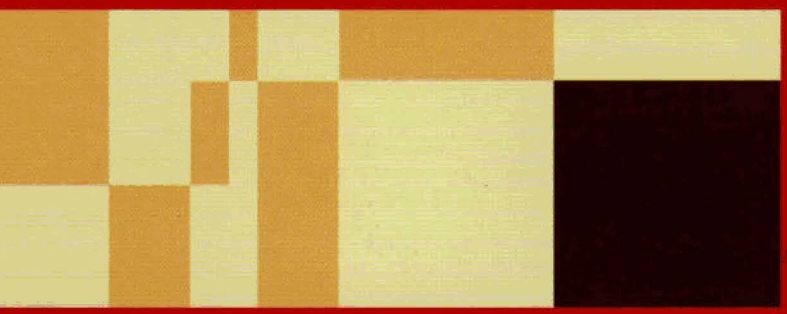
WHO-EM/WRH/043/E

Use of guidelines for making pregnancy safer and family planning



Report of a joint UNFPA/WHO regional workshop

Cairo, Egypt
14–18 January 2005

World Health Organization
Regional Office for the Eastern Mediterranean

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1. Introduction

The WHO Regional Office for the Eastern Mediterranean (EMRO) in collaboration with the United Nations Population Fund (UNFPA) held a joint regional workshop on using guidelines for making pregnancy safer and family planning, in Cairo, Egypt from 14 to 18 January, 2005. The workshop was a consequence of the successful, close collaboration between UNFPA and WHO, and followed the launching, last year, of the Strategic Partnership Programme between the two organizations. The Partnership Programme aims to promote the introduction, adaptation and adoption of practice guidelines developed by WHO to promote reproductive and sexual health at national and subnational levels. The activities proposed within the programme are within the mandates of both UNFPA and WHO. They bring together key work areas of WHO and UNFPA, namely those concerned with the compilation of best practices and with putting evidence-based interventions into practice to improve reproductive health services.

Following the introduction of the participants it was decided that the Chairperson would change on a daily basis, as would the position of Rapporteur. It was decided that there would be a different theme each day. The agenda, programme and list of participants are found in Annexes 1, 2 and 3, respectively.

Dr Mona Khalifa the Assistant Representative of UNFPA, made opening remarks on behalf of UNFPA. She described how UNFPA was one of the main international bodies to have sponsored the Safe Motherhood Initiative in Nairobi in 1987, bringing the attention of the world to the tragically high ratio of maternal mortality and morbidity. The goal was to reduce maternal mortality by 50% by the year 2000 and to further decrease it by half again by the year 2015.

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, the mandate of UNFPA was broadened to consider reproductive health as its major priority area with safe motherhood identified as an important component of reproductive health.

Governments from around the world have pledged to ensure access to a range of higher quality, affordable reproductive health services, including safe motherhood. In September 2000, 189 countries endorsed a series of Millennium Development Goals in order to reduce poverty. One of these goals was to reduce the maternal mortality rate by 75% between the years 2000 and 2015.

The Making Pregnancy Safer Initiative, which was introduced by WHO and is supported by UNFPA, aims to eliminate the problems related to maternal health and health of the newborn through a practical approach addressing the issues within the health care system.

Dr Khalifa stressed that UNFPA was committed to improving women's health in general, and indeed the welfare of the whole population, using strategies which include timely obstetric care, skilled birth attendance and functioning referral systems available to all women in labour, and simply meeting the unmet need for contraceptive services which, it is thought, could further reduce maternal mortality.

The opening remarks on behalf of WHO headquarters were made by Dr Michael Mbizvo, Co-ordinator, Director's Office, Reproductive Health and Research Department, who spoke of the commitment of the WHO and UNFPA Secretariats to serving Member States in their efforts to improve the well-being of their people and communities. He stressed that the participants of the workshop represented Member States and other partners as well as WHO and UNFPA, that the common objective was to attain the highest achievable standard of reproductive and sexual health for all and the challenge was to use the diversity of expertise and experience to deliver high quality sexual and reproductive health services.

Dr Mbizvo emphasized that the participants of the workshop were accountable to governments, communities, mentors and sponsors and to the achievement of the Millennium Goals, which would mean the realization of the sexual and reproductive health goals and targets of ICPD, thereby assisting the acceleration of progress towards achieving WHO's global reproductive health strategy. It was therefore necessary to constantly look at ways for ensuring that they attempt to anticipate and respond to challenges and provide answers to the problems that bedevil the communities of the Region. Finally, he said it should be recognized that sexual and reproductive health services not only improved the health of men, women and children but were also a basic human right.

In his opening message, which was delivered by Dr Ahmad Mohit, Director for Health Protection and Promotion, Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean said that the workshop highlighted priority issues in reproductive health, with specific focus on technical guidelines and norms that had already been developed for making pregnancy safer and enhancing family planning practices in the community. He pointed out that it was an excellent opportunity for full interaction with open and free discussions and exchange of information, experience and advice concerning the required knowledge and skills and the already available technology for improving maternal health and reducing child mortality in countries of the Region.

During his address Dr Gezairy said that despite the remarkable efforts made by countries, progress towards achieving the goal of reducing maternal mortality worldwide, including in the Eastern Mediterranean Region, had been slow. The latest estimates showed that in terms of levels of maternal death, the Eastern Mediterranean Region came directly after the African Region. He stated that every year in the Region, approximately 53 000 mothers died as a result of pregnancy-related complications. At least 10 times more became ill or were left disabled. The health hazards that resulted from poor birth spacing, and thus from too early, too late, too close and too many pregnancies, were well

established. He pointed out that if such high-risk pregnancies were prevented, it was estimated that maternal mortality could be reduced by up to 25% but regretted that in the seven countries that contributed to 95% of the burden of maternal mortality in the Region, the proportion of married women using contraceptives averaged just 26.5%, compared to 40% for the Region as a whole. Dr Gezairy said that promoting family planning was scientifically proven to be an effective intervention to prevent many avoidable deaths, not only among mothers, but also among their children.

Dr Gezairy spoke of the United Nations Millennium Declaration, which had set ambitious goals and targets for improving maternal health and promoting family planning practices between 1990 and 2015. He stressed however, that if the present trends continued some countries in the Region would not be able to achieve the Millennium Development Goals. Hence, accelerated and concerted efforts were urgently needed. Adoption of the WHO strategies for making pregnancy safer, and their implementation at country level, particularly where the levels of maternal death were still high, was expected to strengthen the efforts being made in Member States. Specific attention should be given to certain priority areas, including: strengthening health systems; improving knowledge and skills of health workers about early detection and management of complications in pregnancy and delivery; and educating women and their families about the risks mothers might encounter and about the appropriate actions needed should danger signals be identified. Critical analysis of the current situation in countries, particularly those with high levels of maternal mortality and the use of available knowledge and technology, were expected to backstop national efforts towards achieving the Millennium Development Goals, so that women of childbearing-age and their newborn babies would have a chance to reach the highest possible levels of health.

2. Objectives and methodology

The objectives, methodology and expected outcomes of the workshop were presented by Dr Sameera Al-Tuwaijri, Reproductive Health Policy Regional Adviser, Country Technical Services Team for Arab States (CST), UNFPA. She said that in the Eastern Mediterranean Region approximately 53 000 women of childbearing age died every year from pregnancy-related complications. The causes of maternal death were remarkably consistent around the world; there were huge differences between the risk taken in pregnancy between the women living in rich countries and those living in poor countries. Poverty was the one factor which dramatically increased a woman's chances of dying during, or soon after, pregnancy, she stated. Women dying or suffering from disabilities related to pregnancy was not only tragic and sad, she said, but was a violation of their human rights to life and health.

She described the objectives of the Strategic Partnership Programme as being to improve the sexual and reproductive health of the people of the Region through improving the quality of maternal health and family planning services. The general objective was to implement selected guidelines, using a defined systematic introduction and adoption process involving both WHO and UNFPA. However the specific objectives for the workshop were to:

- familiarize regional and national counterparts with making pregnancy safer and family planning guidelines;
- share information and experiences on existing national programmes, strategies and approaches designed to address safe motherhood issues, including family planning in countries of the Region;
- discuss and identify technical backstopping needs of participating countries;

- develop a framework for action to improve maternal health and family planning services, using the evidence-based guidelines; and
- initiate the next steps for implementation through the development of country plans of action.

She explained that the expected results of the workshop were to increase the familiarity of the participants with the selected making pregnancy safer and family planning guidelines being reviewed during the workshop. It was expected that the knowledge about opportunities and challenges involved in making pregnancy safer and family planning in the various countries of the Region would be updated and that country plans of action for the adaptation and implementation of the selected guidelines would be formulated involving both WHO and UNFPA in the process. The required technical backstopping plans at the regional and country levels would be designed and there would be improved networking among countries and supporting agencies in the implementation of making pregnancy safer and family planning programmes, she said.

The other results of the workshop were in the follow-up actions to the workshop, some of which would be immediate and some of which would take longer to develop, she added.

She went on to say that one of the immediate actions would be that the headquarters of UNFPA and WHO would ensure adequate funding and effective technical support to countries so that the regional capacity was strengthened as required. At the regional and subregional levels of UNFPA and WHO, steps were needed that would to ensure that the appropriate technical support was available to countries in their implementation of guidelines. At the country level, she explained that the participants of the workshop were to debrief senior officers and provide feedback to appropriate UNFPA and WHO colleagues and any other partners who were willing to assist in the implementation process to finalize a framework of plans. The utilization of the guidelines through adaptation and adoption for implementation would

be a further follow-up action, with partners assisting financially and possibly technically in the implementation of the guidelines, she said.

Actions that would take place over the medium term were those of fund raising and seeking partnerships to achieve goals, country level workshops with copies of the guidelines and agreements developed between partners, and, at a country and regional level, support for advocacy and resource mobilization activities.

In the long term, follow-up actions to the workshop would be to identify further specific needs and mechanisms for technical support at the regional level, and the production and publication of a technical report on the Strategic Partnership Programme. She ended by saying that it was also anticipated that there would be an increase in networking and sharing of country experiences, leading to replication in another group of selected countries.

3. Technical presentations

3.1 Overview of the Strategic Partnership Programme

Dr Michael Mbizvo, WHO headquarters

The goal of the Strategic Partnership Programme is to improve support to countries through the implementation of evidence-based norms and tools for reproductive health, thereby allowing a global synthesis of information.

The overall objective is to promote sexual and reproductive health and the partnership hopes to systematically achieve the introduction and implementation of practice guides to improve sexual and reproductive health in the Region, initially in family planning, and in sexually transmitted and reproductive tract infections. The guidelines and tools prepared by WHO's Reproductive Health and Research Department reflect global recommendations on best practices. The linkages with country technical service teams, country offices, and WHO regional offices are critical for maximizing their use and adoption, and in the harmonization of their messages.

The secondary objectives of the Strategic Partnership Programme are to strengthen technical capacity through orientation training and support, to enhance linkages between the creation of evidence-based tools and their implementation to improve programmes that already exist.

Methodological processes are used to bridge the divide between the guidance tools and the countries' adoption of them. As the development and implementation of the Programme depends on the needs and the perspectives of the countries and communities being taken into account, feedback from the countries is used for technical cooperation and for

giving further technical support as required for programme development and implementation.

There should be a systematic introductory process for the guidance tools with a situation analysis first determining the needs of the country and using national policies, practices, epidemiological data and resources. The whole process of introduction is continuous, moving from implementation through to monitoring and evaluation, adoption, scaling-up the activities and use, while at the same time disseminating and continuing to analyse the situation and any changes that might occur. This again may or may not lead to further orientation and adaptation of the tools.

The expected output and outcome are the adoption and scaling up of evidence-based practices, tools and materials leading to improved quality of reproductive health care services, particularly in family planning, the control of sexually transmitted infections, and improved maternal and neonatal health.

The guiding principles are to foster linkages with other partners, take into account existing tools and baseline data, work within existing structures, professional bodies, networks and centres of excellence, advance gender equity and human rights, contribute to the reduction of poverty, and strengthen national capacity and local ownership.

The key issues are those of equity, efficiency and quality. In terms of equity, actions are being taken to give poor people the same chance of survival and healthy development as that enjoyed by the wealthy. Addressing inequities in health contributes to poverty reduction and economic development. Health sector reform should explicitly address the reduction of inequities.

Actions used to improve efficiency include the simple, cost-effective interventions that exist to prevent many premature deaths and disabilities. There is a need to ensure scaled-up implementation and to use the scarce resources available to deliver those interventions that have the greatest effect.

Quality is not a luxury but is a fundamental component of health care. Efficiency and quality are mutually reinforcing and local initiatives to improve quality are often the most successful.

The guidelines presently being introduced are the WHO guidance for family planning, consisting of four documents, namely the *Four cornerstones for family planning*, based on scientific evidence and globally agreed best practices. The four cornerstones are: *Improving access to quality care of family planning: medical eligibility criteria for contraceptive use, Selected practice recommendations for contraceptive use, Decision-making tool for family planning clients and providers* and the *Handbook for family planning providers*.

Also being introduced is the WHO guidance for making pregnancy safer which includes the following guideline documents that are generally called IMPAC (integrated management of pregnancy and childbirth) guidelines: *Pregnancy, childbirth, postpartum and newborn care: a guide to essential practice, Managing complications of pregnancy and childbirth* and *Managing newborn problems*. The activities that have already been employed in the introduction of the guidelines are:

- subregional dissemination workshops
- field-testing
- developing networks of excellence
- implementing best practices dissemination and/or in-country follow up
- in-country adaptation.

The objective of the workshop is to make the participants aware of how these guidelines can be usefully used in their countries as tools to improve quality of life.

3.2 Making pregnancy safer

Dr Matthews Mathai, WHO headquarters

Making Pregnancy Safer is WHO's contribution to the Safe Motherhood Initiative, a health sector strategy that aims to assist countries to identify and implement affordable strategies to address maternal and newborn health.

Integrated Management of Pregnancy and Childbirth (IMPAC) is a comprehensive package of norms, standards and tools which can be adapted and applied at national and subnational levels as well as used in training in order to support the effort of countries in reducing maternal and perinatal mortality and morbidity. The package gives guidance on clinical practices, management of the health care system, and monitoring and evaluation of programmes.

The process involved in the development of guidelines is that of examining the level of evidence to determine the extent to which one can be confident that an estimate or effect or association used is correct. The strength of the recommendation reflects the extent to which it is possible to be confident that adherence to a recommendation will do more good than harm. The set of recommendations is drawn up through reviewing and reporting evidence on efficacy and the implications of adopting recommendations on costs and population health. Thus they have to be effective, cost-effective, affordable, beneficial, acceptable and feasible.

All WHO recommendations should be explicitly based on evidence which assists providers, recipients and other stakeholders to make informed decisions about appropriate health interventions and activities, reflect no conflict of interest, and be periodically reviewed and revised as experience develops.

The pregnant woman and her unborn child are central to guidelines for making pregnancy safer. Health care delivery systems should remember that they are dealing with

individuals, families and communities. It is through situation analysis, planning, programming, monitoring, evaluation and assessment that priorities are established for policies that ultimately affect the lives of individual people within communities.

The IMPAC series of tools consists of tools that answer all the above requirements. They fit together to help in the identification of problems, and revision of standards and protocols, so that policies and regulations can be introduced or changed when possible, training curricula revised and monitoring and evaluation take place. The many modules therefore deal with programming, taking a multisectoral approach for strengthening laws, policies and standards of care, and using human rights to improve maternal and neonatal health, using clinical tools, training tools, and monitoring and assessment tools for evaluation. There are also related tools for family planning, sexually-related infections, reproductive health for conflict and displacement situations, and malaria in pregnancy. Many of the publications are provided in CD format or can be accessed online.

Three of the clinical guides are being introduced during the Strategic Partnership Programme workshop and are specifically for use by doctors, nurses and midwives. These are *Managing newborn problems, Managing complications in pregnancy and childbirth* and *Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice.*

3.3 The four cornerstones of evidence-based guidelines for family planning

Dr Carlos Huezo, WHO headquarters

The four cornerstones of evidence-based guidelines for family planning is a package of guidelines that are based on evidence, developed through consensus and continuously updated. They are guidelines for policy-makers and programme managers as well as tools for health care providers.

Improving access to quality care of family planning: medical eligibility criteria for contraceptive use is a guideline on who can safely use contraceptive methods. The second edition, published in 2001, is available in English, French, Spanish, Chinese and Romanian. This has been updated and the third edition is now ready in English. It has also been translated into French and Portuguese.

Selected practice recommendations for contraceptive use is a guideline on how to safely and effectively use contraceptive methods. The first edition, published in 2002 is also available in English, French, Spanish, Chinese and Romanian. It has been updated and the second edition is now available in English and translations so far are into French and Portuguese.

The guidelines were developed through consensus of country experts at working group meetings with representatives of UNFPA, World Bank, International Planned Parenthood Federation (IPPF), United States Agency for International Development (USAID), Centers for Disease Control and Prevention, Atlanta (CDC), United States National Institute of Child Health and Human Development (NICHD), Engender Health, Family Health International (FHI), Johns Hopkins Center for Communication Programs (JHU/CCP), Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO), IntraHealth, Georgetown Medical Center and Management Sciences for Health. They have been kept up-to-date through monitoring all new evidence by Continuous Identification of Research Evidence (CIRE) and systematic review on selected issues.

There are four classification categories:

1. no restriction for the use of the contraceptive method;
2. the advantages of using the method generally outweigh the theoretical or proven risks;
3. the theoretical or proven risks usually outweigh the advantages of using the method;

4. an unacceptable health risk if the contraception method is used.

The methods of contraception are:

- combined oral contraceptives;
- combined hormonal contraceptives (1 month injectables, patch, vaginal ring);
- progestogen-only contraceptives (pills, implants, 2-3 injectables);
- emergency contraceptive pills;
- intrauterines (copper bearing and levonorgestrel;
- emergency intrauterine (IUD);
- barrier methods (condoms, spermicides and diaphragm);
- fertility awareness-based methods;
- lactational amenorrhea (LAM);
- coitus interruptus;
- sterilization (male and female).

The conditions identified represent either an individual's characteristics (e.g. age, parity, breastfeeding), or a known pre-existing medical condition (e.g hypertension, sexually transmitted infection, diabetes). Three new conditions, antiretroviral (ARV) therapy, obesity and depression have been added to the 2004 publication.

Selected practice recommendations for contraceptive use covers 33 questions on how to use contraceptive methods (second edition) and is based on scientific consensus. The topics for the questions are on the initiation and/or continuation of the method, such as when to start or re-administer the contraceptive, questions concerning the incorrect use of the method, such as missed pills, problems during use, which might include vomiting or diarrhoea, menstrual abnormalities, pelvic inflammatory disease, and pregnancy and programmatic issues such as which examinations or tests should be done routinely and what follow-up is needed.

The Working Group has provided for each question:

- recommendations for key situations;
- comments;
- key unresolved issues;
- information about the evidence.

The third cornerstone is the *Decision-making tool: a multi-purpose tool*. This is a multipurpose tool to aid family planning clients and providers to make decisions on contraceptive use by assisting in counselling and solving problems. It is a job aid, reference guide and training tool. The final tool is the *Handbook for family planning providers*, which is the successor to *The essentials of contraceptive technology*, and is to be published in 2005 and contain all WHO family planning guidance.

The four cornerstones package is designed to contribute to quality of care through improving access, choice, safety, and the confidence of service providers and clients.

3.4 Introduction to making pregnancy safer (IMPAC) guidelines

Dr Mathews Mathai and Dr Rita Kabra, WHO headquarters

The new manual *Managing complications in pregnancy and childbirth: a guide for midwives and doctors* (MCPC) covers emergency care during pregnancy, childbirth and postpartum as well as immediate newborn care. It is written for the doctors, nurses, senior midwives and other health workers at district hospitals in low resource settings who are responsible for the care of newborns with problems during the first week(s) of life. The manual, based on the latest available evidence, provides up-to-date, authoritative clinical guidelines, which are relevant to a district hospital with basic laboratory capability and a supply of selected essential drugs and supplies. The manual provides guidance on the diagnosis and treatment of the most common causes of mortality and morbidity in the early neonatal period.

The manual helps with:

- identification of the problem;
- correct assessment and classification;
- timely and correct management (essential drugs and supplies, procedures);
- general principles (clinical care, organization).

The manual was developed in collaboration with JHPIEGO with support from UNICEF, UNFPA and the World Bank and it is endorsed by International Federation of Gynaecologists (FIGO) and the International Confederation of Midwives (ICM). Contributions and reviews have been made by several experts from different regions. It has been translated into several languages.

The contents of the manual focus on practice and management, based on effective low-cost options suitable for limited resource settings. Practical guidance is given for managing major conditions that cause mortality in the mother and her newborn and simple diagnostic and clinical decision-making based on symptoms, signs and basic tests. It does not contain any detailed description of anatomy, physiology or pathology, any detailed classification of diseases, academic terminology, chapters based on disease classification or non-emergency conditions except normal labour, childbirth and newborn care principles.

Adaptation of the manual can be done through use of different settings, epidemiology, national standards and new evidence, as well as through translation, without changing the basic principles and evidence-based practices.

As with the MCPC, a need was observed for clear, precise practical guidance in dealing with newborn health problems in lower resource settings. This need was not met by any existing manuals or textbooks of paediatrics or neonatology. The new *Managing newborn problems* (MNP) manual is written for the doctors, nurses, senior midwives and other health workers at district hospitals in low resource settings who are

responsible for the care of newborns experiencing problems during the first week(s) of life. The manual, based on the latest available evidence, provides up-to-date, authoritative clinical guidelines, which are relevant to a district hospital with basic laboratory capability and a supply of selected essential drugs and supplies. The manual provides guidance on the diagnosis and treatment of the most common causes of mortality and morbidity in the early neonatal period.

The manual was developed based on lessons learned from the development of the MCPC by an international editorial group. The English publication was in April 2004 and it is endorsed by UNFPA, United Nations Children's Fund (UNICEF), World Bank, FIGO, International Confederation of Midwives (ICM) International Paediatric Association (IPA), with funding from USAID, Australia, Japan and the World Bank.

The content of the MNP is divided into three sections, the first dealing with the newborn with problems and/or the baby born to a mother with complications or diseases (symptomatic or asymptomatic), the second with principles of good newborn care, and the third and appendix relating to procedures, equipment, supplies, drugs and records.

A newborn manual for low-resource settings needed to address several challenges: situations where one sign may indicate many diagnoses, while one diagnosis may be indicated by many signs; the need to prevent the overuse of antibiotics without compromising quality of care, especially with only limited laboratory facilities available; and the need to avoid telling patients to use their own judgement.

Issues for the editorial committee were:

- How much laboratory support is "essential"?
- Should bacteriology be available?
- Is X-ray needed? Is it realistic? If X-rays are taken can they be read correctly?
- What are appropriate treatment durations?
- What therapies, among the various therapeutic options,

should be recommended?

- Should exchange transfusion be included?

The committee solved these as follows:

- MNP's basic organization is according to the signs the baby demonstrates and guides the practitioner to the most likely causes of them and from there to the appropriate treatment;

- primary emphasis is placed on decisions based on clinical assessment but certain basic laboratory procedures that should be available although X-ray services are not included since they are expensive to install and maintain and reading them requires expertise;

- bacteriology is thought crucial to minimize overuse of antibiotics so basic bacteriology is included as are other blood tests (bilirubin, haemotocrit or haemoglobin, blood type and rhesus, etc.);

- the decision on which treatment to include when evidence supported more than one was based on cost, simplicity of application, ease of training providers to use it and logistical considerations.

MNP is being disseminated through WHO distribution lists to all countries, agencies, organizations, donors and publishers. Translations, ongoing or planned, are into French, Spanish, Chinese, Arabic and Russian as well as national translation (e.g. Indonesia).

The next steps are promotion through WHO activities, partnerships and major events, capacity-building in regions and countries, development of managerial guidelines, evaluation of the effectiveness and impact of the manual, the development of mechanisms for continuously updating the evidence, and research on issues as yet unresolved.

The new guideline *Pregnancy, childbirth, postpartum and newborn care: a guide to essential practice* (PCPNC) aims to improve the technical competence of skilled birth attendants at all levels of health care, with a special focus on the primary health care level, by promoting evidence-based interventions. It addresses those complications that have the greatest impact on maternal and perinatal mortality. It emphasizes that all pregnant women should have access to skilled attendance at delivery and to a sound referral system. Using this guide, the skilled birth attendant will be able to provide care for women during pregnancy, childbirth, postpartum and post abortion periods as well as care for newborns. The guide focuses on early detection of complications by assessing common emergency signs, quick treatment and timely referral to the secondary level of health care.

This manual is a practice guide on essential routine and emergency care which should be available at all levels of health care particularly at the primary health care level during pregnancy, child birth, postpartum and post abortion.

The target audience is health care providers and skilled birth attendants, health planners, programme managers, trainers and educators. The principles of the guide are continuum of care for the mother and newborn, a core set of essential interventions, the major causes of maternal and neonatal mortality, evidence-based interventions, an integrated approach, clinical decision-making based on signs and symptoms, and a consistent approach to management.

The guidelines recognize the need to treat at first encounter, detect problems early, stabilize and refer the patient whenever necessary. The quality of care is important, as is communication with the women, confidentiality and organization of services, and using universal precautions for infection control.

The structure of the components is such as to enable rapid assessment and management of an emergency, give routine care for the essential elements of maternal and neonatal care pertinent to the specific visit, respond to the problem, give

preventive measures, advise and counsel. Health promotion messages are integrated in each clinical section, to inform and counsel on such areas as HIV, women with special needs, adolescents and women living with violence. Administrative aid is also given (introduction, principles of good care, equipment supplies and medicines, laboratory issues in terms of HIV, rapid plasma reagin, haemoglobin pattern, urine analysis, and records and forms).

There are supporting materials in the form of facilitators' guides, adaptation guides and a summary of evidence as well as the training materials. While the need for adaptation to suit local needs is recognized, they can be used at many different levels (pre-service, in-service, medical and midwifery) to improve quality of care, review the needs of the health system, increase community awareness and strengthen the referral system.

3.5 Highlight on the contents of *The decision-making tool for family planning clients and providers*

Ms Kathryn Church, WHO headquarters

The *Decision-making tool for family planning clients and providers* is one of the "four cornerstones" of WHO's evidence-based guidance in family planning. The developing partners were WHO and John Hopkins University Center for Communication Programs (JHUCCP), although many other organizations were involved in developing, field testing, reviewing, implementing or evaluating the tool.

This is a multi-purpose tool, which serves in making decisions, solving problems and as a communication job aid, a reference guide and a training tool. Through focusing on counselling, the tool increases client satisfaction, provider satisfaction and correct method use, and therefore ensures the continuation of use. It reduces dropout from services, unnecessary health risks, method failure and unwanted pregnancy.

The decision-making tool recognizes the client's need to:

- choose a method that they are happy with;
- know about side effects;
- know how to use the method correctly;
- know when to come back;
- help and support using their method;
- know how to deal with problems;
- know they can switch methods if they want.

The tool is a client-driven counselling process with flip-over pages providing limited information at the client level on one side and more detailed information for the health care provider on the other. It is easy to use because it is divided into sections by coloured tabs that enable the provider to flip between sections efficiently and without loss of time.

The focus is on reproductive health promoting dual protection, advice for younger clients, advice for postpartum and post abortion clients, advise for clients living with HIV and reproductive health counselling.

The tool works through application of best practices in family planning counselling, encouraging a friendly welcome, establishing rapport with the client, being open to discussion and taking the desires of the client into consideration rather than pressing her to accept a method to which she may feel aversion, resistance and finally not use.

The decision-making tool has been field tested through feedback workshops in Indonesia, South Africa, Trinidad and Tobago and observational studies have been carried out in Indonesia, Mexico and Nicaragua. A summary of the findings of these studies revealed that both clients and providers really liked the tool and that practicing with it helped them perfect their approach and use of it. Providers appreciated the reference information and felt that the tool helped to promote dual protection counselling. Both clients and providers liked the "generic" drawings and felt that although it was important

to receive correct training in its use it was a "tailored approach": quality counselling with time restraints.

Adapting and implementing the tool will be different according to which country is adopting it. There is an implementation guide under development including electronic files, illustrations, additional method sections, advocacy materials, an adaptation guide, a training guide, a demonstration video and an evidence base.

Several considerations should be taken into account for implementing the tool:

- What is the current technical knowledge and skill of the providers?
- What is the current method mix? Is contraceptive choice available?
- Can the programme support the tool? (i.e. equipment, supplies, facilities, patient flow, staffing);
- Is translation needed? Or even several translations?
- What are the costs involved and what is the available budget?
- What other quality improvement programmes are ongoing in the country?

3.6 What is an adaptation process?

Dr Rita Kabra, WHO headquarters

The guideline development process takes place through the generation, synthesis and finally transference of evidence into norms and guidelines. The strength of the recommendations made reflects the extent to which it is possible to be confident that adherence to them will do more good than harm.

Recommendations must be safe, efficacious, cost-effective, affordable, beneficial and acceptable.

It has become apparent that the distribution of written materials and didactic educational sessions are largely ineffective and that multiple methods are needed to effectively implement new practices. Evidence- based practice is not reaching users, often because the guidelines are not adapted to be appropriate to the local context. It is necessary to adapt guidance and introduce change through a process that is driven from within the system and is participatory. Involvement of national stakeholders in development and adaptation of local guidelines should take place from the start. The challenge is the effective exchange and transfer of information to change and improve practice, taking evidence into practice.

Adaptation is an iterative process of deciding on and producing the changes needed to make guidelines suitable to the circumstances of a particular country or region. This can be through altering generic guidelines to a local context, taking local policies or practice into account and updating existing local guidelines and communication formats to highlight new information practices. The WHO development process takes evidence, though randomized trials, case control studies, observational studies and expert opinion, and forms generic practice guidelines which can then be adapted to fit national or local policy taking the needs, resources and priorities of the country into account.

The expected outcomes of adaptation are that the guidelines become national guidelines, incorporating new guidance into existing national policy or guidelines and curricula; promoting local ownership and the commitment of key partners. The adaptation creates linkages between researchers, the scientific community, programme managers and service providers, thus reducing the gap between knowledge and actual practice, so that issues relating to funding, training, policy and programming are identified.

The steps involved in the adaptation process are: to introduce and orient, establish a guideline working group, collect essential background information, review the guideline and gain consensus on the changes, make changes in guidelines/policy, review the adapted version, and pilot testing and controlled implementation.

The key issues for a successful adaptation are that it should be based on evidence and built on existing data and tools. It should be carried out through consultation with all the key stakeholders. The adaptation should encourage end-users participation, be consistent with the guide and allow for flexibility. The ultimate goal is to produce a document that is locally owned and scientifically sound.

3.7 Introduction to family planning guidelines

Dr Carlos Huezo and Dr Nuriye Otali, WHO headquarters

The guideline *Medical eligibility criteria for contraceptive use* is important for improving access to quality of care in family planning by reviewing the medical eligibility criteria for selecting methods of contraception. It updates the second edition of *Improving access to quality care in family planning: medical eligibility criteria for contraceptive use*, published in 2000.

The book summarizes the main recommendations of an expert Working Group meeting in October 2003 that brought together 36 participants from 18 countries including representatives of many agencies and organizations. The document provides guidance to national family planning/reproductive health programmes in the preparation of guidelines for service delivery of contraceptives and should be seen as a reference.

Family planning methods used in the document are:

- low-dose combined oral contraceptives
- combined injectable contraceptives

- combined patch
- combined vaginal ring
- progestogen-only pills
- depot medroxyprogesterone acetate
- norethisterone enantate
- levonorgestrel and etonogestrel implants
- emergency contraceptive pills
- copper intrauterine devices
- levonorgestrel-releasing intrauterine devices
- copper intrauterine devices for emergency contraception
- barrier methods
- fertility awareness-based methods
- lactational amenorrhoea method
- coitus interruptus
- female and male sterilization.

The guidelines provide a basis for rationalizing the provision of various contraceptives in view of the most up-to-date information available on safety of the methods for people with certain health conditions. It is expected that national programmes will use these guidelines for updating or developing their own contraceptive eligibility guidelines.

The document *Selected practice recommendations for contraceptive use* provides guidance on how to use contraceptive methods safely once they are deemed to be medically appropriate. The recommendations contained in the document are the product of a process that culminated in an expert Working Group meeting held in April 2004 which brought together 29 participants including 10 agency representatives from 15 countries to make selected practice recommendations for contraceptive use.

The goal of the guidelines is to provide policy and decision-makers and the scientific community with a set of recommendations that can be used for developing or revising national guidelines on selected practice recommendations for contraceptive use. It addresses ongoing controversies and inconsistencies regarding how to maximize the effectiveness of contraceptive methods and how to manage their side effects or other problems during use.

3.8 WHO reproductive health global strategy

Dr Heli Bathija, WHO headquarters

In 1974, the World Population Conference was held in Budapest. Ten years later in Mexico, the International Conference of Population took place and still more recently in 1994, in Cairo, there was the International Conference on Population and Development (ICPD). These conferences reaffirm the role of the WHO with respect to advocacy, normative functions, research and technical cooperation in the area of reproductive health. The ICPD Programme of Action stated that 'All countries should strive to make accessible through primary health care systems reproductive health [services] to all individuals of appropriate ages as soon as possible and no later than 2015'.

This has led to internalization of the concept in some countries, new policies and programmes, new partnerships formed and new evidence collected. However it has meant sometimes patchy implementation of holistic and integrated programmes, an uncoordinated and fragmented approach by multiple players, failure to scale up from projects to sustainable programmes, weak health systems, relative neglect by new development instruments, "competition" from other issues, and the politicization of reproductive health and reproductive rights.

Consequently, although there has been some improvement in the use of contraception and in infant deaths there is little evidence of improvement in the area of maternal and neonatal deaths, sexually transmitted infections, HIV/AIDS and unsafe

abortion. Reproductive ill health as a proportion of global burden of disease shows no sign of declining and children in poor households still stand a high chance of death before the age of one.

The Millennium Development Goals were a compact between nations to end human poverty. The eight Millennium Development Goals are rooted in the Millennium Declaration adopted by 189 countries at the 2000 United Nations Millennium Summit. Three of the goals are immediately related to reproductive health:

- reduce child mortality;
- improve maternal health;
- combat HIV/AIDS, malaria and other diseases.

The World Health Assembly Resolution WHA 55.19, on WHO's contribution to achievement of the development goals, recognized that 'maternal health and adolescent health and development have a major impact on socioeconomic development'.

4. Country presentations

4.1 Afghanistan

Dr Mehrafzoon Mehr Nesaar

The population of Afghanistan is approximately 22.2 million, of whom 5.1 million are women of childbearing age (aged 15 to 49 years) and about 4.4 million are below the age of five. There is a low literacy rate of 43% for males and 14% for females, and a lack of female health care providers.

The maternal mortality ratio in Afghanistan is 1600 to 100 000 live births, the infant mortality rate is 165 to 1000 live births and the under five mortality rate is 257 to 1000. The total fertility rate is 6.3. Skilled birth attendants attend 5% of deliveries, over 90% of all births take place at home, about 15% receive antenatal coverage of one visit and contraceptive prevalence rate is 2%.

Of maternal deaths, 78% are determined to be preventable. The main causes of maternal deaths are haemorrhage (ante and postpartum), obstructed labour, pregnancy induced hypertension and puerperal sepsis. Newborn deaths are caused by birth asphyxia, birth injuries, septicaemia and neonatal tetanus.

The Women's and Reproductive Health Department was established in the Ministry of Public Health in 2003 and maternal and child health is now the top priority of the Ministry of Public Health. A reproductive health task force has been assigned to coordinate among reproductive health stakeholders, develop strategy, guidelines and protocols, and ensure their use. The national reproductive health strategy aims to promote safe motherhood through emergency obstetric care, skilled attendance at birth and effective

antenatal care. Family planning is also promoted to improve women's health and reduce maternal risk through meeting the previously unmet needs for family planning and increasing access to quality family planning services for men and women.

The reproductive health guidelines and standards include antenatal care, delivery and emergency obstetric care, postpartum care, family planning and contraceptive logistics.

The IMPAC manual *Managing complications in pregnancy and childbirth* has already been adopted and endorsed by the Ministry of Public Health as a guideline and training tool, and the curricula for the midwifery and for the obstetrics and gynaecology departments at the university were developed using it. In-service training of doctors and midwives also uses the manual.

There are many challenges to be faced, with insecurity and instability in many places, as well as inaccessibility of remote and rural areas that cannot be reached with high quality services, inadequate funding and the need to develop adequate and capable national staff for the provision of reproductive health services and for leadership and management in reproductive health.

4.2 Egypt

Dr Salwa Farrag

Egypt has made significant progress in recent years in improving the health and well-being of its population; life expectancy has risen and infant mortality has fallen. The Ministry of Health and Population has adopted safe motherhood strategies to provide maternal health care services during pregnancy, labour and postpartum periods as well as neonatal health care services and family planning as part of these integrated strategies.

The main goals of the safe motherhood strategies are to reduce maternal mortality and morbidity, and to reduce neonatal and infant mortality rates. This is being achieved by providing integrated quality health care services for mothers and children, raising public awareness and mobilization to access and utilize services, and through developing and supporting the health care management system for better maternal and child health care services.

The family planning programme in Egypt is clinic based through physicians to ensure quality services and minimize side effects. All citizens have the right of access to family planning methods from any source and at any age, although sterilization is only allowed when medically indicated.

Services are provided through primary health care facilities and general and district hospitals with the aim of reducing maternal and newborn morbidity; most of the services are free of charge.

The health care package covers:

- antenatal, natal and postnatal care;
- neonatal care and resuscitation;
- early detection of handicaps;
- family planning and reproductive health services;
- pre-school health care services (immunization, integrated management of childhood illness, growth monitoring, etc);
- maternal mortality surveillance system;
- support and enhancement of micronutrient programmes and breastfeeding;
- health information system (health cards and records and network;
- quality assurance and standards.

The family planning methods currently available to clients are combined oral pills and progesterone only pills, IUDs,

injectables, male condoms and subdermal implant.

Since 1993, a number of research studies have taken place to determine the ratio of maternal mortality in the country and the percentage of low birth-weight babies. Indicators show that the maternal mortality rate has improved from 174:100 000 live births in 1993 to 68:100 000 live births in 2003. Since 1997, the infant mortality rate has dropped from 26.9:1000 live births to 23.7:1000 live births in 2003 and the under five mortality has decreased from 36.7:1000 live births in 1997 to 30.2:1000 live births in 2003. There has been an increase in antenatal coverage from 52% in 1997 to 70.5% in 2003 and the increase in deliveries conducted by trained health teams (physician/nurse) has increased from 54.7% in 1997 to 68.6% in 2003. Research is currently being conducted to examine the effect of changing the system from clinic-based to community-based distribution of family planning methods using outreach workers.

The renovation and equipping of health facilities has been taking place over the past few years and the following has been achieved:

- 354 maternity units were established and equipped for normal deliveries within primary health clinics;
- obstetric/gynaecology departments were renovated and equipped in 66 general government hospitals;
- neonatal care centres were renovated and equipped in 127 general and district government hospitals with a total of 1500 incubators;
- health information system (HIS) centres in all directorates in the 27 governorates and 240 districts were established and equipped;
- 1500 primary health care units and centres were equipped with the basic equipment required for the maternal and child health care package;

- primary health care laboratories were upgraded and equipped with all basic instruments to conduct the maternity and child health service package;

- 121 cars were disseminated to all the governorates and some districts to assist the supervisory team services.

Capacity building is ongoing with the development of training protocols and guidelines for safe motherhood services as well as national and international training courses.

Strong support and enhancement of the referral system in the management and control of high-risk cases has been implemented to ensure that health providers are trained on detecting the early signs of high risk cases and conducting appropriate steps to save the lives involved according to protocols of comprehensive essential obstetric care and basic essential obstetric care. There has been cooperation with the curative sector to upgrade and renovate obstetric/gynaecology and neonatal departments to enable them to manage the cases and 143 ambulances, connected to a network, have been provided to act as fast and effective transportation, especially in isolated or remote villages. There is also provision of referral records and formats for registration and follow-up in the primary health care and hospital facilities based on the referral system in health districts.

Mobilizing the community through improving awareness and participation has played a large role in the positive changes that have been accomplished. This has been done through media messages, workshops, campaigns, political reinforcement and advocacy, health education, the cooperation of nongovernmental organizations and through the home visit activities of mobile teams.

There are still enormous challenges to be faced with the desired targets for 2010 of a maternal mortality rate down to 50:100 000 live births and neonatal mortality rate of 12:1000 live births. The skills of health teams, especially obstetric and gynaecology specialists, need to be upgraded to handle high-risk cases and expand the application of protocols by trained

health teams. Trained nurses to deliver normal deliveries at each centre or primary health care centre are also needed. It is necessary to apply infection control technical protocols for the Ministry of Health and Population and quality assurance standards and procedures to ensure service at even the most remote and isolated areas. Community awareness in identifying high-risk cases and strengthening the referral system still further is also necessary.

4.3 Iraq

Dr Naira Al Awqati

The maternal mortality ratio is 294:100 000, the proportion of deaths attributed to maternal cases in women of childbearing age is 31%, and 37.8% of pregnancies are at risk. Of all live births, 23.1% are of low birth weight. The under five mortality rate is 130.6:1000 live births and the infant mortality rate is 107.9:1000 live births, while the neonatal mortality rate is 67:1000 live births. Fifty-five per cent (55%) of all deliveries take place at hospitals, 18% are attended by traditional birth attendants and 27% by licensed endogenous midwives. Caesarean section rates are high in most governorates. In 2002, the Caesarian section rate for public hospitals was 30%–50% of all births compared to the more acceptable standard of 5%–10% in most countries. In private hospitals this rate is even higher due to the financial incentives provided for surgical interventions.

The programmes implemented at the national level are:

- maternal and child health programme;
- breast feeding;
- acute respiratory infection and care of diarrhoeal diseases;
- development of medical education;
- neonatal care screening; prevention of violence and injuries;
- integrated management of childhood illnesses;

- emergency obstetric care;
- maternal mortality surveillance.

The causes of maternal deaths in hospitals in Iraq are:

- bleeding (46.4%);
- acute pulmonary embolism (9.9%);
- hypertension (8.3%);
- abortion (5.7%);
- sudden death (7.15%);
- irreversible shock (2.75%);
- respiratory, kidney or hepatic failure (2.65%);
- amniotic fluid embolism (1.6%);
- unknown (13.9%).

A number of surveys and studies have been carried out recently in various areas of health care: emergency and essential obstetric care, newborn health care, a multiple indicators survey, youth knowledge, practices and attitudes survey in family planning and reproductive health as well as maternal deaths surveillance. The quality of services provided for women and children at the primary health care level has been investigated to find out what users think of the service.

Family planning services are provided mainly through hospital outlets (67%), but also through primary health care centres (20%) and public clinics (13%). The most frequently utilized methods are oral contraceptive pills (89%), intrauterine devices (2.8%) and depo-provera (1.9%). Antenatal care is provided to pregnant women at the primary health care centres. The aim is to achieve at least five visits during pregnancy. During these visits, a complete history, physical examination, and results of routine investigations are written down in the mother's file. The mother is provided with ferrous sulfate and folic acid, tablets, and if not previously vaccinated, two doses of tetanus toxoid.

In collaboration with WHO/UNICEF/UNFPA and supported by the European Commission, a national strategy on maternal, neonatal, and child mortality reduction was prepared by the Ministry of Health for 2004 to 2008.

The areas for future interventions are:

- newborn, infant and child health;
- adolescent health;
- maternal health;
- women's health;
- maternal and child nutrition;
- communicable diseases of children and women including sexually transmitted diseases, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS and reproductive tract infections;
- psychological development and mental health;
- safety and prevention of injuries and violence;
- education and human resource development;
- legislation and policy development.

4.4 Morocco

Dr Abdelwahab Zerrari

There are approximately 8 400 000 women of childbearing age in Morocco and 818 000 infants below the age of one. Maternal mortality is high and the direct causes are haemorrhage (50%), pregnancy-induced hypertension and eclampsia (25%), puerperal infection (10%), and prolonged and obstructed labour (5%). For the final 10%, the exact causes are unknown.

The main factors affecting safe motherhood are unregulated fertility in rural areas, lack of education and knowledge regarding danger signs, cultural practices and religious beliefs, the poor status of women, poor service delivery quality and

means of communication, and road quality. The high percentage of infant and under-five mortality is due to acute neonatal distress, prematurity and low birth rate, macrosomia, infections, other malformations and jaundice or blood incompatibility.

The maternal and neonatal mortality and morbidity reduction policy approach is through improving family planning methods, increasing antenatal visits, promotion of assisted deliveries, better emergency obstetric care management, the introduction of postnatal visits and maternal and neonatal information, education and communication activities. Other means of reduction is through audit implementation, consensus conferences, clinical supervision, and health information and monitoring system improvement.

The strategies and activities being conducted are family planning with counselling, the distribution of pills, IUD insertion and tube legation, antenatal care with clinical assessment, biological examinations and ultrasound investigation in some health centres (four contacts per normal pregnancy). There are assisted deliveries in hospitals and in rural maternity circumstances, and emergency obstetric care at all levels. The postpartum care is through clinical examination for mother and child (three visits), immunization, vitamin A supplementation for the mother and health education (breastfeeding and family planning). Maternal and neonatal services are available during opening hours in rural and urban centres, maternity homes and departments in hospitals. The services are integrated and HIV testing is done in some centres. Services are mainly financed through the government budget, UNFPA, UNICEF, WHO, World Bank, USAID, European Community (EC), Gesellschaft für Technische Zusammenarbeit (GTZ), Japan International Cooperation Agency JICA, Belgium Cooperation, Spanish Cooperation and French Cooperation.

Communication strategies carried out are targeting women of childbearing age, traditional birth attendants and health personnel. The goals are to sensitize them to recognition of danger signs using support from pamphlets, brochures,

television and audio spots, and theatrical excerpts.

The capacity building activities being carried out are:

- in and out service training on maternal and neonatal care standards;
- training on performing obstetrical information support and on monitoring systems;
- implementation of clinical audits;
- clinical assisted supervision;
- organization of consensus conferences (haemorrhage, eclampsia, infection, obstructed labour);
- clinical standards brought in line with the IMPAC guidelines.

4.5 Pakistan

Dr Zahid Larik

The situation in Pakistan is challenging, with high maternal mortality of 340 to 400 deaths per 100 000 live births. One woman in every 38 dies from pregnancy-related causes and 80% of maternal deaths are direct obstetric deaths resulting from haemorrhage (36%), antepartum haemorrhage (17%), infection (16%), eclampsia (14%) and abortion (11%). This has a lamentable effect on infant mortality. An estimated 400 000 infant deaths and 16 500 maternal deaths occur annually in Pakistan, 45% of under five mortality occurs during the first month of life. Forty percent of women in Pakistan are anaemic, the neonatal tetanus mortality, recorded some years ago, was 4.17:1000 live births, low birth weight babies are estimated at over 25% and infant mortality is 77.1:1000 live births.

There are nutritional deficiencies, with pregnant women receiving only 87% of the recommended calories, and lactating women receiving only 74%, while the protein intake for these women is around 85% of the recommended levels.

In Pakistan, 16% of the total burden of disease is associated with pregnancy-related conditions. Ministries and departments of health and population welfare have come to realize the need for addressing the critical areas of reproductive health with a comprehensive approach. The National Reproductive Health Service Package (NRHSP) was developed as a joint collaboration between the Federal Ministry of Health, Ministry of Population Welfare (Federal and Provincial departments), nongovernmental organizations and nationally recognized professionals and experts, in 1999. The four priority areas are family planning services, maternal health care, including safe motherhood, infant healthcare, and prevention and management of reproductive tract infections, sexually transmitted diseases and HIV/AIDS.

A policy review of the health services shows that:

- the availability of lady health workers has increased since the 1990s but the availability of skilled birth attendants remains low;
- 78% of women deliver at home and 76% are not assisted by a skilled birth attendant;
- 60% of women receive antenatal care and 17% receive postnatal care;
- access, quality and utilization of basic obstetrical services is inadequate;
- availability and access to family planning services has been enhanced through the family planning programme, lady health workers and social marketing;
- 50% of women desire no more births;
- tetanus toxoid coverage for pregnant women is 66% and child immunization coverage for children is 57%.

Clearly the challenges are vast but there are several major health initiatives having an effect. The Federal Ministry of Health initiatives include a national programme for family planning and maternal health care, a women's health project, a nutrition project, a reproductive health project, maternal

neonatal tetanus (MNT) supplementary activities an enhanced HIV/AIDS control programme and a Federal Ministry of Health–UNFPA 7th Country Programme. There is also a community midwifery project and a maternal neonatal health project with the United Kingdom's Department for International Development (DFID) and USAID support in the pipeline.

4.6 Somalia

Dr Deq Said Jama

In Somalia the past years were marked by limited progress in reducing maternal mortality and morbidity and a slow down in the steady decline of childhood mortality under five. However the estimate of maternal mortality is 1600 per 100 000 live births and translates into the death of 45% every day, many of those who do not die from complications continue to live in misery with chronic anaemia, chronic infections and fistula.

Complications such as haemorrhage, prolonged labour and obstructed labour, infections and eclampsia are the major causes of death during childbirth. Anaemia and female genital mutilation also has a negative impact on maternal health, poor antenatal delivery and postnatal care, with an almost complete lack of emergency obstetric referral care for birth complications, further contribute to these high rates of mortality and disability.

The challenges facing Somalia are many:

- limited access to antenatal, delivery and postnatal care;
- a chronic lack of qualified health professionals in the country with an estimated doctor for every 50 000 people and 2 nurses per 100 000 people;
- low income levels for women means they cannot avoid adequate health care due to the high cost;

- lower priority is given to female health issues particularly pregnancy and the decision is in the hands of relatives and friends;

- poor nutrition of expectant and lactating mothers;

- majority of pregnant women tend to have antenatal visits only in the later stages of their pregnancy (urban) even though visits during the first months of pregnancy are just as critical to both child and maternal health;

- high fertility rates amongst Somali women;

- antenatal visits during pregnancy is not as good as expected (in the urban areas) and maternal and child health care might not be available in rural areas.

Furthermore, most childbirth takes place without adequate medical facilities since about 88% of childbirth takes place at home. The vast majority of childbirth take place with the help of family members and some traditional birth attendants, this is common in rural and nomadic and even in urban areas, assistance by nurse and midwives is more concentrated in urban areas. The assistance of doctors is confined to towns.

4.7 Sudan

Dr Iqbal A Basheer

Sudan has a surface area of 2.5 million km^2, links the Arab world with sub-Saharan Africa and shares its borders with nine other countries, with free movement across most of these borders. There is massive population movement and displacement and the country is suffering from civil conflict, as well as the effects of drought, desertification and floods. The country has ethnic and cultural diversity, and is poor and highly indebted, with widespread poverty and a highly skewed income distribution.

The perinatal mortality ratio is 31:1000 live births, which constitutes about 50% of the infant mortality ratio of 68:1000 live births. The maternal mortality ratio is 509:100 000 live births with subnational disparities. The antenatal coverage is 71%, with one visit by either a physician or village midwife; 49% have the standard five or more visits. Of all deliveries, 86% take place at home and approximately 56% are attended by nurse-midwives, village midwives, assistant health visitors and health visitors. The prevalence of HIV/AIDS in 2002 in the country was 1.6%.

In 2001, the Federal State Ministers of Sudan declared making pregnancy safer to be a main initiative to promote and protect the health of mothers and children, and to contribute to the reduction of suffering that is attributable to pregnancy and its management and consequences.

The adopted strategies include the improvement of the health system to include the provision of basic and emergency obstetric and neonatal equipment and supplies, and strengthening the malaria indicator survey. The improvement of health workers' performance is a priority through basic and in-service training of all health workers involved in safe motherhood. Community involvement at all levels is taking place through provision and dissemination of messages for the public and strengthening partnerships with others working in safe maternal health and reproductive health in particular.

A comprehensive national policy document on reproductive health, focusing on safe motherhood as its priority and including making pregnancy safer, is at its final stages and will be endorsed and signed in February 2005.

Service provision is at three levels: community, health clinics and hospitals. The integration of maternal neonatal health services means that antenatal care, family planning, childbirth, and HIV testing and treatment, and malaria treatment and prevention are included.

There is partnership and capacity building with a reproductive health steering committee and a substantial

increase in the number of trained care providers in emergency obstetric care (doctors), family planning (doctors and health visitors), management of standard obstetric care (health visitors, assistant health visitors and village midwives) and a post abortion care package using maternal village assistants and including training on family planning counselling. Guidelines have been developed to include standard obstetric care, emergency obstetric care, and the development of human resources, mainly midwifery training and management.

The constraints are a weak health system (management, infrastructure and human resources for health), a large country with widely scattered population settings together with limited resources, and natural and man-made emergencies.

The challenges are the strengthening of health systems to provide comprehensive quality maternal and neonatal health services focusing on emergency obstetric care, human resource development with the focus on midwifery training and management, and increasing community response to support maternal neonatal health.

4.8 Syrian Arab Republic

Dr Reem Dahman

In Syria, health services are provided through both the public and private sector. The number of health centres at the end of 2003 was 1440, of which 1254 provided reproductive health services. There were 35 maternity homes by the end of 2003. Delivery services are provided at all public hospitals throughout the country and all the services provided at health centres are free of charge.

Primary health care, being comprehensive and cost effective, forms the main framework of the Ministry of Health's strategy for providing health for all. Reproductive health became a main programme in primary health care according to the recommendations of ICPD. A special reproductive health strategy was prepared in 2002 including safe motherhood

(antenatal care, safe delivery and postnatal care) and family planning.

The reproductive health components are: safe motherhood; family planning; prevention and management of sexually transmitted disease; early detection of cervical and breast cancer; pre-marital services; care during menopause; adolescent and youth care; and counselling.

The antenatal care programme includes four visits with clinical and laboratory examinations. The antenatal care coverage is 70.9% (with five visits or more). The reasons given for not seeking antenatal care are that there were no problems involved (77%), previous experience (13%), and that the service was either not available or expensive (10%). Another reason noted was that the husband or pregnant woman was too busy to attend antenatal care.

The maternal mortality ratio is 65.4:100 000 and the Ministry of Health is presently conducting a study to determine the main causes of maternal deaths in the country. The infant mortality rate was recorded as 18.2:1000 in 2001. The main causes of neonatal deaths are injuries during the birth, prematurity, congenital abnormalities, septicaemia and neonatal tetanus. Childbirth with skilled attendants was 86.5% for the year 2000, and the Caesarean section rate was 15% (2001).

The main challenges facing the Syrian Arabic Republic are the quick turnover of trained staff and the consequent inadequate distribution of human resources, different social and cultural backgrounds effecting the utilization of services, a lack of legislation to enable staff within the local community, and difficulty in cooperation and coordination between sectors providing services.

4.9 Yemen

Dr Nagiba A. Abdulghani

In Yemen, the maternal mortality rate is 365:100 000 live births. Of these, 9.4% die on the way to hospital and 23.7% in health facilities. Of those dying in the health facilities, 19.7% die in public and 4% in privately-owned facilities; the huge disparity in this figure is because private health centres send the patient to a public facility if they realize the case will end in death.

The causes of maternal mortality in Yemen are antepartum and postpartum haemorrhage, eclampsia, obstructed labour, puerperal sepsis, illegal abortion, malaria and heart diseases. The neonatal mortality ratio in Yemen is 365:100 000 live births, which is 40% of the infant mortality ratio. The causes are birth asphyxia and trauma, septicaemia and premature birth.

The coverage rate for institutional deliveries is 20%, postpartum coverage rate, within 42 days after delivery, is 13% and the Caesarean section rate is 3%. The antenatal care coverage rate of at least one antenatal visit stands at approximately 45% with an average of 3.2 visits. Only about 25% of births take place with a skilled birth attendant, either a doctor, midwife or primary health care worker.

The strategies towards improved maternal health in Yemen are threefold: to avoid unwanted pregnancy through family planning; to avoid complications through antenatal care; and to manage complications through emergency obstetric care.

5. Discussions and conclusions

There was group work and discussion throughout the workshop allowing an exchange of information and advice between participants. Participants expressed their views on the guidelines, their usability and how they might be appropriated by health care programmes.

Group work was carried out on the practical use of the guidelines in turn, using a series of case histories. The participants were divided into random groups with a chairperson and facilitator, and a list of case histories for which they had to make recommendations negotiating the guidelines in order to do so. Each case was discussed thoroughly within the group. This method was very effective because during the course of the group work the participants began to understand how the guidelines should be used, what problems might be associated with the physical layout of the manuals (which they voiced after each session during discussion), whether they agreed or disagreed with the evidence-based recommendation supplied (also voiced during comparison of results during the discussion sessions that followed each session of group work), of what use the guidelines would be within their health care programmes and what they anticipated would need to be removed or adapted for their countries to appropriate the guidelines.

Particularly useful were the discussion sessions that followed each piece of group work. It was found that the conclusions or recommendations reached almost invariably tallied, which indicated clinical soundness.

During day four and five a second type of group work was carried out in order to direct the country teams towards assessing the situation within their countries, identifying the desired situation and the obstacles and challenges they would face in accomplishing it, and then developing and

documenting action plans to carry out on returning to their home countries.

During the fourth afternoon and the morning of the fifth day the action plans were presented and discussed at length. The participants were able to comment on each plan and make suggestions from their own experiences. This was felt to be particularly useful and led to a mutual decision that the countries should increase the amount of contact between them during the coming period after returning to their own countries so that they could continue to share information and experiences.

During plenary in the final session, the participants concluded by exploring the viability of providing logistical, financial and technical support towards the implementation of the action plans submitted and future steps. It was agreed that the completed national plans (see Annex 4) should be submitted to WHO Regional Office for the Eastern Mediterranean and UNFPA/CST Offices in Amman and Kathmandu no later than the February 28, 2005, in order to open dialogue between countries and the Region.

Once the plans are felt to be acceptable workable documents they will be forwarded to WHO headquarters no later than the middle of March 2005 to be reviewed by the Strategic Partnership Programme Focal Point and a final decision reached by May 2005 in order to provide the required support to ensure the momentum of the programme continues.

Furthermore, a country delegation is requested to approach local donors and other interested organizations which might also be able to provide resources. The group was reminded that the Arabic version of the guidelines should be available by May. It was also advised that the participants, benefiting from the experiences gained in the workshop should open and maintain communication by e-mail, networking among countries, sharing ideas and experience between themselves and WHO, UNFPA and other potential partners.

Annex 1

AGENDA

1. Inaugural session.
2. Welcome and opening remarks.
3. Introduction of participants, election of Chairperson and Rapporteur.
4. Adoption of the agenda.
5. Objectives, mechanics and expected outcomes of the workshop.
6. Overview of the Strategic Partnership Programme.
7. Country presentations of existing national programmes, strategies and approaches designated to promoting maternal health and family planning: Afghanistan, Egypt, Iraq, Morocco, Pakistan, Somalia, Sudan, Syrian Arab Republic and Yemen.
8. Overview of the latest WHO guidelines on making pregnancy safer and family planning: making pregnancy safer; the four cornerstones of evidence based guidance for family planning.
9. The need for evidence based guidelines: participatory exercise.
10. What is an adaptation process?
11. Introduction to making pregnancy safer (IMPAC) guidelines: *Pregnancy, childbirth, postpartum and newborn care: a guide to essential practice* (PCPNC); *Managing complications in pregnancy and childbirth* (MCPC); and *Managing newborn problems* (MNP).
12. Work in small groups on the use of IMPAC guidelines at the primary health care and first referral levels.
13. Group presentations and plenary discussion.
14. Introduction to family planning guidelines: *Medical eligibility criteria for contraceptive use; Selected practice recommendations for contraceptive use.*
15. Work in small groups on the use of the family planning guidelines

in the health services.

16. Group presentations and plenary discussion.
17. Highlight on the contents of the *Decision-making tool for family planning clients and providers.*
18. Work in small groups on the use of the *Decision-making tool for family planning clients and providers.*
19. Identifying activities for the implementation of evidence-based guidelines into current and future country plans.
20. Work in country groups on current and future country plans for the implementation of making pregnancy safer and family planning evidence-based guidelines.
21. Group presentations and plenary discussion.
22. Plenary discussion on backstopping needs and next steps.
23. Closing session.

Annex 2

PROGRAMME

Friday, 14 January 2005

8:30–9:00	Registration
9:00–10:30	Inaugural session
10:30–10:45	Introduction of participants Election of Chairpersons and Rapporteurs Adoption of the agenda
10:45–11:00	Objectives, mechanics and expected outcomes of the workshop/Dr Sameera Al-Tuwaijri
11:00–11:45	Overview of the Strategic Partnership Programme/Dr Michael Mbizvo
11:45–16:00	Country presentations of existing national programmes, strategies and approaches designated to promoting maternal health and family planning: Afghanistan Egypt Iraq Morocco Pakistan Somalia Sudan Syrian Arab Republic Yemen
16:00–17:30	Overview of latest WHO guidelines on making pregnancy safer and family planning: Making pregnancy safer/Dr Matthews Mathai; The Four Cornerstones of evidence based guidance for family planning/Dr Carlos Huezo

Saturday, 15 January 2005

8:30–8:45	Report of previous day's activities/Rapporteur
8:45–11:00	The need for evidence based guidelines–participatory exercise/Dr Carlos Huezo
11:00–14:00	What is an adaptation process?/Dr Rita Kabra
14:00–16:00	Introduction to making pregnancy safer (IMPAC) guidelines/Dr Matthews Mathai and Dr Rita Kabra

16:00–17:30	Work in small groups on the use of IMPAC guidelines at the primary health care and first referral levels
17:30–18:00	Display of making pregnancy safer and family planning guidelines, posters and leaflets

Sunday, 16 January 2005

8:30–8:45	Report of previous day's activities/Rapporteur
8:45–9:30	Group work (continued)
9:30–11:00	Group presentations and discussion
11:00–11:30	Introduction to family planning guidelines/ Dr Carlos Huezo and Dr Nuriye Ortali
11:30–13:00	Work in small groups on the use of the family planning guidelines in the health services
13:00–14:00	Group presentations and discussion
14:00–15:00	Reproductive health global strategy/Dr Heli Bathija
15:00–16:00	Highlight on the contents of the *Decision-making tool for family planning clients and providers*/Ms Kathryn Church, WHO/HQ
16:00–17:30	Work in small groups on the Decision-Making Tool for Family Planning Clients and Providers

Monday, 17 January 2005

8:30–8:45	Report of previous day's activities/Rapporteur
8:45–16:00	Country group work on identifying activities for the implementation of evidence-based guidelines into current and future country plans
16:00–17:30	Group presentations and discussion

Tuesday, 18 January 2005

8:30–8:45	Report of previous day's activities/Rapporteur
8:45–11:30	Plenary discussion on backstopping needs and next steps/Dr Heli Bathija and Dr Ramez Mahaini

Annex 3

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Dr Heli Bathija, Area Manager for African and Eastern Mediterranean Regions, WHO headquarters

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Ms Kathryn Church, Technical Officer, Promoting Family Planning, WHO headquarters

Dr Nuriye Ortayli, Medical Officer, Promoting Family Planning, WHO headquarters

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Annex 4

COUNTRY PLANS OF ACTION FOR IMPLEMENTATION OF EVIDENCE-BASED GUIDELINES

Action plan: Afghanistan

Activity	Responsibility		Time-frame	Resources	TA needed
	Lead	Support			
Advocacy and orientation meetings with the policy-makers (MOPH–central and provincial–and relevant key Ministries), planners, programme managers, health care providers, UN agencies, donors, NGOs and other stakeholders	MOPH/WHO	UNFPA	March 2005		WHO/HQ WHO/EMRO UNFPA
Orientation workshop for the above stakeholders to introduce the making pregnancy safer initiative and related evidence-based guidelines	MOPH/WHO/UNFPA	UNICEF USAID/REACH	April 2005		WHO/HQ WHO/EMRO UNFPA
Translation of the guidelines into local language to facilitate the adaptation process	MOPH/WHO/UNFPA	UNICEF USAID/REACH	March–April 2005		
Establishment of an IMPAC/PCPNC committee under the RH task force of WRH Department/MOPH introduce and implement IMPAC-PCPNC in the country	MOPH/W MOPH/WHO/UNFPA HO/UNFPA	UNICEF USAID/REACH JICA NGOs	March 2005		

Activity	Responsibility		Time-frame	Resources	TA needed
	Lead	Support			
Formation of two subgroups under the committee: Adaptation working group Implementation working group					
Coordinator/Focal point will be assigned	MOPH/WHO	UNFPA UNICEF USAID/REACH JICA Others	March 2005		WHO/HQ WHO/EMRO UNFPA
Adaptation process	MOPH/WHO/UNFPA		March–June 2005		WHO/HQ WHO/EMRO UNFPA
Translation of the revised adapted guidelines	MOPH/WHO/UNFPA	UNICEF	July 2005		
Printing and distribution of enough copies of the guidelines to national stakeholders	MOPH/WHO/UNFPA	UNICEF JICA USAID/REACH	August 2005		
Training of Trainers on the guidelines	MOPH/WHO	UNFPA USAID/REACH JICA	August 2005		
Training of managers and health care providers initially from three main provinces that are already providing services (including provision of supplies and equipment)	MOPH/WHO	UNFPA USAID/REACH JICA	September–December 2005		
Supervision and monitoring of the training and service provision	MOPH/WHO/UNFPA	UNICEF USAID/REACH JICA	September 2005		
	MOPH/WHO/UNFPA	UNICEF	January–December		

Activity	Responsibility		Time-frame	Resources	TA needed
	Lead	*Support*			
Expansion to other provinces	MOPH/WHO/UNFPA	USAID/REACH JICA UNICEF	2006 March–June 2005		
Review, update and revise the existing IEC materials to be in consistency with the MPS guidelines	MOPH/WHO/UNFPA	USAID/REACH JICA UNICEF USAID/REACH JICA	July-August 2005		
Printing and distribution of IEC materials, job aids, posters and brochures	MOPH/WHO/UNFPA	UNICEF USAID/REACH JICA	September 2005		
Dissemination of the messages to the community through clinics, community health workers, TV, radio, mass media, etc.	MOPH/WHO/UNFPA	UNICEF USAID/REACH JICA	September 2005		
Involvement of the community in the planning process.					

Action plan: Egypt

Activity	Responsibility		Time-frame	Resources	TA needed
	Lead	Support			
Formulation of national committee.	Head of family planning and population sector Ministry of Health and Population				
Identification of gap between current standard operating procedures and WHO guidelines through meetings	Head of family planning and population sector	National committee	3 months	WHO	Consultant from WHO to participate in national committee
Preparation of updated guidelines disseminated	National committee	Family planning and population sector staff	3 months	Ministry of Health and Population	
Orientation seminar for key persons and supervisors	Family planning and population sector	National committee	2 months	Ministry of Health and Population + WHO	WHO consultant to follow up on implementation
Step down training to governorates and districts up to service providers	Family planning and population sector		3 months	WHO and donors	

Action plan: Iraq

Activities	Responsibility		Resources	Time-frame	TA needed
	Lead	Support			
Workshop for policy and decision-makers to introduce the guidelines	Ministry of Health	WHO, UNFPA and other partners	Provision of guidelines	June 2005	To facilitate workshop
Distribute the guidelines Advocacy workshop(s)	Ministry of Health	WHO, UNFPA and other partners	Financial support Logistical support	June 2005	
Provision of the guidelines	Ministry of Health WHO and UNFPA	WHO, UNFPA and other partners	Financial support Logistical support	April 2005	
Workshop(s) to adapt WHO guidelines and produce national guidelines	Ministry of Health WHO and UNFPA	WHO, UNFPA and other partners	Financial support Logistical support	August 2005	To facilitate workshop
Assessment of the already existing reproductive health and family planning indicators	Ministry of Health WHO and UNFPA	WHO, UNFPA and other partners	Financial support Logistical Support	June 2005	
Pilot implementation of the guidelines	Ministry of Health	WHO, UNFPA and other partners	Financial support Logistical Support	October 2005	
Updating the existing national monitoring and evaluation tools Workshop for the above Printing and distribution of the new tools	Ministry of Health	WHO, UNFPA and other partners	Financial support Logistical support	September–November 2005	To facilitate workshop
Workshops to involve the academic sector in the process of adaptation, implementation, monitoring and evaluation of the guidelines	Ministry of Health Ministry of Higher Education, WHO and UNFPA	WHO, UNFPA and other partners	Financial support Logistical support	April 2005	To facilitate workshop
Orientation, workshops and training courses for	Ministry of Health	WHO, UNFPA and other	Financial support Logistical	September 2005	

professionals on the guidelines		partners	support		
Distribution of special forms of the guidelines to women's groups and organizations through workshops and training courses	Ministry of Health and Ministry of social affairs, Ministry on nongovernmental organizations, Ministry of Women	Financial support Logistical support	Technical assistance needed to facilitate workshop	October 2005	Financial support Logistical support
Mobile clinics in remote areas Financial incentives for work in remote areas	Ministry of Health	Financial support Logistical support	Technical assistance needed to facilitate workshop	December 2005	Financial support Logistical support

Action plan: Morocco

Activity	Responsibility		Time-frame	Resources	TA needed
	Lead	Support			
Analysis of national situation with respect to national guidelines and training	Population Directorate	WHO UNFPA	February 2005		WHO UNFPA
Produce enough copies in French	WHO	WHO UNFPA	April–May 2005		WHO UNFPA
Organize a first report meeting with all actors involved with MNH (National MN Health, university committees, institutions, nursing schools, politicians, policy makers, NGOs, international agencies etc.) with WHO TA	Population Directorate	WHO UNFPA	June 2005		WHO UNFPA
Have a national technical committee that will look in depth at the guidelines and see the gap between national standards and WHO standards.	Population Directorate, University, Nursing Institutions, Public health institutions	WHO UNFPA	June 2005		WHO UNFPA
Organize a second meeting to endorse the WHO guidelines, have the desired commitment and secure funding.	Population Directorate, University, Nursing institutions, Public health institutions		October 2005		
Set up a plan of action in which the objectives will be mentioned and the activities will be described and developed.	Population Directorate	WHO UNFPA	November 2005		WHO UNFPA
Start the adaptation of the manuals. Identify the trainers in order to start the training.	Population Directorate	WHO UNFPA	November December 2005		WHO UNFPA
Have the first training session (TOT) to test the guidelines, to identify and correct the gaps, and to master the methodology of training.	Population Directorate	WHO UNFPA	January 2006		WHO UNFPA

After that we can validate officially the new national guidelines and begin the duplication of the materials.	Population Directorate	WHO UNFPA	March 2006		WHO UNFPA
Start the training.	Ministry of Health University	WHO UNFPA UNICEF	April 2006		WHO UNFPA UNICEF
Monitoring and evaluation	Ministry of Health, University, Public health institutions	WHO UNFPA UNICEF	June 2006		WHO UNFPA UNICEF

Action plan: Pakistan

Activity	Responsibility		Timeframe	Resources	TA needed
	Lead	Support			
Specific training/awareness programmes for national, provincial, regional and local levels Formation of national steering committee including politicians	National Commission for Human Development Sustainable Development Programme Ministry of Health	Ministry of Health Ministry of Health Department of Health District government	Material prepared 1 year implementation 1 year 3–6 months	Additional resources required Within existing resources	Local health promotion experts needed
Formation of an expert committee to review the curriculum	Ministry of Health	WHO, UNFPA, UNICEF, USAID, Other partners	6–8 months	Additional resources required	Full-time international technical officer and 5 national officers (4 provinces, 1 federal)
Put CMH report at the federal level for the awareness of policy-makers/advocacy Rationalization of private sector expenditure Integration of vertical programmes	Ministry of Health	Deptartment of Health Ministry of information NCHD PRSP Government partners	Ongoing Ongoing Under progress	Within existing Additional Additional required	Not needed International and local consultant for commissioning of the study International consultant
Inclusion of all the regulatory bodies in the national steering committee Capacity building of human resources in the country: new courses in reproductive health In-service training of staff	National Commission for Human Development Sustainable Development Programme Ministry of Health	Ministry of Health Department of Health and district government Ministry of Higher	Material prepared 1 year Implementation 1 year 3–6 months New courses in reproductive health 2 years In service planning 1 year	Additional resources required Within existing resources Additional resources	Local health promotion experts needed Training with reputable universities National officer for HR development International master trainer

		Education and UGC		required	
Putting it at the agenda of Islamic Ideology Council Development of a training package for all school of thoughts	Ministry of Health	Ministry of Religious Affairs	6–9 months 2 years	Additional resources required	International consultant
Provincialization of the Ministry of Population Planning	WHO, World Bank UNFPA UNICEF USAID	Department of Health	Required policy directions	Additional resources required	5 programme officers

Action plan: Somalia

Activity	Responsibility		Time-frame	Resources	TA needed
	Lead	Support			
Preparatory advocacy informal meeting to feedback on this workshop with Ministry of Health in Hargeisa (advocacy) Ministry of Health and myself to meet with WHO, UNFPA and other partners in Hargeisa (advocacy) WHO must contact SACB to insert this programme into monthly agenda meeting (Somali Aid Coordination Body) Attend the SACB meeting in Nairobi (with assistance of WHO/EMRO/HQ and/or UNFPA/CST) to reach consensus on programme	Dr Deq	WHO, UNFPA	February–April 2005	Airfare to Nairobi (can an initial request for funds be made before full SPP proposal developed?)	WHO EMRO/WHO headquarters and/or UNFPA/CST
Develop monitoring and evaluation framework	WHO/EMRO and UNFPA/CST	Ministry of Health	February–March		WHO/EMRO and UNFPA/CST
Steering committee meeting for advocacy and planning at national level (Ministry of Health, health workers, nongovernmental organizations, UNICEF, UNFPA, WHO, other sstakeholders)	Ministry of Health	WHO/UNFPA/ SACB	April–May	US$ 10 000	Highly technical officers for advocacy (WHO EMRO, WHO headquarters UNFPA/CST)

Activity	Responsibility		Time-frame	Resources	TA needed
	Lead	Support			
(maximum 30) Arrange meeting with different representatives from all regions of Somalia (3 days) Determine which guides to use (MPS) Discuss recommendations and need for adaptation Plan implementation process					
Adapt guideline(s) through small technical working group	Consultant as lead, with small team (max 4)	SACB	June	US$ 5000	(WHO/EMRO/HQ, UNFPA/CST)
Translating the guideline(s) into Somali language Translation Production of copies	Consultant	WHO	June	US$ 8000 US$5000	Editing
Implementing training programmes Curriculum development: Meeting to compare existing guidance and discuss changes Print curriculum and disseminate Training of the trainers: Develop trainers of trainers programme around the adapted guidelines Hold training workshop (10 days minimum) pre-services	Ministry of Health training unit and reproductive health unit	WHO/UNFPA	May-June	15–20 people might need to be trained as trainers of trainers (all over Somalia)	Facilitators for trainers of trainers

Activity	Responsibility		Time-frame	Resources	TA needed
	Lead	Support			
training and in-services training Ensure pre-services training are updated with new curriculum Conduct in-services training using good centres (8 trainings in different regions)					

Action plan: Sudan

Activity	Responsibility		Time-frame	Resources	TA needed
	Lead	Support			
briefing and reporting to senior officials and policy maker at Federal Ministry of Health, SFPA, WHO and UNFPA	Federal Ministry of Health SFPA, WHO and UNFPA participants in the workshop		January 2005		
Introduction and orientation workshops for policy makers and managers	Federal Ministry of Health SFPA, WHO and UNFPA	Other related health sector and professionals	March	WHO, UNFPA country offices	WHO, UNFPA
Avail and distribute enough guidelines (200 copy from each)	Ministry of Health	WHO/	February	WHO	
Formulation of a national committee	Ministry of Health	WHO/UNFPA	February		
Formation of a national technical committee for adaptation and incorporation in national ones.	Federal Ministry of Health	WHO, UNFPA, IPPF Professional associations and institutions	March		
Working groups to review and adapt the Guidelines (for in service and pre service midwifery guidelines)	Ministry of Health	WHO, UNFPA, IPPF Professional associations and institutions	March-May	WHO/UNFPA and Ministry of Health	WHO/UNFPA/IPPF
2 days workshops for consensus building on adapted guidelines	Ministry of Health	WHO, UNFPA,IPPF Professional associations and institutions	June	WHO/UNFPA and Ministry of Health	WHO/UNFPA/IPPF
Field testing of the guidelines	Ministry of Health	WHO/UNFPA/ IPPF/Professional associations and institutions	July–September	WHO/UNFPA and Ministry of Health	
Adjustment of guidelines after testing	Federal Ministry of Health	WHO, UNFPA, IPPF Technical groups Professional associations and institutions	August		

Activity	Responsibility		Time-frame	Resources	TA needed
	Lead	Support			
Production of the adapted guideline	Federal Ministry of Health	WHO, UNFPA, IPPF	September	WHO, UNFPA, Ministry of Health	
Advocacy and dissemination of materials	Federal Ministry of Health	WHO, UNFPA, IPPF Professional associations and institutions	March–October	WHO, UNFPA, Ministry of Health	
Training of core trainers at central and State level	Federal Ministry of Health	WHO, UNFPA, IPPF	November–December	WHO, UNFPA, Ministry of Health	WHO/UNFPA/IPPF
Working group to review and adapt the Guidelines for Doctors pre service guidelines) MCPC/MNP	Ministry of Health	WHO, UNFPA, IPPF Professional associations and institutions	November–Early 2006	WHO, UNFPA, Ministry of Health	
Training of care providers	Federal Ministry of Health	WHO, UNFPA, IPPF	March 2006	WHO, UNFPA, Ministry of Health, IPPF	
Strengthening the health system to support the implementation	Federal Ministry of Health	WHO/UNFPA/ IPPF	March 2006	WHO, UNFPA, Ministry of Health, IPPF	
Monitoring and evaluation of the implementation	Federal Ministry of Health	WHO/UNFPA/ IPPF	Continuous	WHO, UNFPA, Ministry of Health, IPPF	

Action plan: Syrian Arab Republic

Activities	Responsibility		Time-frame	Resources	Technical assistance needed
	Lead	Support			
vidence-based advocacy by WHO/UNFPA CO. to policy makers	WHO/EMRO, UNFPA/CST	Ministry of Health Reproductive Health division IPPF, UNICEF	February 2005		WHO/EMRO UNFPA/CST
Reforming the current national technical committee toward adaptation of the guidelines with specific ToRs which should include socialization of the guidelines	Ministry of Health Reproductive Health division	Medical and Nursing School representatives	February 2005		
Writing and submitting the national proposal	Ministry of Health, Reproductive Health division	WHO, UNFPA/CST and CO.	March 2005		WHO/HQ, EMRO, UNFPA/HQ and CST
Introductory workshop to bring all the partners and potential key players including OBGYN professors in the Four Medical Schools and programme managers in Midwifery schools	Ministry of Health, Reproductive Health division	WHO/EMRO, UNFPA/CST, IPPF, UNICEF Technical committee	June 2005	Financial support WHO/UNFPA/IPPF	WHO/EMRO, UNFPA/CST, IPPF
Introductory workshop to Reproductive Health directors and the governorate levels (14	Ministry of Health Reproductive Health division	Technical committee	July 2005	Financial support WHO/UNFPA/IPPF	Country Co. WHO/UNFPA/UNICEF

governorates)					
Conduct training of trainers at the central level to train and supervise staff at the peripheral levels -trainers of trainers on counselling in reproductive health	Ministry of Health reproductive health division	EMRO, UNFPA/CST Technical committee		Financial support WHO, UNFPA, IPPF	WHO/EMRO, UNFPA/CST For introducing the guidelines and for counselling training
Design supervisory tools toward the implementation of the guidelines	Ministry of Health reproductive health division	MIS division at the PHC			Might be needed to review the competency-based assessment
To identify process, outputs and outcome indicators in relation to the implementation of the guidelines and to monitor progress in MH	Ministry of Health reproductive health division	MIS division at the PHC			WHO/EMRO UNFPA/CST

Action plan: Yemen

Activity	Responsibility		Time-frame	Resources	TA needed
	Lead	Support			
Report to Ministry of Health, WHO country office, and UNFPA	The team who attend Cairo meeting		2 weeks from today		
Call for a donor meeting	Ministers office	WHO	Within 2 months	30 copies of the updated manuals	One WHO staff from EMRO or headquarters
Form a national team for RH	Ministry of Health	WHO	Within 3 months	Secretary/facilitator (part time salary) Stationery	
Call for 1 day meeting for all director general in the governorates	Ministry of Health	WHO YFCA	After 6 months	Arabic copies of the guidelines US$ 5000	
Form a taskforce of national experts to do the adaptation and incorporation	Ministry of Health	WHO, Faculty of Medicine, Sana'a	Starting after 3 months from now, ending after another 3 months	US$ 30 000 ($3000 for each expert) Secretary/typing stationery around US$ 10 000	
Call for 1 day meeting of the faculty of medicine staff	Ministry of Health	WHO	Early 2006	US$ 5000	
Incorporate the updated national guidelines in the pre-in service training	Ministry of Health	WHO FOH/HMI	March 2006	Printing the national guidelines 100 000 copies or more	
Develop indicators for the supervision and update the supervision manuals and M/E	Ministry of Health	WHO	Within three months	Secretary/facilitator (part-time salary) Stationery	
Training on the indicators for the supervision manuals	Ministry of Health	Faculty of Medicine WHO	December 2005	US$ 10 000	WHO staff speaker