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Report of the Joint Meeting of HQs-RO-CO Focal Points for MPS/RHR

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Executive summary

A joint meeting of, focal points for Making Pregnancy Safer and Reproductive Health and Research (MPS/RHR) from WHO Headquarters, the Regional Office and Country Offices was organized at the Regional Office for South-East Asia, New Delhi, from 15 to18 April 2008. This annual event was aimed at streamlining close collaboration and effective programming across the Organization at its country, regional and global levels. It also provided an opportunity for interaction with other inter-related technical units and departments. Participants shared achievements and lessons learned from the implementation of the 2006-2007 workplans in the areas of MPS and RHR; and agreed on joint activities and coordinated efforts for effective implementation of the 2008-2009 workplans.

During the meeting, participants also reviewed the progress of MPS/RHR programmes in relation to the achievement of Millennium Development Goal 5 (MDG 5 – on maternal health). This review is in keeping with the vision of the Regional Director to assess progress on MDG 5 in the countries of the Region building on evidence of epidemiological data and analysis over the past decades. This joint exercise contributed to improved collaboration between headquarters, the Regional office and the country level in implementing results-based programmes in the area of MPS/RHR and optimized common efforts towards achieving MDG 5 targets.

1. Introduction

Dr Dini Latief, Director, Family and Community Health, WHO/SEARO delivered the opening remarks, emphasizing the commitment of the Regional Office (RO) to achieving Millennium Development Goal (MDG) 5 and prioritizing actions in the areas of reproductive health (RH) including maternal and newborn health (MNH) in particular. There were stark inter-country differences in the South-East Asia Region in relation to the progress towards achievement of MDG 5. Many countries in the Region are struggling with the high burden of reproductive morbidities and mortalities. Home to about a quarter of the global population, the Region accounted for over one third of the global maternal and neonatal deaths. About 37% of the unsafe abortions in the world occurred in South-East Asia.

As guided by the Regional Director, revitalizing maternal, newborn and child health care in the context of Primary Health Care (PHC) was one of the regional WHO priorities. The delivery of timely, safe, affordable, and a high-quality range of reproductive health services was a major challenge, as the proportion of deliveries attended by skilled health personnel was less than 50% in five Member countries in 2007; substandard quality of available MNH care oftentimes hindered its utilization. Issues of manpower, poor logistics and inadequate supply of essential reproductive health commodities, gaps in referral care and inequalities of access to care were some of the other issues requiring special attention. Thus, addressing these gaps required strengthening health systems to deliver quality MNH and reproductive health services. These efforts were in line with the Regional Six-Point Strategy for Health Systems Strengthening based on the PHC approach, Dr Dini Latief added.

2. Objectives

The general objective of the meeting was to optimize collaboration between WHO/Headquarters, the Regional Office and country offices (HQ-RO-COs) in implementing MPS and RHR activities in 2008-2009. The specific objectives focused on:

- Reviewing achievements/performance in 2006-2007 and the WorkPlan 2008-2009 related to MPS/RHR programmes for the development of plans for possible HQ-RO-CO collaboration.
- Reviewing MPS/RHR programmes in relation to the achievement of MDG 5.
- Sharing technical updates on key MPS/RHR issues.

3. Making Pregnancy Safer Programme Review

3.1 Review of the 2006-2007 performance and plans for 2008-2009

Dr Jelka Zupan presented the organizational structure of the Making Pregnancy Safer (MPS) Department, WHO/HQ and explained the roles of three teams: Norms and Country Support Coordination (NTC), Monitoring and Evaluation (MEV) and Partnership (PSH). A number of achievements in 2007 were made in addressing perinatal mortality and newborn health, strengthening maternity workforce, costing of MNH programmes (AFRO), recognition of the role of women, families and communities for pregnancy outcomes (AMRO, EMRO, EURO), acute response to emergencies (Global), orientation workshops for WHO partners, facility-based and population-based surveys (AFRO, AMRO), and participation in the global international forums, e.g. Women Deliver, Countdown to 2015 and Women Parliamentarians meetings. Low financial performance of MPS with an overall global financial implementation of 75%[1] and low ceiling were stated as the main disappointments.

With regard to the implementation of the 2008-2009 MPS WorkPlan, Dr Zupan highlighted key planned activities in the areas of evidence building, organization and service delivery; MNH workforce; costing of interventions, financing of services, emergency preparedness and response; monitoring and evaluation, and continuous support to WHO offices and capacity building through regional activities. Ninety percent of the MPS Department's current biannual budget is allocated for staff (USD 8.9 million), while USD 912,000 is transferred to regional offices. Resource mobilization remains the major challenge for 2008-2009. Innovative approaches, such as multi-country activities, Global Fund, GAVI and health

[1] MPS 2006-2007 financial implementation: globally 75%; SEARO 94% and HQ 60%

system strengthening could provide opportunities for resource mobilization at all levels. Dr Zupan mentioned the key advocacy events planned in the current biennium, i.e. the Countdown to the 2015 Conference and the Asia Pacific Investment Case.

Dr Ardi Kaptiningsih, Regional Adviser, Making Pregnancy Safer and Reproductive Health and Research, WHO/SEARO reported on the work done at the regional level in 2006-2007. The main highlights included assisting the Governments of Bangladesh, Bhutan, India, Nepal and Timor-Leste in addressing the issues of human resources for MNH at primary care level, i.e. training, review of pre-service curriculum, training of trainers (ToT) of midwifery teachers and supervision. SEARO also organized two batches of ToT on essential newborn care (ENC) and supported ENC activities in Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar and Nepal. Eight countries of the Region were supported in adaptation and use of WHO MNH guidelines; while three (Bhutan, India and Maldives) are using the MNH guidelines as a reference.

Other activities included strengthening implementation of maternal death review in three countries (India, Nepal and Myanmar), as well as strengthening analysis of facility-based maternal death review through information sharing and technical update meetings. Other activities include regional meetings on strengthening MNH programme management and improving performance of skilled birth attendants (SBAs). Resources were mobilized for the MPS programme at the regional level (Voluntary Contribution: USD 931,653 with an implementation rate of approximately 90%) from MPS Department/HQs, AS funds/SEARO and ACCESS/USAID. However, the funding gap remains large considering priority needs of countries.

The main MPS activities for 2008-2009 for the Region included provision of support to countries in strengthening human resources for MNH to achieve *Skilled Care for Every Birth*, promoting universal access to MNH service by strengthening collaborative networking and promoting use of evidence-based guidelines/tools; improving quality of MNH care at primary care level, first referral unit and their linkage; strengthening MNH programme management; development, adaptation and implementation of educational materials on newborn care for mothers, families and communities. It was pointed out that all activity funds need to be mobilized (approximately USD 2,500,000) to implement the 2008-2009 regional MPS/RHR workplan, of which USD 162,000 has been committed from the core voluntary contribution (CVC) funds.

Countries highlighted their main achievements which, among others included the following:

- strengthening human resource development and management strategy and practices in maternal and newborn health;
- strengthening MNH service provision through promotion of *Skilled care for every birth* using various approaches depending on the country situation (e.g. including community-based SBA programme, midwifery training, Essential Newborn Care (ENC) training, improving quality of care and introducing evidence-based MPS guidelines and tools, improving management of services);
- resource mobilization (Bangladesh: development and implementation of DFID/EU-funded and the Royal Netherland Embassy-funded projects; DPR Korea: Republic of Korea and Italian Government funded projects);
- using human rights for maternal and neonatal health and publishing provincial RH/MPS profile in Indonesia and evaluation of MNH programme in Sri Lanka.

The 2008-2009 workplans were shared and discussed. It was felt that countries with support from the Regional Office and HQ should continue their follow-up on:

- addressing issues of human resource management for accelerating the reduction of maternal and neonatal mortality and acting upon the Regional Committee's resolution adopted in 2005 for promoting *Skilled care at every birth*;
- adaptation and use of WHO promoted guidelines and tools, work towards improvement of newborn care through promotion of the essential newborn care course;
- meeting the family and community needs and demands in MNH;
- strengthening MNH programme management, monitoring and evaluation and improving quality of care through better supervision and monitoring, use of quality improvement processes and resource planning and costing tools.

Participants discussed individual country requests for technical support with SEARO and HQ in specific thematic areas, which, among others, included: monitoring of MDG indicators, MPS Integrated Health Technology Package (i-HTP), prevention of postpartum haemorrhage, and assistance for development of the Global Fund proposals. These requests will be followed-up to finalize technical support activities and plans in consultation between country offices, SEARO and HQ. Development of resource mobilization plans and raising voluntary contributions (VC) required urgent attention and action, especially at the country level. Staffing requirements (i.e. recruitment of NPOs in Bhutan, Myanmar and Timor-Leste) will be discussed further based on the individual country office situation. Dr Jelka Zupan shared a matrix on possible collaborative activities drawn from the information contained in the country presentations. The plan for joint activities needs to be further discussed between HQ-RO and COs before its finalization.

3.2 Use of the Global Fund for MNH service delivery: Global experience

Dr Viviana Mangiaterra from MPS Department/HQ shared the global experience of using the Global Fund as a mechanism for ensuring universal access to MNH services. Prevention of mother-to-child transmission of HIV (PMTCT) and malaria in pregnancy (MIP) programmes address HIV and malaria in MNH services, but there was little progress in scaling them up. The separation of MNH, HIV and malaria programmes is recognized as a causative factor in limited access to and low uptake of HIV and MIP services. WHO recommends implementing PMTCT and MIP as integral components of essential MNH services within functioning health systems.

The purpose of the recently organized workshop on *"Capacity Building Workshop for Global Fund Proposal Writing to Include MNH Service Delivery Area for Health Systems Strengthening"* was to provide guidance and support to WHO focal points and national counterparts on how to strengthen health systems to ensure continuum of care and universal coverage of essential MNH interventions using malaria and HIV as entry points. Dr Laksami Suebsaeng from HIV/SEARO complemented this subject by sharing detailed information on the regional situation in relation to the Global Fund grants implementation and proposals from countries for Round 8. She emphasized on the ways of integrating services of reproductive health, sexually-transmitted infections and HIV/PMTCT.

Participants expressed strong interest in the Global Fund MPS/HQ workshop to be organized for the South-East Asia Region in 2009.

3.3 MDG 5A: Progress and challenges

The presentation by Dr Jelka Zupan aimed at reviewing country and regional progress on MDGs 4, 5 and 6; sharing key lessons learnt, and identifying issues and challenges and areas for joint collaboration. MDG global targets and indicators and those for sub-national and national level were discussed. Barriers for tracking national progress towards MDG 5 and related MDGs include the following: lack of data at the sub-national level, often poor data reliability and credibility; lack of time series data; disaggregated data (equity issues) and inconsistency in definitions and descriptions.

Linkages between data analysis, its use and formulation of policies, strategies and programmes were weak across all levels of health systems. International reports use internationally gathered data that may differ from the nationally generated data. To the extent possible MDG country reports should be based on national data. If national and international data give a different picture, efforts should be made to enhance statistical capacity in countries.

Dr Ardi Kaptiningsih said that the targets for MDG 5 had recently been revised to include the target of MDG 5B, which is universal access to RH. The regional trends related to the main MDG 5A indicators (MMR and proportion of deliveries by skilled attendants) were presented. The programmatic gaps in the Region are closely related to health systems issues. These include lack or inadequacy of human resources for skilled attendance at birth; critically insufficient MNH programme financing; and inadequate programme management capacity in monitoring progress and addressing priority problems. In order to close the existing gaps, the Regional Office and Country Offices promote various approaches and strategies to meet the needs for midwifery skills at the community/primary health care level and its referrals; advocating for increased health spending for the MNH programme and establishing policies/strategies for reaching the poor and marginalized; and strengthening district MNH programme management to ensure access to and quality of MNH services.

It was stated that the cost of concerted efforts to achieve MDG 5 according to the World Health Report 2005 is between USD 0.6 to USD 1.25 per capita. The South-East Asia Region accounts for approximately a third of the global burden and the total cost of action is estimated at USD 13 billion by 2015, increasing annual costs from USD 330 million in 2006 to USD 2 billion in 2015. On the other hand, the Coogee Beach Group "Investment Case for Asia-Pacific" in 2007 estimated the cost at USD 5 billion per year from 2008-2015. The national and sub-national indicators, sources and quality of data for MDG tracking and the role of country and regional focal points in MDG reporting was discussed. It was concluded that WHO should work closely with the ministries and national statistics centres to assist in MDG monitoring.

3.4 Country case studies

Dr Akjemal Magtymova, MO-RHR (TIP) WHO/SEARO briefed on the review of the Programmes for Maternal and Neonatal Mortality Reduction in South Asia, which was a joint review commissioned by UNICEF/ROSA in collaboration with UNFPA/CST-SAWA, WHO/SEARO and EMRO. The review was undertaken by a group of researchers based in Aberdeen, UK (Ipact) during August-December 2007 in five countries: Afghanistan, Bangladesh, Nepal, Pakistan and India. The purpose of the review was (i) to identify the strengths and weaknesses of current and recently completed programmes to reduce maternal and neonatal mortality in South Asia and (ii) to propose ways to improve efficiency, effectiveness and sustainability of programmes.

The inception paper defined the conceptual framework and suitable methodology for the review that included document review, interviews with key informants and group discussions during field visits to five countries. At the time of the presentation, the iterative review of the draft report by the Steering Committee comprising of UNICEF/WHO/UNFPA/ WB representatives was on-going. It is expected that the final review report will be launched during high level events of UNICEF and WHO, which are envisaged in the second half of 2008.

Dr Anoma Jayathilaka presented the external Review of the Maternal and Newborn Health Programme in Sri Lanka and explained that the review aimed at assessing components of the national MNH programme and identifying achievements, gaps and challenges, and making recommendations to help the development of a new MNH strategic plan

for the period 2008-2012 and beyond. In-depth assessment of organizational structure and implementation strategies of MNH care and service delivery; linkages of MNH service with other RH services; management information system and MNH programme reviews and audits was carried out.

The methodology included document review; stakeholder workshop; key informants interviews at various levels; field observations and focus groups discussions. The review recommended that MNH services should be particularly targeting vulnerable groups that experience highest rates or burden of maternal and newborn mortality. This would lead to the "Elimination of maternal mortality as a public health problem". Sri Lanka requested WHO technical assistance in the development of the MNH Strategic Plan to address the key findings and recommendations of the review.

Sri Lanka adapted the WHO Essential Newborn Care (ENC) course by adding an advanced resuscitation module, expanding chapters on universal precautions, including concept of lactation management centres and simplifying some chapters (e.g. eye care, Intra Muscular injections). Translation into local language was undertaken only at the final stage once the adaptation of the training manual was complete. Revision of nursing and midwifery curriculum was planned to include elements of Essential Newborn Care Course (ENCC) in pre-service education, for which external assistance was sought. It was noted that while an adaptation of evidence-based guidelines was virtually a simple undertaking, ensuring evidence-based clinical practices as per guidelines at the facility level was a long and tedious process, involving cooperation of multiple stakeholders along with professional organizations, referral hospitals, and primary health centres and required systematic approach.

Myanmar conducted an assessment of skills among ENC trainees on immediate care at birth, resuscitation of newborn, examination of newborn baby, including breastfeeding observation and technique for selected medical procedures. The analysis showed that trainees experienced difficulties in using Pregnancy Childbirth Postpartum and Newborn Care (PCPNC) guide; they were unable to perform simple calculations if the ampoule or vial contents were not the same as in the PCPNC guide, and they were lacking decision making skills. Translation of skills gained during the training into day-to-day practice was poor.

3.5 Technical updates

MPS technical updates were made on the issues of skilled birth attendance, the role of misoprostol for postpartum haemorrhage and the MPS Integrated Health Technology Package (iHTP tool) for costing. Dr Zupan and Dr Matthews Mathai from the MPS Department/HQ elaborated on the above topics. Dr Mathai emphasized that oxytocin remains the drug of choice for preventing postpartum haemorrhage when administered as soon as the baby delivered, as a part of the active management of the third stage of labor. Indonesia and Sri Lanka expressed their interest in using the costing tool.

Dr Ashok Deorari and Dr Vinod Paul of the All India Institute of Medical Sciences shared with the participants adaptation of ENC training materials in India. The work was supported by SEARO and was developed for nurse teachers and nurses. They also shared locally developed video clips on low birth weight infant feeding.

4. Programme Management: WorkPlan 2008-2009

Dr Mark Brooks, PLN, WHO/SEARO provided guidance on programme management and funding with regard to the 2008-2009 workplans. The participants demonstrated a shared understanding of the challenges posed by the changes in the Organization's business processes. These include the new strategic-objective (SO) approach within the framework of the Medium-term Strategic Plan 2008-2013 and the introduction of the Global Management System (abbreviated as GSM), which requires additional efforts for optimal programme and financial management.

Discussions were structured around the practical issues faced by the country focal points in managing their workplans. Country case studies on resource mobilization and channelling funds from the donors through the WHO operations system to the implementation level were shared by Bangladesh and Indonesia country offices. The need for clear linkages between allocations and programme results, e.g. between SO 5 generated allocations and programme outputs under SO 4 was discussed on the example of the Republic Of Korea funded project "Improving Maternal and Children's Health" of the DPR Korea workplan.

Although resource mobilization was recognized as being a difficult process at all levels, there were successful cases of resource mobilization at the country level. However, with limited staff and capacity, engaging in resource mobilization and direct negotiations with potential donors was seen as an arduous task. Provision of orientation training on WHO rules and regulation on management of grants could improve the resource mobilization capacity of country staff. One of the suggestions was to take a more conservative approach in planning VC ceilings so that more realistic, achievable targets are set for generating extra-budgetary funds early in the planning stage. Moreover, the absorption capacity of country offices and national stakeholders needs to be accounted as often it is not sufficient to maximize the implementation of available funds.

Country focal points raised concerns with regard to insufficient or inadequate training of country office technical staff in programme management and administration. The reasons were either due to lack of interest and ownership from technical staff or insufficient or inadequate training focusing for the needs of technical staff. It was strongly felt that technical staff should be given clear instructions on their responsibility, functions, roles and rights in operating AMS/GSM to enable them to smoothly implement their workplan budgets. Currently, AMS rights of country office technical staff were limited either to browsing functions or issuing requisitions for payment transactions. It was felt that "budget owner" rights should be given to technical staff as this would entail more frequent engagement of staff with AMS and a more efficient and productive operational workflow.

Dr Brooks informed about the distribution of allotments under SO4 at the country level. He pointed out the importance of linking allotments in order to make the conversion from AMS to GSM smooth. He assured the participants of continued PLN-SEARO assistance to countries including further operational support through scheduled visits to country offices.

With regard to resource mobilization and allocation of VC funds, he recommended that country focal points: (i) synchronize the project and the workplan and make programme changes if necessary; (ii) use standard donor agreements; (iii) understand that 80% of funds can be allotted upon signing of a donor agreement; and (iv) follow-up with SEARO to ensure that the allotments were issued.

5. Thematic Discussions

5.1 Adolescent pregnancy

Dr Viviana Mangiaterra presented existing epidemiological evidence on adolescent pregnancy (women between 15-19 years old) demonstrating the relationship of multiple determinants, such as age at marriage, education, geographic residence, cultural values and norms, socio-economic status, sexual coercion and access to prevention services on adolescent pregnancy. Adolescent pregnancy carries high risks of perinatal and maternal mortality due to unsafe abortion, preterm birth, low birth weight, anaemia and obstructed labour.

The clinical care of pregnancy in adolescents is similar to that of mature women, although special attention should be given to the pregnant adolescent as reflected in the IMPAC guidelines. These include an early start for antenatal care, prevention of anaemia, special counseling and nutritional supplementation during pregnancy and the postpartum period. Special obstetric care is required for adolescents younger than 15 years old with counseling and prevention of early second pregnancy.

A conceptual framework was presented, which described actions for addressing adolescent pregnancy both within health systems and at the community level using four MPS strategic directions: (i) building a conducive social, political and economic environment to support timely actions in countries; (ii) responding to country needs to achieve universal coverage of essential interventions that will ensure skilled care at every birth; (iii) building effective partnerships across relevant programmes and partners for coordinated actions in countries; and (iv) strengthening assessment, monitoring and evaluation for better decision-making by policy-makers and planners.

Dr Ardi Kaptiningsih shared the regional situation, which demonstrated high levels of early marriages among girls and a high proportion of birth to adolescents aged 15-19 years, in particular in Bangladesh (22.6%), Nepal (18.4%) and Indonesia (13.2%). Programmatic approaches to address adolescent pregnancy were discussed, i.e. in- and out-of-school health education programmes, advocacy, partnership with local NGOs in provision of RH information, improving access to MNH service for pregnant adolescents, establishing counseling and support systems for pregnant adolescents, strengthening capacity of health providers as well as data analysis and its use.

5.2 Sexually transmitted infections

Dr Akjemal Magtymova in her presentation on the elimination of congenital syphilis said that Globally, each year there are an estimated 0.75-1.5 million cases of congenital syphilis. It is a major cause of stillbirth globally and an important cause of preterm delivery, low birth weight, and neonatal death. Perinatal mortality due to congenital syphilis is on par with that of HIV or malaria, while low-cost and effective public health interventions exist. WHO had launched a new initiative for the "Global Elimination of Congenital Syphilis as a Public Health Problem" in October 2007 during Women Deliver Conference in London. Letters of Commitment were signed by 26 nations and international agencies. The initiative is based on four pillars: (i) sustained political commitment and advocacy; (ii) increased access and quality of MNH services; (iii) screening and treating pregnant women and their partners; and iv) surveillance, monitoring and evaluation.

The role of WHO, in cooperation with international partners, is to develop an integrated framework for surveillance and monitoring, scale-up successful interventions, establish recommendations on treatment and testing algorithms, support operations research for rapid tests and other practical technologies and to ensure congenital syphilis information is adequately addressed in clinical guidelines. In order to mobilize resources for action, WHO/CDC initiated an investment case. The initiative is based on the integrated approach to services and priority steps at the national level that includes, among others, creating the foundation for costing the plan and financial sustainability for the envisaged interventions through advocacy and resource mobilization and strengthening the surveillance, monitoring and evaluation of the planning process.

SEARO supported projects on integration of STIs in MNH/FP services in Sri Lanka and Indonesia in 2007. Experiences of both projects were shared. The Sri Lankan project focussed on expanding and improving testing, reporting and a follow-up of syphilis patients in antenatal settings; while Indonesia implemented a pilot project on antenatal syphilis screening and strengthening reporting of RTIs/STIs. Indonesia planned the expansion of the project with potential support from UNFPA in order to document and analyze options for congenital syphilis prevention, including the feasibility study on the use of rapid syphilis test at the community midwives level.

6. Reproductive Health and Research Programme Review

6.1 Review of the 2006-2007 performance and plans for 2008-2009

Country focal points shared their analysis of the 2006-2007 programme performance and key activities envisaged during 2008-2009. SEARO highlighted activities in the regional 2008-2009 RHR workplan, which builds on the activities initiated in 2007 in the areas of MNH, FP, prevention of unsafe abortion, prevention and management of RTIs/STIs through MNH/FP services, including elimination of congenital syphilis, and promoting healthy interactions between boys and girls. Planned regional meetings included: (i) Regional workshop on strengthening FP programme management in September 2008; (ii) High level advocacy meeting for achieving MDGs 4 and 5 in October 2008 and iii) Bi-regional meeting on strengthening human resources and services for MNH (with WPRO) in November 2008.

Dr Katherine Ba-Thike led the discussion on how to optimize the 2008-2009 workplan activities across the Organization and pointed out the options for joint planning by HQ, Regional office and Country offices. The participants verified common activities in a draft matrix which can be used for further detailed planning. Discussion topics included addressing reproductive health holistically in national programmes by transforming the WHO Global RH Strategy to the country level, which remained a challenge. Concerns were also expressed at the lack of integration of RTI/STI with MCH services and lack of policy and programmatic attention to adolescent health. Adopting culturally sensitive programmatic approaches, establishing close interaction with interrelated vertical programmes and addressing adolescent pregnancy in the policy, advocacy and programmatic agenda were encouraged.

6.2 Update on Global Reproductive Health Strategy

Dr Ardi Kaptiningsih updated the participants on WHO's first Global Reproductive Health Strategy adopted by the 57th World Health Assembly in 2004. The Strategy aims to improve sexual and reproductive health and targets five core elements: (i) improving antenatal, delivery, postpartum and

newborn care; (ii) providing high-quality services for family planning, including infertility services; (iii) eliminating unsafe abortion; (iv) combating STIs, including HIV, RTIs, cervical cancer and other gynaecological morbidities; and v) promoting sexual health.

In consultation with Member States, SEARO has adopted the *Framework for Implementing the Reproductive Health Strategy* for the Region as a guide for policy makers in governments, international agencies, professional associations, NGOs and other institutions. The Framework reflects five core strategies to achieve universal access to reproductive health by 2015 by: (i) strengthening health systems capacity; (ii) improving information for priority setting; (iii) mobilizing political will; (iv) creating supportive legislative and regulatory frameworks and (v) strengthening monitoring, evaluation and accountability.

6.3 MDG 5B: Universal access to Reproductive Health

Dr Akjemal Magtymova presented an overview of progress on MDG 5B: universal access to Reproductive Health. The rate of progress and current status of achieving MDG 5B was measured by contraceptive prevalence rate, adolescent birth rate, antenatal care coverage and unmet need for family planning, which are varied among countries in the Region. While some countries demonstrated good progress, achievement of MDG 5B needs concerted efforts for filling the gaps for improving access to and quality of antenatal care and family planning services for underserved and vulnerable population groups, including adolescents. Sources of data, frequency of collection, utility of disaggregated data in analysing progress and prioritizing actions were discussed.

Dr Katherine Ba-Thike presented the global issues and progress related to universal access to sexual and reproductive health. The new MDG 5B target recognizes the centrality of reproductive health and reproductive rights in improving maternal and newborn health and in reducing poverty. Measuring universal access to RH in the health care context is about measuring the provision of services, its update and sustained usage. Indicators should be prioritized as: "core" indicators (all the four indicators for MDG 5B) that all countries should report on; "additional" indicators for countries with high coverage for relatively developed health information systems (e.g. proportion of women screened for cervical cancer); and "extended" indicators that are relevant to countries with particular problems (e.g. prevalence of female genital mutilation).

At the country level, it was recommended to use the indicators framework along with targets set for diagnosing sexual and reproductive health issues and identifying interventions. The ability to interpret and use data at sub-national and sub-population levels need to be taken into account. Dr Ba-Thike also presented examples of the indicators reflecting linkages between sexual and reproductive health and HIV/AIDS. Timor-Leste requested support for national capacity building and technical assistance in data gathering and data management for tracking MDG5-related data. Analysis of data disaggregated by age, sex and socio-economic determinants can highlight equity issues and subsequently facilitate rights-based reproductive health approaches. The importance of data collection, analysis, and dissemination for use by the programme managers at the country and sub-national levels was emphasized.

6.4 Overview of RHR Department

Dr Katherine Ba-Thike presented the history, structure and mandate of the Department of Reproductive Health and Research (RHR), which was created in November 1998 from two pre-existing entities: i) WHO Division of Reproductive Health (Technical Cooperation with Countries) and ii) UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP). She provided detailed information related to the work of RH Technical Cooperation with Countries and HRP clarifying their specific roles, structures, terms of reference and modus operandi. Plans, priorities and on-going projects, including the Global Survey for Asia, other studies and work of thematic areas were highlighted.

Dr Ba-Thike clarified practical issues related to technical support for national research capacity building, application processes, timeframes, roles and eligibility for grants. Current support for national research covers RTI/STI studies in different populations, antenatal syphilis screening, emergency obstetric care, post-abortion family planning, peer education for adolescents and approaches to improve cervical cancer screening.

6.5 Updates on FP evidence-based guidelines

Dr Katherine Ba-Thike presented the WHO Four Cornerstones of evidence-based guidelines for family planning. They address a broad range of readers: policy and programme managers (*Medical Eligibility Criteria for*

Contraceptive Use; Selected Practice Recommendations for Contraceptive Use), as well as health practitioners (*Decision-Making Tool for Family Planning Clients and Providers; Handbook for Family Planning Providers*).

Recent and current work on FP evidence-based guidelines include: (i) *Generic Adaptation Guideline for all RH Guidelines and Tools;* (ii) *Reproductive Choices and Family Planning for People with HIV, an adaptation of the Decision-Making Tool for Family Planning Clients and Providers*; (iii) review of evidence regarding the effects of hormonal contraception on bone mineral density and fracture risk; (iv) evaluation of both published and new data related to HIV risk and hormonal contraception use and (v) provider's brief on the risk of STI acquisition and hormonal contraception.

A press release after the expert meeting convened by the International Agency for Research on Cancer (IARC) in June 2005 emphasized the carcinogenic risks to humans posed by combined estrogen-progestogen oral contraceptives (COCs) and combined estrogen-progestogen hormonal menopausal therapy. However, assessments based on risk-benefit calculations carried out by the Expert Panel of Medical Eligibility Criteria concluded that for most healthy women, the health benefits clearly exceed the health risks. The agenda of the 2008 Meeting of the Expert Working Group to update FP guidance include new guidelines and clarifications on earlier ones. More information could be found on the website: http://www.who.int/reproductive-health/family_planning/index.html.

7. Conclusions and closing

Dr Ardi Kaptiningsih led the discussion on country needs and technical support from the Regional office and HQ. She reiterated SEARO's technical assistance in writing proposals and research grant applications. While special attention is given to countries with a high burden of MNH/RH problems, equal attention is also given to countries with a small population, such as Bhutan, Maldives and Timor-Leste, where external support is essential.

The priority areas for close technical collaboration between the country offices, the Regional Office and RHR/HQ were identified (Annex 3). Dr Katherine Ba-Thike summarized the key points for technical support to countries, including: research capacity building in Bangladesh, Indonesia

and Bhutan; service quality improvement in India; prevention of unsafe abortions in Indonesia; development of RH Strategic Plan in Myanmar; cervical cancer and FP issues in Nepal; training of master trainers on ENC in Sri Lanka; MDG monitoring in Thailand and Timor-Leste; adaptation of MNH/RH guidelines in Bhutan, Timor-Leste and Maldives.

The closing remarks were given by Dr Jelka Zupan, Dr Katherine Ba-Thike, Dr Mattews Matthai and Dr Ardi Kaptiningsih. The joint planning meeting ended on a positive note for achieving the MDGs 4 and 5. Follow-up actions will be carried out at different levels, as agreed. The workplan for inter-country and individual country support and technical assistance will be finalized by HQ in consultation with SEARO and country offices.

Annex 1

Programme

Tuesday, 15 April 2008

09.00 – 09.30	➢ Opening remarks	Dini Latief
	➢ Objectives and Tentative Programme	Ardi Kaptiningsih
	➢ Introduction of participants	Akjemal Magtymova
	➢ Appointment of Chairperson	Dini Latief
	➢ Announcement	
09.30 – 10.00	➢ Analysis of MPS 2006-2007 performance HQ and RO (10 minutes each)	Jelka Zupan Ardi Kaptiningsih
	➢ Discussions	
10.00 – 10.30	Country presentations: MPS achievements/ performance in 2006-2007 and plans for 2008-2009 activities (technical and financial, following a template: 10 minutes/country):	
	➢ Bangladesh	Long Chhun
	➢ Nepal	Vijaya Manandhar
	➢ India	Sonia Trikha
11.00 – 11.20	Discussions	
11.20 – 12.00	Country presentations (continued):	
	➢ Bhutan	Dorji Phub
	➢ Timor-Leste	Telma JC De Oliveira
	➢ Indonesia	Imma Batubara
	➢ Myanmar	San San Myint
12.00 – 12.30	Discussions	
13.30 – 14.00	Country presentations (continued)	
	➢ Sri Lanka	Anoma Jayatilaka
	➢ Thailand	Somchai Peerapakorn
	➢ DPR Korea	Arvind Mathur
14.00 – 14.15	Discussion	

14.15 – 14.45	Discussion on achievements and performance	
14.45 – 15.00	Plan activities for 2008-2009 HQ and RO (10 minutes each)	Jelka Zupan Ardi Kaptiningsih
15.00 – 15.30	Use of the GF for including MNH service delivery area in health system strengthening: Global experience.	Viviana Mangiaterra Laksami Suebsaeng
16.00 – 16.30	Analysis and discussion on: ➢ plans, funding gaps, absorption capacity ➢ planned VC ➢ resource mobilization ➢ potential donors ➢ other resources Discussion	All participants

Wednesday, 16 April 2008

09.00 – 10.00	Implementation of Work Plan 2008-2009	Mark Brooks
10.00 – 10.30	Country case study in resource mobilization and in channelling funds to the WHO system	Long Chhun Imma Batubara
11.00 – 12.00	Optimizing implementation of the MPS WorkPlan 2008-2009: ➢ support for activities in 2008-2009 ➢ identifying and planning for joint activities ➢ monitoring and ensuring performance Discussion	Jelka Zupan
12.00 – 12.30	MDGs 5, 4 and 6: ➢ WHO focus ➢ Assisting countries in monitoring progress and reporting on MDG indicator	HQ and RO team
13.30 – 14.30	MDGs 5, 4 and 6 (continued) DG priorities related to MDGs Discussion	HQ and RO team
14.30 – 15.30	Technical updates	Jelka Zupan Matthews Mathai
15.30 – 16.30	Technical updates Discussion	Jelka Zupan Matthews Mathai

Thursday, 17 April 2008

09.00 – 10.00	Country case studies: ➢ MNH programme review in SRL and in BAN, IND, NEP ➢ Expanding skills of primary health care providers/skilled birth attendants in essential newborn health care in SRL and MMR	 Country MPS Focal Points Akjemal Magtymova
10.00 – 10.30	Briefings on country activities and expectations	Jelka Zupan Ardi Kaptiningsih
11.00 – 12.00	Thematic discussion on adolescent pregnancy: ➢ update ➢ activities at each level ➢ link with MDG ➢ support Discussion, conclusion and recommendations for MPS	 Viviana Mangiaterra Katherine Ba-Thike Ardi Kaptiningsih
12.00 – 12.30	Thematic discussion on RTIs/STIs: ➢ Elimination of Congenital Syphilis ➢ Integration of RTIs/STIs in MNH/FP service: Experience from Indonesia and Sri Lanka	 Akjemal Magtymova Country MPS Focal Points
13.30 – 14.00	Discussion	
14.00 – 15.30	Analysis and discussions on RHR achievements/performance in 2006-2007 and plans for 2008-2009 activities	All participants
16.00 – 16.30	Analysis and discussions on RHR achievements/performance in 2006-2007 and plans for 2008-2009 activities (continued)	All participants

Friday, 18 April 2008

09.00 – 10.30	Optimizing implementation of the WorkPlan 2008-2009: ➢ support for activities in 2008-2009 ➢ identifying and planning for joint activities ➢ monitoring and ensuring performance Discussion	Katherine Ba-Thike Ardi Kaptiningsih

11.00 – 12.00	Update on Global Reproductive Health Strategy	Ardi Kaptiningsih
	Review of progress on MDG5B: Universal access to reproductive health care	Katherine Ba-Thike Akjemal Magtymova
12.00 – 12.30	Overview of RHR and HRP	Katherine Ba-Thike
	Work of Technical Co-operation with Countries	
	Discussion	
13.30 – 14.45	Overview of RHR and HRP	Katherine Ba-Thike
	Work of thematic areas	
	Discussion	
14.45 – 15.30	Updates on FP evidence-based guidelines and other issues	Katherine Ba-Thike
	Discussion	
16.00 – 16.30	Conclusion, next step and closing	SEARO

Annex 3

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Annex 3

Areas of technical collaboration/support from RO/HQ[2]

Bangladesh

1. Revision of policy and strategy on MNH/RH.
2. Capacity building for six research institutions on RH.
3. Adaptation of MNH guidelines and community support system.

Bhutan

1. Technical support for midwifery pre-service curriculum
2. Hands on in-service training
3. Capacity building on research on RH.
4. Development of EmOC model.
5. Essential newborn care.

DPRK

1. Maternal Health: review of training package on EmOC; Ob/Gyn pre-service curriculum; applying MPS costing tool; supervision tools.
2. Newborn Health: development of standard essential newborn drug list based PCPNC and MNP; pre-service curriculum assessment and review.
3. Quality of training and service provision: master plan on scaling up of MNH training; introduction of QI in MNH facilities preceded by a situational assessment.
4. Institutional strengthening: building capacities through linkages with overseas institutions/WHOCCs.
5. Global Fund and resource mobilization opportunity for MPS.
6. Assistance in adaptation of RH tools at country level and development of communication strategy.

India

1. Strengthening of pre-service education of ANM/GNM: curriculum development.
2. Quality Improvement of MNH in four states.
3. Guidelines for medical methods of abortion.

Indonesia

1. Strengthening national research capacity and network.
2. Strengthening pre-service midwifery curriculum (D3) and clinical practice.

[2] Areas of technical assistance and collaboration will be further discussed between Country offices-Regional office-Headquarters for finalization of detailed plans.

3. Development of Confidential Enquiry of Maternal Deaths.
4. Specific issues of RH, i.e. preventing unsafe abortion, overmedicalization of MNH care.
5. Finalizing advocacy materials for MNH.

Myanmar

1. Essential newborn care: pre- and in-service training, the need to have training materials and manuals, curriculum strengthening.
2. Revision of RH Strategy.

Nepal

1. Pre-service midwifery education: ToT.
2. Training of ANMs in collaboration with ACCESS.
3. Essential newborn care.
4. Cervical cancer prevention programme assessment.
5. FP programme strengthening.

Sri Lanka

1. Development of MNH strategic plan with costing
2. PPH prevention and treatment – QI activity.
3. Development of master trainers on ENC.
4. Functional analysis of curriculum for midwifery education.
5. Training on VIA.

Thailand

1. MDG monitoring: capturing vulnerable groups and areas given due attention related to RH strategy.
2. Continue support for prevention of unsafe abortion, including technical input for national survey, adolescent pregnancy and medical abortion.
3. Resource mobilization.

Timor-Leste

1. Adaptation of guidelines for verbal autopsy.
2. Adaptation of PCPNC in Spanish for Cuban doctors.
3. ENCC: tools and printing.
4. RH tools/ curricula on adolescent health for high school.