WHO-EM/WRH/052/E

WHO/UNFPA Strategic Partnership Programme

Report of a joint regional review meeting
Alexandria, Egypt, 15–16 March 2006

© World Health Organization 2006
All rights reserved.
The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.
The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.
The World Health Organization does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.
Publications of the World Health Organization can be obtained from Distribution and Sales, World Health Organization, Regional Office for the Eastern Mediterranean, PO Box 7608, Nasr City, Cairo 11371, Egypt (tel: +202 670 2535, fax: +202 670 2492; email: DSA@emro.who.int). Requests for permission to reproduce WHO EMRO publications, in part or in whole, or to translate them – whether for sale or for noncommercial distribution – should be addressed to the Regional Adviser, Health and Biomedical Information, at the above address (fax: +202 276 5400; email HBI@emro.who.int).

Cover design by Suhaib Al Asbahi
Printed by

Document WHO-EM/WRH/052/06.06/500

Contents

1. Introduction ... 1

2. Technical presentations ... 2
- 2.1 Strategic Partnership Programme in the Eastern Mediterranean Region ... 2
- 2.2 Taking evidence-based guidelines: Challenges in sexual and reproductive health globally ... 4
- 2.3 Evidence-based guidance in family planning and in maternal and neonatal health ... 6
- 2.4 Family planning guidelines: What's new? ... 8
- 2.5 Integrated management of pregnancy and childbirth ... 10
- 2.6 Extending service delivery: USAID Office of Population Global Project ... 11

3. Country presentations ... 12
- 3.1 The Strategic Partnership Programme in Afghanistan ... 12
- 3.2 The Strategic Partnership Programme in Egypt ... 15
- 3.3 The Strategic Partnership Programme in Morocco ... 16
- 3.4 Maternal health situation in Somalia ... 17
- 3.5 The Strategic Partnership Programme in Sudan ... 19
- 3.6 The need to adopt evidence-based protocols and guidelines in the Syrian Arab Republic ... 21

4. Group work ... 22
- 4.1 Group work 1 ... 22
- 4.2 Group work 2 ... 25

5. Future steps ... 29

Annexes
1. Agenda ... 31
2. Programme ... 32
3. List of participants ... 34
4. Country plans ... 37

1. Introduction

A joint UNFPA/WHO regional review meeting on the Strategic Partnership Programme was held in Alexandria, Egypt, on 15 and 16 March, 2006. The meeting was attended by national reproductive health programme managers and representatives from ministries of health, the United Nations Population Fund (UNFPA), the Population Council, and the World Health Organization headquarters, Regional Office for the Eastern Mediterranean and country offices. The objectives of the review meeting were to:

- familiarize regional and national counterparts with progress made in the implementation of the Strategic Partnership Programme in countries of the Region;
- examine the difficulties and constraints that were encountered in the implementation of the Strategic Partnership Programme in countries and suggest solutions to overcome identified difficulties;
- discuss and identify technical backstopping needs of participating countries; and
- develop a framework for action to further support the implementation of UNFPA/WHO Strategic Partnership Programmes in countries of the Region.

The meeting was chaired by Dr Ramez Mahaini, Coordinator, Family and Community Health, WHO Regional Office for the Eastern Mediterranean, Dr Heli Bathija, Area Manager for the African and Eastern Mediterranean Regions, Dr Sameera Al-Tuwaijri, Reproductive Health Adviser, country support team for Arab States in Amman (UNFPA) and Dr Saramma Thomas Mathai, Reproductive Health Adviser, country support team for Asia in Kathmandu (UNFPA). The agenda, programme, list of participants and draft country plans are included as Annexes 1, 2, 3 and 4, respectively.

2. Technical presentations

2.1 Strategic Partnership Programme in the Eastern Mediterranean Region

Dr Ramez Mahaini, Coordinator, Family and Community Health, and Regional Adviser, Women's and Reproductive Health, WHO/EMRO

Approximately 53 000 women of childbearing age die every year in the Region as a result of pregnancy-related complications. The average maternal mortality rate in 2004 was estimated at 370 per 100 000 live births, compared to 465 per 100 000 live births in 1990, a reduction of only 20.4%, and yet the regional target for this period, established in 1990 by the Thirty-seventh session of the Regional Committee for the Eastern Mediterranean in resolution EM/RC37/R.6, was to reduce maternal mortality ratio by 50% between 1990 and 2000.

The health hazards resulting from poor birth spacing, resulting in too early, too late, too close and too many pregnancies are very well established. If such high-risk pregnancies were to be prevented, it is estimated that maternal mortality could be reduced by between 25% and 50%. Unfortunately, in several countries with high maternal mortality rates, average contraceptive usage among married women is around 26.5%, compared to 40% for the Region. Promoting family planning among married women is an effective intervention to prevent many avoidable deaths, not only among mothers, but also among their children.

Human resources development for maternal health in the Region requires further attention. The inadequate pre-service (basic) education of health providers in many countries overburdens their health systems, which are already weak. There is a continuing need to improve and update the knowledge and skills of health workers. Low quality in-service training of health providers and the high turnover of trained staff are also major obstacles to providing good quality health services to mothers and their families, particularly where they are most needed. The increased

attention that was given to upgrading the technical knowledge of health workers of making pregnancy safer services improved the quality and management of these services in many countries.

The UNFPA/WHO Strategic Partnership Programme (SPP) was initiated in 2003 in order to transfer evidence-based and consensus-driven guidance from the international level to regions and countries in order to improve reproductive health care, with a specific focus on maternal and neonatal health, family planning and the control and management of sexually transmitted infections, including HIV/AIDS. In 2005 during the first phase of the implementation of SPP-related activities, making pregnancy safer, family planning, sexually transmitted diseases, including HIV/AIDS, and gender and rights in reproductive health guidelines were planned to be introduced in the Eastern Mediterranean Region. The guidelines are intended to ensure quality reproductive health services in countries of the Region. During the year under review, the WHO Regional Office and the Department of Reproductive Health and Research in WHO headquarters (RHR/HQ), in collaboration with 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 resulted in the formulation of nine country plans of action to implement the guidelines on maternal and neonatal health and family planning at local settings. Out of the nine plans of action drafted during the workshop, only five were finalized and approved by the SPP in Afghanistan, Iraq, Morocco, Pakistan and Sudan. The Regional Office has also formulated a plan of action to introduce and technically backstop the implementation of the formulated and approved country plans of action. This workplan has been implemented in close collaboration with the Reproductive Health and Research Department at WHO headquarters and the country support teams in Amman and Kathmandu. A regional workshop on guidelines for the management of sexually transmitted infections was also held in Alexandria, Egypt, from 11 to 14 March 2006.

Advancing gender equality and equity and the empowerment of women, ensuring the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. To help reforming health systems to enable health services to be gender sensitive and to uphold women's and reproductive rights, WHO developed a core curriculum on transforming health systems for gender and rights in reproductive

health. In order to ensure that training tools and standards in this curriculum are used in line with sociocultural norms and values prevailing in countries of the Region, an adaptation workshop was organized by the Regional Office and the Department of Reproductive Health and Research at WHO headquarters in collaboration with the Institute for Women, Gender and Development Studies, Ahfad University for Women, Khartoum, Sudan, from 29 March to 2 April, 2004. Subsequently, the first training workshop was held in the Institute for Women, Gender and Development Studies in 2004. The SPP programme supported the convening of the second workshop, which was conducted from 18 November to 1 December 2005, in which 24 national health staff from Afghanistan, Ethiopia, Morocco, Nigeria, Sudan, Tanzania and Yemen participated to prepare a final training curriculum.

The main challenges to the programme include an insufficient knowledge of its mission, strategic approaches, objectives and plans in participating countries, and poor experience with the administrative and financial rules and regulations of UNFPA-funded projects executed by WHO applied to SPP-supported country plans of action (the SPP budget is an annual budget not a biennial budget as many people mistakenly believe). Poor compliance with intended future steps that were agreed upon in the workshop on using guidelines for making pregnancy safer and family planning, in Cairo, in 2005, and also inadequate transparency of communication at some occasions.

2.2 Taking evidence-based guidelines: Common challenges in sexual and reproductive health globally

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

More than 120 million couples in developing countries have an unmet need for safe and effective contraception and an estimated 340 million new cases of sexually transmitted infections (STI) occur annually. Risky sexual practices are the second most important global risk factor to health (HIV/AIDS is a major manifestation of sexual ill-health). Ninety nine per cent (99%) of an estimated 529 000 maternal deaths occur in developing countries and this failure to address women's reproductive health is a perpetual violation of human rights which disregards women’s right to life and to health. Accordingly, a strong linkage

between WHO and UNFPA as development partners concerned with sexual and reproductive health is a necessity. The goal of the SPP programme is to improve support to countries through the implementation of evidence-based guidelines and tools for reproductive health.

Guidelines and tools prepared by WHO reflect global recommendations on best practices. Linkages with country support teams are critical in maximizing their use and adoption and for creating a harmonization of messages. The primary objectives of the guidelines and tools are to introduce selected practice guides systematically in order to improve sexual and reproductive health and to support dissemination, adaptation and adoption of guidelines within countries through country support teams, WHO country offices and country representatives and civil associations. The secondary objectives include the strengthening of technical capacity through orientation training and backstopping and to enhance linkages between the creation of evidence-based tools and their implementation in order to improve programmes.

The expected output and outcomes of implementation include the adoption and up-scaling of evidence-based practices, tools and materials and the improved quality of reproductive health care services, particularly in family planning, STI control and maternal health settings. The guiding principles of the implementation process are to foster linkages with other partners, take into account existing tools and baseline data, work within existing structures, and with professional bodies, networks and centres of excellence, to advance gender equity and human rights and to contribute to poverty reduction, strengthened national capacity and local ownership.

The progress and achievements of the programme include global and interregional activities, regional and intercountry activities and in-country national activities. The guidelines are being used for advocacy on best practices, for reference, to update national guidelines, to develop national strategies on sexual and reproductive health, and for training and the development of curricula. The nature of activities currently under way include the translation of the guidelines into national languages, workshops for updating national guidelines and reviewing policies, training to improve use of recommended practices and the collation of baseline data to guide implementation and to measure improvement. There are 25 countries of intensified focus in which

the lessons learnt from the programme have been unique and have created greater interaction at all levels with endorsement from higher levels representing a key element of the partnership. Ensuring “reach” and “utilization” requires a systematic approach and the institutionalization of the guidelines into national plans which must be fostered for sustainability. The need for regular follow-up and communication is also essential.

To ensure multilevel and interagency partnership towards a common goal, enhanced “buy-in” by countries and partners of WHO/UNFPA’s endorsed practices and interventions is essential, as is their shared understanding and common interpretation. This can be achieved through the harmonization of messages and in developing a process that promotes local ownership. The way forward for the SPP programme must include greater advocacy efforts to scale-up activities, the intercountry sharing of progress, enhanced accountability, improvements in quality and partnership, technical backstopping and evidence-based decision-making and gender mainstreaming.

2.3 Evidence-based guidance in family planning and in maternal and neonatal health

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

The four cornerstones of evidence-based guidance developed by WHO are *Medical eligibility criteria for contraceptive use*; *Selected practice recommendations for contraceptive use*; the *Decision-making tool for family planning clients and providers* and the *Handbook for family planning providers*. This guidance was created for policy-makers and programme managers and represents a valuable tool for health-care providers. The evidence-based guidelines were developed through consensus reached during a series of expert working group meetings comprising country experts and representatives of many different agencies and organizations. All of the guidance is kept up-to-date through the monitoring of all new evidence by Continuous Identification of Research Evidence (CIRE) and through the systematic review of selected issues by expert working groups.

The *Medical eligibility criteria* provides guidance on who can or cannot use various methods of contraception according to clients’ personal or medical conditions. There are four condition

classification categories: 1) no restriction on the use of the contraceptive method; 2) the advantages of using the method generally outweigh the theoretical or proven risks; 3) theoretical or proven risks usually outweigh the advantages of using the method; (4) there is an unacceptable health risk if the contraceptive method is used. There is also a simplified classification of conditions giving advice for practitioners only able to exercise limited clinical judgement. It provides recommendations for various clients based on their age and behaviour or health status, for instance, contraceptive advice for smokers based on age and how many cigarettes are smoked daily.

Selected practice recommendations for contraceptive use (second edition) has 33 selective questions relating to the use of contraceptives and was developed through scientific consensus. The topics for these questions cover: the initiation and continuation of methods; incorrect use (i.e. missed pills); problems during use, such as vomiting and or diarrhoea, menstrual abnormalities (progestogen-only methods and intrauterine devices (IUDs), pelvic inflammatory disease (PID), pregnancy; and programmatic issues involving which examinations or tests should be undertaken routinely, follow-up, how to be reasonably sure a woman is not pregnant and routine examinations or tests.

The *Decision-making tool* is a multi-purpose tool which aims to aid decision-making and problem-solving, and which acts as a job aid, reference guide and training tool. (See 2.4 Family planning guidelines: What's new?) Currently under development is the *Handbook for family planning providers*, which is the successor to *The Essentials of Contraceptive Technology*. It is to be published in 2006 and will contain all WHO family planning guidance.

Evidence-based practice guidelines for maternal and newborn health care include: *Pregnancy, childbirth, postpartum and newborn care* (PCPNC), *Managing newborn problems* (MNP) and *Managing complications in pregnancy and childbirth* (MCPC). *Pregnancy, childbirth, postpartum and newborn care* 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 periods. Its target audience include health-care providers/skilled birth attendants, health planners, programme managers and trainers and educators. This guide is based on the principles of a continuum of care for the mother and neonate, and it presents a core set of essential interventions, the major causes of

maternal and neonatal mortality and evidence-based interventions. It adopts an integrated approach which involves clinical decision-making based on signs and symptoms and a consistent approach to management. The structure of the clinical component is rapid assessment and the management of emergency, routine care for the essential elements of maternal and neonatal care pertinent to the specific visit, response to the problem, preventive measures and advice and counsel.

2.4 Family planning guidelines: What's new?

Dr Nuriye Ortayli, Reproductive Health and Research Department, Promoting Family Planning Team, WHO headquarters

The *Decision-Making Tool* (DMT) *for family planning clients and providers* was published in September 2005. The *Decision-making tool* is a valuable decision-making aid for clients, a job aid, a reference manual for providers and a training resource for programmes. It is an interactive tool and has one page for the client containing helpful pictures and key points, and a corresponding page for providers containing key points and detailed reference materials. It includes evidence-based technical information on 14 family planning methods, including medical eligibility criteria, side-effects, when to start and how to use each method of contraception. It guides health-care providers in a step-by-step process to help clients make informed choices that suits and responds to their differing needs, including clients choosing a method, returning clients and clients with special needs. The *Decision-making tool* is easily adaptable to suit different programme and country contexts.

A CD ROM for the DMT implementation guide will be available soon and can be used to help programmes adapt and introduce the *Decision-making tool*. It includes:

- electronic files of the pages that can easily be translated or adapted to suit the local context;
- an adaptation guide;
- a training guide with modules on using the tool, counselling skills, and contraceptive technology;
- additional method sections;

- a demonstration video; and
- advocacy materials and other useful supporting materials and Internet links.

WHO's reproductive health guidelines *Introducing WHO's reproductive health guidelines and tools into national programmes: principles and process of adaptation and implementation* are currently in draft form and when available will represent a generic adaptation guideline for all reproductive health guidelines and tools. All guidance is evidence-based and kept up-to-date through a process of monitoring all new evidence through CIRE, also through a systematic review of selected issues and through consultations with expert working groups. The technical consultation which reviewed the complete body of evidence regarding the effects of hormonal contraception on bone mineral density and fracture risk is one case in point. Another important consultation was held on hormonal contraception and HIV was held in Nairobi, Kenya, in September 2005 and involved policy-makers, programme managers, scientists, donor organizations and representatives of people living with HIV/AIDS from 17 sub-Saharan countries. This meeting reviewed previously published and new data relating to HIV risk and hormonal contraception use and resulted in important recommendations.

Another important meeting was convened by the International Agency for Research on Cancer (IARC) to review the scientific evidence on the carcinogenic risks to humans posed by combined estrogen-progestogen oral contraceptives (COCs) and combined estrogen-progestogen hormonal menopausal therapy (HRT) in June 2005. A press release following the meeting emphasized that COCs and HRT were carcinogenic to humans. Evidence available to this recent review was not new but published several years ago, and had therefore already been discussed and evaluated by other bodies. IARC do not evaluate the overall risk-benefit profile of compounds in public health terms but assessments are based on risk-benefit calculations carried out by different teams within WHO, for instance, the expert panel of the *Medical eligibility criteria*.

2.5 Integrated management of pregnancy and childbirth

Dr Jelka Zupan, Making Pregnancy Safer, WHO headquarters, Geneva

Interventions in maternal health are increasing rapidly in increasingly technical settings, and WHO is directing major efforts in the promotion of mother and child health as evinced by the theme of the World Health Report in 2005 *Make every mother and child count* and high-level policy meetings held on maternal and newborn health. Many problems have been identified including a lack of access to services, insufficient uptake of services and discrimination, and it is clear that the standards laid out in the guidelines *Integrated Management of Pregnancy and Childbirth* (IMPAC) are generally not being met.

The publication *Pregnancy, childbirth, postpartum and newborn care* (PCPNC) summarizes the recommendations of 10 WHO set of guidelines and links with family planning tools, including revised recommendations on the prevention of HIV transmission in mother-to-child transmission and birth to pregnancy spacing. It also provides recommendations for preventive measures and care and is designed for use at the primary health care level, for the home and community.

Publications currently in progress will present guidelines for the management of the third stage of labour, avian influenza, managing newborn health for acute and chronic emergencies (interagency guidelines), and optimal fetal development. Optimal fetal development is a complex area and there has been a recent paradigm shift in this area away from birth weight as an optimal indicator. New training material includes updated midwifery modules and new modules on post-abortion care (PAC), vacuum extraction and antenatal care, including the prevention of mother-to-child transmission. There is also an essential newborn care course, a handbook for counselling and a learning resource package for managing newborn problems.

Interactive tools include *Managing complications of pregnancy and childbirth* (MCPC), *Pregnancy, childbirth, postpartum and newborn care* (PCPNC) and *Managing newborn problems* (MNP), and new supportive tools include *Standards of care, Working for change: Handbook for counselling, Beyond the numbers, Perinatal death review*, and *Costing* (an essential technology package).

2.6 Extending service delivery: USAID Office of Population Global Project

The Extending Service Delivery (ESD) project, funded by the Office of Population and Reproductive Health, Bureau for Global Health, USAID, is designed to address an unmet need for family planning and increase the use of reproductive health and family planning services at the community level, especially among underserved populations, in order to improve health and socioeconomic development. To accomplish this, ESD strengthens global learning and the application of best practices, increases access to community level reproductive and family planning services, and improves capacity for supporting and sustaining reproductive health and family planning services. ESD works closely with USAID missions to devise tailored strategies that meet the service delivery needs of specific countries.

The project follows a two-track approach of adopting best and assessing promising practices. The steps for best practice include: adoption and adaptation, the scanning of each project to identify opportunities for the application of best practices, the specification of best practices in the application and the review process of introduction and the monitoring and institutionalization of best practices. The steps for promising practice include: documentation and dissemination, identification and submission, internal review, external review and finally, dissemination. The project has a technical and a group area of focus. The technical areas of focus include: comprehensive post-abortion care, community-based postpartum care and birth spacing. The group focus is on internally displaced persons and refugees, youth, postpartum women, the urban and rural poor and work settings.

The approaches of the project include the integration of family planning with other services, in particular HIV/AIDS interventions and other reproductive health services, collaboration with other agencies and governments in the planning and delivery of services, in identification, application and dissemination of best practices, fostering corporate social responsibility for sustainability and working with the private sector. ESD partners include: Pathfinder International, Management Sciences for Health, IntraHealth International, Meridian Group International (social responsibilities), the International Centre for Migration and Health (refugees, displaced people), and Save the Children.

3. Country presentations

3.1 The Strategic Partnership Programme in Afghanistan

Dr Anna Begum, Reproductive Health Medical Officer, WHO Afghanistan

Afghanistan is one of the least developed countries in the world. Civil strife over the past two decades has resulted in a devastated country with a poor economy and almost non-existent social services. The health care system has been severely affected and health indicators have worsened. Women and children, in particular girls, suffer a higher burden of illness and death. One in seven women die of pregnancy- and childbirth-related causes. There is a shortage of skilled birth attendants and low coverage of maternal and child health and family planning services. Health facilities are often in very poor condition; in addition, there is a shortage of essential equipment and supplies and a lack of a functional referral system. These are all major factors contributing to unacceptably high maternal and infant mortality rates. The major causes of maternal mortality are: haemorrhage, obstructed labour, pregnancy-induced hypertension, anaemia, malaria and sepsis. The percentage of preventable maternal deaths in the country has been estimated at 74%.

The coverage rate for TT (tetanus toxoid) vaccination for pregnant women is estimated at 40%. The rate of contraceptive usage is only 2%, with only 29% of basic health facilities providing three methods of contraception. Maternal health care services are not equally distributed and the majority of women, particularly from rural areas do not have access to essential obstetric care. Only 12% of women have access to antenatal care and only 17% of basic primary health care facilities provide basic reproductive health services. In health facilities where only male health personnel are available, utilization of services by women is very low due to social and cultural barriers. Local traditions and custom in Afghanistan make the treatment of women by male doctors and nurses difficult and serve as a constraint for women seeking health care. Increasing female representation in the health care sector is one way to address this problem. The few existing female health personnel need refresher training to upgrade their skills

and knowledge in basic health care provision, including essential drugs and treatment, and maternal health and emergency obstetrics care. There are no emergency services available to transport women to referral facilities when complications arise. Ninety per cent (90%) of deliveries take place at home, and only 15% of all deliveries are attended by trained health personnel.

The female literacy rate in Afghanistan is one of the lowest in the world, and is estimated to be 1%–2% in rural areas, in which 80% of the total population live. There are no confirmed data on STI prevalence in the country; however, information from clinical records, particularly from private clinics in large towns, suggests that there are high rates of sexually transmitted infections.

Complications of pregnancy pose substantial health dangers to women in Afghanistan, and the prompt and appropriate management of these complications is an essential intervention to reduce maternal morbidity and mortality. Unfortunately, reproductive health programmes are not based on evidence, and the standards that have been developed so far in the country need reviewing and updating. Introducing the adaptation, adoption and implementation of evidence-based practices and guidelines related to family planning and making pregnancy safer will improve service delivery and will enable skilled attendants to provide quality maternal and newborn health services to women and infants. This, in turn, will support improvements in the health of women and their newborn babies to reduce the rates of maternal and neonatal mortality and morbidity.

During the UNFPA/WHO joint regional workshop on using guidelines for making pregnancy safer and family planning held in January 2005, a plan of action for Afghanistan was developed to systematically introduce, adapt and implement the guidelines. The following activities were included in the plan:

- holding advocacy and orientation meetings;
- conducting a three-day workshop to introduce the making pregnancy safer and family planning guidelines;
- translating and printing 50 copies of the guidelines that will be used to facilitate the adaptation process;
- forming adaptation working groups and holding meetings and workshop;

- holding a one-day workshop to introduce the adapted guidelines;
- translating and printing 100 copies of the adapted guidelines;
- training 10 trainers on the adapted guidelines;
- piloting the guidelines in three provinces (second phase);
- training health-care providers from the three provinces on the guidelines (second phase);
- following up after training (second phase);
- expanding to other provinces (third phase).

In accordance with the above plan, the WHO country office held advocacy and orientation meetings with policy-makers from the Ministry of Public Health and other ministries, planners, programme managers, health-care providers, UN agencies, donors, nongovernmental organizations and other stakeholders to inform and orientate them on the making pregnancy safer and family planning guidelines. In December 2005, a three-day workshop was conducted for all stakeholders to introduce the WHO evidence-based making pregnancy safer and family planning guidelines and tools. The adaptation process was discussed during the workshop and the plan for implementation was developed with the recommendations of all key stakeholders. *The essential practice guide: pregnancy, childbirth, postpartum and newborn care* (PCPNC) and *Decision-making tool for family planning clients and providers* (DMT) have been translated into Dari and 50 copies each were distributed during the workshop.

Under the general guidance of the Deputy Minister for reproductive health and maternal and child health, and with the support of WHO, the two directors of reproductive health and safe motherhood are responsible for setting up the adaptation working group and overseeing the implementation and adaptation of IMPAC–PCPNC and family planning guidelines. Two adaptation working groups (the PCPNC and family planning adaptation working groups) were formed in January 2005 comprising representatives from reproductive health and maternal and child health units, directors (obstetrician and gynaecologist) from two maternity hospitals in Kabul,

representatives of professional associations including obstetricians and midwives, international and national nongovernmental organizations working in the reproductive health field, UNFPA and WHO. The PCPNC working group is working on the adaptation of the PCPNC guidelines and the family planning working group on adaptation of the *Decision-making tool*. The adapted guidelines will be translated into Dari and 100 copies will be printed initially to disseminate to all stakeholders through a workshop. These guidelines will be piloted in three provinces. Ten (10) trainers (health care providers) will be trained from Kabul and the three selected provinces. After evaluation, the implementation of the guidelines will be expanded to other provinces.

3.2 The Strategic Partnership Programme in Egypt

Dr Alaa Sultan, Director of Obstetric Care, on behalf of Dr Esmat Mansour, Head of Integrated Health Care and Nursing Sector, Ministry of Health and Population

The Government of Egypt has prioritized its focus on maternal and child health and health sector reform. Consequently, Ministry of Health and Population programming has reflected the Government's commitment to improving the health of vulnerable groups, particularly mothers and children, and all social determinants of health are taken into consideration in national strategies implemented by the Ministry. In this respect, the Ministry strongly supports the integration of family planning, maternal neonatal and child health services, at the service delivery level to improve the quality of services.

Strategies have included the application of family medicine as one of the health system reforms to provide an integrated package of high-quality health services through all primary health care units and centres, with a focus on remote, rural and high-risk areas. There has also been the development of a comprehensive package of services directed to the most vulnerable groups in the community, in particular mothers, infants and children, creating greater health awareness, and the provision of community mobilization activities through women's and family clubs.

The Government is seeking to address prevalent health problems through maternal health care programmes including antenatal care and early detection of high-risk cases, basic and essential obstetric care (safe and clean delivery and referral of risky

pregnancies), postnatal care for mothers and neonates, micronutrient supplementation and nutritional education. Child health care programmes have also been introduced and cover neonatal basic and essential resuscitation care; neonatal screening and early detection of abnormality; breastfeeding promotion and micronutrient supplementation; Integrated Management of Child Health (IMCI) preventive care programmes, including children's routine immunization, campaigns and eradication of communicable diseases. Women's and reproductive health care programmes address family planning and child spacing, reproductive tract infections, sexually transmitted infections (STIs), and the early detection of genital tract tumours.

3.3 The Strategic Partnership Programme in Morocco

Dr Abdelwahab Zerrari. Director of Maternal and Child Health, Ministry of Public Health

The objectives of the SPP in Morocco include the adaptation and implementation of WHO and UNFPA clinical guidelines. The programme is important in Morocco as it addresses the high maternal and infant mortality rates and although there is strong political commitment in addressing the problems and many achievements have been made in managing maternal health guidelines, there is a need for improved guidelines in managing neonatal health and to reinforce the family planning programme. In March 2005, six evidence-based modules were adopted, working groups were formed and the first adaptation meeting took place from 26 to 30 September 2005. There are three working groups for newborn health, family planning and making pregnancy safer. These groups are further divided into a further three subgroups (antenatal, normal delivery and postpartum and emergency obstetric care). There are four teaching university and nursing schools represented in each working group, and each group or subgroup is headed by senior teaching staff.

The objectives of the adaptation process are to identify the gap between the evidence-based and national guidelines, to adapt screening, assessment and treatment protocols and to adopt the new guidelines. The methodology behind the process involves the adaptation of each module by a teaching university under the supervision of a senior teacher. After a module is adapted, it is submitted to the other faculties and is finalized during a process of a minimum of five consensus meetings at national level.

Progress made in the adaptation process have included the development of new family planning and managing newborn problems modules and developments in the management of complications in pregnancy and childbirth. The first draft of all the modules will be available by 7 April 2006.

Some of the constraints affecting the progress have included: the time-consuming nature of the process and the many modifications required for adaptation, the lack of availability of experts, inappropriate electronic format of modules, the unavailability of family planning counselling support and poor coordination with local UN organizations. The recommendations include the need for greater involvement of country-based UN organizations and the need for WHO technical assistance and financial support in the printing, training and evaluation of the national guidelines.

3.4 Maternal health situation in Somalia

Ms Asia Osman Ahmed, Reproductive Health Coordinator, WHO Somalia

In Somalia the past few years have been marked by limited progress in reducing the high levels of maternal and infant mortality and morbidity. In 1996 WHO/UNICEF estimated the maternal mortality rate in Somali at 1600 per 100 000 live births. Complications of pregnancy and childbirth include: haemorrhage, prolonged labour, obstructed labour, infections and eclampsia. Anaemia and female genital mutilation also have a negative impact on maternal health. In Somalia the levels of antenatal, delivery and postnatal care are poor, and there is a complete lack of emergency obstetric referral care for childbirth complications which further contributes to the high rates of mortality and morbidity. About 80% of childbirth takes place at home without adequate medical facilities and is often attended by family members or untrained attendants who have no skills in delivery.

National reproductive health strategies and plans include: a definition of the reproductive health concept and its adaptation to the local situation in addition to consensus-building on the concept; assessment of the needs and collection of baseline data with a view to adapting and translating the findings into concrete action; determination of priorities; preparation of plans of action for the development of district health systems; implementation (definition of policies, revision of legal texts, updating of norms and procedures); mobilization of resources, including internal and

external expertise for the implementation of plans of action; work monitoring and supervision and programme evaluation; and the development and updating of the health information system. The development of the national reproductive health programme in Somalia has involved: an intercountry workshop for the dissemination of the regional reproductive health strategy; a situation analysis to identify needs and define national reproductive health policies and strategy; consensus-building on the reproductive health concept through a workshop organized by the Ministry of Health and WHO; and interventions involving the Ministry of Health and WHO.

Setting objectives for methodology and programmes of work using a participatory process has involved a multidisciplinary core group comprising: representatives from the Ministry of Health, universities, national nongovernmental organizations and UN agencies (UNFPA and WHO) and the identification of key participants and resource people, including decision-makers, planners, managers of health sector programmes, particularly reproductive health programmes, decision-makers and planners in related sectors, service providers including members of professional associations (gynaecologists, obstetricians, midwives), national and international nongovernmental organizations, organizations and representatives of community groups (women, youth, consumers), and bilateral and multilateral cooperation agencies.

General objectives include strengthening the capacity of the Ministry of Health to coordinate reproductive health interventions and more specific objectives include reaching a consensus on the new concept of reproductive health, analysing the reproductive health situation in Somalia, defining priority options and strategies needed to create a change in existing programmes and determining the steps which are needed to draw up a national reproductive health programme.

The expected outcomes of the SPP in Somalia are an understanding of strategic planning and a common understanding of the priority issues in reproductive health. It is also expected that prioritization of problems and concerns that call for measures based on the situation analysis will emerge, and an analysis of proposed interventions taking into account the strengths and constraints noted at national level, resulting in an alternative for change and a process that will be continued.

While implementing the SPP in Somalia it is recommended that the skills of health workers are improved through adapted guidelines and standards for the management of pregnancy and childbirth at different levels of the health care system, and interventions are undertaken to improve the health care system's response to the needs of pregnant women and their newborn infants. District level management of health services also needs to be improved, including the provision of adequate staffing, logistics, supplies and equipment and health education promotion of activities that improve family and community attitudes and practices in relation to pregnancy and childbirth.

The challenges in Somalia include the lack of skilled attendance during the antenatal, delivery and postnatal period, the limited access to antenatal, delivery and postnatal care, the lack of qualified health professionals in the country, low income levels making health services unaffordable and poor nutrient levels in expectant and lactating mothers. The majority of pregnant women only attend antenatal visits during the later stages of their pregnancies. There is insufficient national commitment to solve the problems faced, and in conclusion, it should be noted that health indicators in Somalia are very poor and that the country requires greater coordinated effects in order to ensure equitable and accessible high-quality health services.

3.5 The Strategic Partnership Programme in Sudan

Dr Siham Ahmed Balla, National UNFPA Project Director, UNFPA Sudan

The achievements of the SPP in Sudan have included an orientation workshop held in May 2005, leading to the formation of a national technical committee and three working groups, the production of basic midwifery training and emergency obstetric and neonatal care guidelines and family planning training modules. The workshop held in July 2005 reviewed the progress of the working groups and concluded that the evidence-based guidelines would require little adaptation before implementation in Sudan. Copies of the guidelines are to be printed for testing in March 2006. The guidelines will then be revised following a consensus meeting, and 1000 copies will be printed and used in the training of core trainers at central and state levels and for the training of health-care providers in rural and needy areas.

The constraints of the programme in Sudan are the lengthy process of adapting the village midwife curriculum to the evidence-based guidelines and the insufficient numbers of technical staff at national level. The necessary involvement of members of the working groups in other activities (obstetrics and paediatrics), and the involvement of the national reproductive health department in SHFS also adds to delays. Accordingly, one of the challenges faced includes implementation of the guidelines within the new time frame. There are also other challenges which include the improvement of the quality of basic midwifery training based on evidence-based guidelines, the screening of midwifery schools and trainers, the additional time required in village midwife basic training, the selection criteria for new candidates and the lack of adequate training methodology and materials.

The programme now needs to record the skills and competencies of village midwife tutors using a checklist prepared by the national committee, retrain tutors on the curriculum, record the skills and competencies of existing village midwifes, schedule retraining (according to the screening), and impart management skills, including monitoring and supervision procedures for reproductive health managers at state and local levels. It is also necessary to address the maternal and neonatal information system which requires improvement and the training of different reproductive health-care providers on the evidence-based guidelines. The strengthening of reproductive health information, education and communication (IEC) and of the reproductive health commodity distribution system is necessary, as is the integration of voluntary testing and counselling (VCT) services into antenatal care and family planning clinics at the primary health care level.

3.6 The need to adopt evidence-based protocols and guidelines in the Syrian Arab Republic

Dr Ghada Mehjazi, National Programme Officer, WHO Representative's Office, Syrian Arab Republic

The components of the reproductive health programme in the Syrian Arab Republic include maternal health and family planning, prevention and management of STIs including HIV/AIDS, detection and management of infertility, early detection of cervical and breast cancers, pre-marital services, menopausal care, adolescent services and counselling. Reproductive health strategies include provision of antenatal care at health care centres, training of traditional birth attendants, provision of delivery services at hospitals and birthing centres, training of midwives and promotion of contraceptive usage. Births are attended by trained health personnel and antenatal care is provided by trained personnel. Almost 1500 public health care centres provide maternal and child health services, in addition to the private sector and civil society services. Accessibility to health care services does not represent a problem in the country, but the country's ability to meet targets 4 and 5 of the MDGs depends on improving the quality of health services through the implementation of evidence-based guidelines and protocols.

4. Group work

4.1 Group work 1

The objectives of the first group work were for participants to reflect on the country presentations and to discuss how the challenges, strategies, best practices and lessons learned could be linked to experiences in their country. Groups were asked to consider the following questions:

- What were the key challenges that countries faced? Did your country experience similar or different challenges from other countries?

- What were the key strategies that were used to respond to the challenges? Has your country team used any of these key strategies to respond to challenges? If yes, how have you responded? If not, what strategies did your team use?

- What were lessons learned/challenges/best practices presented that were applicable to your team? Were there specific tools that were described that you have or could use for needs assessments?

- What were the key strategies for developing and maintaining (successful) coordination committees; were these similar to strategies your team has used?

- What were best practices for unified national planning and coordination with multiple partners?

The outcomes of the group work were for groups to submit a synthesized list or matrix of best practices, challenges and lessons learned from the discussions and to return to their country with their draft country plan to be revised and finalized in-country with national teams.

Subgroup 1: Afghanistan, Egypt, Iraq, Somalia, Syrian Arab Republic and Yemen

Subgroup 1 identified the challenges for adaptation of the guidelines as: low priority among government officials, lack of capacity among ministry officials to submit proposals, poor communication between UN agencies and ministries, inadequate utilization of guidelines, the considerable time needed for adaptation, the existence of more than one set of guidelines, the problem of different guidelines being produced by different organizations which requires closer coordination between all partners, and the rapid turnover of ministry staff which creates problems in terms of sustainability.

The group made recommendations which included the need for government officials to delegate responsibilities to less senior officials and the necessity for both UNFPA and WHO to be represented in all activities. They recognized the need for standardization of guidelines and the creation of various task forces to develop the guidelines through consultative working groups and technical advisory groups comprised of representatives from the Ministry of Health, WHO, nongovernmental organizations and community associations. All agreed that greater coordination between all partners and greater advocacy was needed from WHO/UNFPA in order to elicit government support. It was suggested that WHO should build partnerships with other organizations and community associations in order that all partners reach shared and common goals, and that workshops could be conducted to familiarize ministries and other stakeholders with the new guidelines. The involvement of UNICEF at global, regional and local levels was requested.

The group wanted to see the guidelines distributed to clinics by the ministry following ministry endorsement, and believed it was necessary to develop a tool or mechanism to monitor and evaluate the use of guidelines. They identified the need for health provider's pre-service training courses on the use of the guidelines, the development of a consensus centre in the ministry in which endorsed materials and guidelines could be stored and Ministry of Health ownership of guidelines and programmes.

Subgroup 2: Afghanistan, Egypt, Morocco and Sudan

Subgroup 2 believed the challenges included the uncertainty of how to link adaptation to implementation and believed there was a gap in adaptation between the guidelines proposed and standard practices in any particular country. They also recognized that resistance to change and religious considerations and guidance were obstacles to the process but saw nationalization of the guidelines and the need for consensus as best practice. They believed that the adaptation process represented a challenge in terms of time and agreement, in addition to the issue of training, including quality and the financial constraints, the lack of integration between different sectors involved in the process and the lack of assessment of the adequacy of service provision and performance.

Subgroup 2 proposed that discussions between stakeholders take place to aid the formation of a plan which included both adaptation and implementation, and identified the need to increase awareness among the community (at different levels and sectors) to the importance of the guidelines. The group felt that any revision of existing national guidelines and current practices could only be achieved through the consensus of all experts and that approval of the chosen guidelines could only be achieved through a broad meeting with representatives of all levels of the health sector. The periodic updating of the guidelines was identified as a crucial element for programme success, and participants stressed that challenges in relation to time should address the issue of continuous supervision over short periods of time in order to be able to regularly report achievements and constraints in the process of adaptation.

The group requested the provision of on-the-job training and recognized the importance of integration between different working sectors, and the commitment of stakeholders in terms of financial support at different stages of implementation according to changing situations. The group identified ongoing supervision and provision of technical assistance as essential, in addition to the need for a continuous assessment component.

Subgroup 3: Afghanistan, Egypt and Yemen

Subgroup 3 identified existing but outdated national guidelines in some countries as representing a barrier to the process of adaptation of the new guidelines, but recognized that the adoption

of evidence-based guidelines would streamline efforts and address gaps and deficiencies in current services to improve the health of mothers and infants. Yemen, Afghanistan and Egypt are at different stages in the implementation of the guidelines and the extent of their implementation has thus far been reflected in lower rates of maternal and neonatal mortality and morbidity, and through increasing and maintained usage of family planning methods.

The group noted that some countries had some way still to go in achieving implementation of the guidelines and identified the following actions to help facilitate the process: a workshop to introduce the guidelines; identification of the gaps between existing national and the new evidence-based guidelines; adoption and adaptation of the guidelines into national guidelines; and the need for pre-service education of physicians and health care workers in the use of the guidelines.

The group felt that each country should have intrinsic mechanisms to update national guidelines in line with revisions to WHO/UNFP guidelines and that this mechanism in each country should be linked to programme quality assurance. They viewed the involvement of stakeholders from the beginning of the process as crucial and the need for the distribution of the *Medical eligibility criteria* and selected practice guidelines to policy- and decision-makers, not just to health-service providers following translation of guidelines into the local language. They wanted to see the integration of maternal and child health services and family planning services taking place at service level in addition to at a political level, and the process of implementation being facilitated through on-the-job training which could help to ensure the successful implementation of evidence-based guidelines.

4.2 Group work 2

The objectives of the country group work were to identify key priorities for their countries synthesizing the key issues, challenges and successes and best practice approaches for coordination with country counterparts. The outcome of the country group work was for groups to create a table of these specific key priority areas and a six-month time line for country level work to facilitate ongoing planning, implementation and coordination (Annex 4). Suggested priority areas that had arisen in

some other regions were discussed, but it was suggested that country's priority areas should be limited to two or three as it would be difficult to address more than two or three priorities in a six-month time frame.

The suggested priority areas included:

- capacity-building, including development of technical capacity for guideline adaptation; filling information/data gaps, developing job aides, training capacity which addresses policy issues, and management and leadership;
- clarifying roles and expectations regarding planning and implementation of the SPP;
- developing stakeholder buy-in, communication, and coordination in light of barriers such as staff attrition, lack of understanding and/or full support from country leadership, etc. advocating for the use of evidence-based practices;
- developing peer consultancy and learning from experiences of other regions or countries;
- difficulty of coordination of multiple organizations in a country: how can the skills and resources available from nongovernmental and donors agencies be better coordinated at the national level? How can linkages between public (government), private (community and agency) and donor linkages be strengthened?;
- coordination of community needs and expectations.

Plenary discussion on group work

During the previous workshop held in Cairo, Afghanistan produced a national action plan for implementation of guidelines. Afghanistan stressed the importance of translating the guidelines before the adaptation process is started and translation of the guidelines is expected to be complete by the end of May 2006. The country is currently not requesting funding for activities although has requested technical assistance in the process of adaptation. Egypt has an action plan for 2006 but raised the need for clarification of the actual situation in the country, clarification of the existing guidelines and pointed out the need for greater

technical coordination between the various agencies and partners involved in the process. Egypt intends to create various working groups under the responsibility of the Ministry of Health and Population with support from WHO and UNFPA and the country's future plans involve working closely with the STI guideline team. Due to the present instability in Iraq and the country's security concerns, no country plan was formulated during this workshop. The Iraqi representative said that time would be required for the development of a country action plan and that the proposal would be prepared at a later date.

Morocco produced a draft of their country plan and will send the final action plan to WHO Regional Office in April after meeting with representatives from the Ministry of Health in March. Morocco suggested a meeting with the Ministry of Health on the process of adaptation to examine the ongoing process, the amount of adaptation required and to produce a time frame for proposed activities. A national consultative workshop will be held in November 2006. Somalia has particular difficulties as the country has no central government and activities are coordinated through the bureau office in Nairobi due to security and logistical concerns. The situation in Somalia is similar to the situation in Afghanistan 5 years ago, with many partners, including UN agencies, working within the health sector in each province of the country. There is the need for a task force for each region. Somalia was reminded of the importance when preparing their country proposal of specifying whether one workshop for all regions would be conducted or whether three separate workshops would be conducted for the different regions, as in sensitizing policy-makers the incorporation of all areas is essential. Somalia expressed its intention of holding a one-day consultative workshop in three separate regions of the country involving all UN agencies, donors and policy-makers from the Ministry of Health. A technical workshop will also be held although this workshop does not need to be supported by all three regions. Working group meetings will then be convened for the process of adaptation. There is already one working group working in reproductive health. A further one-day consultative workshop will be conducted before the process of translation, editing and printing takes place. In Somalia translation needs to incorporate all languages but translation can begin as soon as the guidelines are received. Somalia also stressed the need for pragmatism and realism and the creation of an effective mechanism for monitoring and evaluation.

Sudan presented a country action plan that included activities not covered by the mandate of the SPP but this was clarified by explanations of which activities would be included for funding as part of the programme. Sudan said that the gap between the actual situation in the country and the desired situation was large, but were confident that proposed activities would take place particularly as a result of the support of UNFPA and WHO and the interest that USAID has in the introduction of guidelines in countries. Nutritional guidelines were identified as a gap in Sudan's national plan. In the Syrian Arab Republic a consultative meeting will take place between all stakeholders and comprising representatives from the reproductive and child health department in the Ministry of Health, UNFPA and WHO. The purpose of the meeting will be to introduce materials, prepare the action plan and create a mechanism for follow-up.

The representative from Yemen said that funds could be taken from the maternal and newborn health project which is operating in 5 out of 21 governorates, but that the country still required additional funding and technical assistance. The reproductive health technical committee will discuss whether the country will update existing guidelines or embark on the adaptation process. They perceived that there may be some missing guidelines within the national guidelines and that this needed to be assessed. The country assessed March/April as the time frame for technical assistance in translation and April/May for a consultant in order to complete the process by June. Yemen has also requested technical assistance in the training of trainers.

5. Future steps

Most of the participating countries have guidelines and standard protocols but the need for adaptation and translation of the evidence-based guidelines at country level was discussed. It was agreed that adaptation at regional level was inappropriate as the guidelines must be adapted according to local resources and country situations. Participants pointed out that much available data relating to maternal and infant morbidity and mortality presented clear evidence for revising existing guidelines but pointed out that there are many things a country must do to build activities and the guidelines were just one aspect of this. The issue of what happens following adaptation of the guidelines was raised, and the need for the process of adoption and adaptation to be linked to quality assurance programmes to ensure that the guidelines were being used was stressed. Challenges presenting difficulties for the implementation of guidelines were given as lack of political commitment and the sometimes weak capacity of health service providers and staff. Some of the other issues presenting challenges were described as the lack of communication between agencies that had resulted in the production of different sets of guidelines. Facilitators referred to the guidelines that were available on the adaptation process itself.

During the final plenary session, 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 revised national plans should be submitted to the WHO Regional Office for the Eastern Mediterranean no later than 30 April 2006 for the proposals to be reviewed over a period of one month. Following technical clearance country plans will be forwarded to WHO headquarters no later than 30 May to be reviewed by the Strategic Partnership Programme Focal Point and a final decision will be reached by 30 June in order that required support for the adoption, adaptation and translation process can be provided.

The need for a monitoring and evaluation component was stressed and participants were reminded that monitoring tracks priority information relevant to programme planning, functioning and costs and provides a basis for evaluation. Evaluation involves

collecting information about programme activities, intervention characteristics and assessing outcomes to determine the merit or worth of a specific programme or intervention. Evaluation is used to improve programmes or interventions and to inform decisions about future resource allocations. In assessing the impact and value of interventions, it is necessary to assess if collective efforts are being implemented on a large enough scale to impact in terms of coverage and effectiveness. If the answer is no, then a situation analysis and surveillance is necessary to determine the problem and the contributing factors. Input then requires identification of which interventions work and which resources are needed. Activities need to be clearly defined and the output and outcomes of these activities need to be assessed in terms of whether the programme is being implemented as planned and whether the interventions are working and making a difference.

Monitoring and evaluation areas to be assessed include technical support; dissemination and awareness of guidelines; translation, adaptation and use and implementation; results at national level; and the involvement of partners and stakeholders. It was suggested that monitoring activities be undertaken every six months by WHO or UNFPA in coordination with national staff, and that evaluation of activities should be undertaken using a questionnaire to be completed by national programme managers, similar to the one used in the initial situation analysis.

The four focal points at regional level who can be contacted for guidance were listed as: Dr Sameera Al-Tuwaijri (UNFPA Amman), Dr Saramma Mathai (UNFPA Kathmandu), Dr Ramez Mahaini (WHO/EMRO) and Dr Gabriele Riedner (WHO/EMRO). Participants were thanked for their participation in the regional review meeting and facilitators described the meeting as productive and useful and a unique opportunity to learn from country experiences and activities and expressed the wish and desire of the Strategic Partnership Programme of working closely with countries in the future. Country representatives were requested to approach local donors and other concerned organizations who may be able to provide additional financial resources, and it was also advised that the participants should open and maintain communication through the internet, networking among countries, sharing ideas and experience between themselves and WHO, UNFPA and other potential partners and to explore any linkages between different programmes.

Annex 1

AGENDA

1. Welcome and opening remarks
2. Introduction of participants
3. Adoption of the agenda
4. Objectives, mechanics and expected outcomes
5. The Strategic Partnership Programme in the Eastern Mediterranean Region
6. Taking evidence-based guidelines: common challenges in sexual and reproductive health globally
7. Evidence-based guidance in family planning and in maternal and neonatal health
8. Family planning guidelines: What's new?
9. Integrated management of pregnancy and childbirth
10. Extending service delivery, USAID
11. Review of SPP-related activities in countries: Afghanistan, Egypt, Morocco, Somalia, Sudan and Syrian Arab Republic
12. Group work to share experiences, achievements and constraints towards adopting the IMPAC and family planning guidelines
13. Country team work to finalize workplans on applying the guidelines of maternal and neonatal health and family planning
14. Presentation of country SPP workplans: 2006–2007
15. Plenary discussion on country SPP workplans, monitoring and evaluation
16. Recommendations and future steps

Annex 2

PROGRAMME

Day 1: Wednesday, 15 March 2006

8:30–9:00	Registration
9:00–9:15	Opening remarks
9:15–9:30	Introduction of participants Adoption of the agenda
9:30–9:45	Objectives, mechanisms and expected outcomes
9:45–10:15	Review of SPP-related activities of RHR/HQ
10:15–11:15	Review of SPP-related activities of WRH/EMRO-UNFPA/CST
11:15–14:00	Review of SPP-related activities in countries: • Afghanistan • Egypt • Morocco • Somalia • Sudan • Syrian Arab Republic
14:00–14:15	Extending service delivery, USAID
14:15–16:00	Group work to share experiences, achievements and constraints towards adopting the IMPAC and family planning guidelines (MCPC, PCPNC, MNP, MEC, SPR and DMT)
16:00–17:30	Plenary discussion

Day 2: Thursday, 16 March 2006

8:30–9:00	Update on making pregnancy safer and family planning guidelines
9:00–9:15	Integration of health services in Egypt

9:00–11:00	Country team work to finalize workplans on applying the introduced guidelines of maternal and neonatal health, family planning and sexually transmitted diseases
11:00–12:00	Presentation of the formulated country SPP workplans: 2006
•	Afghanistan
•	Egypt
•	Morocco
•	Sudan
•	Syrian Arab Republic
12:00–13:00	Plenary discussion on country SPP workplans, monitoring and evaluation
13:0–13:30	Closing

Annex 3

LIST OF PARTICIPANTS

AFGHANISTAN
Dr Rahela Kaveer
Director of Reproductive Health
Ministry of Public Health
Kabul

Dr Kawsar Salehi
Medical Officer, Family Planning Programme
Ministry of Public Health
Kabul

Dr Ahmed Shah Salehi
Director of International Relation Department
Ministry of Public Health
Kabul

EGYPT
Dr Alaa Sultan
Director of Obstetrics Care
Ministry of Health and Population
Cairo

Dr Alaa El DinEl Etriby
Professor of Obstetrics and Gynaecology
Ain Shams University
Cairo

Dr Ashraf Kortam
Professor of Obstetrics and Gynaecology
Ain Shams University
Cairo

Dr Ezzeldin Osman
Executive Director,
Egyption Fertility Care Society
Cairo

MOROCCO
Dr Abdelwahab Zerrari
Director
Maternal and Child Health,
Ministry of Health
Rabat

SUDAN
Dr Siham Ahmed Balla
National UNFPA, Project Director
Federal Ministry of Health
Khartoum

UNITED NATIONS POPULATION FUND (UNFPA)
Dr Sameera Al-Tuwaijri
Reproductive Health Adviser
Country Technical Services Team for Arab States
Amman
JORDAN

Dr Saramma Thomas Mathai
Reproductive Health Adviser
Country Technical Services Team for South and West Asia
Kathmandu
NEPAL

Dr Sukanta Sarker
Technical Adviser, for Reproductive Health
Kabul
AFGHANISTAN

Dr Nashat Hanafi
Programme Specialist
Baghdad
IRAQ

Dr Ashwaq Ahmed Moharram
Officer-in-charge of Sexually Transmitted Infections
Sana'a
YEMEN

Dr Fawziah Jaffer
UNFPA Project manager
MNH project
Sana'a
YEMEN

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)
Dr Marwan Abdel Fattah
Field Operations Specialist
TAHSEEN/Pathfinder Project
Cairo

Ms Pauline Muhuhu
Best Practices Adviser
Extending Service Delivery Project
Washington DC

POPULATION COUNCIL
Dr Nahla Abdel-Tawab
Dr Khaled Nada

WHO SECRETARIAT
Dr Ramez Mahaini, Coordinator, Family and Community Health, Regional Adviser, Women's and Reproductive Health, WHO/EMRO
Dr Heli Bathija, Area Manager for the African and Eastern Mediterranean Regions, Reproductive Health and Research, WHO/HQ
Dr Jelka Zupan, Making Pregnancy Safer, WHO/HQ
Ms Julie Samuelson, Reproductive Health and Research, WHO/HQ
Dr Nuriye Ortayli, Reproductive Health and Research, WHO/HQ
Dr Anna Begum, Medical Officer, WHO Afghanistan
Dr Daher Aden, Medical Officer, WHO Somalia
Ms Asia Ossman, Coordinator, Reproductive Health, WHO Somalia
Dr Mona Modwahi, Medical Officer, WHO Yemen
Dr Ghada Mehjazi, National Programme Officer, WHO Syrian Arab Republic
Mrs Maha Wanis, Secretary, Women's and Reproductive Health, WHO/EMRO
Ms Fatma Abdelmageed, Help Desk Assistant, WHO/EMRO
Ms Hadeel El Shabba, Technical Assistant, Women's and Reproductive Health, WHO/EMRO
Ms Samantha Ward, Temporary Adviser, WHO/EMRO

Annex 4

COUNTRY PLANS

Country: Afghanistan

Activity	Responsibility		Time frame	Materials/tools	Resources	TA needed
	Lead	Support				
Advocacy and orientation meetings with the policy-makers (Ministry of Public Health—central and provincial, and relevant key ministries), planners, programme managers, health-care providers, UN agencies, donors, nongovernmental organizations and other stakeholders	Ministry of Public Health WHO	UNFPA	March 2005			WHO/HQ WHO/ EMRO UNFPA
Orientation workshop for stakeholders to introduce the Making pregnancy safer initiative and related evidence-based guidelines	Ministry of Public Health WHO UNFPA	UNICEF /USAID/ REACH	April 2005			WHO/HQ WHO/ EMRO UNFPA
Translation of the guidelines into local language in order to facilitate the adaptation process	Ministry of Public Health WHO UNFPA	UNICEF /USAID/ REACH	April–June 2005			
Establishment of an IMPAC-PCPNC committee under the reproductive health task force of the women's reproductive health department The Ministry of	Ministry of Public Health WHO UNFPA	UNICEF USAID/ REACH JICA NGOs	March 2005			

Public Health to introduce and implement IMPAC-PCPNC in the country Formation of two subgroups under the committee Adaptation working group Implementation working group						
Advocacy and orientation meetings with the policy-makers (Ministry of Public Health-central and provincial, and relevant key ministries), planners, programme managers, health-care providers, UN agencies, donors, nongovernmental organizations and other stakeholders	Ministry of Public Health WHO	UNFPA	March 2005			WHO/HQ WHO/ EMRO UNFPA
Coordinator/Focal Point will be assigned	Ministry of Public Health WHO	UNFPA	January 2006	Coordinator/ Focal Point will be assigned		
Adaptation process	Ministry of Public Health WHO UNFPA	UNICEF USAID/ REACH JICA Others	January– April 2006	Adaptation process		
Translation of the revised adapted guidelines	Ministry of Public Health WHO	UNICEF JICA USAID	May 2006	Translation of the revised adapted guidelines		

Workshop to introduce the adapt guideline to stakeholders (To conduct back to back with to introduce the STI guidelines)	Ministry of Public Health WHO UNFPA	UNFPA USAID JICA UNICEF	End May 2006	Workshop to introduce the adapted guideline to stakeholders		
Printing and distribution of enough copies of the guidelines, to national stakeholders	Ministry of Public Health WHO	UNFPA USAID JICA	July 2006	Printing and distribution of enough copies of the guidelines, to national stakeholders		
Training of Trainers on the guidelines	Ministry of Public Health WHO	UNFPA UNICEF USAID JICA	August–September 2006	Training of Trainers on the guidelines		
Selection of three pilot provinces	Ministry of Public Health WHO UNFPA	UNICEF USAID JICA	August 2006	Selection of three pilot provinces		
Training of managers and health-care providers initially from three main provinces	Ministry of Public Health WHO UNFPA	UNICEF USAID JICA	October–November 2006	Training of managers and health-care providers initially from three main provinces		
Follow-up training Supervision and monitoring of the training and service provision	Ministry of Public Health WHO UNFPA	UNICEF USAID JICA Donors	January–March 2007	Follow-up training Supervision and monitoring of the training and service provision		
Expansion to other provinces	Ministry of Public Health WHO UNFPA	UNICEF USAID JICA	April–December 2007	Expansion to other provinces		
Training of health-care providers from these provinces	Ministry of Public Health WHO UNFPA	UNICEF USAID JICA	April–June2007	Training of the health-care providers from these provinces		

Review, update and revise the existing IEC materials to be consistent with the making pregnancy safer/family planning guidelines	Ministry of Public Health WHO UNFPA	UNICEF USAID JICA	Second half of 2006	Review, update and revise the existing IEC materials to be consistent with the making pregnancy safer and family planning guidelines		
Printing and distribution of IEC materials, job aids, posters and brochures	Ministry of Public Health UNFPA		January 2007	Printing and distribution of IEC materials, job aids, posters and brochures		

Country: Egypt

Activity	Responsibility		Time frame	Materials/ tools	Resources	TA needed
	Lead	Support				
Development of a task force to design follow-up and implementation of guidelines	Ministry of Health and Population	WHO/ UNFPA	May 2006		Human resources Funding	
Development of working groups	Ministry of Health and Population	Universities, international organizations and experts	August 2006		Health facilities Adequate reporting system	
Broad meeting to standardize implementation of protocols			April 2006			

Country: Morocco

Activity	Responsibility		Time frame	Materials/ tools	Resources	TA needed
	Lead	Support				
Feedback	Dr Zerrari		March 2006	*Guide to essential practice*		
One-day meeting on the ongoing adaptation process	Ministry of Health	WHO UNFPA	April 2006		US$ 2000	WHO UNFPA
Adaptation process (to be continuous)	Ministry of Health and universities	WHO UNFPA	April–October 2006		Five meetings and three working groups (US$ 30 000)	
Consensus meeting	Ministry of Health	WHO UNFPA	November 2006		US$ 5000	WHO UNFPA
Printing	Ministry of Health	WHO UNFPA	December 2006		US$ 2000	

Country: Sudan

Activity	Responsibility		Time frame	Materials/tools	Resources	TA needed
	Lead	Support				
Production of the guidelines and development of supportive materials	Federal Ministry of Health	WHO/ UNFPA/	March 2006	*Guidelines to essential practice*	Taskforce for designing, Word art and copying (US$ 4600)	
Field testing in selected pilot areas	Federal Ministry of Health	WHO/ UNFPA/ SFPA/ Professional associations and institutions	March 20006	*Guidelines to essential practice* Structured questionnaire sheet	Field visits supported by the Federal Ministry of Health	
One-day meeting for adjustment of guidelines after testing (18 members of the working group)	Federal Ministry of Health	WHO/ UNFPA/IPPF Technical groups Professional associations and institutions	April 2006	*Guidelines to essential practice*	DSA Stationary (US$ 816)	

Country: Syrian Arab Republic

Activity	Responsibility		Time frame	Materials/ tools	Resources	TA needed
	Lead	Support				
Convene a meeting including all stakeholders to present the guidelines, revise the previously prepared proposal, identify the main challenges Prepare the initial workplan and form a committee for follow-up	Ministry of Health (Reproductive and Community Health) Community medicine Obstetrics and gynaecology departments	WHO/ UNFPA/ Syrian Family Planning Association	May 2006	*Guidelines to essential practice*	Human resources	