been declining globally, but the progress has been slower in some regions, such as Africa and Oceania. In 2017, ten countries had the third dose of diphtheria-tetanus-pertussis vaccine (DTP3) or one dose of measles vaccine (MCV1) coverage below 50% *(11)*.

Many health systems are still not robust enough to cope with ongoing challenges or prepare for new ones.

- Often the packages of SRMNCAH services have not addressed all health needs or disparities. An example of such a "blind spot" is sexual and reproductive health (SRH) care, which is often aimed only at pregnant women. This narrow focus, often combined with a limited, stand-alone approach to provision of family planning, has resulted in poor access or a complete lack of SRH care for anyone who is not a woman of reproductive age, including adolescents, men of all ages, and women past their reproductive years. As a result, essential SRH services related to fertility, abortion, control of sexually-transmitted infections and sexual function that should be part of PHC have not been fully available.
- Health workers have limited capacity and incentives to address SRMNCAH needs in a comprehensive and integrated manner due to, inter alia, vertical training initiatives driven by disease and not by people's needs, weak health leadership at country and sub-national levels, difficulties in priority setting, inadequate budget allocations, management deficiencies, inadequate staff remuneration and frequent staff turnover, and resource gaps (e.g. equipment, transport, supervision) at local level, especially in poor or remote rural areas. This has been well illustrated by the implementation of Integrated Management of Childhood Illness (IMCI), a strategy that has been embraced by over 100 countries in the past two decades but that did not fully deliver on its promise due to fragmentation in technical and financial support and limited investment in integrated management capacity at all levels *(12)*.
- Weak national and subnational civil and vital registration data systems, and lack of age- and sex-disaggregated data, have made monitoring progress difficult, and leads to poorly-informed decisions on investments.

The development of digital technology and its penetration into all levels have changed the way communities, especially adolescents, live, learn and communicate. It has provided opportunities, such as easier and more rapid communication on health issues, but also challenges for health, including increased screen time and reduced physical activity, amplification of cyberbullying and online child abuse. Urbanization and globalization have changed family and community structures and the nature of social interactions.

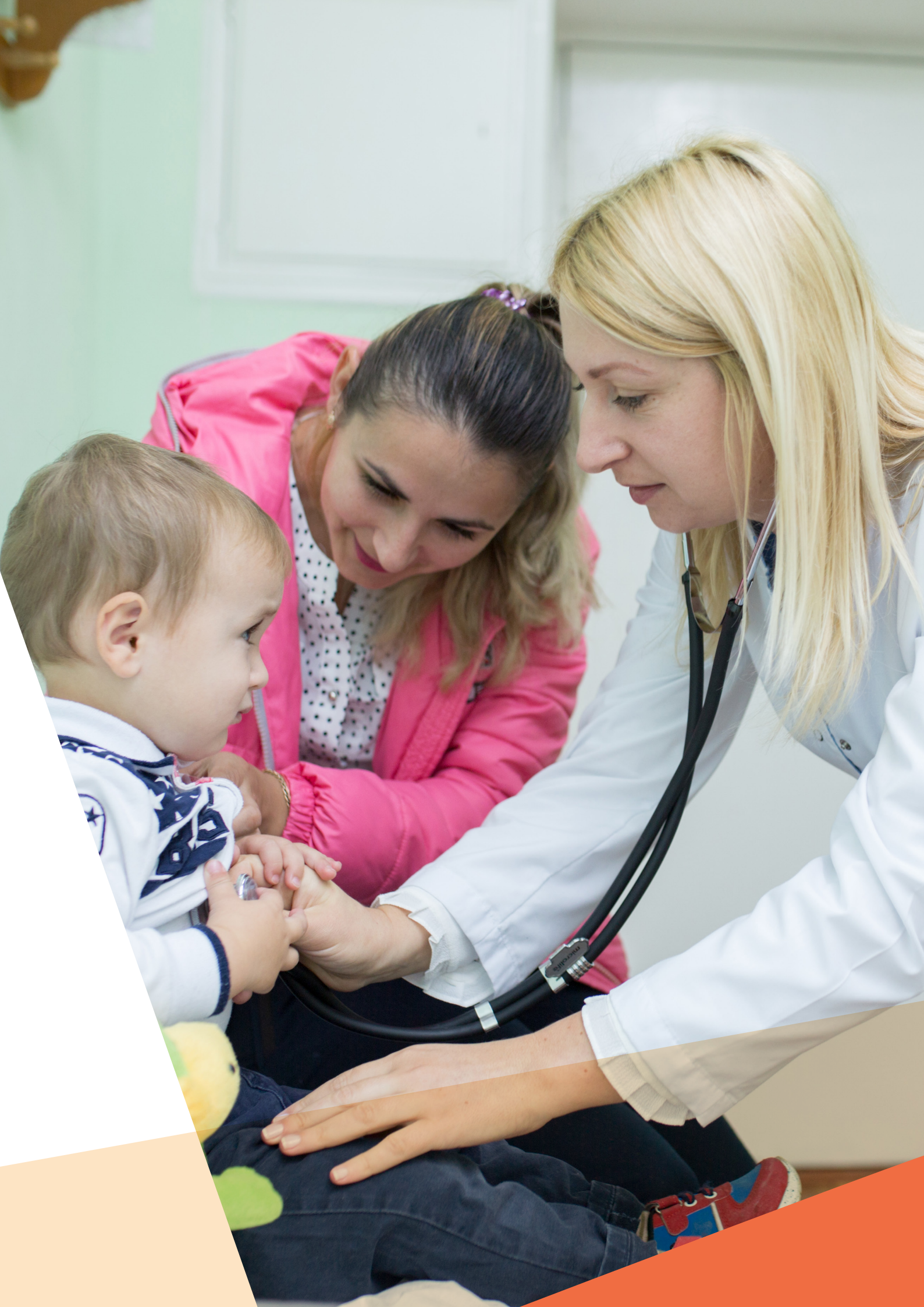
Seizing opportunities to ensure SRMNCAH for all in the new PHC era

The changing epidemiology, shifting demographics, and emerging health priorities as described above call for a rethink on the role of PHC as vehicle to deliver actions required to attain the common goal of improving the health and well-being of all women, children and adolescents. A holistic view necessitates a deliberate and targeted response to the health determinants that promote or prevent health, and taking in consideration everything that influences health and wellbeing of the population. Strategic choices have to be made to move from delivery of fragmented single interventions to more integrated, PHC-based service delivery.

Building on the SRMNCAH achievements over the past 40 years, and with the unique opportunity now to reflect on the new role of PHC as a vehicle for attaining quality universal health care, the spotlight turns to what can be done differently.

- First, it should be recognized that health and well-being cannot be achieved by fragmented single interventions. PHC should be a vehicle, not only for delivering in an integral manner the interventions and services that are needed by everyone, but also for addressing the health and well-being of the women, children and adolescents who require additional services. These interventions should address physical, mental, social and environmental factors that determine their health and well-being. An example is the nurturing care framework for early childhood development, which brings together elements of health, nutrition, safety and security, responsive caregiving and early learning, and promotes these through effective policies, information and multiple interventions *(8)*.
- Second, to ensure continuity, interventions and services have to be delivered at multiple levels: individual and family, community, primary health care facility and first referral. In many settings, there is little continuity in services that provide support, counselling and information on health and well-being at different stages of life. WHO and UNICEF have initiated a large-scale effort, entitled Child Health Redesign, which will look at improving this situation in relation to children.
- Third, PHC investments must put better quality on a par with expanded coverage, if they are to improve substantially the health and well-being of all women, children and adolescents. Often, increased coverage of services has been pursued at the expense of quality. Evidence shows that coverage without quality does not result in impact and hence, quality of care should be central to PHC *(13)*. This calls for the efforts towards universal health coverage to be accompanied by substantial investments into high-quality health systems by national governments.

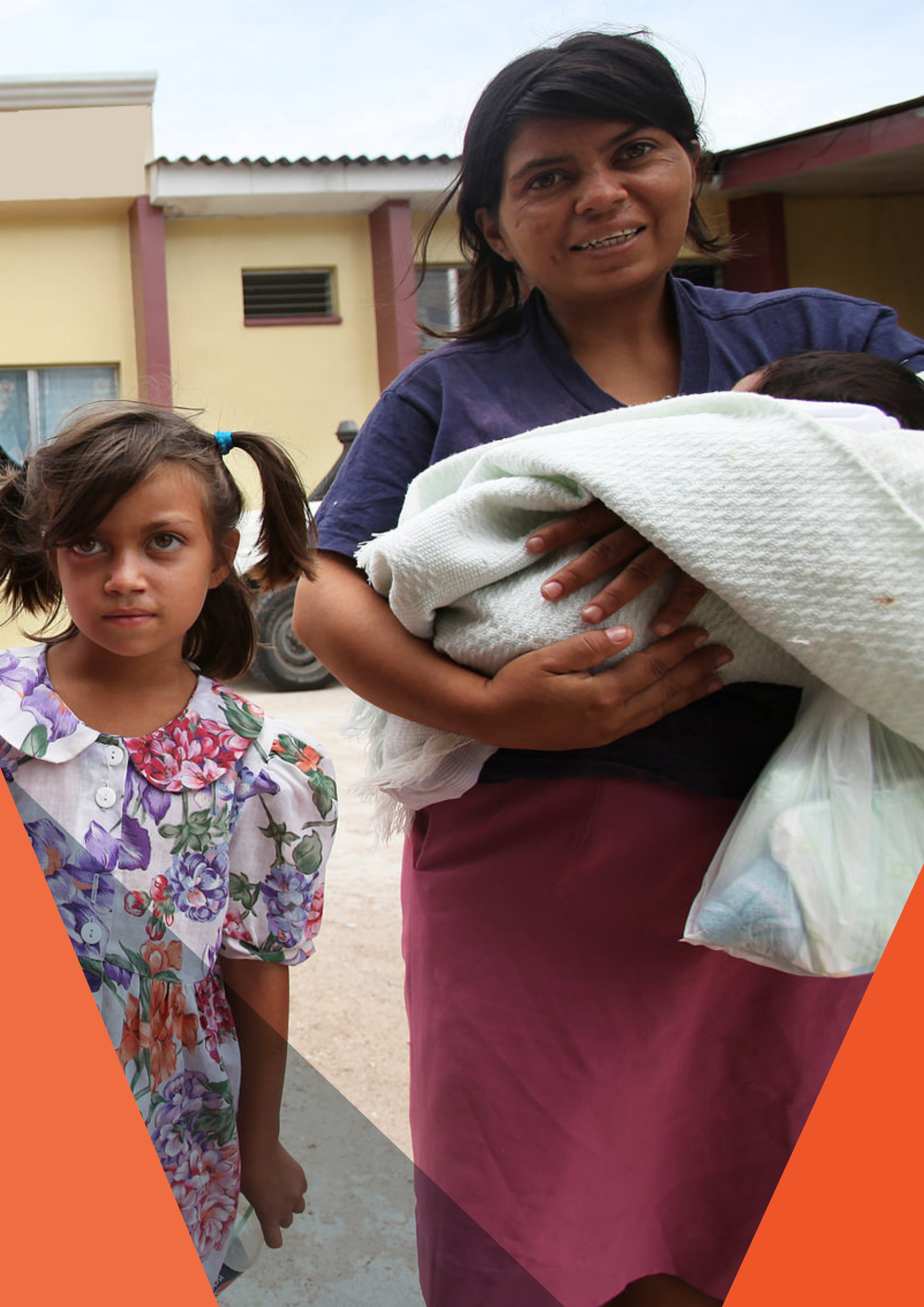
  In order to move forward towards SRMNCAH for all, actions are required in the following three areas.



1. Address the social, economic, environmental and commercial determinants of people's health, with a focus on SRMNCAH, through evidence-based public health policies and actions across all sectors

All sectors of government should be accountable for putting in place policies that protect and promote SRMNCAH. Some examples of appropriate action are given below.

- Legislate for maternity, breastfeeding and parental leave to create conditions for responsive and nurturing caregiving.
- Support early childhood development by bringing together health, nutrition, education, child and social protection, and other relevant sectors in a whole-of-government approach.
- Enforce legislation related to marketing and taxation of unhealthy foods and breast-milk substitutes.
- Support adolescent development by promoting safe internet use, enforcing online child protection, creating new economic opportunities for young people, regulating marketing and sales of alcohol and tobacco, creating safe physical environments for play and study, and ensuring road safety. Establish laws, policies and procedures to empower adolescents to participate and make informed decisions.
- Establish legislation that respects the sexual and reproductive rights of all people, such as prohibiting all forms of gender-based violence, including harmful practices (e.g. female genital mutilation and child marriage), upholding informed consent for health services, and respecting autonomous decision-making and bodily integrity. Repeal laws that criminalize SRH services (e.g. abortion) or certain forms of sexual conduct (e.g. same-sex activity, adultery, sex work).
- Provide universal access to primary and secondary education covering life-skills and sexuality.
- Promote education and economic empowerment opportunities for girls and women, and eliminate gender inequalities.
- Tackle indoor and outdoor air pollution, and ensure adequate hygiene, sanitation and running water in schools, homes, health facilities and other services.



2. Empower all people to take control of their SRMNCAH

- Leverage digital technology to make SRMNCAH information available to all, users and providers, to increase the health literacy of individuals and communities. People should learn how to promote, protect and restore their own health and that of their children, and how to access SRMNCAH-related resources and services. Everyone should be empowered to participate in the planning and appraisal of health care, in particular hard-to-reach and vulnerable mothers, children and adolescents.
- Harness the dynamics of civil society to press for change in a policy debate supported by evidence and information on SRMNCAH from reliable health resources.
- Shift community norms, especially those relating to gender equality, in order to reduce or eliminate harmful traditional practices, such as female genital mutilation and child marriage. Increase community support for all individuals using services without prejudice, stigma or discrimination.
- Invest in development of smart, simple and low-cost innovations that simplify care and make them widely accessible. Make validated services and commodities available outside of facility settings, especially for the most vulnerable, in order to support self-care and community-based care, and increase access and equity.

3. Develop and promote people-centred models of PHC

- Ensure universal health care with SRMNCAH evidence-based interventions (see Table), recognizing that PHC-based health systems are key to achieving this. Interventions need to be packaged and every contact of a caregiver and child with the health system needs to be optimized to provide promotive, preventive and curative care as needed.

- Ensure that PHC is organized, supported and enabled to demonstrate accountability, not only for use of services but also for quality and respectful SRMNCAH care. Primary health facilities should be models of good practice and all facilities should have adequate water supply, sanitation and electricity.

- Pursue a people-centred approach that recognizes that needs evolve and change over the life course, and that targeted efforts are needed to reach the most vulnerable. Health systems need to be adaptable in order to respond to the local epidemiological and demographic context.

- Promote PHC as the foundation of an effective health system that addresses people's needs in an integrated, comprehensive and holistic manner, providing preventive, promotive, curative, rehabilitative and palliative care throughout the life course. To support this, link PHC to social care networks to ensure an integrated response with social protection, educational and other necessary services, to address the social determinants of SRMNCAH.

- Bring SRMNCAH services closer to people. Develop community health services (e.g. home visits to support SRMNCAH, healthy growth and development of young children, and mental health of caregivers) that have strong links with health facilities, including through supervision, joint learning, common monitoring and reporting, and appropriate referrals. Strengthen school health services and develop digital health to democratize the process of care, and offer easy access and the possibility for confidential and anonymous interactions where indicated.

- Ensure that the primary care workforce has multidisciplinary skills and a supportive working environment to deliver a comprehensive package of SRMNCAH interventions. Health staff, including policy-makers, should be empowered to learn and adapt, and to combine biomedical and social perspectives in their work to achieve quality, equity, and patient centredness.

- Implement individual health records across the life course with due diligence for data protection.

- Introduce innovative mechanisms to ensure social and financial protection of mobile and unemployed populations and the portability of social protection benefits, so that SRMNCAH coverage is responsive to the needs of increasingly mobile populations.

Life Course	Intervention Packages	Enabling Environment
Women's health	• comprehensive health information and education • nutrition counselling and supplementation • contraception counselling and provision • prevention, control and management of sexually-transmitted infections including HIV • fertility care • screening and management of cervical and breast cancer • gender-based violence prevention, support and care • management of communicable and non- communicable diseases • pre-pregnancy risk detection and management	**Health system enablers** • policies for universal health coverage • sufficient and sustainable financing • health workforce supported to provide good-quality care everywhere • commodity supply • health facility infrastructure • community engagement • mainstreaming emergency preparedness • human rights-, equity- and gender-based approaches in programming; • accountability at all levels
Pregnancy, childbirth and postnatal care	• safe abortion care • antenatal care • intrapartum care including essential newborn care • prevention and management of maternal and newborn complications and appropriate referral • prevention of mother-to-child transmission of HIV and syphilis • maternal and infant birth dose vaccinations • nurturing care • postnatal care for mother and baby • extra care for small and sick babies	
Child health and development	• Exclusive and continued breastfeeding • infant and young child feeding • responsive caregiving and stimulation • routine vaccination for child diseases • prevention and management of common childhood illness and severe acute malnutrition; • supplementation and prevention of undernutrition, overweight and obesity; • prevention of childhood accidents and injuries • prevention and response to child maltreatment and harmful practices; • treatment and rehabilitation of congenital abnormalities and disabilities, and care for developmental delays	**Multisector policies and interventions** • finance • social protection • education • gender • water and sanitation • protection services, birth and death registration, law and justice • agriculture and nutrition • environment and energy • labour and trade • infrastructure, • information and communication technologies and transport
Child health and development	• supportive parenting • nutrition • routine vaccination • prevention, management and psychosocial support for mental health and wellbeing; • prevention of injuries, violence, self-harm, harmful practices and substance abuse • comprehensive health information and education including sexuality education • prevention and management of communicable and non-communicable diseases • gender-based violence prevention, support and care • contraception counselling and provision • prevention, control and management of sexually-transmitted infections including HIV	

Conclusion

PHC has played a critical role in improving SRMNCAH outcomes. However, continued progress towards better SRMNCAH for everyone, everywhere, requires a commitment to renewed PHC that: has the capacity to deliver continuous, integrated and quality services across the life course; addresses the social, economic and environmental determinants of SRMNCAH; and puts people first by enabling individuals, households and communities to obtain the knowledge, skills and resources necessary to take and shape decisions that affect their lives. WHO will work towards making this happen.

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