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Abstract

Background: The private healthcare sector in the Eastern Mediterranean Region (EMR) is active and growing, providing curative, preventive, and promotive services related to reproductive, maternal, newborn, child, and adolescent health (RMNCAH).

Aims: To understand the contribution of formal for-profit private health-care sector in delivering RMNCAH services and explore best practices for improvement.

Methods: Desk review of available literature from Saudi Arabia, Oman, Iraq, Egypt, Sudan, Yemen, Pakistan, and Islamic Republic of Iran, followed by stakeholder interviews in Iraq, Pakistan, and Oman were carried out. Directed content analysis using Maxqda 2020 was performed, and information was triangulated according to a priori themes: governance, health information systems, financing, and service delivery related to RMNCAH.

Results: Formal and informal public–private partnerships exist in RMNCAH but lack a strategic roadmap to guide collaboration. The private healthcare sector is minimally represented in the main policy stream at national and subnational levels due to resistance from the private and public sectors. They are weak in collecting, maintaining, and sharing health information. Data on abortion and postabortion complications are scarce. Various models of supply and demand financing (voucher schemes, private and social health insurance) related to antenatal care and contraception have been implemented in the EMR. Despite the higher cost of care in the private sector, limited training of providers, ill-defined service delivery packages, and lack of continuity-of-care and team-based approaches, the private sector remains the predominant sector providing RMNCAH services in the EMR.

Conclusion: Partnering with the private sector has huge untapped potential that should be harnessed by national governments for expanding RMNCAH services and progressing towards Universal Health Coverage.

Keywords: private healthcare, reproductive health, maternal health, newborn health, child and adolescent health

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Introduction

The World Health Organization (WHO) for the Eastern Mediterranean Region (EMR) comprises a diverse group of 22 countries, and presents a varied picture of reproductive, maternal,

neonatal, child and adolescent health (RMNCAH). The EMR has an average maternal mortality ratio (MMR) of 164 per 100 000 and under-5 mortality rate (U5MR) of 46 per 1000 live births (second to the region of Africa) (1). The MMR improved by 50% from 1990 to 2013, and U5MR by 46% (2). Despite the downward trend, the EMR missed the United Nation's Millennium Development Goals (2000–2015) to decrease MMR by three quarters and U5MR by two thirds (3,4). It is estimated that 26 000 maternal and 845 000 under-5 child deaths occur each year in the region (2).

The EMR countries have been implementing the Sustainable Development Goals (SDGs) and aim to reduce U5MR to

The public sector has a mandate to provide health services and improve RMNCAH. However, with the whole of society and whole of government approach, the vital role of the private sector is increasingly highlighted and its engagement advocated for (12). The private sector includes private healthcare providers, pharmaceutical and health technology industries, media and advertisements, information technology, private insurance, associations of private sector industries, services provided by religious institutions, trade unions and philanthropic organizations. In the context of service provision, the private healthcare sector is defined as "the individuals and organizations that are neither owned nor directly controlled by governments and are involved in provision of health services. They can be classified as for profit and not-for-profit, formal and informal, domestic and international." (13).

The private healthcare sector is an active provider in the EMR, providing ambulatory, hospital, and medical educational services in many countries (14). It is estimated that the private healthcare sector delivers 11–81% of services to the poorest quintile and 33–86% of outpatient services, and owns more than 60% of pharmacies in the region. The WHO Regional Committee for the Eastern Mediterranean Region endorsed the Framework for Action on Effective Engagement with the Private Sector in 2018, to expand service coverage for achieving Universal Health Coverage (UHC) (15). The private healthcare sector is now increasingly recognized as a major stakeholder in healthcare provision and is considered an untapped resource in the context of RMNCAH services and UHC. It is acknowledged that contracting with private healthcare sector providers for the delivery of essential health service packages can help countries achieve UHC (16). Engagement of the private healthcare sector to deliver agreed quality essential healthcare services for RMNCAH, using strategic purchasing and financial protection arrangements is no longer an option but a necessity (17).

There is dearth of data regarding the role, contri-bution and engagement of the private healthcare sector in RMNCAH services in the EMR. We designed this study to: (1) elaborate the contribution of the private healthcare sector in governance, health information systems, financing, and service delivery related to RMNCAH services at primary, insert space here

secondary and tertiary care levels; (2) explore the best practices of engagement with the private healthcare sector and identify potential areas for improvement; and (3) formulate recommendations to improve and leverage private healthcare sector engagement in RMNCAH services at policy, programme and service delivery levels in the EMR.

Methods

The private healthcare sector includes for-profit and not-for-profit, formal and informal, domestic and international individuals and organizations that are neither owned nor directly controlled by governments and are involved in provision of health services (13). We only explored the private formal, for-profit healthcare providers in this study. An analytical framework was developed to guide the study, based on field experts' opinions, literature review and WHO health systems framework (Table 1). The study was based on a desk review followed by stakeholder interviews and data synthesis (Figure 1).

The desk review was based on 1) systematic search using PubMed and Google Scholar; 2) solicitation of documents from WHO Regional Office for the Eastern Mediterranean; and 3) manual search for relevant reports. The countries selected for the desk review included Saudi Arabia, Oman, Iraq, Egypt, Sudan, Yemen, Pakistan and Islamic Republic of Iran. The search was carried out in August 2020 and no time filters were applied. The review helped identify gaps in evidence that were bridged through the stakeholder interviews. Based on the recommendations of the regional office, Pakistan, Iraq and Oman were selected for interviews. The WHO focal person for RMNCAH in each country served as the starting point for the interviews. Subsequently, a snowball technique was used to reach other relevant stakeholders from the public and private healthcare sectors and academia. The interviews were semistructured and based on the analytical framework and a priori themes and gaps identified by the literature review. Each key informant interview was web-based, conducted in English language and lasted for about 45–70 minutes. Verbal consent was obtained before the start of the interview, which was audio/video recorded and subsequently transcribed. An effort was made to include interviewees from the public, private and academic sectors of each country. The interviewees were key informants representing the RMNCAH section of the public sector or Ministry of Health, WHO country office, or noteworthy representatives of private healthcare organizations and academia, working directly or indirectly with the government. Gaining access to key informants was cumbersome and the maximum number of interviews from each country was conducted. Directed content analysis using Maxqda 2020 was performed, and information was triangulated with the findings of the desk review. SWOT analysis (strengths, weaknesses, opportunities, threats) based on study findings was performed to yield meaningful insights.

The Ethical Review Committee, Aga Khan University (ERC No. 2020-5383-14096) and National Bioethics Committee, Pakistan provided ethical clearance for conduct of the study.

Results

A total of 36 documents were eligible for inclusion in the desk review (14 peer reviewed articles, 4 dissertations, 18 reports; Figure 2) (16,18–52). Thirty-three documents addressed the EMR: 13 from Pakistan, 8 from Egypt, 6 from Iraq, 2 each from Jordan and Saudi Arabia, and 1 each from the Islamic Republic of Iran and Yemen. Sixteen stakeholder interviews were conducted from Iraq (n = 3), Pakistan (n =7) and Oman (n = 6) (Table 2). The results of the desk review and interviews were organized according to the a priori themes of the analytical framework.

RMNCAH governance

The study results indicated a minimal role of the private healthcare sector in national and subnational policy-making related to RMNCAH in the EMR. Involvement of the private healthcare sector in decision-making was not well received by public sector professionals in Pakistan and Iraq. The private sector also lacked interest due to negligible incentives and high opportunity costs. On the contrary, in Oman, the private healthcare sector was represented in policy-making at the national and subnational levels. The private partners participated in the formation of strategies/policies on maternal health and infectious diseases, with the final authority resting with the government.

Public–private partnerships (PPPs) are prevalent in the EMR in the field of RMNCAH. A WHO background paper on private sector engagement for advancing UHC mentioned the dominant role of PPPs in the quality, costs and use of services (antenatal, postnatal and newborn care, and birth facilities) in Pakistan and the Islamic Republic of Iran (16,52). The national policies of Oman and Pakistan recognize the importance of PPPs for improving healthcare and achieving global targets related to RMNCAH. The not-for-profit private sector has been more active in partnerships with the government, than the for-profit sector. Apart from formal partnerships, many informal collaborations exist between the public and private sectors. However, a major gap is the lack of planning and a clear direction for rolling out PPPs. One of the academic participants in Pakistan stated: “PPPs are implemented on an ad hoc basis…and to place a burden on the private sector. They collaborate just to avoid their responsibilities. The government needs to wake up. ”

The available literature reiterates regulation of the private healthcare sector as a universal challenge. There are almost 50 000 private clinics in Egypt and 75 000 private general practitioners in Pakistan that cannot be classified under any proper regulatory system (16). The Ministry of Health has a mandate and responsibility for regulation, and regulatory policies exist on paper (Iraq and Pakistan); however, there was no evidence of regulation (16,35).

High-income countries such as Oman had a healthier situation: licensing of private providers and establishments was strict and inspection teams were operational to monitor quality.

Health information systems with data on RMNCAH indicators

The available literature indicates that the private healthcare sector is lagging in collecting, maintaining and sharing health-related data with the government across the EMR. Data regarding abortion and postabortion complications are limited in low- and middle-income countries (38,44). The interviewees from Iraq stated that secondary and tertiary care hospitals shared monthly data related to spontaneous vaginal deliveries and caesarean sections with the Ministry of Health; however, data flow from private clinics remained limited. One of the public sector respondents in Iraq stated: “The private sector information only comes indirectly via the population-based surveys.” Similarly, the private healthcare sector of Pakistan is obliged to notify about child and maternal death, but other indicators of RMNCAH are not routinely shared with the government.

Oman presented an encouraging scenario of continuous recording of number of pregnancies, maternal and child births, and deaths. The public sector offered a central health information system that kept track of patients; however, data in the public and private sectors were not comprehensive and many vital

indicators of RMNCAH were missing. A public sector interviewee from Oman stated: “We feel our patients get lost in the private sector.” Our findings suggest that a centralized health information system was being developed in Oman through which “the public and private sectors would be able to tap into each other’s systems” (private sector interviewee).

Financing modalities for RMNCAH

There was a large variation in out-of-pocket payments as proportion of total health expenditure across the EMR, ranging from 10% in Oman to 70% in Yemen (53). Catastrophic payments were common for the private healthcare sector, including caesarean sections and postnatal complications (52). As a response to high out-of-pocket payments in Egypt (62%), the government rolled out a new insurance scheme to achieve UHC, based on a family physician model that separates financing from service provision; however, the impact of the model remains inconclusive (22). Private and social health insurance in Iraq was minimal. A health insurance law was drafted in 2014, but is yet to be endorsed. Public healthcare services (including RMNCAH) were free for Omani citizens and the insured population. The private sector was generally used by expatriates or people without insurance. However, there were no standard insurance packages for antenatal care.

Various models of supply- and demand-side financing have been tested in the EMR, with varied results. Financing vouchers complemented by social franchising in the form of demand-side financing have been rolled out in Pakistan for over a decade to improve family planning practices (29). Supply-side financing has been improved through social health insurance and private health insurance, which are generally available for residents of urban areas (31). Task sharing by building PPPs via the community midwives model, and community health workers connecting clients with local facilities, have been instrumental in improving family planning practices in Pakistan (31). Organizations such as Green Star, Marie Stopes, and Suruj Network have worked with mid-level private sector providers to increase the uptake of long-acting contraceptives (29). Their effectiveness is well documented in increasing family planning; however, the geographical coverage is too small to create an impact at the national or subnational levels.

In Oman, some vouchers for antenatal and postnatal care were commonly distributed during campaigns to commemorate Mother's Day, Breast Feeding Week, Birth Spacing Week etc. Community financing was common in Najaf and Karbala (holy shrines), as stated by one of the public sector interviewees in Iraq: "Free mobile clinics are provided during holy events by the community. These services are however, not constant throughout the year".

RMNCAH service delivery

Types and use of private healthcare sector services

The private healthcare sector remained the sector of choice for RMNCAH-related services in most of the developing countries in the EMR (31,37,38,40,45,46,49). Anecdotal evidence suggested that around 50% and 80% of RMNCAH-related healthcare services in Iraq and Pakistan were provided by the private healthcare sector (38). The role of the private healthcare sector was particularly prominent in providing postabortion care in Pakistan, given that it treated about 50% more postabortion cases (62% vs 38%) than public health facilities treated (44). The caesarean section rates tended to be higher in the private healthcare sector. In 2002, the caesarean section rate for public hospitals in Baghdad (Iraq) was 30% of all births (compared to an acceptable standard of 5–10% in most countries) and the recorded rate was much higher, at 48% in private hospitals (25). Availability of drugs such as misoprostol was better in the private healthcare sector in Pakistan (89% vs 54% in the public sector) (44). The stakeholder interviews elaborated that the service delivery packages of RMNCAH care were not well defined in the private healthcare sector. In high-income countries such as Saudi Arabia and Oman, the public sector remained the predominant provider of care (23% child health services in Saudi Arabia are provided by the private healthcare sector) (40).

Quality of services

In low- and middle-income countries of the EMR, the private healthcare sector was perceived by the public to offer higher quality of services than the public sector (45,49). However, this perception was not supported by scientific evidence. People preferred the private healthcare sector for reasons such as hospitality, short waiting time, and better laboratory and diagnostic facilities, nursing care and infrastructure. Although the communities preferred the private sector, one of the key informants from Pakistan stated: “The public and private sectors are equally incompetent.” Other concerns were raised regarding the private healthcare sector of Pakistan. Some respondents said it was a “money-making machine”, with poor quality of services. The providers were accused of using “quick relief formulas” for treating the patients. They said providers in private clinics often use steroids, antibiotics and intravenous analgesics that provided instant relief to patients. One of the academic respondents in Pakistan stated: “Everyone in the private sector gives clomid (clomiphene) for management of infertility….which can increase the risk of polycystic ovarian disease”.

In Oman, the public sector was said to be better than providers in private clinics in the provision of RMNCAH services, because of its team-based approach, skill mix and continuity of care. Public healthcare providers had better training opportunities in Oman while continuous capacity building for private providers was limited. In contrast, data from 6 private clinics in Sudan suggested that private healthcare providers had limited to no training in the diagnosis and management of sexually transmitted diseases (54). Dual practice was commonly reported in the developing countries, leaving providers with little time and interest to provide quality care for patients in the public healthcare sector.

SWOT analysis

A SWOT analysis for the engagement of private healthcare sector in RMNCAH in the EMR was conducted, based on the results of desk review and interviews. Major strengths of private healthcare sector included its vast spread, diversity of services, trust of the masses, high-quality laboratory and diagnostic support and specialized care (e.g. in vitro fertilization and neonatal care) in some countries. The sector suffered from the weaknesses of being focused on curative care for enhanced monetary benefits, uneven geographical distribution, urban bias, and poor record keeping and continuity of care. However, the sector offered opportunities such as indirect referral linkages between public and private sectors, higher technical capacity in some countries, and a drive at national and subnational levels to incorporate private healthcare sector into the mainstream. At the same time, stakeholders needed to be mindful of the accompanying threats: there was no clear roadmap for incorporating the private healthcare sector and old legislation remained incompatible with PPPs; corruption in the public sector affected regulation and accountability of the private healthcare sector; and dual practice by healthcare providers raised conflict of interest.

Discussion

Private healthcare sector is a vital stakeholder in the provision of RMNCAH care in the EMR. It has grown greatly over the past few decades and is now widespread. A general trend of a predominant private sector was reported in developing countries where the public sector was lagging, whereas its role was less prominent in high-income countries that had strong health systems, such as Oman. The international and national platforms acknowledge the need to incorporate the private healthcare sector into related activities of the public sector. Its representation, though minimal, is seen in the formation of clinical guidelines, standards and policies pertaining to RMNCAH in some countries. PPPs have been popular in the EMR, being tested for family planning, antenatal care, immunization and child nutrition, etc. However, there is lack of vision and framework to guide the PPPs. Regulation of the private healthcare sector remains a challenge in developing countries, where corruption and lack of accountability and transparency in the public sector hamper regulation.

Private healthcare sector remains an unexplored domain due to lack of information flow to the public sector. Private tertiary care hospitals collect, maintain and share records with the public sector regarding number of deliveries and caesarean sections. The lower tiers seldom share patient records. Private healthcare sector is the preferred option due to shorter waiting time, better perceived quality, laboratory and diagnostic support, hospitality of staff and clean environment; although the technical capacity is questionable. In countries such as Pakistan and Islamic Republic of Iran, there is over-reliance on the private sector, which culminates in a potentially negative impact such as high out-of-pocket payments, caesarean section rate, and overuse and misuse of drugs. Thus, streamlining the private healthcare sector in a public-led system is critical to ensure its proper use in advancing UHC. A similar scenario of widespread private healthcare sector and limited engagement with the government has been reported across the WHO African Region (55). It is believed that the private healthcare sector can be a valuable contributor to improving population health and moving towards UHC in the WHO Region of the Americas (56). The alignment of the private healthcare sector with the public sector is similar worldwide, with limited engagement but a huge untapped potential that needs to be efficiently used by the government.

Based on our study findings, we present the following suggestions for strengthening engagement of the private healthcare sector with the public sector. We believe that a clearly stated policy needs to be formulated to engage the private healthcare sector in all health domains including RMNCAH, at the regional and national levels. The countries need to develop a guiding framework to engage the private healthcare sector in RMNCAH for all service delivery tiers of healthcare. Planning for PPPs needs improvement by building the technical capacity of the government. A separate department of private healthcare establishments (with allocated budget) should be established in the public sector for PPPs, contracting out services, ensuring accountability, licensing, regulation and accreditation of the private healthcare sector. If a

separate department is not feasible, the function inside the ministry of health should be strengthened. The allocated health budget to the ministry of health should be increased, with separate allocation for PPPs. The range of services should be clearly stated with designation of responsibilities of both parties such that the collaboration is mutually beneficial. We suggest that the PPPs should typically address abortion and postabortion services, family planning, neonatal care and community awareness raising.

The private healthcare sector professionals need to be represented at the policy level for formulation of clinical standards, guidelines and strategies related to RMNCAH. The licensing of practitioners should be renewed every 5 years with strict requirements for continuous medical education to maintain standards of care. A separate directorate/commission should be established to ensure registration of all private facilities and licensing of providers. Similarly, the private facilities should be accredited and only those clearly eligible should be engaged by the public sector. Capacity building related to antenatal and postnatal care, family planning, weaning practices, integrated management of newborn and childhood illnesses guidelines, and syndromic management of sexually transmitted diseases should be offered to private healthcare providers at a minimal cost, and participation encouraged through certification and recognition. Health information systems should transit to electronic databases with standardized comprehensive data forms capturing number of antenatal visits, immunizations, postnatal and neonatal care, uptake of contraception and child mortality. The private sector should be incentivized to share data with government and such information should be incorporated in the formulation of RMNCAH-related strategic and operational plans. A legal claims department should be established in the ministries of health to address the concerns of patients, indirectly ensuring accountability of private providers. Demand-side financing in the form of voucher schemes could be implemented to improve contraceptive uptake. Regulatory mechanisms should be established to implement updated clinical guidelines and protocols related to RMNCAH in the private healthcare sector.

This study has highlighted engagement of the private healthcare sector in RMNCAH in some countries of the WHO EMR, with particular focus on Oman, Pakistan and Iraq. It captures insights of stakeholders from WHO, public and private sectors, and academia across all tiers of service delivery. The study has some limitations. Interviews were conducted in only

three countries, and findings cannot be generalized to the Eastern Mediterranean Region. There was no representation from the low-income countries, which would have added robustness and balance to the results. The point of saturation for the interviews was not reached and we believe additional interviews could have helped strengthen the findings. However, this study provides a foundation for further research and identifies areas of action for engagement with the private healthcare sector.

Conclusion

The private healthcare sector offers a huge untapped potential for improving RMNCAH-related services across EMR. The public sector needs to incorporate and align services of the private sector to the national and subnational health agendas, to improve RMNCAH towards achieving UHC

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Competing interests: None declared.

Participation du secteur privé de la santé aux soins de santé reproductive, maternelle, néonatale, infantile et des adolescents dans la Région de la Méditerranée orientale

Résumé

Contexte : Le secteur privé des soins de santé dans la Région de la Méditerranée orientale est actif et en pleine évolution, fournissant des services curatifs, préventifs et promotionnels liés à la santé reproductive et à la santé de la mère, du nouveau-né, de l'enfant et de l'adolescent.

Objectifs : Comprendre la contribution du secteur privé des soins de santé formel à but lucratif dans la prestation des services de santé reproductive et de santé de la mère, du nouveau-né, de l'enfant et de l'adolescent ainsi qu'examiner les meilleures pratiques pour les améliorer.

Méthodes : Revue documentaire de la littérature disponible (Arabie saoudite, Égypte, République islamique d'Iran, Iraq, Oman, Pakistan, Soudan, Yémen), suivie d'entretiens avec les parties prenantes en Iraq, au Pakistan et à Oman. Une analyse de contenu dirigée a été réalisée à l'aide du programme Maxqda 2020, et les informations ont été triangulées en fonction de thèmes a priori : gouvernance, systèmes d'information sanitaire, financement et prestation des services liés à la santé reproductive et à la santé de la mère, du nouveau-né, de l'enfant et de l'adolescent.

Résultats : Des partenariats public-privé formels et informels existent dans le domaine de la santé reproductive et de la santé de la mère, du nouveau-né, de l'enfant et de l'adolescent, mais aucune feuille de route stratégique n'est disponible pour orienter la collaboration. La représentation du secteur privé des soins de santé dans le courant politique principal aux niveaux national et infranational est faible en raison de la résistance des secteurs privé et public. Ils sont faibles dans la collecte, la conservation et le partage des informations sanitaires. Les données sur les complications liées à l'avortement et au post-avortement sont rares. Divers modèles de financement de l'offre et de la demande (systèmes de bons, assurance-maladie privée et sociale) liés aux soins prénatals et à la contraception ont été mis en œuvre dans la Région de la Méditerranée orientale. Malgré le coût plus élevé des soins dans le secteur privé, la formation limitée des prestataires, les ensembles de prestations de services mal définis et le manque de continuité des soins et d'approches d'équipe, le secteur privé reste le secteur prédominant qui fournit des services de santé reproductive et de santé de la mère, du nouveau-né, de l'enfant et de l'adolescent dans la Région de la Méditerranée orientale.

Conclusion : Le partenariat avec le secteur privé présente un énorme potentiel inexploité dont les gouvernements nationaux devraient tirer parti pour étendre les services de santé reproductive et de santé de la mère, du nouveau-né, de l'enfant et de l'adolescent et progresser vers la couverture sanitaire universelle.

WHO EMRO | Engagement of private healthcare sector in reproductive, maternal, newborn, child and ado

ومصر والسودان واليمن وباكستان وجمهورية إيران الإسلامية) ، أعقبته مقابلات مع الأطراف المعنية في العراق وباكستان وعُمان . وقد أجرى الباحثون تحليل محتوى موجَّهًا باستخدام نظام 2020 Maxqda ، ثم أجروا مسحًا للمعلومات بطريقة التثليث وفقًا لمواضيع محددة مقدمًا : الحوكمة، ونظم المعلومات الصحية، والتمويل، وتقديم الخدمات المتعلقة بالصحة الإنجابية وصحة الأمهات والحديثي الولادة والأطفال والمراهقين .

: توجد شراكات رسمية وغير رسمية بين القطاعين العام والخاص في مجال الصحةالنتائ ج الإنجابية وصحة الأمهات وحديثي الولأدة والأطفال والمراهقين، ولكن لا توجد لهذه الشراكات خريطة طريق استراتيجية لتوجيه التعاون . وتمثيل قطاع الرعاية الصحية الخاص ضعيفٌ في السياسات الرئيسية على الصعيدين الوطني ودون الوطني، بسبب المقاومة من القطاعين الخاص والعام، اللذين يتسمان بضعف جهودهما في جمع المعلومات والاحتفاظ بها وتبادلها . والبيانات المتعلقة بالإجهاض ومضاعفات ما بعد الإجهاض نادرًا ما تتوفر . وقد نُفِّذت في إقليم شرق المتوسط نماذج مختلفة لتمويل العرض والطلب (أنظمة القسائم، والتأمين الصحي الخاص والاجتماعي) فيما يتعلق بالرعاية السابقة للولادة ووسائل منع الحمل . وعلى الرغم من ارتفاع تكلفة الرعاية في القطاع الخاص، والتدريب المحدود لمقدمي الخدمات، وعدم تحديد حزم تقديم الخدمات جيدًا، وافتقاد استمرارية الرعاية والنُّهج القائمة على فريق، فما يزال القطاع الخاص هو المتصدر في تقديم خدمات الصحة الإنجابية وصحة الأمهات والحديثي الولادة والأطفال والمراهقين في إقليم شرق المتوسط .

: هناك فوائد كبيرة غير مستغلة لإقامة الشراكات مع القطاع الخاص، ولذلكالاستنتاجات ينبغي للحكومات الوطنية أن تستفيد منها للتوسع في خدمات الصحة الإنجابية وصحة الأمهات والحديثي الولادة والأطفال والمراهقين، وتحقيق التقدم صوب بلوغ التغطية الصحية الشاملة .

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