Report of the
Fifth Meeting of the South-East Asia
Regional Technical Advisory Group (SEAR-TAG)
towards reduction of maternal mortality and
stillbirths in the context of
Universal Health Coverage
25-27 November 2019, New Delhi, India

Meeting of the South-East Asia Regional
Technical Advisory Group (SEAR-TAG) on
Sexual and Reproductive Health
28-29 November 2019, New Delhi, India
Report of the Fifth Meeting of the South-East Asia Regional Technical Advisory Group and first meeting of Sexual Reproductive Health Technical subcommittee towards reduction of maternal mortality and stillbirths in the context of universal health coverage

New Delhi India, 25–27 November, 2019

Meeting of the South-East Asia Regional Technical Advisory Group (SEAR-TAG) on Sexual and Reproductive Health

New Delhi India, 28–29 November, 2019
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Background</td>
<td>1</td>
</tr>
<tr>
<td>2. Objectives of the meetings</td>
<td>1</td>
</tr>
<tr>
<td>3. Inaugural session</td>
<td>2</td>
</tr>
<tr>
<td>4. Session 1: Setting the stage: Accelerating reduction in maternal mortality and stillbirths</td>
<td>3</td>
</tr>
<tr>
<td>5. Session 2: Strategies for accelerating reduction in maternal mortality</td>
<td>5</td>
</tr>
<tr>
<td>6. Session 3: Strategies for accelerating reduction in stillbirths</td>
<td>8</td>
</tr>
<tr>
<td>7. Session 4: Strengthening the health system for reduction in maternal mortality and stillbirths</td>
<td>10</td>
</tr>
<tr>
<td>8. Session 5: Strengthening Family planning and comprehensive abortion care</td>
<td>13</td>
</tr>
<tr>
<td>9. Session 6: Regional strategy on Sexual reproductive health and rights</td>
<td>15</td>
</tr>
<tr>
<td>10. Session 7: Country actions on proposed TAG recommendations</td>
<td>15</td>
</tr>
<tr>
<td>11. TAG Recommendations</td>
<td>16</td>
</tr>
<tr>
<td>1. Objectives of the meetings</td>
<td>24</td>
</tr>
<tr>
<td>2. Session 1: Progress on Implementation of previous TAG recommendations</td>
<td>24</td>
</tr>
<tr>
<td>3. Session 2: Prioritizing actions in focus countries</td>
<td>26</td>
</tr>
<tr>
<td>4. Session 3: Comprehensive abortion care situation and challenges</td>
<td>26</td>
</tr>
<tr>
<td>5. Session 4: Improving UHC for sexual and reproductive health (SRH) through health systems approach</td>
<td>26</td>
</tr>
</tbody>
</table>

## Annexes

- Agenda .............................................................................................................. 29
- List of participants ......................................................................................... 35
- Regional Director’s message ............................................................................. 40
- Country action plan ........................................................................................ 42
1. **Background**

A Technical Advisory Group (TAG) for women’s and children’s health was created by WHO’s South-East Asia Regional Office (SEARO) by the Regional Director in 2015, to support the Regional Flagship Priority Area on ‘ending preventable maternal, newborn and child deaths with a focus on neonatal deaths’. Through the last four TAG meetings, recommendations have been provided to accelerate reduction of preventable mortality among mothers, newborns, children, and improve adolescent health. While sustaining the gains in mortality reductions, guidance has been provided to address elements of thrive and transform of Global strategy on Women’s, children’s and adolescents’ health. The recommendations have been shared with the Member States.

To further strengthen the regional efforts in reducing maternal mortality, a WHO global project on ‘Sexual and Reproductive Health and Rights (SRHR): A ten-year vision for enhancing WHO’s capacity to support countries in achieving universal access to SRHR’ has been initiated in the Region. To guide the implementation of the project, a sub-TAG on SRHR has been constituted under the existing TAG for women’s and children’s health. The terms of reference of the SRHR-TAG includes (in addition to maternal health), family planning (FP), cervical cancer and comprehensive abortion care (CAC) with a focus on reproductive and sexual rights.

A meeting of the TAG members, SRHR sub-committee members along with H6 Regional Working Group Members, National Programme Managers from Ministries of Health, Representatives of academic institutions, WHO Collaborating Centers, professional associations and development partners was held from 25-27 November 2019, New Delhi, India. The focus of this meeting was accelerating reduction of maternal mortality and stillbirths in Member States. Another meeting of the TAG and SRHR sub-committee to discuss maternal health, stillbirth prevention and other areas of sexual reproductive health was held between 28-29 November 2019. The agenda for both the meetings and the list of participants are given in Annex 1.

2. **Objectives of the meetings**

(1) Review the progress of the previous TAG recommendations.

(2) Review status of maternal mortality and stillbirths in the Region.

(3) Develop a shared understanding of Draft Regional Strategic Framework on Sexual and Reproductive Health and Rights (SRHR) with focus on accelerating reduction of maternal mortality and stillbirths.

(4) Review the regional situation of abortion/post-abortions care/post-abortions family planning and identify the needs of Sexual Reproductive Health and Rights in SEA Region.

(5) Develop recommendations for actions, country action plans and identify technical assistance required by Member States.

(6) To identify the needs of Sexual Reproductive Health and Rights (SRHR) in South East Asia Region.

(7) To make recommendations on SRHR with focus on strengthening abortion, post abortion care and post abortion family planning for SEA Region.
3. Inaugural session

Dr Neena Raina, Director a.i., Department of Family Health, Gender and Life course welcomed the TAG members and distinguished participants. She highlighted that the Region has achieved highest overall percent reduction in maternal mortality ratio (MMR), substantial reduction in infant and child mortality and also urged the countries not to be complacent as the SDG 3 targets for mortality reductions need to be achieved by 2030. She highlighted the issue of high stillbirths in the region and lack of attention to the issue in most Member States. She also mentioned the need to focus on comprehensive abortion care (CAC) and family planning (FP). Dr Raina reminded the participants that the day (25 November) is the first day of the ‘16 days of activism against gender-based violence’ with a request to wear the orange scarfs provided in commemoration of the event.

The Regional Director’s address was delivered by Dr. Pem Namgyal, Director, Programme Management (see Annex 3). While acknowledging the Region’s achievements in reducing the MMR and neonatal mortality reduction, the RD emphasized that that the Region aims to ensure that no country in the Region should have an MMR of more than 140 per 100,000 live births. The RD also expressed concerns about the slow reduction of stillbirths (31.7 percent) and urged the countries to adopt strategies to accelerate the reduction. Several key areas for action were identified such as increasing institutional deliveries, adapting WHO guidelines and increasing community engagement, rationalization of caesarean sections, improving community based postnatal care and increased access to SRHR services. Universal access to FP services, especially access to adolescents were emphasized. RD hoped that through the above actions, the Region’s vision of ‘Sustain, Accelerate and Innovate’ of the Flagship Priorities and SDGs will be achieved. RD thanked the TAG for its contributions in the past and expressed the confidence that the recommendations of the TAG meetings will contribute towards achieving targets in Member States.

The Chair of the TAG, Dr Vinod Paul while complementing the countries for the progress in reducing maternal, neonatal and child mortality, further reiterated the need to reduce MMR and stillbirth rate through Universal Health Coverage (UHC) and Primary Health Care (PHC) approaches. He strongly recommended that the Region should reduce MMR to 70 per 100,000 live births or two-thirds reduction based on 2010 levels, whichever is lower and advance the target year before 2030. He also emphasised that Member States need to have a greater focus on still births reductions.
4. Session 1: Setting the stage: Accelerating reduction in maternal mortality and stillbirths

The Presentation from WHO Headquarters on maternal mortality estimates and ending preventable maternal deaths (Dr. Doris Chou on behalf of UN MMIEG) covered the UN MMIEG MMR estimation process including the use of Bayesian model of estimation and emphasized that the estimates are meant to ensure comparability across countries and need not necessarily be the same as national estimates and does not supersede data generated by each country. It was pointed out that the new estimates of MMR included several data sources from the countries and therefore is more representative of country data. It was emphasized that each round of estimates supersedes the previous estimates as each round involves re-estimating the entire MMR curve and affects historical trends. The presentation pointed out that by reaching the 2030 targets for MMR will save 1 million lives between 2016 and 2030. The importance of country’s health systems ensuring equity, quality and universal coverage, addressing all causes of maternal mortality and socio-economic determinants of women’s empowerment in achieving maternal mortality reduction was highlighted. Ending preventable maternal mortality (EPMM) strategic objectives focusing on equity, quality, health systems, addressing all causes of death by implementing evidenced based interventions, empowerment of women and girls and accountability were also presented and also its linkages with every new-born action plan (ENAP). Information on the upcoming publications on tools for estimating country level targets, causes of death and estimations on proportion of maternal deaths among 15-19 years were shared.

The Presentation from WHO SEARO on maternal and reproductive health in the context of Universal Health Coverage (UHC) (Dr. Chandani Anoma Jayathilaka) covered the progress in reducing MMR and stillbirths in the Region and challenges as well as issues related to coverage of essential interventions and enabling factors. While highlighting the reduction of MMR in SEAR and the expected further reduction, region may miss the SDG/EPMM target of 2/3rd reduction from 2010 level unless there is acceleration in the annual rate of reduction (ARR) of maternal mortality. The presentation clarified that all individual countries must focus on achieving the 2/3rd reduction from 2010 level with no country reporting an MMR of more than 140 by 2030 and those countries with low levels to focus on further reduction focusing y focusing on equity and quality issues. Reframing each country’s intermediate targets based on the 2017 estimates at national and subnational levels, to be achieved earlier than 2030, was recommended as a means to ensuring achieving the targets. While stillbirth rates have decreased in the Region, it is unlikely that the Region will achieve the global target of stillbirth rate of 9 per 1000 total births and each country achieving a stillbirth rate of 12 or less per 1000 births. Universal access to SRH services particularly ANC, intrapartum care and FP services is important for achieving reduction in still births. Almost all the countries have established national Maternal Death Surveillance and Response (MDSR) systems and in hospitals, but the community-based surveillance is well established in only about 50 percent of the countries. Response mechanisms are well established in almost all Member States, but the quality is not known. Comprehensive nationwide perinatal death surveillance and response is being implemented only in Sri Lanka.
Implementation of WHO recommendations are important to further improve the coverage and quality of services. While supportive policies for ANC exists in all the countries, only 4 countries have updated their guidelines to align with WHO’s 2016 recommendations for a positive pregnancy experience. The regional coverage of 4 ANC visits was 55 percent; where as eight visits with at least 5 visits during the last trimester and provision of relevant services as recommended is critical for preventing stillbirths. Intrapartum recommendations for positive childbirth 2018 have been adopted by few of the countries and others are in the process of adaptation. Deliveries by skilled birth attendants (SBAs) have increased in all the countries; however, there are concerns whether the providers meet the criteria for being skilled birth attendant. While institutional delivery has increased in all the countries, home deliveries by unskilled health providers are still significant in some (ranges from 14%-40%). Lack of respectful care during childbirth is a major global and regional concern though no data is available in the countries in the Region (disrespectful care includes lack of support, lack of consent in performing procedures and mistreatment during childbirth). Postnatal contacts, especially with new-borns is low, compared to antenatal and intra-natal coverage though postnatal policies include visits. The major role played by health system arrangements in determining the level of MMR was illustrated through the obstetric transition model and health system categorisation. Other issues related to health system such as health workforce shortages, poor quality of care and access to supplies and equipment were discussed. Member States Highlighted The S-curve showing the countries according to modern contraceptive prevalence rate (mCPR), grouped according to various stages was presented with specific strategies for improving coverage and quality of FP services. Most of the member states are in stage 2 in S curve and advised to continue demand creation, removing barriers, and improving quality of services and focusing on equity and quality in stage 3 countries (4 countries). The prevalence of cervical cancer in SEAR is 15 percent of all female cancers and second highest after breast cancer and is a priority issue.

Key points discussed
- Strong recommendation to countries to reach SDG Target of 70 or 2/3rd reduction from 2010 level, whichever is lower.
- Reframe intermediate MMR targets based on ARR and 2017 value and focus on early achieving of country targets (by 2025).
- Develop sub-national MMR targets.
- Improving quality of care is critical to achieve MMR reduction.
- Focus on reducing inequity by strengthening PHC to improve ANC, institutional delivery and post-natal care and tackle demand side interventions to improve coverage in ANC and institutional delivery.
- Improve the quality of MDSR including community surveillance which is critical for not only providing information on maternal deaths but also for developing strategies to prevent more deaths.
- Need to analyse the situation by focusing on delivery points (engaging private sector) identify how non-proximate determinants influence the health care deliverables and need to establish evidence based strategies
- Lessons can be learnt from countries with emphasis on those strategies and best practices, which have been proven successful and make specific recommendations for countries in all the areas
- EPMM 11 priority areas can provide guidance to countries on achieving reduction in maternal mortality- focus on women and girls, integration of mother-baby dyad, country ownership, UHC, quality of care, inequity, health system strengthening, human rights, accountability, etc.
- The recommended 8 antenatal visits, coverage of services to be provided at each visit and 80 percentage coverage was discussed at length and a time-bound update of national guidelines based on WHO’s 2016 guidelines and its implementation was discussed

5. **Session 2: Strategies for accelerating reduction in maternal mortality**

*Strengthening intrapartum care: institutional deliveries* was deliberated through a panel representing Bangladesh, Myanmar and Timor-Leste that have low institutional deliveries and high home deliveries. The panellists were asked to define institutions that conduct deliveries, who conducts home deliveries, what is the contribution of home deliveries to MMR in respective countries, neonatal mortality and stillbirth rate, what are the obstacles to institutional delivery and what are the strategies planned to increase institutional deliveries in the coming years. The three countries reported that the national policies promote institutional deliveries and have standards for institutional deliveries which are often not met due to challenges in implementation. Traditional birth attendants and auxiliary midwives and midwives conduct home deliveries. The delay in recognition of complications and timely transfer from home were noted as contributors to maternal mortality and stillbirths as well as neonatal mortality. Geographical access, illiteracy, inadequate health providers, etc were noted as barriers to institutional delivery. Timor-Leste focuses on birth preparedness which includes plans for institutional deliveries and also has developed standards and protocols for intrapartum care and the midwives are being trained.

**Key points discussed**
- Though the guidelines/ protocols for institutions where deliveries take place are available, implementation of the guidelines/ protocols is a challenge. All the countries are making efforts to implement the guidelines
- Need a system to identify whether institutions meet the standards for facility delivery and set up a system to register /de-register facilities
- Need to maintain three factors critical for quality institutional delivery—standardization of institutions where the delivery is taking place with skilled care and well-maintained referral system and highlighted the importance of 24/7 running of the institutions
- Birth preparedness and complication readiness plan developed during ANC was discussed as a critical element for increasing institutional deliveries
Emphasis was laid on 8 ANC contacts and how it contributes to promoting institutional deliveries
Barriers such as terrain, costs of delivery in institutions (even in public facilities), attitudes of providers were pointed out leading to inequity
Issues such as timing of transportation to facilities and deliveries taking place on the way were discussed
Demand side interventions to enable access to institutional deliveries such as maternity waiting homes, transportation, etc. were recommended
The need to update national guidelines based on 2018 WHO recommendations and implementation schedule was discussed.
Respectful maternity care was highlighted

The Chair summarized by pointing out that deliveries without skilled care is not going to benefit in reducing MMR, stillbirths and neonatal deaths. The evidence related to 4 + ANC attendance and institutional deliveries was discussed. Poor skills of providers as well as attitudes of providers as well as financial barriers (high out of pocket expenditure even for normal deliveries in institutions), etc. were discussed as barriers.

A panel representing India, Indonesia and Nepal shared their experiences in the session on Strengthening intrapartum care: emergency obstetric care. The panellists were asked questions about basic and comprehensive emergency obstetric care (EmOC) in their respective countries, the most difficult signal function to deliver, impressions about the current tools to assess the readiness of facilities to provide EmOC and innovations in service delivery to meet the EmOC needs in their respective countries. Indonesia reported that though investments have been made in improving access to EmOC services, geographical barriers, gaps in human resources and lack of recognition of danger signs are barriers. In India, MOH has invested in demand side financing schemes to enable access to facilities with EmOC services and also for transportation. Training to non-specialist doctors is being provided in EmOC and obstetric anaesthesia for improving access. In Nepal EmOC needs assessments have identified gaps in facilities, skilled provider and quality of care and with the assistance of OBGYN society has made efforts to strengthen EmOC services in the district and regional facilities. However, geographical terrain is a main barrier. Countries identified administering parenteral Mag Sulphate, parenteral antibiotics and manual removal of placenta as difficult to implement.

Key points discussed
- Countries have invested in EmOC but the accessibility is an issue in some countries
- Need to create awareness among health planners and administrators that EmOC is not limited to CS and it involves a range of interventions to manage obstetric complications to reduce maternal mortality and morbidity.
- Need to review the current EmOC assessment tools and simplify them to make it more user-friendly and less costly and time-consuming without sacrificing the quality and content of the exercise
- Important to focus on referral linkage between facilities providing delivery and EmOC facilities
• Quality of EmOC services is critical for saving lives and along with access, quality must be emphasized
• Reducing MMR needs a multisectoral approach and readiness of health facilities to delivery evidence-based interventions with accountability. Regular monitoring of the EmOC facilities for readiness and mentoring of the skills of health workers was recommended.

The session on Rationalizing caesarean section started with a presentation by WHO headquarters (Dr Doris Chou) on WHO recommendations on caesarean sections followed by a presentation on country experience of application of Robson classification and evidence-based interventions (Country: Sri Lanka by Dr Hemantha Senanayake).

The WHO presentation emphasized that there was no justification for any country to have a caesarean section (CS) rate higher than 10-15 percent and there was no added benefit to maternal or perinatal mortality and at population level CS rates more than 10 percent are not associated with reductions in maternal and neonatal mortality; no evidence that CS is required after a previous CS and vaginal deliveries after a previous CS should be encouraged in facilities with surgical capability. The presentation also provided evidence that the higher level of CSs were in higher economic quintiles and poor had little access. WHO does not promote any specific rate to be achieved at population level or institutional level. Adoption of Robson classification system as a global standard for assessing, monitoring and comparing CS rates and indications was proposed. CSs can cause significant and sometimes permanent complications, disability or death, particularly in settings that lack the facilities or capabilities to do the procedure safely and manage surgical complications. To reduce the level of CSs, reviews have identified three levels of interventions: interventions targeted at women – educating women about implications of unnecessary CSs, preferably starting at ANC and also regular communications with the woman during labour; interventions targeted at health care providers- implementation of evidence-based clinical guidelines on CS indication, CS audits and timely feedback; and interventions targeted at health systems- Availability of midwife and obstetrician 24 hours working together to provide primary labour care for all private and public patients and ensuring no financial incentives.

Sri Lanka’s experience on application of Robson classification in the referral facility clearly showed that it is possible to classify every woman who comes in for childbirth, identify which group of women contribute maximum and least to CSs, develop strategies to address these, assess the quality of care and clinical management practices by analysing outcomes and raise staff awareness. Described the process of assessing the CS rate using Robson classification at hospitals and education of mothers during ANC about danger of CS without indications and communications with the woman and her family.

Key points discussed
• The issue of increasing CS rates in the population, despite lack of resources and poor coverage of other maternal health interventions, was discussed at length.
• It also highlighted that still some MS has population coverage CS rates below 5% and some settings it is very low
• The use of Robson classification to assess CS was not universal in SEAR countries.
• Increase CS rate should be viewed as an indicator for poor quality of intrapartum care. If hospital has CS rate > 30% or 40%, recommended to review the situation using Robson methodology and such facilities should be made accountable and prepare an action plan to improve the situation.
• Financial incentives to mothers and to consultant Obstetrician for CS could be a possible cause of increased CS rate and these practices need to be reviewed.
• Companionship during childbirth is an evidence-based intervention allowed practice only in few countries and must be encouraged in all the countries.
• Important to document changing trends in management of intrapartum care with changing epidemiological pattern of increasing NCDs, increasing age of mothers (especially primipara), etc. which may warrant CS.

Poster presentations on strengthening coverage and quality of antenatal and postnatal care were made by countries, showcasing best practices.

November 26, 2018

6. **Session 3: Strategies for accelerating reduction in stillbirths**

The session covered the current situation of stillbirths and prevention strategies followed by the stillbirth prevention programme – country experience (Sri Lanka) and stillbirth surveillance in NBBD. The presentation on current situation and prevention strategies (Dr. Chandani Anoma Jayathilaka) showed that about 2000 stillbirths happen every day in SEAR. Stillbirths have reduced in the Region but still the numbers are high, with highest rates in India, Bangladesh and Indonesia. Though Maldives, Sri Lanka and Thailand have achieved target of 12 per 1000 births or less, the Region has a long way to achieve the target by 2030. Most of the countries have set a national target for stillbirths. Most of the risk factors for stillbirths are preventable and are mostly due to maternal infections such as syphilis and malaria, non-communicable diseases and few due to birth defects. More than half of the stillbirths in SEAR happen during labour. Evidence based 10 interventions during pre-conception stage, antenatal period and intrapartum period with a 99 percent coverage of the interventions could prevent 45 percent of stillbirths at a cost of US $ 9.6 billion. Provision of EmOC and CSs could reduce a significant number of stillbirths. During ANC screening for syphilis and non-communicable diseases as well as ensuring high
quality ANC (5 visits during the last trimester) and institutional delivery with quality services and foetal monitoring are critical interventions to prevent stillbirths. Few countries in the Region conduct stillbirth reviews and some link it to MDSR. Definition of stillbirth in relation to gestational weeks adopted by countries is not uniform which makes it difficult for international comparison. In case 22 weeks of gestation is considered as the cut-off point the number of still birth will be higher, managing work load and reviews can be difficult. Perinatal audit and classification using ICD 10 Perinatal Mortality (ICD10 PM) should be encouraged. Most of the member states do not have a systematic mechanism to review stillbirths in the hospital and community. Stillbirths is considered as a quality indicator of intrapartum care in few countries. If stillbirth happens, it is equally important to provide support to the mother for bereavement.

The country case study of Sri Lanka illustrated few key factors in contributing to the success in reducing stillbirths- a multipronged approach of implementation of all 10 evidence-based interventions¹ during pre-conception period, antenatal care (8+ visits, screening for maternal infections and NCDs and >90% coverage, quality intrapartum care (adherence to guidelines, skilled providers), bereavement care in case of stillbirths (rosebud service), almost 100 percent institutional delivery, access to BEmOC and CEmOC facilities, functional referral system, reduced unmet need for family planning, perinatal death surveillance using international definition of stillbirths, inclusion of stillbirths in CRVS, etc. Functioning accountable health system is a major contributory factor in success.

The presentation on Stillbirth surveillance, India (PGIMER, Chandigarh) described the surveillance system being followed in ten hospitals using the Newborn Birth Defect platform. The hospitals follow MoH guidelines on stillbirth surveillance and use of ICD PM for classification. The data collected using the stillbirth surveillance tool developed by SEAR (based on WHO document on every baby count) is verified by a team of OBGYN and Paediatrician (first level). Second level verification on quality has just been initiated and needs improvement. The surveillance data showed that the ARR of stillbirths is low (one percent) and the causes of death have not changed over the years, hypertensive disorder of pregnancy remains the most important preventable cause of stillbirth. Currently the surveillance is limited to few hospitals. The importance of involvement of all levels of health care workers in stillbirth surveillance was emphasised.

---

**Key points discussed**

- The TAG chair and members acknowledged the slow progress and challenges with regard to prevention and management of stillbirths.
- Stillbirths should be brought to the highest level of political and academic discourse including that of the UN organizations, international and national organizations in the Region. Need to advocate for CHAMPIONS at different levels who can drive the agenda forward. The first and important step forward could be to issue a “wake up call” by declaring the year 2020/2021 as the year for “AVERTING STILLBIRTHS”.
- Stillbirth monitoring should be done for all facility births.

---

7. Session 4: Strengthening the health system for reduction in maternal mortality and still births

The session included optimum health system for delivery of maternal and reproductive health services, panel discussion on maternal and reproductive health services in national essential services package that included representatives of Bangladesh, Bhutan, Myanmar and Maldives, evidence and impact of models of midwifery care and a panel discussion on experiences in midwifery-led continuity of care that included representatives of Indonesia, Myanmar and Timor-Leste. The presentation on optimal health system for delivery of maternal and reproductive health (Dr. Dilip Mavlankar) focused on health system building blocks and the importance of patient involvement in health system, dimensions of UHC, the importance of quality of care by adhering to standards of care, respectful care, accessibility during the prescribed timing of the facilities, continuous care and referral system. The importance of skilled human resources, equitable distribution and their accountability was highlighted. In addition, the importance of having adequate number of health managers, in addition to health workers was discussed. Importance of investing in midwifery, developing strategies for rural retention were highlighted. The presentation also covered the importance of accurate and complete HMIS, strong logistics management systems to avoid stockouts of critical medicines and supplies, financing and
leadership to ensure motivation, mobilize resources and monitor progress of the programmes.

The *panel discussion on maternal and reproductive health services in essential services package* was based on questions related to whether the maternal and reproductive health services are currently included in the essential services package, the criteria for inclusion of the services and lessons learned. Bhutan’s health system is free and includes all services except provision of abortions. Periodic assessments are done to assess the coverage and quality of services and the information is used to update relevant guidelines and are done in collaboration with stakeholders. In Bangladesh, all maternal and reproductive health programmes are part of the essential services package. Respectful maternity care is incorporated in the package of services. In Myanmar, post-abortion care was added in 2017 to the existing package of maternal and reproductive health. Priority areas are identified through consultative meetings. Feasibility and affordability of engaging the private sector and accountability of service providers are important concerns. In Maldives, the components of the package of services vary according to the tier of the health system. Geographical access is a big barrier in access and increasing the coverage.

**Key points discussed**

- High level of political commitment is important for strengthening health systems as in the case of Bhutan
- All the countries are trying to strengthen their health systems though there are big challenges to maintain the quality of services and accountability
- Inequity is a major issue in the countries and have developed actions to address inequity but need to scale up and improve coverage including remote areas
- Budget estimates must include costs of technology and high impact interventions that are cost effective.

The presentation on *evidence and impact of models of midwifery care* (Dr. Jane Sandall) showed evidence on reduction of maternal and newborn mortality, less preterm birth and low birthweight, reduction in maternal morbidity such as infections, anaemia, eclampsia, etc., reduced unnecessary interventions in labour, improved psychosocial outcomes, increased birth spacing, increased breastfeeding, shorter hospital stay, improved referrals, etc. Educated and regulated midwives can provide 87 percent of the essential care for women and newborns. Universal coverage (95 percent) coverage of midwifery services reduced maternal mortality by 82 percent and reduce neonatal mortality and stillbirths (with 10 percent of service coverage by midwives, maternal mortality reduction is by 27 percent and with 25 percent service coverage by midwives, reduction of MMR is by 50 percent). Midwifery continuity of care model was defined. The group was informed that continuity of care is at the heart of maternity policy in the UK that has helped to reduce the MMR, neonatal mortality and stillbirths.
The panel discussion on experiences in midwifery-led continuity of care included the following topics: midwifery care in the country including responsibilities of midwives, applicability of midwifery-led continuity of care model, possibilities of scaling up – enabling factors and barriers, if the model is not applicable, strategies for strengthening existing midwifery. The panel was shared by midwives from Indonesia, Myanmar and Timor-Leste. In Indonesia, mostly ANC and FP services are provided by midwives. The skills of midwives are strengthened through training and recertification every 5 years. In Myanmar, the midwives provide a range of MCH services including immunization and elderly care. Quality of services in monitored regularly and refresher training. Shortage of midwives is a major concern. In Timor-Leste, midwives provide maternal care services, post-abortion care and FP. Lack of standardized curriculum for midwives and limited availability of human resources are concerns.

Key points discussed
- There is need for standardization of the licensing, education and practice of midwives. Quality education to meet the ICM standards for education and continuing training for midwives is a big challenge.
- Introduction of information technology in the midwifery led care is important in improving quality and coverage of services.
- Indonesia has a wide network of midwives but still high MMR because of the poor referral system owing to difficult geographical terrain. Moreover, the health insurance does not cover transpiration costs. Limited number of specialists at sub-national and rural areas is another important reason.
- There is need to focus on the definition of the institutional delivery and the standardization of the facilities where the delivery is taking place.
- The skill birth attendant with optimum training need to be monitored and mentored regularly.
8. **Session 5: Strengthening Family planning and comprehensive abortion care**

The session included a presentation on FP and abortion care in SEAR, followed by country experience in FP - Preventing adolescent pregnancy in Thailand and postpartum FP in Indonesia and country experiences in abortion care – Task shifting in post abortion FP in Nepal, Menstrual regulation programme in Bangladesh and CAC programme in India. The presentation on FP and abortion care in SEAR (Dr. Meera Thapa Upadhyay) highlighted the decrease in fertility (SEAR-2.1), increase in CPR for modern methods (mCPR) (SEAR-53 percent) and decrease in unmet needs (SEAR-13) and demand satisfied (73 percent). Majority of the countries are stage 2 of the S-curve which points to the need for increased coverage through removal of barriers, high quality services and demand creation. Majority of the contraceptives are included in the essential drug list of countries. Doctors, midwives and nurses are allowed to provide most of the contraceptive methods including IUCD. Non-medical barriers to contraceptive services are prevalent in approximately half of the countries. The presentation also illustrated contribution of meeting unmet needs to reducing unwanted pregnancies and abortions and reduction in maternal mortality. Unintended pregnancies are high in South Asia and the likelihood of abortions are also high. Abortion can save a woman’s life in all the countries and abortion is restricted on other grounds in most of the countries except India and Nepal. Improving the quality and coverage of post-abortion care is crucial to saving lives and protecting women’s health and all countries accept the care as an essential reproductive health service; however, only six countries have post-abortion care guidelines and include FP. Lack of coverage of abortion care under UHC is a concern. Recommendations to prevent abortion through reducing unmet needs in sub-populations included increasing access to post-partum FP, expanding method choice and provision of long-acting methods and improving access of adolescents. Provision of safe abortion services using WHO’s safe abortion guidelines was also recommended.

The presentation on *Prevention of adolescent pregnancy in Thailand* covered the status of adolescent fertility 15-19 years (36 per 1000 15-19 years) and that of 10-14 years (1.3 per 1000 10-14 years) and percentage of repeat pregnancy 10-19 years is 9 percent. The national FP policy incorporates adolescent fertility issues and provision of contraception to adolescents, irrespective of their marital status creating an enable environment for adolescents to access contraceptives. Condoms, followed by oral contraceptives, are the main methods used by adolescents. Innovative measures to reduce adolescent pregnancies, such as the Act for prevention of adolescent pregnancy 2016 and the action plan, youth friendly health services and the accreditation process of the facilities providing services, provision of long acting contraceptives to adolescents, capacity building of health providers and repeat teen pregnancy project, were shared. In addition, information was shared on the safe abortion project and the introduction of combi package of mifepristone and misoprostol for termination of pregnancy and the provision
of long acting methods for post-abortion FP. The UHC benefit package has been extended to include abortion services and post-abortion FP. Royal Thai Referral System for Safe Abortions (RSA) was another interesting concept in provision of safe abortion services.

The presentation on Post-partum FP in Indonesia highlighted the efforts in improving the coverage of post-partum FP services. Postpartum FP is promoted through education for couples at the pre-conception period and during ANC. Injectables, Copper T and implants are provided in the post-partum period, predominantly by the private sector midwives. FP services are included in the health benefit package; however, due to major challenges in its implementation, coverage is limited. Main challenges identified in provision of post-partum FP services are lack of awareness of women about the importance of post-partum FP use, negative attitudes and poor skills of the providers and lack of coverage of FP services under UHC if deliveries take place at referral level facility.

The presentation on task shifting in post-abortion FP in Nepal showed an increase in post-abortion FP to 75 percent; however, the long-acting method use was only 17 percent. Post-abortion contraception among medical abortion clients was 82 percent compared to 65 percent surgical abortion clients. Auxiliary nurse midwives, staff nurses and medical officers trained in FP services are providing post-abortion FP services. Public and private sector promote post-abortion FP services. The presentation on Menstrual regulation programme in Bangladesh included information about the legal limit of menstrual regulation which is 8-10 weeks of a missed period. There are about 1.9 million induced abortions (of the 2.8 million unintended pregnancies) with one third experiencing complications. A comi pack is available for medical abortion, used only by the private sector and can be only administered by trained providers. Menstrual regulation is considered a woman’s choice and its promotion through community awareness was emphasized. Linking the data on menstrual regulation with health information systems for complete information was also highlighted. The presentation on CAC programme in India indicated that complications of abortion is the third leading cause of maternal death (8 percent), despite the fact the Medical Termination of Pregnancy (MTP) act 1971. Two of the three abortions performed are unsafe and is responsible for almost half of all the pregnancy related deaths among women and girls below 24 years. The comprehensive abortion guidelines have been updated in 2018. Initiatives taken by the MOH to improve the quality and coverage of CAC, model care centres have been created in several states (14) that focuses on standards of care including adequate drugs and supplies, counselling, post-abortion FP, training and post-training mentoring, etc. Guidelines and IEC materials have been developed and distributed.

Key points discussed
- Reduce levels of unintended pregnancy and resulting abortions by increasing access to high-quality family planning services, including counseling and the provision of a range of methods, especially in remote areas.
- Accreditation of health posts, primary health centers, private and NGO facilities that meet the standards for provision of abortion care (medical and surgical) and monitoring their capacity is critical.
- Expand access to safe and legal abortion.
- While task-shifting for abortion care, important to develop guidelines, ensure supervision and build accountability.
- Reduce women’s recourse to clandestine procedures by disseminating information about the legal status of abortion and where to obtain legal abortion services.
• FP and CAC are sensitive issues and with added legal and religious complexities, need to be handled sensitively.
• Medical abortion drug /kit needs to be standardized for quality and monitored for quality especially over-the-counter availability.
• Leveraging information technology to provide FP and safe abortion services by increasing access to information, counselling and contraceptive services to help more women prevent unintended pregnancies must be prioritized.
• Adoption of updated clinical guidelines on CAC and FP and their implementation is important for further reducing unintended pregnancies and for provision of safe abortions.
• Need to reduce stigma through public education campaigns and provider training on non-judgmental care and treatment, especially younger women and unmarried women, who may face higher barriers to accessing sexual and reproductive health services than their older and married counterparts.

November 27, 2019

9. Session 6: Regional strategy on Sexual reproductive health and rights

The draft regional strategy on SRHR was distributed to the six groups of participants and each group was asked to review selected sections and provide feedback. In general, there was consensus on the domains and prioritized areas and key actions. Newborn care was mentioned as an omission under intrapartum care.

10. Session 7: Country actions on proposed TAG recommendations

The preliminary draft of the recommendations of the TAG after the 2-day meeting were presented to the country participants for feedback (The finalized TAG recommendations are in Annex 4). Feedback is given below.

• ANC: Doubts were raised about the feasibility of 8 ANC visits by 2025 as countries still follow the 4 visits schedule. Quality of coverage was emphasized.
• Intrapartum care: Develop alternate mechanisms to improve institutional deliveries through demand side financing and other strategies and creating awareness.
• Rationalization of CS and use of Robson classification and creating public awareness was endorsed. The need for capacity building in the use of Robson classification was highlighted.
• Stillbirth prevention and management: (a) Develop guidelines for management of pregnancy following the stillbirth.; (b) Pre-conception package of essential interventions was strongly recommended; (c) Endorsed addition of pregnancy box in CRVs; and Agreed on the need for global level advocacy for stillbirths (year 2023).
• Abortion as woman’s right and de-stigmatization was unanimously added.
• Under contraception recommendations demand generation, spacing and Male involvement were included.
• Health systems recommendations Skill development (competency, behaviors and responsiveness) of the providers using appropriate training packages, was stressed upon by the countries.
• Countries wanted more focus on Logistics management, Health financing policies (abortion), ensure availability of equipment, commodities and supplies.
• Also, strengthening the health information systems specially under (abortion and post-abortion care.
• Examine the workload of health workers in the context of the implementation of the updated antenatal and intrapartum guidelines was added.

Each member states as a team have developed the country action plans after receiving the updates in various SRH area (Annex 4)

Dr Neena Raina concluded the meeting by extending vote of thanks. She hoped that the TAG recommendations will be implemented at the country level.

11. TAG Recommendations

The TAG members noted and appreciated the progress made on recommendations made since the TAG meetings in 2015 on newborn mortality, 2016 on child mortality, 2017 on adolescent health and 2019 January on reducing preventable maternal and mortality and stillbirths.

Sustainable development goals (SDGs)

• All countries should consider reaffirming their national SDG targets and aim for Maternal Mortality Ratio (MMR) of ≤70 or 2/3rd reduction based on 2010 levels \textit{(whichever is lower)}, aligned with other global frameworks such as Global strategy for Women, Children and Adolescent health, and Ending Preventable Maternal Mortality (EPMM), as relevant.

Countries should:

a) Consider advancing achievement of this target before 2030
b) Reframe the intermediate targets based on their Annual Rate of Reduction (ARR) and 2017 MMR level and accelerate the progress towards achieving their SDG targets
c) Consider developing sub-national targets to address inequities as appropriate (for example: geographical and wealth quintiles)

**Antenatal care**

Antenatal care provides a platform for improving maternal health, improve institutional deliveries and reducing maternal mortality and reducing stillbirths. In 2016 WHO introduced the recommendations for positive pregnancy experience and a regional dissemination meeting on the recommendations was held in 2018.

- Countries should improve quality and coverage of ANC, ensuring optimum visits, contents and good quality through the following actions:
  a) Update the national ANC guidelines and training packages as per 2016 WHO ANC recommendations focusing on recommended practices and discouraging non-recommended practices, its adoption complete by 2020 and roll out by 2022 encompassing 8 antenatal contacts and its contents,
  b) Develop plans to achieve a coverage of at least 80 percent or more for 8 contacts by 2025 (recognizing the challenges due to health system constraints)²
  c) Review the ANC programme including service delivery models/platforms in low coverage countries and develop and implement a scaleup plans with innovative service delivery approaches by 2021.

**Intrapartum care**

Key components include 24/7 accessibility to institutional delivery and quality intrapartum care.

In 2018 WHO introduced the intrapartum recommendations for positive childbirth experience and a regional dissemination meeting was held in 2018. High quality intrapartum care reduces maternal and newborn mortality and stillbirths and is a triple investment.

- Within the national policy of institutional deliveries, countries should improve the quality and coverage of intrapartum care through the following actions:
  b) Ensure 24/7 functionality of such facilities and its periodic accreditation for compliance with national standards.
  c) In situations where access to institutions is a problem, consider developing mechanisms to improve institutional deliveries by addressing demand side factors related to access, knowledge, etc. (example: developing maternity waiting homes as per standards, facilitating access to free of cost transportation and educating communities about importance of institutional deliveries).

- Countries should update national guidelines and training packages for intrapartum care as per 2018 WHO recommendations, focusing on recommended practices and actively discouraging non-recommended practices, its adoption by 2020 and roll out across the country by 2022.

---

² TAG recognizes the targets are very ambitious and might not be feasible in all countries due to health system constraints; however, the TAG considers that aggressive targets are required to move in right direction and at the right pace. However, it is an advice and countries may adapt it to their contexts
• Ensure respectful maternity care including availability of a companion in the labor room to humanize the birthing experience ensuring dignity and respect.

**Emergency obstetric and neonatal care (EmONC)**

Inequitable access to EmONC is a major reason for continuing preventable maternal and neonatal mortality and around 15% of pregnant mothers will encounter life-threatening complications without adequate warning.

• Access to 24/7 EmONC should be improved through periodic EmONC assessment and improvement plan (and its regular monitoring) that includes adequate training of all the concerned healthcare professionals to provide Basic and Comprehensive EmONC, availability of essential equipment, drugs and supplies and a functional referral system.

**Rational caesarean section coverage**

While recognizing Caesarean Section (CS) as a life-saving intervention, the TAG is concerned about the increasing population—based CS rates in some countries at the national levels and among sub-populations and the low coverage (below the acceptable minimum level) in some countries. Countries should rationalize CS as a mode of delivery to optimize maternal and perinatal outcomes through the following actions:

• The CS rates at population level (national and sub-national) should be continuously to identify underutilization (<5%) and over utilization (>10-15 %) of CS rates.
• The mode of delivery at institutional level should be monitored to track the trends of various modes of delivery.
• Adopt Robson classification system as a global standard for periodic assessment, monitoring, and comparing CS rates within and between healthcare facilities.
• Action should be taken to optimize the CS rates in facilities and population by implementing the 2018 ‘WHO recommendations on non-clinical interventions to reduce unnecessary caesarean sections’ and improving the capacity to conduct assisted vaginal deliveries.
• Create public awareness about the risks of unnecessary caesarean section while at individual level, through ANC counselling, women should be discouraged from requesting CS when it is not medically indicated.

**Stillbirths**

The TAG members noted with concern that ‘stillbirths’ has been INVISIBLE in the continuum of maternal and newborn care and appreciate the efforts of WHO-SEARO to bring spotlight on this issue.

• SEAR-TAG strongly recommends countries to commit themselves to achieve a stillbirth rate of 10-12 per 1000 total births by 2030 and define interim targets and subnational targets.
• Undertake high level advocacy at regional level for stillbirths through (i) WHO and UN agencies (details provided under WHO actions) (ii) building national, regional and global partnerships for action on stillbirth prevention and
• Undertake high level advocacy at national level for stillbirths and involve professional organizations like -OBGYN, perinatology, nursing and midwifery- to champion prevention of stillbirths.
Country level actions should be undertaken urgently for stillbirth prevention and management, as part of the maternal, perinatal and neonatal mortality reduction programmes, through the following actions:

a) Develop and implement national action plans for prevention and management of stillbirths by 2020, in collaboration with stakeholders including professional bodies/societies and ensure inclusion of modifiable risk factors, assessment of foetal well-being during pregnancy and labour, correct use of uterotonics, timely induction of post-term pregnancy, bereavement management, management of the pregnancy following a still birth, etc.

b) Strengthen national commitment and accountability for prevention and management of stillbirths by establishing a programme unit, as part of the maternal health division with responsibility in the MOH with linkages to the neonatal health programme.

c) Include registration of stillbirths at various levels as part of vital registration system and prepare a special report on stillbirths by responsible national authority at the earliest.

d) Strengthen stillbirth surveillance and response, applying International Classification of Diseases on Perinatal Mortality (ICDPM), linking to maternal death surveillance and response (MDSR).

**Strengthening and expansion of maternal and perinatal deaths surveillance and response (MPDSR)**

- Strengthen and expand maternal and perinatal death surveillance and response through the following actions:
  
a) Develop coverage targets for MPDSR/MDSR programs for scaling up nation-wide by 2022 using ICD-MM and ICD-PM; improve the quality of review and ensure that actions are taken on review findings, linking to improvement in quality of care within the health system.

b) Countries should generate MMR data and annual report from surveillance.

c) Triangulate MMR data bases from sources such as MDSR, vital registration and Health Management Information System (HMIS) and include pregnancy box in death declaration form.

d) Scale up maternal near-miss enquiry as a mechanism to improve survival in case of severe life-threatening obstetric complication.

**Comprehensive abortion care**

- Within the boundaries of legal status of abortions, countries should take the following actions to reduce mortality and morbidity due to complications of unsafe abortions:

a) Adopt WHO guidelines (2012, 2015 and 2018) on safe abortion (including post abortion care) by (i) expanding the provider base including nurses and other mid-level service providers as recommended in the WHO 2015 guidelines, (ii) building capacity of providers through pre-service and in-service education that emphasizes respectful and compassionate care without bias and stigmatization.

b) Strengthen health systems in support of comprehensive abortion care by (i) including comprehensive abortion care under UHC, (ii) improving data on abortion and post-abortion care by strengthening health information systems, (iii) including instruments, drugs and supplies for Manual Vacuum Aspiration (MVA) /Menstrual Regulation (MR) in essential medicine list and essential supplies.
c) Expand access to vulnerable populations including adolescents.

**Contraception**

- Based m-CPR of the countries, countries should develop appropriate strategies, taking into consideration the gaps in policies and programmes and quality of services as well as the following actions:
  a) Consider in-depth analysis of Demographic Health Survey (DHS) data while developing the strategy to identify inequities in coverage, unmet need in selected groups such as post-partum mothers as well as underlying factors.
  b) Increase access and expand method-choice, especially Long Acting Reversible Contraceptives (LARC) to (i) improve access of vulnerable populations with unmet needs such as adolescents (irrespective of their marital status), divorcees, widows, differently abled and those affected by humanitarian crisis, (ii) meet the changing contraceptive needs across the life course during post-pregnancy, interpregnancy and peri-menopause periods and (iii) improve availability of methods that are acceptable according to faith and culture.
  c) Improve universal access to FP services by (i) integrating with UHC package, (ii) strengthening multi-sectoral involvement (e.g. Ministry of education, labour, etc.) and involvement of private sectors, non-governmental organizations and community.
  d) Strengthen demand creation for FP services through various channels of communication and increased male involvement and engagement for utilization and continuation of methods.
  e) Update national FP guidelines by incorporating global updated guidelines such as Family Planning – A Global Handbook for Health Providers 2018, Medical Eligibility Criteria (MEC) for Contraceptive Use 2015, Selected Practice Recommendations (SPR) for Contraceptive Use 2016 and promote use of tools such as mobile app on MEC wheel and Post-Partum (PP) compendium.
  f) Build capacity through competency-based training using training resource package on FP.

**Health systems strengthening**

Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAH) being fundamental to contribute to human capital, it should be the core / fulcrum of Universal Health Coverage (UHC) agenda of the Member States. Member States should commit adequate investment of financial and other resources for provision of good quality healthcare across RMNCAH life-course. The recommendations related to different blocks of health system are as below.

a) Financial resources for RMNCAH

- Countries to ensure adequate budget allocation to ensure high quality SRMNCAH services under UHC.
- Track RMNCAH budgets within the National Health Accounts and RMNCAH sub accounts and ensure that these should not diminish, rather increase over time during the progress to UHC, and the out-of-pocket expenditures on RMNCAH are minimized.
Health financing policies should ensure that essential sexual reproductive health services like abortion are covered under public/private health insurance mechanisms.

b) Healthcare workforce

- Strengthen technical and managerial capacity at national and sub-national levels for efficient and effective management of the RMNCAH programmes. For this, develop appropriate public health and health management cadres.
- Conduct a labour market analysis of human resources for health in both public and private sectors with special focus on the availability of functional RMNCAH human resources by cadre, competency/scope of practice, level of healthcare (primary, secondary or tertiary), and density in the population.
- Strengthen Human Resources for Health for RMNCAH services considering workload demand and workforce supply; ensuring competency, behaviours and responsiveness; and consider task shifting / task sharing as appropriate. Take policy decisions and use innovative approaches to improve staff retention, create supportive and safe work environment for health personnel, with a focus on rural and remote areas and develop career pathways.
- Ensuring an appropriate skill mix (midwives, nurses, general medical doctors, obstetrician and gynaecologists, paediatricians/neonatologists, anaesthetists) to ensure quality of healthcare at all levels ranging from primary to tertiary. This may include creating a new cadre of community health workers (CHWs) as per the WHO guidance.
- Define clear scope of practice for RMNCAH professionals including midwives and doctors and specialists at different levels of service delivery and ensure availability at EmONC sites on 24/7 basis.
- Invest in strengthening quality of midwifery care through pre-service education programmes to produce competent midwife professionals based on ICM standards for education and practice. Engage professional organizations/councils and educational institutions to regulate the quality of midwifery education and accreditation.
- Strengthening in-service training programme(s) and link to continuing professional development requirements for licensing and re-registration to optimize the full scope of practice of skilled health personnel/professionals.

c) Service delivery

- Develop optimal service delivery models to ensure good quality and equitable SRMNCAH services at all levels of care with functional referral mechanisms including emergency transport.
- Develop of and adherence to national standards of care in line with WHO standards, strengthen monitoring and supervision, community engagement and feedback. Community, professional organizations and civil society should be engaged to play an active role in the process.
- Periodically review and strengthen the health facilities for adequacy of physical infrastructure, health workforce, uninterrupted availability of essential supplies, commodities and equipment; and practice of quality improvement, focusing at the care around time of birth.

d) Health Information Systems
• Civil registration and vital statistics system should strengthen maternal and perinatal mortality data processing reaching over 90% completeness of reporting by 2025 in all SEAR countries.

• WHO to support countries to adopt a standard list of the data variables and strengthen systems of CRVS, health management information system and household surveys to collect and process data for SRMNCAH.

Research

• TAG strongly notes that more resources and efforts to strengthen research capacity are urgently required, if 2030 targets for RMNCAH are to be met. Therefore, WHO and partners to support research especially implementation research, on stillbirth prevention and management, and maternal, neonatal, child and adolescent health in pursuit of 2030 targets

Overarching recommendations

• TAG reinforces the previous recommendations on constituting national TAGs for women and children’s health to take forward the implementation recommendations by the Regional TAG

Recommendations to WHO-SEARO and partners

• Assist countries to develop interim targets towards the 2030 SDG targets based on reliable modeling (WHO).

• Build technical capacity to provide program stewardship by enhancing technical teams and capacity at the country and regional office levels to lead RMNCAH work under the Regional Flagship Programme.

• Support countries in adaptation of WHO guidelines on ANC, intrapartum care and FP and plan for implementation and scale-up of the adapted guidelines.

• Develop and pilot technical guidelines on healthy transition of adolescents, pre-conception, pre-pregnancy and inter-pregnancy care, and when the countries should introduce these packages depending on their health system readiness.

• Support documentation of best practices and country to country learning through various mechanisms for e.g., trainings, fellowships, exchange visits and inter-country transfer of technology and best practices.

• Support Governments for appropriate engagement and participation of the private sector for effective implementation of UHC.

• Support countries to assess the gaps in service delivery models/platforms for ANC in low coverage countries.

• Simplify EmONC assessment guidelines for quick and easy assessment

• Assist countries to develop evidence-based communication materials to create awareness about implications of unnecessary caesarean sections (when not medically indicated) (public awareness and counselling to pregnant mothers) (WHO).

• Build capacity of Member States to implement Robson classification (WHO).

• In support of high-level advocacy at international and national levels on the importance of focusing on stillbirths, WHO HQ, WHO SEARO and UN partners should pass resolutions advocating high level visibility to stillbirths through various strategies such
as designating a special day or declaring 2021 as a year for ‘averting stillbirths’, RC agenda item on prevention of still births.

- Develop country capacity on use of ICD PM and ICD MM and review and response mechanisms (WHO).
- Finalize the WHO SEARO strategy and action plan for maternal and perinatal mortality reduction with specific focus on stillbirth prevention and management by 2020 (WHO).
- Advocate to countries to improve access to surgical and medical services through enabling policies and laws (WHO).
1. Objectives of the meetings

- To identify the needs of Sexual Reproductive Health and Rights (SRHR) in South East Asia Region.
- To make recommendations on SRHR with focus on strengthening abortion, post abortion care and post abortion family planning for SEA Region.

2. Session 1: Progress on Implementation of previous TAG recommendations

Dr Neena Raina Director a.i FGL welcomed the TAG members and informed the group about the objectives of the meeting. Presentations were made by Dr Rajesh Mehta on status of recommendations of TAG on child mortality, new-born mortality and adolescents and Dr Chandani Anoma Jayathilaka on status of recommendations of TAG on preventable maternal and newborn mortality and stillbirths.

*Progress of recommendations of TAG on child mortality, new-born mortality and adolescent health*

Dr Rajesh Mehta presented the progress on the recommendations.

Progress has been achieved about buying in by National Governments on the TAG recommendations through the establishment of RMNCAH task forces and H6 platforms or similar platforms. A recent recommendation to establish a national TAG has not been achieved but countries are being encouraged.

The coverage gap in new-born mortality is being addressed in the six priority countries -Bangladesh, India, Indonesia, Myanmar, Nepal, Timor-Leste- through development of policies, guidelines and action plans such as essential new-born action plans, upscaling interventions, strengthening postnatal care of new-born, strengthening neonatal intensive care units, improving the skills of human resources such as midwives and others in new-born care, efforts by countries through UHC to reduce out-of-pocket expenditure for services for mothers and children.

To reduce child mortality, efforts are being made to address main causes such as pneumonia, diarrhoea and malnutrition through strengthening of IMNCI as well as addressing birth defects. Strengthening health information systems to improve the quality of data on RMNCH are underway in several countries. Reviews of neonatal and childhood deaths are being improved and expanded to sub-national levels to enable action to further reduce mortality. To promote early child development, intervention packages as well as
training packages have been developed by countries and violence against children (that has a detrimental effect on development) is being addressed through approaches for child protection.

Improving access to adolescent health services is being addressed through advocacy to include the services under UHC, regional strategic guidance and capacity building. Comprehensive sexuality education in schools is being reviewed and improved. Several Member States have initiated strengthening efforts to provide quality health services to adolescents and efforts are also being made to strengthen health services in schools and colleges through multi-sectoral approaches.

**Progress of recommendations of TAG on preventable maternal and newborn mortality and stillbirths**

Dr Chandani Anoma Jayathilaka presented the situation with the recommendations of TAG January 2019 on maternal mortality and stillbirths reduction.

Compilation of best practices has been initiated by creating a web-platform and other efforts are underway. Status on implementation of TAG recommendations has not been documented yet.

About SDG targets, all countries have defined national SDG/EPMM MMR, interim targets also set in countries but needs to be refined based on latest 2017 MMR estimates, Targets for Adolescent birth rate also fixed in most countries. The monitoring system to track the progress and readiness to achieve MMR target is available in all SEAR countries. Stillbirth national targets are fixed in most countries. Adoption of guidelines has been slow – only 4 countries have adopted 2016 ANC recommendations especially 8 visits and 2018 intrapartum recommendations adopted only by four countries. Institutional delivery was promoted by all the countries and Robson classification for monitoring CS is only being used in Sri Lanka. Initiatives to rationalize CS have started in several countries. With regard to stillbirths, only few countries have included stillbirth as a quality indicator for intrapartum care. However, there is progress with perinatal death surveillance and response as more countries have a functioning system and others are in the process of developing. SEAR has incorporated stillbirth surveillance and response in national birth defect data base and with ROSA, jointly organized a regional meeting on skill building of perinatal and neonatal death surveillance and response (PNDSR). With regard to MDSR, all Member States have a policy to notify and review all maternal deaths; national coverage of MDSR is improving but quality of review and response is a concern. Near miss reviews are functioning in 4 countries.

Countries have strategies to improve contraceptive prevalence for modern methods, particularly among adolescents. FP accelerator project is planned in Timor-Leste and Myanmar.

WHO guidelines on safe abortion have been adopted by India and Nepal because of their liberal abortion related laws. Nepal programme promotes task shifting for CAC and PAC services. Post-abortion care is promoted in all the countries and also included in the pre-service and in-service training of health staff.

Cervical cancer elimination is a priority for WHO SEARO and had done a regional workshop on elimination of cervical cancer as a public health problem and there was an agenda item in 72 Regional Committee. The recommendations covered primary, secondary and tertiary preventive strategies, strengthening health systems to diagnose and treat cervical cancer as well as palliative care, essential medicines and supplies for
prevention and diagnosis. The recommendations are being followed up. The Member States are striving to achieve the 2030 interim targets for elimination of cervical cancer.

Plans to improve availability of competent human resources for RMNCAH through task shifting, investing in midwifery and policy options for rural retention through incentives are being promoted.

Plans for monitoring RMNCAH sub-accounts within the national health accounts are being planned.

3. **Session 2: Prioritizing actions in focus countries**

The discussion on TAG recommendations continued focusing on priority countries in the Region for MMR reduction and stillbirth reduction. The need for technical assistance by WHO was highlighted.

4. **Session 3: Comprehensive abortion care situation and challenges**

Dr. Bela Ganatra, Scientist, WHO RHR, Geneva emphasized the importance of health system backup for effective implementation of safe abortion services. Abortion being a sensitive topic in most of the countries in the Region, legal, cultural and religious barriers have to be kept in mind while working on the specific strategies to address unsafe abortions. Accountability and quality of care are extremely important considerations while providing safe abortion services. Combi-packs of medical abortion pills has become available and will help to overcome some of the barriers but needs countries to regulate and include in essential medicines list and make the cost affordable. Guidelines need to be developed for education and quality assurance. A strong recommendation to the TAG was to include the combi-packs as part of the essential medicines list, improved capability of the health system to forecast needs of medicines for medical abortions and strengthening the supply chain management and task shifting.

5. **Session 4: Improving UHC for sexual and reproductive health (SRH) through health systems approach**

The session included a presentation on human resources for health and SRH in SEAR and Access to medicines in SEAR- success and barriers. The presentation on human resources for health (Dr. Tomas Zapata) highlighted the need for the health services to meet the changing health needs and the health workers also need to adapt to the changing needs – additional competencies, task shifting, skill-mix (teams), etc. The presentation also shared the global competency framework for UHC that includes people-centeredness, decision making, communication, collaboration, evidence-informed practice and personal conduct which are all critical for SRH services. The presentation showed the gaps in human resources in SEAR countries except Maldives and DPR Korea that have met the global standards for doctors, nurses and midwives per 10,000
population, Myanmar and Bangladesh have the lowest ratio. The presentation emphasized that while density of the workforce is important, distribution is critical for achieving reduction in mortality as was illustrated comparing similar health workforce density between Sri Lanka, India and Timor-Leste and the significant differences in MMR. The importance of frontline health workers, in addition to five professional groups (doctors, nurses, midwives, dentists and pharmacists) was discussed. SEAR Member States needs to increase the density of health workers including nurses and midwives, ensuring equitable distribution through recruitment in rural areas and poor urban areas and retention especially in rural areas. Task shifting should be considered where there are shortages of workers with special skills with adequate training, supervision and remuneration. Quality of pre-service education to develop competencies is important. Countries need to decide what is the right skill-mix, should midwifery be a separate cadre (direct entry or promoting an existing cadre with additional training) and if so, education, accreditation and posting should be considered.

**Key points discussed**

- Member States need to decide whether they need as a separate cadre for midwifery, decide on the number of midwives required based on the case load and activities, distribution, etc. Community’s involvement in creating demand for such cadres was emphasized.
- Task shifting needs to be decided based on the type of services, type of workers, laws of the country, etc.
- The importance of developing a cadre of hospital administrators was recommended.
- Development and recruitment of supervisory cadre for SRH services to ensure quality of services and achieving UHC was deliberated and recommended.

The presentation on access to medicines in SEAR - success and barrier (Dr Klara Tisocki), listed the challenges in SEAR with regard to medicines and supplies that include UHC coverage, expenditures on medicines with high out-of-pocket expenditures, irrational use of medicines, challenges in procurement and affordable pricing, supply chain issues, last mile delivery gaps- all of which impacts UHC of SRH services. Average availability of medicines in Bangladesh, Myanmar, Nepal and Sri Lanka ranges from 43 percent to 70 percent in the public sector and slightly more in the private sector, the average being 74 percent. The main challenges identified are supply side gaps in forecasting, financing, procurement efficiency, supply chain, quality, availability, market dynamics etc. and demand-side gaps such as accessibility, acceptability, cultural and social barriers for patient use, appropriate use and patient knowledge. The Member States under WHO’s leadership committed among other actions, to attain universal accessibility and affordability of essential products by 2030, to allocate sufficient financial resources etc. (Delhi Declaration on Improving access to essential medical products in the South-East Asia Region and Beyond). Such commitments should be leveraged to improve access to essential medicines for SRH. The need for meeting the WHO pre-qualification criteria for medicines produced in countries was emphasized. The ongoing quality assurance policy for reproductive health medicines, led by UNFPA was briefly discussed.

**Key points discussed**

- Medicines for CAC are already in the essential drug list and should be made available as per the regulatory framework of the country. Procurement mechanisms for medicines for medical abortion need to be strengthened.
• Availability of standardized combi pack for medical abortion (with pictorial directions) was recommended.
• While emergency contraceptive pills are available over the counter in almost all the Member States, it is critical to ensure that it is not misused as it is happening in few of the Member States.

At the concluding session, the Chair of TAG Dr. Paul suggested that the recommendations of the TAG should be presented to the Regional Director and reflected in the Regional Committee meetings. The Chair also appreciated the TAG’s efforts to accelerate achievement of MMR and stillbirth targets and highlighting quality improvement. The TAG SRH meeting was closed by Dr Neena Raina by giving vote of thanks to the participants.
Annex 1: Agenda
Day 1: Monday, 25 November 2019

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30 – 09:30</td>
<td>Registration</td>
<td>WHO-SEARO</td>
</tr>
<tr>
<td>09:30 – 10:15</td>
<td>Inauguration</td>
<td>WHO-SEARO</td>
</tr>
<tr>
<td>10:15 – 10:45</td>
<td><em>Group photograph and tea break</em></td>
<td></td>
</tr>
</tbody>
</table>
| **Session 1** | **Setting the stage: Accelerating reduction in maternal mortality and stillbirths**  
*Chair: Prof Vinod K. Paul*  
*Co-chairs: Prof Jane Sandall and Dr Unnop Jaisamrarn* |                    |
<p>| 10:45 – 11:15 | <em>Maternal mortality estimates and strategies for ending preventable maternal mortality</em> | WHO-HQ             |
| 11:15 – 11:45 | <em>Maternal and Reproductive Health in the context of UHC in SEAR</em>          | WHO-SEARO          |
| 11:45 – 12:00 | Discussions and reflections by TAG (15 min)                              |                    |
| <strong>Session 2</strong> | <strong>Strategies for accelerating reduction in maternal mortality</strong>          |                    |
| 12:00 – 13:00 | <em>Strengthening intrapartum care – Institutional deliveries</em>              | WHO-HQ             |
|               |   - MNH standards and WHO norms of institutional delivery (10 min)       | <em>Moderator:</em> Dr Saramma Mathai |
|               |   - <em>Panel discussion 1</em> – Institutional deliveries                      |                    |
|               |     Panelists : MOH – Bangladesh, Myanmar and Timor-Leste (30 min)       |                    |
|               |     Discussions and reflections by TAG (15 min)                          |                    |
| 13:00 – 14:00 | <em>Lunch break</em>                                                            |                    |
| 14:00 – 15:00 | <em>Strengthening intrapartum care – Emergency obstetric care</em>             | Moderator: Prof Kiran Regmi |
|               |   - <em>Panel discussion 2</em>: Emergency obstetric care                      |                    |
|               |     <em>Panelists</em>: Obstetric societies: India, Indonesia and Nepal (45 min) |                    |
|               |     Discussions and reflections by TAG (15 min)                          |                    |
| 15:00 – 15:30 | <em>Tea break</em>                                                              |                    |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>15:30 – 16:30</td>
<td><strong>Rationalizing caesarean sections:</strong></td>
<td>WHO-HQ Hemantha Senanayake</td>
</tr>
<tr>
<td></td>
<td>WHO recommendations on caesarean sections (20 min)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Country experience of application of Robson classification and evidence-based interventions (20 min)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discussions and reflections by TAG (20 min)</td>
<td></td>
</tr>
<tr>
<td>16:30 – 17:30</td>
<td><strong>Strengthening coverage and quality of antenatal and postnatal care:</strong></td>
<td>All countries’ posters</td>
</tr>
<tr>
<td></td>
<td>Poster presentation</td>
<td></td>
</tr>
<tr>
<td>17:30 – 18:30</td>
<td><strong>Meeting of TAG members</strong></td>
<td></td>
</tr>
<tr>
<td>18.30 – 20.30</td>
<td><strong>Reception</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Day 2: Tuesday 26 November 2019**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session 3</strong></td>
<td><strong>Strategies for accelerating reduction in stillbirths</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Chair:</em> Prof Vinod K. Paul</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Co-chairs:</em> Dr Marie-Andrée Romisch Diouf and Dr Mohammad Baharuddin Hasanudin</td>
<td></td>
</tr>
<tr>
<td>09:00 – 10:40</td>
<td>Stillbirths: Current situation and prevention strategies (30 min)</td>
<td>WHO-SEARO Sri Lanka</td>
</tr>
<tr>
<td></td>
<td>Country experience: Stillbirth prevention programme (20 min)</td>
<td>WHO-CC, PGIMER</td>
</tr>
<tr>
<td></td>
<td>Stillbirth surveillance: SEAR-NBBD (20 min)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discussions and reflections by TAG (30 min)</td>
<td></td>
</tr>
<tr>
<td>10:40 – 11:00</td>
<td><strong>Tea break</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Session 4</strong></td>
<td><strong>Strengthening the Health System for reduction in maternal mortality and still births</strong></td>
<td></td>
</tr>
<tr>
<td>11:00 – 11:20</td>
<td><strong>Optimum Health System</strong> for delivery of MRH interventions under UHC</td>
<td>Dr Dilip Mavalankar</td>
</tr>
<tr>
<td>11:20 – 12:30</td>
<td><strong>Panel discussion 3:</strong> MRH services in National Essential Service Package (45 min)</td>
<td>Moderator: Mr Manoj Jhalani</td>
</tr>
<tr>
<td></td>
<td><strong>Panellists:</strong> MOH Bangladesh, Bhutan, Myanmar, Maldives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discussions and reflections by TAG (25 min)</td>
<td></td>
</tr>
<tr>
<td>12:30 – 13:30</td>
<td><strong>Lunch</strong></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>13:30 – 14:45</td>
<td>Evidence and impact of models of midwifery care</td>
<td>(15 min)</td>
</tr>
<tr>
<td></td>
<td><strong>Panel discussion 4</strong>: Experiences in midwife-led continuity of care</td>
<td>Moderator: Prof Jane Sandall</td>
</tr>
<tr>
<td></td>
<td><strong>Panellists</strong>: Midwifery societies of Indonesia, Myanmar and Timor-Leste</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(45 min)</td>
<td>Discussions and reflections by TAG (15 min)</td>
</tr>
<tr>
<td>14:45 – 15:00</td>
<td>Tea break</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Session 5</strong></td>
<td><strong>Strengthening family planning and comprehensive abortion care</strong></td>
</tr>
<tr>
<td>15:00 – 16:30</td>
<td>Status of FP and abortion care in SEAR (20 min)</td>
<td>WHO-SEARO</td>
</tr>
<tr>
<td></td>
<td><strong>Country experiences of FP programme</strong>:</td>
<td>MOH, Thailand</td>
</tr>
<tr>
<td></td>
<td>(10 min each)</td>
<td>MOH, Indonesia</td>
</tr>
<tr>
<td></td>
<td>• Preventing adolescent pregnancy: Thailand</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Post-partum FP: Indonesia</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Country experiences of abortion care</strong>:</td>
<td>MOH, Nepal</td>
</tr>
<tr>
<td></td>
<td>(10 min each)</td>
<td>MOH, Bangladesh</td>
</tr>
<tr>
<td></td>
<td>• Task shifting in post abortion FP: Nepal</td>
<td>MOH, India</td>
</tr>
<tr>
<td></td>
<td>• Menstrual regulation programme: Bangladesh</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Comprehensive abortion care programme: India</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discussions and reflections by TAG (20 min)</td>
<td></td>
</tr>
<tr>
<td>16:30 – 17:30</td>
<td><strong>Meeting of TAG members</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Day 3: Wednesday, 27 November 2019

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter</th>
</tr>
</thead>
</table>
| **Session 6** | **Regional strategy on Sexual reproductive health**                      | **Chairs**: Prof Vinod K. Paul  
**Co-chairs**: Dr Natela Menabde and Dr Shams El Arifeen                      |
| 08:30 – 10:00 | Regional Strategy on Sexual Reproductive Health: Sharing the draft       | WHO-SEARO  
- Introduction of strategy followed by group work | Group work |
| 09:00 – 10:00 | TAG members: Finalize the Recommendations  
(Venue: Emily Eden) |                                                                                      |
| 10:00 – 10:30 | TAG Recommendations: Presentation in Plenary  
(Venue: Royal Ballroom) | TAG Chair and WHO                                                                 |
| 10:30 – 11:00 | *Tea break*                                                               |                                                                                      |
| **Session 7** | **Country actions on TAG recommendations**                                |                                                                                      |
| 11:00 – 12:00 | Continue group work                                                      | Group work in country teams                                                      |
| 12:00 – 13:00 | Key country actions based on TAG recommendations: Facilitated by TAG Member | Group work in country teams                                                      |
| 13:00 – 14:00 | *Lunch break*                                                            |                                                                                      |
| 14:00 – 15:30 | Consultations among countries  
Country presentations | Group work in country teams                                                      |
| 15:30 – 16:00 | **Closing**                                                              |                                                                                      |
| 16:00       | *Tea*                                                                    |                                                                                      |
### Day 4: Thursday, 28 November 2019

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00 – 10:00</td>
<td>Review and finalize recommendations of Fifth TAG meeting</td>
<td></td>
</tr>
<tr>
<td>10:00 – 10:30</td>
<td><em>Tea break</em></td>
<td></td>
</tr>
<tr>
<td><strong>Session 1</strong></td>
<td><strong>Progress on Implementation of previous TAG recommendations</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Chair: Prof Vinod K. Paul</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Co-chairs: Dr Nozer Sheriar and Prof Ferdousi Begum</em></td>
<td></td>
</tr>
<tr>
<td>10:30 – 11:30</td>
<td>Implementation of previous TAG recommendations on newborn-child and</td>
<td>Dr Rajesh Mehta</td>
</tr>
<tr>
<td></td>
<td>adolescent health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TAG recommendations (Jan 2019) on maternal mortality, stillbirths and</td>
<td>Dr Anoma Jayathilaka</td>
</tr>
<tr>
<td></td>
<td>reproductive health: Country situation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discussions and reflections by TAG members</td>
<td></td>
</tr>
<tr>
<td><strong>Session 2</strong></td>
<td><strong>Prioritizing actions in focus countries</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Chair: Prof Vinod K. Paul</em></td>
<td></td>
</tr>
<tr>
<td>11:30 – 13:00</td>
<td>Problem analysis and recommended actions: Maternal, newborn and still births</td>
<td>Secretariat and TAG members</td>
</tr>
<tr>
<td>13:00 – 14:00</td>
<td><em>Lunch break</em></td>
<td></td>
</tr>
<tr>
<td><strong>Session 3</strong></td>
<td><strong>Comprehensive abortion care situation and challenges</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Chair: Prof Vinod K. Paul</em></td>
<td></td>
</tr>
<tr>
<td>14:00 – 15:30</td>
<td>Problem analysis and recommended actions: SRHR: Strengthen comprehensive abortion care</td>
<td>Secretariat and TAG members</td>
</tr>
<tr>
<td>15:30 – 16:00</td>
<td><em>Tea break</em></td>
<td></td>
</tr>
<tr>
<td>16:00 – 17:00</td>
<td>Discussion on TAG recommendations</td>
<td></td>
</tr>
</tbody>
</table>
### Session 4

**Improving UHC for SRH through Health Systems Approach**

*Chair: Prof Vinod K. Paul*

*Co-chairs: Dr Hemantha Senanayake and Dr Dileep V. Mavalankar*

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:30 – 11:00</td>
<td>Global initiative: Health system approach in SRHR</td>
<td>WHO-HQ</td>
</tr>
<tr>
<td>20 min each</td>
<td>Access to safe SRH drugs, products and technology</td>
<td>WHO-SEARO (EDM)</td>
</tr>
<tr>
<td></td>
<td>Health work force in SRHR</td>
<td>WHO-SEARO (HRH)</td>
</tr>
<tr>
<td>11:00 – 11:30</td>
<td>Tea break</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discussions and reflections by TAG (45 min)</td>
<td></td>
</tr>
<tr>
<td>11:30 – 13:15</td>
<td>Problem analysis and recommended action in strengthening SRHR in Health System approach</td>
<td></td>
</tr>
<tr>
<td>13:15 – 14:00</td>
<td>TAG: Conclusions and recommendations on strengthening SRHR service in Health System Approach</td>
<td>Dr Vinod K. Paul</td>
</tr>
<tr>
<td>14:00 – 15:00</td>
<td>Lunch</td>
<td></td>
</tr>
</tbody>
</table>
## Annex 2: List of participants

### Member States

#### Bangladesh
- **Dr Md. Shamsul Haque**
  - Line Director
  - MNC&AH
  - Directorate General of Health Services (DGHS)
  - Mohakhali, Dhaka
- **Dr Mohammad Mushair-ul-Islam**
  - Deputy Director & Program Manager (MH)
  - MNC&AH
  - Directorate General of Health Services (DGHS)
  - Mohakhali, Dhaka

#### Bhutan
- **Mr Pema Lethro**
  - Sr. Program Officer
  - Department of Public Health
  - Ministry of Health
  - Royal Government of Bhutan
  - Thimphu

- **Dr Devendra Kumar Sharma**
  - Gynaecologist
  - Samtse Hospital
  - Thimphu

#### India
- **Dr Sumita Ghosh**
  - Additional Commissioner
  - Ministry of Health and Family Welfare
  - Room No. 525A, Nirman Bhawan
  - New Delhi 110011
- **Dr S.K. Sikdar**
  - Additional Commissioner
  - Ministry of Health & Family Welfare
  - Room No. 452A, Nirman Bhawan
  - New Delhi 110011

#### Indonesia
- **Dr Nida Rohmawati**
  - Deputy Director for Maternal and Neonatal Health
  - Directorate for Family Health
  - Ministry of Health
  - Jakarta, Indonesia
- **Dr Wita Nursathi Nasution**
  - Head of Section of Inpatient, Intensive and Surgical
  - Directorate Referral Health Services
  - Jakarta, Indonesia

#### Maldives
- **Ms Saina Ali**
  - Public Health Programme Manager
  - Health Protection Agency
  - Roashanee Building, Sosun Magu
  - Male
- **Ms Rahuma Abbas**
  - Registered Nurse Midwife/Hdh
  - Kulhuduhufushi Regional Hospital

#### Myanmar
- **Dr Than Lwin Aung**
  - Deputy State Health Director
  - State Health Department
  - Rakhine State
- **Dr Hnin Hnin Lwin**
  - Deputy Director
  - Maternal and Reproductive Health
  - Department of Public Health
  - Nay Pyi Taw

#### Nepal
- **Dr Bhim Singh Tinkari**
  - Director
  - Family Welfare Division
  - Department of Health Services
  - Teku, Kathmandu
- **Dr Punya Paudel**
  - Senior Consultant Gynecologist
  - Director
  - Family Welfare Division
  - Department of Health Services
  - Teku, Kathmandu

#### Sri Lanka
- **Dr I. L. Kapilasiri Jayaratne**
  - Consultant Community Physician
  - Family Health Bureau
  - Ministry of Health
  - 231 De Saram Place
  - Colombo 10
- **Dr Sanjeeva S. P. Godakandage**
  - Consultant Community Physician
  - Family Health Bureau
  - Ministry of Health
  - 231 De Saram Place
  - Colombo 10
- **Dr Chithramalie de Silva**
  - Director
  - Maternal and Child Health
  - Family Health Bureau
  - Ministry of Health
  - 231 De Saram Place
  - Colombo 10
Thailand
Dr Pimolphan Tangwiwat
Medical Officer, Expert Level
Bureau of Health Promotion
Department of Health
Ministry of Public Health
Tivanond Road
Nonthaburi 11000
Dr Manus Ramkiattisak
Medical Officer, Senior Professional Level
Bureau of Reproductive Health
Department of Health
Ministry of Public Health
Tivanond Road
Nonthaburi 11000

Timor-Leste
Mrs Apolonia dos Santos
Director of Health Service
Municipality of Liquica

TAG Members
Prof Vinod K. Paul
Member, Niti Aayog
National Institution for Transforming India
Sansad Marg
New Delhi 110001
Dr Dileep V. Mavalankar
Director
Indian Institute of Public Health
Gandhinagar
Gujrat 382042
Dr Hemantha Senanayake
Professor and Head of Obstetrics & Gynaecology
Faculty of Medicine
Kynsey Road
Colombo 8, Sri Lanka
Dr Kiran Regmi Ghimire
Professor, Gynecology and Obstetrics
Karnali Academy of Health Sciences
Ministry of Health and Population
Jumla, Karnali, Nepal

Dr Mohammad Baharuddin Hasanuddin
Director
Budi Kemuliaan Health Institution
Jl. Budi Kemuliaan No. 25
Jakarta 10110, Indonesia

Dr Nozer Sheriar
Gynaecologist and Obstetrician
15 Summer Breeze, 15th Road
Bandra (West)
Mumbai-400050

Dr Shams El Arifeen
Director and Senior Scientist
Centre for Child and Adolescent Health
International Centre for Diarrhoeal Disease Research (icddr,b)
Dhaka, Bangladesh

Dr Unnop Jaisamram
Department of Obstetrics and Gynaecology
Faculty of Medicine
Chulalongkorn University
Rama IV Road, Pathumwan
Bangkok 10330, Thailand

Prof Ferdousi Begum
Professor, Obstetrics and Gynaecology
Ibrahim Medical College & BIRDEM Hospital
122, Kazi Nazrul Islam Avenue
Shahabag, Dhaka 1000
Bangladesh

Prof Jane Sandall
Department of Women and Children’s Health
School of Life Course Science
Faculty of Life Sciences and Medicine
King’s College London, 10th Floor North Wing
St. Thomas’ Hospital
London SE1 7EH

Special invitees
Dr Marie-Andrée Romisch Diouf
Independent Senior Consultant
Development Cooperation and Global Health
11 A Rue des Lotins
13510 Equilles, France

Dr Natela Menabde
WHO Office at the United Nations
1 Dag Hammarskjold Plaza
885 Second Avenue, 26th floor
New York, NY 10017, USA

Dr Saramma Thomas Mathai
B-35, 12 Sham Nath Apartments
Civil Lines, Delhi-110054

Dr Senait Fisseha
Professor of Obstetrics and Gynecology
University of Michigan
503 Thompson Street
Ann Arbor, MI 48109-1340, USA

Dr Mukesh Chawla
Adviser - Health, Nutrition & Population
The World Bank
1818 H Street
NW Washington, DC 20433, USA

Professional Associations

India
Prof Mitali Adhikari
President
Society of Midwives, India
#215, Amruthaville Apts
Raj Bhavan Road
Somajiguda
Hyderabad-500082

Dr Ajay Mane
Chairperson – Website Committee
The Association of Maharashtra Obstetrics and Gynaecological Societies (AMOGS)
Room No. 25-R, 9th floor, Building No. 3,
Navjivan Co-op Society Ltd.,
Dr Dadasaheb Bhadkamkar Marg
Lamington Road
Mumbai – 400008

**Indonesia**
Dr Emi Nurjasmi
President
Ikatan Bidan Indonesia (IBI)
Indonesian Midwives Association
Jl Johar Baru V No. D13
Jakarta Pusat 10560

Dr Dwiana Ocviyanti
Head of Working Group of MMR Reduction
Perkumpulan Obstetri Dan Ginekologi Indonesia (POGI)
(Indonesian Society of Obstetrics & Gynecology)
Jl. Taman Kimia No. 10
Jakarta Pusat 10320

**Maldives**
Ms Aishath Shafeeu
Head Nurse
Labour Room/Neonatal Intensive Care Unit
Tree Top Hospital
Hulhumalé

**Myanmar**
Prof Daw Thein Thein Kyi
Vice President
Myanmar Nurse and Midwife Association
80/84 1st Floor, Shwebontha Street
Pabedan Township
Yangon

Dr Sanda Saw
Associate Professor
Department of Obstetrics and Gynecology
University of Medicine 1
No.245, Myoma Kyaung Street
Lanmadaw Township
Yangon

**Nepal**
Dr Laxmi Tamang
President
Midwifery Society of Nepal (MIDSON)
150/31, Kumari Marga-3
PO Box 5543
Tripureshwar-11
Kathmandu

Dr Heera Tuladhar
President
Nepal Society of Obstetricians and Gynaecologists
Propokar Maternity and Women's Hospital
GPO Box: 23700
Thapathali
Kathmandu

Dr Sanda Saw
Associate Professor
Department of Obstetrics and Gynecology
University of Medicine 1
No.245, Myoma Kyaung Street
Lanmadaw Township
Yangon

**Timor-Leste**
Ms Sara Maria Filomena Xavier
President
Midwives of Dili Municipality
Dili

**UN Agencies**
Mr Rajnish Ranjan Prasad
Programme Specialist - HIV/AIDS
UN Women Regional Office for Asia and the Pacific
5/F UN Building, Rajdamnern Nok Avenue
Bangkok 10200, Thailand

Dr Atnafu Getachew Asfaw
Health Specialist-Neonatal
UNICEF Regional Office for South Asia
P.O. Box 5815, Lekhnath Marg
Kathmandu, Nepal

Ms Shirley Mark Prabhu
HIV/AIDS Specialist - Knowledge and Advocacy
UNICEF East Asia and Pacific Regional Office
19 Pra Athit Road
Chana Songkram, Pra Nakhon
Bangkok,10200, Thailand

Ms Catherine Breen Kamkong
SRH Adviser
UNFPA-APPRO
4th Floor, United Nations Service Building
Rajdamnern Nok Avenue
Bangkok, Thailand

Dr Kirti Iyengar
National Programme Officer
Reproductive Health
UNFPA India Country Office
55 Lodi Estate, New Delhi 110 003

Dr Dewan Hoque
Maternal Health Specialist
UNFPA Bangladesh Country Office
IDB Bhaban (15th floor)
E/8-A, Begum Rokeya Sarani
Dhaka 1207, Bangladesh

Dr Yin Yin Htun Ngwe
Assistant Representative
UNFPA Myanmar Country Office
No. 6, Natmauk Road
UN Building, P.O Box 650
Tamwe Township
Yangon, Myanmar

Dr Domingas Da Paixao De Jesus Bernardo
Assistant Representative
UNFPA Timor-Leste Country Office
UN House, Caicoli Street
Dili, Timor-Leste

Dr Neeta Shrestha
RH Specialist
UNFPA Nepal Country Office
Jhamsikhel, Sanepa
Lalitpur, Nepal
Dr Asheber Gaym  
Health Specialist  
UNICEF India Country Office  
73 Lodi Estate  
New Delhi 110 003

Ms Chahana Singh  
Health Officer  
Maternal and Newborn Health  
UNICEF Nepal Country Office  
P.O. Box 1187  
UN House, Pulchowk  
Kathmandu, Nepal

**Partner organizations**

Dr Bulbul Sood  
Country Director  
Jhpiego  
29, Okhla Phase 3  
New Delhi – 110020

Dr T. Dileep Kumar  
President  
Indian Nursing Council  
8th Floor, NBCC Center  
Plot No. 2, Community Center  
Okhla Phase-I  
New Delhi – 110020

Dr Jaganath Sharma  
MNCH Senior Advisor, Health Office  
U.S. Agency for International Development (USAID)  
U.S. Embassy, Maharajgunj  
Kathmandu, Nepal

**WHO Collaborating Centres**

Dr Bishan Swarup Garg  
Director and Professor  
Dr Sushila Nayar School of Public Health  
Mahatma Gandhi Institute of Medical Sciences  
Sewagram 442102  
Wardha, Maharashtra

Prof Korakot Sirimai  
Associate Professor  
Siriraj Reproductive Health Research Centre  
Faculty of Medicine  
Siriraj Hospital, Mahidol University  
2 Prannok Road, Bangkok Noi  
Bangkok 10700, Thailand

Dr Neelam Aggarwal  
Professor  
Department of Obstetrics and Gynaecology  
Post Graduate Institute of Medical Education and Research (PGIMER)  
Chandigarh

Dr Sunesh Kumar  
Head  
Department of Obstetrics and Gynaecology  
All India Institute of Medical Sciences (AIIMS)  
Safdarjung Enclave  
New Delhi – 110029

Dr K. Aparna Sharma  
Professor  
Department of Obstetrics and Gynaecology  
All India Institute of Medical Sciences (AIIMS)  
Safdarjung Enclave  
New Delhi – 110029

Dr K P Tshering  
President  
Khesar Gyalpo University of Medical Sciences of Bhutan (KGUMSB)  
P.O. Box: 446, Old Medical Block  
JDWNRRH, Menkhang Lam  
Thimphu, Bhutan

Ms Aniqa Tasnim Hossain  
Research Investigator  
Maternal and Child Health Division (MCHD)  
International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b)  
GPO Box 128, Dhaka 1000  
Bangladesh

Dr Thasneem Faroog  
Senior Consultant  
Dept of Obstetrics and Gynaecology  
Indira Gandhi Memorial Hospital  
Male, Maldives

**WHO Secretariat**

**WCO Focal Points**

Dr Pushpa Deo Chaudhary  
Team Leader (RMNCAH)  
WCO India

Dr Priya Karna  
Technical Officer  
Reproductive Health  
WCO India

Dr Ram Chahar  
National Professional Officer  
Maternal and Reproductive Health  
WCO India

Dr Mohamad Shahjahan  
Technical Officer  
Reproduction, Maternal, Newborn, Child & Adolescent Health  
WCO Myanmar

Dr Amrita Kansal  
Technical Officer  
Reproductive Health  
WCO Nepal

Dr Pooja Pradhan  
National Professional Officer  
WCO Nepal
Annex 3: Regional Director’s message

Distinguished TAG Members, participants and partners, ladies and gentlemen,

Welcome to this SEAR-TAG meeting on accelerating reductions in maternal mortality and stillbirths in the context of universal health coverage.

Although our Regional Director, Dr Poonam Khetrapal Singh, would have liked to attend this important meeting, she is unable to do so due to a prior commitment. It is my pleasure to deliver this message on her behalf.

The Regional Director begins by acknowledging the Region’s remarkable progress in reducing maternal mortality. Between 2000 and 2017 the Region reduced maternal mortality by 57%. This is compared with a global reduction of 38.4%.

The Region’s maternal mortality ratio is similarly distinguished. Whereas the Region’s MMR is now 152 per 100 000 live births, the global MMR is 211 per 100 000 live births.

The Region aims to ensure that by 2030 no country has an MMR of more than 140 per 100 000 live births, and that each reduces maternal mortality by at least two-thirds based on 2010 levels. All countries must therefore focus on achieving the interim MMR targets, including subnational targets. Notably, the present annual reduction rate must be accelerated to reach the 2030 targets. All country-specific strategies must be fully implemented.

The picture for neonatal mortality is similarly positive. Between 1990 and 2018 the Region reduced neonatal mortality by about 72%. DPR Korea, Indonesia, Maldives, Sri Lanka and Thailand have already reached the relevant global Sustainable Development Goal target. The present rate of reduction will ensure that all countries bar one reach the 2030 SDG target.

Dr Khetrapal Singh commends Member States on their progress. She thanks this TAG for its contributions. She nevertheless notes that the Region’s share of the global burden of stillbirths is disproportionate.

Of the estimated 2.5 million stillbirths that occur each year, the South-East Asia Region accounts for around 800 000, despite making up just over a quarter of the world’s population. Between 2000 and 2015 the rate of reduction in the Region was just 31.7%.

It is for this reason that, in line with the Region’s updated Flagship Priority, we must focus on accelerating the reduction of stillbirths to achieve the SDG target of less than 12 stillbirths per 1000 births. To their credit, Maldives, Sri Lanka and Thailand have already achieved this outcome.

The Regional Director is certain that this meeting will ensure each of the Region’s countries reaches the target.

She says that with the right mix of quality services, and high coverage of essential interventions – especially around the time of delivery – there are significant opportunities to save the lives of mothers and their newborns, reduce stillbirths and accelerate towards the SDG targets.

She urges you to focus on several key areas.

The first is increasing demand for institutional deliveries. India, Maldives, Sri Lanka and Thailand have demonstrated the impact on all mortality indicators that access to
quality institutional birthing facilities has. As countries Region-wide increase the range and quality of services available, and adopt WHO guidelines, they must ensure that demand for institutional births is similarly increased. Effective public outreach and community engagement is crucial to making this happen.

Second, the Regional Director says there is a need to rationalize the use of caesarean sections. Though caesareans are a potentially lifesaving intervention, and help reduce maternal and newborn mortality, as well as stillbirths, when used inappropriately they can be harmful to both mother and baby. We must therefore look at ways to roll-back this increasing trend.

Third, Dr Khetrapal Singh urges you to consider ways to promote community-based post-natal care, the provision of which remains low. Post-natal care helps encourage a variety of health interventions, from breastfeeding to family planning and nutrition. As such, opportunities to increase access to post-natal care must be considered, with a specific focus on taking a community-based, primary health care approach. Access to ante-natal services should also be scaled up.

Finally, the Regional Director emphasizes the need to increase access to sexual and reproductive health services. To achieve universal access to services that provide family planning and contraception, intensified efforts must be made. A special emphasis must be placed on ensuring adolescents can access services without their guardian’s permission.

Distinguished TAG Members, participants and partners,

Your objectives in the coming meeting are straightforward.

To review progress on previous TAG recommendations.

To review the status of maternal mortality and stillbirths in the Region.

To develop a shared understanding of the draft regional strategic framework on SRH, including accelerating reductions in maternal mortality and stillbirths.

To review the Regional situation on abortion and post-abortion care, as well as post-abortion family planning. This is in addition to identifying the state of sexual and reproductive health and rights in the Region.

And to develop recommendations for actions and country action plans and identify the technical assistance Member States require.

Dr Khetrapal Singh urges you to make the most of this opportunity to realize the Region’s ‘Sustain. Accelerate. Innovate’ vision and advance towards the Region’s updated Flagship Priorities and the SDG targets.

She wishes you an engaging meeting and looks forward to being apprised of the outcome.

I echo that sentiment and wish you a comfortable stay in New Delhi.

Thank you.
### Annex 4: Country action plan based on next step on implementation of TAG recommendations

<table>
<thead>
<tr>
<th>Country</th>
<th>Key actions</th>
<th>Technical assistance needed from WHO SEAR</th>
</tr>
</thead>
</table>
| **Bangladesh**| • Situation analyses of the Maternal, Neonatal, Child, Adolescent, Reproductive health and Stillbirths would be conducted to identify the key gaps on the implementation and policies based on the recommendations.  
• Policy dialogues with the government, development partners, INGOs, NGOs and professional bodies (e.g. BMDC, Obstetrics and Gynaecology Society of Bangladesh (OGSB), midwifery association, Bangladesh Nurses Association (BNA)).  
• Strategy and action plan will be developed within the time frame by the government with concerned stakeholders.  
• Development of the Technical Guidelines  
  a) Review of current ANC practices compared with 2016 WHO recommendations for positive pregnancy experience.  
  b) Review of current intrapartum practices with 2018 WHO recommendations on intrapartum care for positive childbirth experiences.  
  c) Responsibility for update of current guidelines will be delegated to professional societies. | • Technical assistance needed for the following:  
  a) Adaptation of regional SRH strategy, situation analysis, references and resource materials for development of country strategy, support for data validation, monitoring, analysis and reporting.  
  b) Financial assistance for situation analysis. |
| **Bhutan**    | • Sensitize Department and relevant Divisions and Programs on the Recommendations from the Fifth TAG Meeting.  
• Build Capacity of relevant Health Professionals on maternal, perinatal, neonatal death surveillance and response (MPNDSR) Guideline including response to incidents both at central and local levels, linking with the POCQI:  
  a) Form the technical committee  
  b) Develop Plan of Action  
  c) Mobilize resources  
  d) Executive  
• Study tour for observing best practices around RMNCAH in the SEAR Member States.  
• Capacity building of health professionals on Updated National Midwifery Standard 2018 including EmONC services. | Technical support needed for the following:  
  a) Building capacity for MPNDSR  
  b) Study tour  
  c) Capacity building on updated national midwifery standard 2018 including EmONC |
| **India**     | Priority areas:  
• Achieving SDG Targets – national and state level.  
• Optimum Pregnancy Care – ANC and IPC.  
• Mandatory registration of every Stillbirth – national system. | • Provide technical/financial support as needed. |
• Maternal and Perinatal Death Surveillance and Review (MPDSR)
• Midwifery.
• Adolescent Sexual and Reproductive Health.
• Ensure universal access to FP with suitable method-mix.
• Integrate Comprehensive Abortion Care (CAC).
• Ensure RMNCAH is prioritized within the UHC framework.

Process of addressing priority areas:
• Undertake consultation with Ministry and other stakeholders.
• Operationalize National TAG- Replicate SEAR TAG at national/subnational levels.
• Leverage Digital technology – Support RCH portal use for all pregnancies and outcomes.
• Integrate with national priorities/ongoing programs.

<table>
<thead>
<tr>
<th>Indonesia</th>
<th>MMR:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review the estimation of MMR reduction:</td>
<td></td>
</tr>
<tr>
<td>a) Discuss with National Planning Board.</td>
<td></td>
</tr>
<tr>
<td>b) Conduct statistician’s meeting.</td>
<td></td>
</tr>
</tbody>
</table>

ANC: Indonesia has adapted the ANC recommendation to be 6 contacts:
• Conduct meeting to finalize of revised ANC Guideline.
• Synchronize the 6 x ANC contacts with health financing by doing advocacy and meeting with Center for Financing and Health Insurance and Social Security Management Agency.
• Establish MoH Decree to implement the new ANC guideline.

Institutional delivery:
• Conduct meeting to finalize standard of institutional delivery with professional organization and hospital association.
• Set up the national indicator such as response time for emergency SC in 30 minutes.
• Improving the referral system by mapping the level hospital competency link with IT and financing scheme.

Stillbirths:
• Conduct meeting to develop the guideline to improving prevention and management of stillbirths.
• Do stillbirth audit and reporting at district level, monitor by province and central level.
• Conduct national meeting on stillbirths prevention.

CAC:
• Calculating the feasible target.
• Costing for additional 2 ANC contacts with additional USG examination, etc.
• Need technical assistance
- Develop the implementation guideline for PAC and CAC, including the competency and authority of the health providers and determination of health facilities.
- Develop the curriculum and modules and training the practitioners (Midwife, general practitioner, or OBGYN).
- Increasing the awareness of the community about the safe abortion.

### Maldives

- Inform Minister of health about the WHO TAG recommendations and the need for implementing the recommendation and obtain the needed support.
- Revise and update existing national guidelines to incorporate new recommendations.
- Roll out new guideline to all health facilities and reinforce using the guideline (create awareness of health professionals).
- Make all health care professionals accountable for implementing and following the new guideline based on new recommendations.
- Technical and financial support in preparing and dissemination of the guideline.

### Myanmar

**Intrapartum care**

- To promote institutional delivery with SBA
- To develop standards for institutional delivery in Myanmar
- To conduct EmONC assessment (need to mobilize funding)
- To enhance demand generation for institutional delivery in both public and private sectors
- To develop national guideline for intrapartum care

**ANC**

- To increase accessibility of ANC with the support of community volunteers and mobile clinics in the conflict affected areas.
- To ensure all midwives are provided with the new ANC guideline and are aware of providing 8 ANC contacts for every pregnant mother.
- To initiate dialogue with concerned department of MoH in order to include ANC 8 contact in the revised HMIS.
- To , proper referral pathway for complications during antenatal, intrapartum and postnatal periods.

**MDSR**

- To strengthen implementation of MDSR across the country and enable appropriate responses are untaken at different levels. To integrate MDSR in the routine health information system, DHIS-2.

### Nepal

- Identify relevant TAG recommendations to be
- WHO and other UN agencies to provide

None requested
- Recommendations to consider:
  a) Subnational targets need to be defined for all relevant indicators.
  b) Comprehensive guideline spanning across life cycle approach (preconception care, ANC, intrapartum and postnatal care, incorporating Golden 1000 days and early child development) to be discussed/developed.
  c) Adopt Robson classification to rationalize CS.
  d) Adopt ICD MM and ICD PM for assigning cause of deaths.
  e) Develop implementation plan based on the final WHO SEARO maternal, perinatal and neonatal strategy after finalization.
  f) Expand/strengthen MPDSR and review stillbirth data.
  g) Expanding method mix and postpartum and post abortion family planning.

Next steps:
- Consultative meeting to share and prioritize TAG recommendation with stakeholders working in RMNCAH.
- Develop action plan to implement TAG recommendations together with timeline.
- Discuss action plan with recommendations (for endorsement) with Ministry of health and Population and Provincial Ministries, National Planning Commission, Ministry of Finance and other relevant Ministries.
- Incorporate recommended actions into annual workplan and advocate for budget allocation with National Planning Commission and Ministry of Finance.
- Discuss and incorporate recommendations in line with six health system building blocks - focusing on availability of skilled HR.

<table>
<thead>
<tr>
<th>Sri Lanka</th>
<th>NO TA request</th>
</tr>
</thead>
<tbody>
<tr>
<td>- WHO should send TAG recommendations through Hon. Minister of Health, Sec/ Health, DGHS, DDG/PHS to D/ MCH.</td>
<td></td>
</tr>
<tr>
<td>- Recommendations will be reviewed by an expert group comprised of National programme manager, Professional college representatives and other related stakeholders.</td>
<td></td>
</tr>
<tr>
<td>- Discuss &amp; include as an agenda item at the national Technical Advisory Committee TAC (Maternal health &amp; FP, Newborn &amp; Child Health; Adolescent &amp; Youth Health).</td>
<td></td>
</tr>
<tr>
<td>- Select &amp; adopt recommendations at the TAC.</td>
<td></td>
</tr>
<tr>
<td>- Recommendations requiring policy decisions will be discussed at the National Committee on Family</td>
<td></td>
</tr>
<tr>
<td>Health chaired by the Sec/ health.</td>
<td></td>
</tr>
<tr>
<td>Health chaired by the Sec/ health.</td>
<td></td>
</tr>
<tr>
<td>• Disseminate recommendations using appropriate measures (circular instructions, revision of existing guidelines, training, etc).</td>
<td></td>
</tr>
<tr>
<td>• Monitor progress of implementation at TAC meetings.</td>
<td></td>
</tr>
<tr>
<td>• Advocacy and communication for required recommendation.</td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>Perinatal Death surveillance &amp; response</td>
</tr>
<tr>
<td>Thailand</td>
<td>Perinatal Death surveillance &amp; response</td>
</tr>
<tr>
<td>• High Level meeting for Policy Advocacy &amp; participate from multisectoral coordination &amp; Partnership : DOH, MOPH</td>
<td></td>
</tr>
<tr>
<td>• Building Capacity (PNSDR) by training medical personal to conduct the perinatal death Review (PNDR) : RTCOG &amp; MOPH.</td>
<td></td>
</tr>
<tr>
<td>• Monitoring &amp; Evaluation by MOPH committee or National MCHB.</td>
<td></td>
</tr>
<tr>
<td>Safe Abortion &amp; family planning</td>
<td></td>
</tr>
<tr>
<td>Safe Abortion &amp; family planning</td>
<td></td>
</tr>
<tr>
<td>• Promote safe MTP &amp; MVA by building capacity of RSA</td>
<td></td>
</tr>
<tr>
<td>• Building capacity &amp; Scaling up for Increase Expertise &amp; Training program for General Practitioner &amp; Paramedics: DOH, MOPH &amp; RTCOG &amp; Thai Nursing and Midwife council (TNMC) &amp; Thai Medical Council.</td>
<td></td>
</tr>
<tr>
<td>• Increase acknowledgement about Right &amp; Responsibility of Medical personal &amp; and key population: DOH, MOPH &amp; RTCOG &amp; Thai Nursing and Midwife council (TNMC) &amp; Thai Medical Council.</td>
<td></td>
</tr>
<tr>
<td>Timor Leste</td>
<td>• Present the recommendation of TAG meeting to MOH and other stakeholders</td>
</tr>
<tr>
<td>Timor Leste</td>
<td>• Present the recommendation of TAG meeting to MOH and other stakeholders</td>
</tr>
<tr>
<td>• Adopt recommendation of TAG meeting base on country context and country priorities</td>
<td></td>
</tr>
<tr>
<td>• Establish National Technical advisory group on RMNCAH</td>
<td></td>
</tr>
<tr>
<td>• Update the existing National Strategy on RMNCAH (including elimination of ca.cx)</td>
<td></td>
</tr>
<tr>
<td>Priorities</td>
<td></td>
</tr>
<tr>
<td>Priorities</td>
<td></td>
</tr>
<tr>
<td>• Strengthen EmONC (BEmONC, CEmONC, referral system)</td>
<td></td>
</tr>
<tr>
<td>• Implement comprehensive post abortion care</td>
<td></td>
</tr>
<tr>
<td>• Implement health sector response to IPV</td>
<td></td>
</tr>
<tr>
<td>• Strengthen pre-service training in midwifery by standardizing midwifery curriculum base on ICM standard</td>
<td></td>
</tr>
<tr>
<td>• Develop National Guidelines on stillbirths</td>
<td></td>
</tr>
<tr>
<td>• Strengthen MPDSR (specially responses)</td>
<td></td>
</tr>
<tr>
<td>• Technical support and funding.</td>
<td></td>
</tr>
<tr>
<td>• Technical support and funding.</td>
<td></td>
</tr>
</tbody>
</table>
Fifth Meeting of the South-East Asia Regional Technical Advisory Group (SEAR-TAG) towards reduction of maternal mortality and stillbirths in the context of Universal Health Coverage

25-27 November 2019, New Delhi, India