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ABBREVIATIONS

AFHS	-	Adolescent Friendly Health Services
CPR	-	Contraceptive Prevalence Rate
CSTs	-	Country Support Teams
DMT	-	Decision Making Tool
FHI	-	Family Health International
NG/CT	-	Neisseria gonorrhoea/Chlamydia trachomatis
GEP	-	Guide to Essential Practice
GMSTI	-	Guidelines for the Management of STIs
GUD	-	Genital Ulcer Disease
HIV/AIDS	-	Human immuno-deficiency virus/ Acquired immuno-deficiency syndrome
HSV2	-	Herpes Simplex type 2
ICPD	-	International Conference on Population and Development
IEC	-	Information, Education and Communication
IPPF	-	International Planned Parenthood Federation
IUD	-	Intra-Uterine Device
LAM	-	Lactational Amenorrhoea Method
MDGs	-	Millennium Development Goals
MEC	-	Medical Eligibility Criteria
MMR	-	Maternal Mortality Ratio
MoH	-	Ministry of Health
NGO	-	Nongovernmental Organization
RHR	-	Reproductive Health and Research
RTI	-	Reproductive Tract Infection
SBA	-	Skilled Birth Attendants
SPP	-	Strategic Partnership Programme
SPR	-	Selected Practice Recommendations
SRH	-	Sexual and Reproductive Health
STD	-	Sexually Transmitted Disease
STI	-	Sexually Transmitted Infections
TFR	-	Total Fertility Rate
VDRL	-	Venereal Disease Research Laboratory Slide Test

1. OPENING SESSION

1.1 Welcome Remarks

Dr Denham Pole, Acting WHO Representative for Sri Lanka, welcomed the participants on behalf of Dr Samlee Plianbangchang, Regional Director of WHO/SEARO. Dr Pole explained that UNFPA and WHO were initiating collaboration under the Strategic Partnership Programme (SPP) for the introduction, adaptation and implementation of evidence-based practice guides developed by WHO. For 2004-2005, the global partnership will focus on family planning and sexually transmitted infections (STIs). In the South East Asia Region challenges in maternal and newborn health would also be given special attention. He stressed that the promotion, utilization, and adherence to evidence-based practices and guidelines were critical to improve quality of services.

He pointed out that while most SEAR countries had made significant progress in the area of family planning, much work remained to be done. In 2000-2002, the contraceptive prevalence rate (CPR) in Bangladesh, Indonesia, Sri Lanka and Thailand ranged from 51% to 72%. However, in Bhutan, India, Maldives, Myanmar and Nepal it ranged from 20% to 48%, and in Timor-Leste it was 7%. The poor quality of family planning services, predominance of non-reversible methods, limited use of male methods and condoms for dual protection, and high levels of unmet needs and discontinuation rates were important issues in many countries in the Region.

Among women of child-bearing age, STIs - excluding HIV infection – are second only to maternal-related factors causing disease, death and healthy life lost. There was a need to explore new and innovative approaches in order to curtail the spread of STIs, and address the associated complications and the strong link with HIV transmission.

Dr Pole said that the issue of maternal and newborn health posed a major challenge in the Region, and was interconnected with family planning and STIs. Annually, approximately 174,000 women, 136,000 in India alone, died due to pregnancy and childbirth-related complications in the Region. In addition, nearly 1.4 million newborns died every year. Factors commonly associated with these deaths were: the lack of skilled health personnel during childbirth; inability to provide emergency obstetric and neonatal services for complicated cases; inequities and gaps in accessing maternal and neonatal health services in communities; and ineffective

referral systems. Since most pregnancy and childbirth complications could not be predicted, the continuum of care, particularly skilled care at every birth, was crucial in saving lives. Unfortunately, the proportion of deliveries attended by skilled health personnel was very low in some countries of the Region. In 2002 the figures for Nepal, Timor-Leste, Bangladesh and Bhutan were only 13.5%, 19.5%, 21.8% and 23.7% respectively, and in India 42.3% of deliveries were attended by skilled health personnel.

He explained that in order to achieve the Millennium Development Goals (MDGs) and other international development milestones in maternal and newborn health, we need long-term commitments and investments were needed. "We must ensure that women have access to timely, safe, affordable, and high quality maternal and obstetric care. This meeting should serve as a step toward ensuring that 80% of all births are attended by a skilled health personnel by 2005, or 40% of births in countries with a high maternal mortality ratio (MMR). By 2010, 85% of births globally, or 50% of births in countries with a high MMR, should be attended by a skilled health care provider", he added.

Regional and country level partnerships and integrated efforts must be maintained in order to adequately address key issues in family planning, STIs and in achieving *Skilled Care at Every Birth*. UN agencies, particularly UNFPA and UNICEF, international Nongovernmental Organizations and other development partners, including major donors, were obvious partners for future work in these areas of reproductive health.

He also noted that representatives from Member States, WHO headquarters, UNFPA Country Support Teams (CSTs) in Kathmandu and Bangkok, UNFPA country offices and other development agencies were participating in the meeting. He was confident that strategic collaboration between WHO, UNFPA and Member States would be further strengthened through these efforts. Dr Pole thanked the Executive Director, Family Planning Association of Sri Lanka, Dr Abeyasinghe, for the local arrangements, and wished all participants a successful and productive meeting.

Ms. Malathi Weerasooriya, Acting Representative, UNFPA, Sri Lanka and Dr Katherine Ba-Thike, Reproductive Health Research Department (RHR), WHO Geneva, also welcomed the participants.

In his opening remarks, Mr. Ranjith Maligaspe, Secretary to the Ministry of Health, Nutrition and Welfare, Sri Lanka expressed satisfaction that UNFPA, WHO and other agencies were collaborating to improve the quality of care in sexual and reproductive health (SRH) services through the introduction and application of

evidence-based guidelines. He explained that this collaboration would contribute to achieving the International Conference on Population and Development (ICPD) recommendations and Plan of Action, as well as the Millennium Development Goals (MDGs).

1.2 Objectives of the Meeting

Dr Ardi Kaptiningsih, Regional Adviser for Reproductive Health and Research WHO/SEARO, presented the objectives of the meeting. These were:

- (1) To review country situations in terms of current policies, practices, guidelines, epidemiological data and identified needs in family planning, STI management and skilled birth attendance promotion.
- (2) To introduce evidence-based guidelines and tools for family planning, prevention and management of STIs, and promotion of skilled birth attendance.
- (3) To develop the framework for an action plan to improve family planning services, prevention and management of STIs, and promotion of skilled birth attendance, including adoption and utilization of best practices/evidence-based guidelines.
- (4) To identify technical backstopping needs for countries in implementing the action plans.

1.3. Opening Procedures

After Dr Saramma T. Mathai invited all participants to introduce themselves, Dr Iyanthi Abeywickrema, Director, Consultant Venereologist, Sri Lanka/National STD/AIDS Control Programme was unanimously selected as the Chairperson and Dr Y.V. Pradhan, Director Logistic Management Division, Department of Health Services, Nepal, as the Co-Chairperson.

The following participants were selected as rapporteurs:

- First day:* Dr Peden Pradhan, Assistant. Representative, UNFPA, Nepal;
- Second day:* Dr Dinesh Agarwal, Technical Adviser Reproductive Health, UNFPA India;
- Third day:* Dr Ne Win, National Programme Officer, Reproductive Health, UNFPA, Myanmar, and

Fourth day: Dr Melania Hidayat, National Programme Officer, Reproductive Health, UNFPA, Jakarta.

2. OVERVIEW OF THE STRATEGIC PARTNERSHIP PROGRAMME

Dr Katherine Ba-Thike, Department of Reproductive Health and Research (RHR), WHO/HQ, gave an overview of the WHO/UNFPA Strategic Partnership Programme (SPP). She explained that the overall objective was to improve the quality of sexual and reproductive health (SRH) services through the introduction and application of evidence-based practices. The guidelines and tools prepared by WHO and partners reflected globally recognized recommendations on relevant best practices. She also pointed out that links with CSTs were critical in maximizing the use and adaptation of these guidelines and tools, and for the harmonization of messages.

More specifically, SPP aims to:

- Systematically introduce selected practice guides to improve reproductive health, initially family planning and STI/RTIs;
- Support the dissemination, adoption and/or adaptation of guidelines in countries through CSTs, WHO/ RO, UNFPA and WHO Country Offices and national counterparts;
- Enhance links between the creation of evidence-based guides and their implementation, in order to improve programmes, and
- Strengthen capacity in application of guidelines through technical updates and backstopping.

In assessing the dissemination and utilization of evidence-based guidelines, it is important to examine:

- the extent to which they are disseminated at the country level;
- who has access to them;
- the extent to which they are used to improve services; and
- by whom.

Dr Ba-Thike explained that the expected outputs and outcomes of SPP are:

- the adoption and up-scaling of utilization of evidence-based practices, tools and materials, and
- the improved quality of reproductive health services.

The initial focus will be particularly on family planning, STI/RTIs and promotion of skilled care at birth. The evidence-based guidance tools to be reviewed during the workshop and introduced during the first year of this partnership are:

2.1 Family Planning

- Medical Eligibility Criteria for Contraceptive Use: intended for use by policy-makers and programme managers.
- Selected Practice Recommendations for Contraceptive Use: intended for use by policy-makers and programme managers.
- Decision-Making Tool for Family Planning Clients and Providers: intended for use by health care providers in their counselling to clients.

2.2 STIs / RTIs

- Generic Guidelines: intended for use by healthcare providers.
- Guidelines for the Management of STIs (GMSTI).
- Sexually Transmitted and other Reproductive Tract Infections: A guide to essential practice (GEP).

2.3 Maternal and Newborn Health Care

Guides on MNHC which will be introduced in the following year include:

- Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice.
- Managing Newborn Problems: A guide for doctors, nurses and midwives.
- Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors.

During the discussion that followed, it was pointed out that while technical guidance and assistance should be provided by WHO and other UN agencies, national bodies and professional societies, such as those of gynaecologists and obstetricians, should also be consulted in the process of finalizing the guidelines. It

was noted that professional societies played a major role in several countries in the Region, and that flexibility was needed in the adaptation process and in the design of evidence-based programming.

3. SITUATIONAL ANALYSIS

3.1 Overview of Country Reports

Dr Ardi Kaptiningsih presented an overview of country situation analysis on family planning and STI activities. The salient points are outlined below:

(1) Family Planning

- (1) While national guidelines for family planning exist in all participating countries, not all are using WHO guidelines.
- (2) Restrictions in access to services persist, for example, in Indonesia only married couples have access to contraception.
- (3) Services through the government are provided on a cost-sharing basis in Indonesia, Myanmar and Sri Lanka.
- (4) Services are provided free of charge by the government in Bangladesh, Bhutan, Nepal and Thailand.
- (5) There are different coordination mechanisms in the Region, including the use of reproductive health committees and monthly coordinating meetings.
- (6) In all participating countries the provision of services is carried out at the primary health care level and through NGOs. Services at Primary Health Centres (PHCs) include providing all methods (Sri Lanka); providing all methods except female sterilization (Bangladesh, Indonesia, and Nepal); providing all methods except sterilization and Intra-Uterine Device (IUD) (Myanmar); and providing all methods except sterilization, IUD and implants (Thailand).
- (7) In all participating countries, family planning-related training includes: pre-service, in-service and refresher training.

Barriers and constraints in service provision in participating countries include: poor quality of services, limited skills among providers at the PHC level, insufficient commodities and supplies, limited coverage, lack of guidelines and training, and policy- related and social obstacles.

Suggestions for improving the quality of family planning services include: improving health provider technical and counselling skills; integrating essential reproductive health services at PHC level; improving the logistic management system; strengthening the health system; revising family planning guidelines and protocols and widely distributing them; and improving the monitoring, supervision, and research on quality of care.

(2) STIs/RTIs

- (1) Data is limited in all countries.
- (2) All participating countries have national guidelines, and some use WHO guidelines.
- (3) All participating countries have adopted the syndromic approach at the PHC level.
- (4) STI services are provided free of cost by the government in Bangladesh, Bhutan, Myanmar, and Sri Lanka. In Indonesia services are provided on a cost-sharing basis.
- (5) Coordination mechanisms include holding monthly meetings, using a reproductive health committee, and managing public health service provision.
- (6) In Bhutan, services are provided only by the government, while in Indonesia and Myanmar, NGOs also provide STI services.
- (7) STI service providers include gynaecologists and obstetricians, STI specialists, general practitioners, nurses and midwives, medical assistants, and urologists.
- (8) Training includes counselling skills, STI treatment and care, STI syndromic approach, and links with HIV.
- (9) STI surveillance in Bhutan, Myanmar and Sri Lanka is based on clinics using the syndromic approach.

Key constraints in RTI/ STI service provision include cultural and social barriers such as stigma; lack of or inaccurate information; poor awareness of STI prevention and care among high risk groups; inadequate services including counselling; very limited resources, especially in laboratory facilities and medicine.

Suggestions for improving the quality of STI/RTI services include: Information, Education, Communication (IEC) on STIs; integration at all levels of STI services with family planning, maternal and child health, and adolescent health; training on STI

prevention and care, especially counselling for providers; strengthening of laboratory facilities in hospitals and at the primary health care level, including availability of Gram stain and Venereal Disease Research Laboratory Slide Test (VDRL); and improved coordination and collaboration among stakeholders.

Dr Kaptiningsih also outlined key factors that negatively impact reproductive health in participating countries. These include:

- Higher risk sexual behaviour
- Limited knowledge and misconceptions
- Limited access to or unavailability of services
- Discrimination and stigma
- Poor quality of services
- High cost of services
- Insufficient resources within the health system
- Gender-based inequities in accessing services.

A discussion followed Dr Kaptiningsih's presentation. A participant from Bangladesh pointed out that there are serious barriers to open discussions on STI-related issues in some countries in the Region. In Bangladesh, those who are not married do not have easy access to condoms, and contraceptives are only available on medical grounds. However, services were provided free of charge.

It was pointed out that in Bhutan, the use of male sterilization is very high and inquiries were made regarding the strategies taken to achieve this. A participant from Bhutan explained that non-scalpel vasectomy was performed for male sterilization, and some incentives are provided to clients undergoing the procedure.

A participant from Nepal suggested that WHO should also consider discussing issues such as commodity security, and the role of social marketing and the private sector with regard to the quality of family planning and STI services. A participant from Bangladesh added that laws and regulations that serve as barriers to accessing family planning and STI services should also be explicitly discussed.

A participant from Sri Lanka explained that the lack of reporting by NGOs and the private sector was a major constraint in providing quality services. It was added that an analysis should be carried out of the data on CPR, the contraceptive method mix, the total fertility rate (TFR), and abortion. This would permit better understanding of family planning related needs among different groups.

3.2 Looking at the Quality of Family Planning Services More Closely

An overview of the quality of family planning services in selected countries was presented by Dr Saramma T. Mathai, Reproductive Health Adviser, UNFPA CST for South and West Asia.

Dr Mathai first reviewed the role of family planning within the ICPD framework and outlined the family planning situation in South Asia. Overall awareness of family planning and access to services had increased since ICPD. Disaggregated data from Bangladesh and Sri Lanka showed no significant difference among economic quintiles. However, findings from Nepal and Sri Lanka, and preliminary evidence from an on-going study in Bangladesh, showed high discontinuation rates for contraception. Furthermore, the Region was seeing an increasing number of abortions carried out.

Dr Mathai explained that the framework used for the assessment of the quality of family planning services in selected countries was the International Planned Parenthood Federation's (IPPF) *Framework for the Rights of Clients and the Needs of Providers*. Client rights include: information; access to all services; informed choice; safe services; privacy and confidentiality; dignity, comfort and expression of option; and continuity of care. Provider needs include: facilitative supervision and management; information, training and development; and supplies, equipment and infrastructure.

The right to information and informed consent involved the provision of complete and accurate information on method benefits and side effects by providers to clients. In South Asia, while information on all methods available was increasingly being shared with clients, provider bias remained strong. Evidence from clients who discontinue use of a contraceptive method suggests that complete and accurate information on method risks, benefits, and side effects are not being adequately provided. Furthermore, the provision of information on method effectiveness in preventing HIV and STI transmission was also inadequate.

Data from Sri Lanka showed that health providers gave incomplete information on proper use of methods, especially on the side effects and effectiveness of methods in preventing STIs/HIV. Findings also showed that sometimes the information given was inaccurate.

The right to safe services included the use of service delivery guidelines, counselling, recognition and management of problems. Service guidelines existed in Nepal, Bhutan and India. Nepal was using the Medical Eligibility Criteria (MEC) 2000 and the first edition of Selected Practice Recommendations (SPR), while India had

adapted the MEC and SPR according to its needs. In Sri Lanka, service guidelines were being developed for IUD and surgical contraception among others. Dr Mathai pointed out that not all methods of contraception were accessible in all countries. Condoms, pills, IUDs, and surgical contraception were available in all countries, to at least some groups. However, injectibles were not available in the public sector in India. The Emergency contraceptive pill was not available in the public sector in India and Sri Lanka, and Norplant was not available in India and in some facilities in Sri Lanka.

Counselling was of poor quality throughout the Region. It often involved the provision of standard information, which was not based on client's needs, not shared in an interactive manner, and not responsive to overall client needs. Client concerns regarding privacy and confidentiality were also not adequately addressed. Counselling on side effects and follow up counselling were negligible. Findings from Nepal and Sri Lanka showed that follow-up counselling was the weakest link in family planning service provision. Furthermore, client screening in the Region was weak, significantly contributing to discontinuation rates, and dual protection was rarely discussed. While ICPD outlined the right to continuity of care, follow up to services in the Region was weak. It was found that Sri Lanka was the only place where there was follow-up. However, follow-up did not necessarily involve high quality visits.

Addressing the needs of service providers was also important in assessing the quality of family planning services. Provider needs included information, training and development. Evidence from the Region indicated that providers often received poor quality or no training, and that there was a lack of technical competence assessment. Dr Mathai pointed out that Nepal had one of the best family planning training, and national medical standard guidelines for family planning in South Asia. She clarified that the training strictly followed these national guidelines. However, she cautioned, this did not necessarily mean that the knowledge and skills acquired in the training were being utilized in practice during service delivery; there was a lack of follow up in the field. In Sri Lanka, while manuals for health providers were being revised and counselling training was on-going, the quality of these materials and training needed to be evaluated. Facilitative supervision was another provider need, which was inadequate in this Region,. Resource needs, such as supplies and equipment, and infrastructure were issues in all countries in the Region.

Dr Mathai's presentation was followed by a lively discussion. A participant from Bangladesh explained that there were 5,000 family welfare visitors in Bangladesh, allowing for good follow-up services. Dr Mathai agreed that Bangladesh's home visits programme was good, but added that the quality of the visits could be strengthened.

A participant from Sri Lanka clarified that the discontinuation study carried out in Sri Lanka was limited and could not be generalized. It was added that delivering dual protection information to married couples should be done with caution. Dr Mathai stated that dual protection should be discussed and emphasized, irrespective of a couple's or individual's marital status, using a proper approach. With regard to provider bias, participants from Sri Lanka and India explained that it played a potent role in service delivery and that more attention needed to be given to ensuring that clients received accurate and complete information. Another participant from India pointed out that in order to achieve a high quality of care, management and supervision needs must be addressed and not only the technical aspects of programming.

4. OVERVIEW OF LATEST WHO GUIDELINES

4.1 WHO Family Planning Guidelines

Dr Carlos Huezo, Reproductive Health and Research Department, WHO/HQ, explained that WHO's family planning evidence-based guidelines:

- Adhere to WHO's "Guidelines for Guidelines";
- Are based on systematic reviews of evidence,
- Provide citations of evidence used for decision-making; and
- Are a product of consensus among reproductive health organizations and experts.

The WHO global guidelines and tools were subject to continuous monitoring and updating. To keep WHO guidelines updated, the Continuous Identification of Research Evidence System is used. This involves:

- Identifying studies that address a topic covered in a guideline;
- Undertaking critical appraisal of new evidence;
- Evaluating the impact of new evidence on guidelines;
- Systematic review of evidence;
- Review by Guidelines Steering Group;
- Review by Guidelines Working Group, and

- Update recommendations in the Guidelines.

Dr Huezo presented WHO's Four Cornerstones of Evidence Based Guidance for Family Planning:

- The two guidelines for policy-makers and programme managers are:
 - Medical Eligibility Criteria for Contraceptive Use: who can use which contraceptive methods, and
 - Selected Practice Recommendations for Contraceptive Use: how to use each contraceptive method.
- The other tool and guideline developed for health care providers are:
 - Decision-Making Tool for Family Planning Clients and Providers, and
 - Handbook for Family Planning Providers.

Dr Huezo added that the guidelines were developed through consensus at the Expert Working Group meetings organized by WHO. This Group consists of country experts, as well as representatives from UNFPA, the World Bank, IPPF, USAID, The Centers for Disease Control, The National Institute of Child Health and Human Development, Engender Health, Family Health International, The Johns Hopkins University Centre for Communication Programs, JHPIEGO, Management Sciences for Health, IntraHealth, and the Institute for Reproductive Health, Georgetown University.

(1) Medical eligibility criteria for contraceptive use (MEC)

The Medical Eligibility Criteria for Contraceptive Use was first published in 1996. The second edition was published in 2000 and the third edition was to be published in 2004. It provides over 1,700 recommendations on who can use which contraceptive methods. The methods of contraception included are:

- Combined hormonal contraceptives: pills, 1-month injectibles, patch, vaginal ring
- Progestogen-only contraceptives: pills, implants, two and three month injectibles
- Emergency contraceptive pills
- IUDs: copper bearing and levonorgestrel
- Emergency IUD
- Barrier methods: condoms, spermicides and diaphragm

- Fertility awareness-based methods
- Lactational Amenorrhoea Method (LAM)
- Coitus interruptus
- Sterilization: male and female.

The MEC also provides guidance for women with medical problems or other special conditions. There are four Condition Classification Categories:

- Category 1:* no restriction for the use of the contraceptive method.
- Category 2:* the advantages of using the method generally outweigh the theoretical/proven risks.
- Category 3:* the theoretical or proven risks usually outweigh the advantages of using the method.
- Category 4:* there is an unacceptable health risk if the contraceptive method is use.

(2) Selected practice recommendations for contraceptive use (SPR)

The first edition of the Selected Practice Recommendations for Contraceptive Use was published in 2002, and the second edition is currently being prepared and will be published in 2005.

The overall goal is to standardize delivery of contraceptive services. The tool includes 23 selected questions on how to use contraceptive methods. These questions are broken into the following categories:

- Initiation/Continuation:
 - When to start?
 - When to re-administer?

Incorrect use:

- Missed pills
- Problems during use:
 - Bleeding (progestogen-only methods and IUDs)
 - Vomiting and diarrhoea (pills)
 - Pelvic inflammatory disease (IUDs)
 - Pregnancy (IUDs)

- Programmatic issues:
 - What examinations or tests should be done routinely?
 - What follow-up schedule is needed?
 - How to be reasonably sure a woman is not pregnant?

For each question:

- Working Group recommendations are provided;
- Comments by the Working Group are stated;
- Key unresolved issues are presented;
- Information about the evidence is given: literature search questions; level of evidence found; and references identified through systematic reviews.

Numerous modifications have been made in the second edition of the SPR, i.e: 10 new questions have been added and 12 of the original questions have been revised. In addition, a summary of the Expert Working Group discussion is provided.

Discussion:

Dr Huezo used the example of smoking to explain to participants how to determine the MEC category under which a contraceptive is classified given a condition. He also used an example from the SPR, discussing the question “when can a woman start using combined oral contraceptives?” There was a lively discussion in both instances.

Following Dr Huezo’s presentation, there were numerous questions. One participant asked if these guidelines include guidelines for HIV-positive women. Dr Huezo explained that the MEC guidelines include HIV infection as a condition and that anti-retroviral therapy (ART), which may have drug interactions with hormonal contraceptives, is also considered in the new MEC.

Dr Huezo added that guidance on adolescents is also covered in the MEC. He explained that the only contraceptive which is not Category 1 for adolescents, is Depo Provera; before the age of 18 it is listed as Category 2. This is because it has an anti-estrogenic effect, which *may* interfere with bone mineral density, although there has been no evidence of a clinical effect so far.

A participant from India inquired about the evidence on safety and efficacy of Depo Provera as per WHO Guidelines, and whether it is relevant for developing countries. Dr Huezo explained that evidence included data from research undertaken

in developing countries, including countries in the SEA Region, such as Thailand, and that research done by WHO included collaborating centres in developing countries.

A participant from Bangladesh asked if it is possible to provide family planning services by using these guidelines at the grassroots level in countries throughout the Region. Dr Huezo explained that the guidelines should be adapted to meet provider needs and to suit the local context. In addition, there should be a good referral mechanism for cases where health workers cannot properly assess a condition.

(3) Tools for health care providers

Dr Huezo explained that WHO's Four Cornerstones of Evidence Based Guidance for Family Planning: *Handbook for Family Planning Providers* had been conceptualized to serve as a reference guide and tool for providers. A consensus meeting for the tool was scheduled to be held in early 2005. The tool would contain all of WHO's family planning guidance. It was being produced in partnership with the creators of "The Essentials of Contraceptive Technology" (Johns Hopkins University, Centre for Communication Programme).

Dr Ba-Thike presented *The Decision Making Tool (DMT) for Family Planning Clients and Providers: Translating guidelines into practice* (DMT). She explained that the tool was produced by WHO and JHUCCP, with the involvement of many other organizations during its development and field-testing. The DMT was designed for primary or secondary level family planning providers and their clients. It was meant to facilitate the interaction between the client and the provider. It was also meant to promote the informed choice of a contraceptive method. Dr Ba-Thike pointed out that in some settings the DMT may be too advanced for the primary level, and may need adaptation. The version distributed to participants was a draft. The final version will be published in late 2004 or early 2005.

The DMT helps clients choose and use the method of family planning that suits them best. At the same time, evidence-based technical information gives the provider the essential information needed to offer high-quality family planning care to clients. Guidance for new and returning clients is provided in the tool, consisting of information for decision-making and problem solving. There are also communication reminders for providers, which offer tips and guidance on how to communicate with and counsel clients effectively.

This family planning flipchart can be used for informational purposes on facts about contraceptives and also provides a counselling process with a tailored approach. It was explained that the technical information in the DMT is based on the MEC and SPR. Additional technical information in the tool is based on *The Essentials*

of Contraceptive Technology (JHUCCP). The counselling process is based on the latest available evidence in health communication research.

The DMT is a multi-purpose tool:

Decision-making tool: it helps clients make a decision using evidence-based practices.

Problem-solving tool: it helps the provider assist clients who are having problems with their methods

Job aid: it has useful illustrations, reminder points, charts etc.

Reference guide: the tool contains detailed reference information for providers

Training tool: the tool can be used in pre-service or in-service training.

The tool includes information on 14 different family planning methods. If it is a new client, the provider helps the client make an initial choice about a method and then flips to one of the method tabs in order to provide detailed information. Usually, the provider will use about 10 pages with each client. For returning clients, even fewer pages may be used as providers can refer to the relevant pages within the returning client tab. There is a tab titled "appendices", which contains additional counselling information and aids for providers.

Most "method" sections contain information on all reproductive health topics. The sections include:

- Overview and information for choice
- Medical eligibility criteria
- Possible side effects
- How to use the method
- When to start using the method
- What to remember.

The tool contains several best practices in client-provider interaction. Simple things like welcoming the client are often not done in counselling, even though this could help providers build trust with the client and establish a good rapport. In addition, evidence shows that offering a client the method that they have "in mind" increases satisfaction and continuation rates. It also gives guidance on providing

advice for dual protection, to younger clients, postpartum and post-abortion clients and clients living with HIV/AIDS.

The tool has been introduced in five countries during field-testing. In 2002, focus group workshops were carried out in South Africa, Indonesia, and Trinidad and Tobago. In 2003, observational studies were conducted in Indonesia and Mexico. In May 2004, an impact evaluation commenced in Nicaragua. After field testing, the tool was adapted by the STARH Programme in Indonesia. The tool will be disseminated through various partner agencies in Indonesia. BKKBN, the Indonesian National Family Planning Coordinating Board, is keen to implement the tool nationally with all family planning providers. Experience from Indonesia has shown that adaptation can make the tool cheaper. For example, removing methods, which are not applicable to a country or area, reduces the number of pages; and the use of a two-colour instead of a multi-colour layout makes printing even cheaper.

There are additional ongoing and planned activities with the DMT. Since field-testing, the DMT has been integrated into IPPF's Global Quality of Care Programme. Many countries are also involved in a training programme to implement the tool in their member associations. There are also global and regional training-of-trainers; in SEA Region: Bangladesh, Nepal, India, Indonesia, and DPR Korea. Translations are also planned into Bengali, Nepali and Urdu.

The participants expressed interest in the tool and found it easy to navigate. This was followed by discussions on issues related to the size, cost and adaptation of the tool. Participants from Indonesia, who had been involved in the field testing and pilot implementation of the tool, presented their experiences. There was also discussion related to restructuring so that there are separate tools for the provider and the client. It was suggested that the pre-testing of the DMT should also focus on the ultimate impact of the tool, addressing the quality of services. The pre-testing of this tool in a South Asian country was also suggested.

4.2 WHO STI/RTI Guidelines

Dr Francis Ndowa, Reproductive Health and Research Department, WHO/HQ, presented WHO's guidelines and tools for STIs and RTIs. He explained that the WHO package for STI/RTI control aims to assist programme managers and health-care providers with tools suited to their needs and the environment. The following table shows the guidelines and tools designed thus far.

Guidelines and tools on STIs

Type of Tool	Name of Tool	Remarks
Programmatic guidance	<ol style="list-style-type: none"> 1. STI/ RTI Programme Guidance Tool. 2. STI Prevention and Care (draft awaiting revision) 	Field-tested in four countries, and are being finalized as two volumes.
Generic guidelines for health care providers	<ol style="list-style-type: none"> 3. Guidelines for the Management of STIs: focuses on clients seeking care for perceived STI symptoms. 4. Sexually Transmitted and Other RTI: A Guide to Essential Practice (GEP) 	<p>Revised in 2002 and reprinted in 2003.</p> <p>Undergoing final editing.</p>
Implementation guidance	<p>Training modules will be available as:</p> <ul style="list-style-type: none"> • 7 modules and a trainer's guide • CD ROM version • Interactive self-learning CD ROM 	Training modules are currently undergoing final revisions prior to printing.
	Adaptation Guide: under development in collaboration with the London School of Hygiene and Tropical Medicine	To be finalized
Implementation guidance	<ol style="list-style-type: none"> 1. Guidelines for STI Surveillance. 2. Initiative on second generation of HIV surveillance systems. 3. Laboratory diagnosis of STDs: currently does not include newer diagnostics; discussions have commenced to review the book before reprinting. 4. Managing drug supply. 5. The Male Latex Condom. 	

Dr Ndowa emphasized that each country should decide its needs to adopt the guidelines to its local context/setting with the involvement of stakeholders.

Main issues raised during subsequent discussion:

- Country adaptation, according to needs based on country data, and stakeholder involvement are crucial.

- The specific needs of groups such as men who have sex with men must be addressed, and integrated guidelines for services must be developed. Other issues raised included the concept of dual protection, and the involvement of the community, particularly to address religious beliefs and practices.

(1) Adolescent friendly health services (AFHS)

Dr Ndowa described the adolescent friendly health services (AFHS) tools, designed to strengthen action at the country level. The following table highlights the AFHS tools.

Type of Tool	Name of Tool	Format
Tools to advocate attention to, or investment in AFHS.	<ol style="list-style-type: none"> 1. The Second Decade: Improving adolescent health and development. 2. Adolescent Friendly Health Services: An agenda for change. 3. Health Services for Adolescents: What we know and what we don't know 	Booklet Booklet PowerPoint Presentation
Tools to re-orient health service providers to make them more adolescent- friendly.	<ol style="list-style-type: none"> 1. AFHS: Making it happen. 2. AFHS: Methods and tools to measure quality, coverage and cost. 	Consultant resource kit format and workshop format – draft. Draft.
Tools to improve the performance of health workers.	<ol style="list-style-type: none"> 1. Orientation programme on adolescent health: binder contains modules, each of which contains a facilitator's guide and a handout for participants. 2. Adolescent job-aids: adolescent chart/patient management guidelines and links with WHO and other national guidelines. 	Draft.

(2) Guidelines for the management of STIs (GM STI)

Dr Ndowa explained the following aspects on management of STIs.

(i) Guidelines for STI management in health services

The STI guidelines provide recommendations to expand coverage. For the purpose of identifying asymptomatic cases, partner notification and appropriate screening, as

well as case finding are addressed. To improve health care seeking behaviour, recommendations are provided including improving the quality of care, counselling and education. For diagnosis and treatment, the syndromic approach is recommended. For this approach to be successful, algorithms should be adapted for local epidemiology and drug resistance patterns. It is also important that STD drugs are included on the essential medicines list, that a single dose is prescribed, and that counselling regarding compliance is included.

(ii) *Diagnostic approaches for STIs*

Clinical diagnosis approach: Identify the STI causing symptoms based on clinical experience. The disadvantages are: STI providers often misdiagnose STIs; it is neither sensitive nor specific; mixed infections cannot be detected; and surveillance is difficult.

Aetiological/laboratory diagnosis approach: Identify the organism causing the symptoms with laboratory tests and microscopy. As simple tests are not available or do not exist, disadvantages are that tests can be time consuming and results are not readily available; tests are expensive, for example, cultures cost US\$12-40 and take up to six days; even rapid tests require equipment to obtain and process specimens, at about US\$7 per test; and tests are dependent on technician and laboratory accuracy.

Syndromic diagnosis approach: Identify all possible STIs that could cause the syndrome and give recommended treatment. This approach is based on epidemiological and laboratory data. Advantages include that with immediate treatment there is a decrease in transmission and a decrease in complications. Furthermore, it is possible to carry out syndromic surveillance. However, the ability to treat as many infected people as possible (sensitivity) needs to be weighed against the risks involved in over-treatment (specificity). Disadvantages include antimicrobial resistance, the cost of over-treatment, side effects of over-treatment, and diagnosis-based stigma.

(iii) *The syndromic approach*

Dr Ndowa explained that in developing countries the emphasis was placed on the syndromic approach. He stressed that flowcharts and treatment tables should be adapted to reflect local syndromic management algorithms, where available.

The syndromic approach involves:

- Syndromic diagnosis: the identification of a consistent group of symptoms and easily recognized signs/syndromes;
- Syndromic treatment: treatment of the main organisms responsible for causing the syndrome;
- Syndromic management: includes a series of algorithms, which guide the health-care provider through the correct identification and treatment of an STI-associated syndrome; the health care provider offers a comprehensive care package ranging from history taking and examination, to counselling/education on risk reduction and partner management.

Dr Ndowa gave an overview of WHO's Guidelines for the Management of STIs, 2003 revised edition. He explained that the guide provided global management and treatment recommendations for syndromes and individual STIs, key for STI management in resource-limited settings. This tool addressed the needs of clients presenting with complaints and/or symptoms of an acute STI. It could be used by a broad range of health care workers but should be adapted according to regional/local disease prevalence, and antibiotic resistance and availability.

The main contents of the guidelines cover risk factors in relation to cervical infection, criteria for the selection of drugs, treatment of STI-associated syndromes, treatment of specific infections, key considerations underlying treatments, practical considerations in STI case management, STIs and children and adolescents.

Dr Ndowa pointed out that STI case management included: accurate diagnosis, treatment at first encounter and rapid cure with effective drugs, maintaining simplicity and an integrated approach. Condom promotion, partner notification and education/counselling were also important components of STI case management.

He also outlined the key changes in the 2003 edition of the Guidelines for STI Management. These changes primarily addressed Genital Ulcer Disease (GUD) and vaginal discharge. New data on GUD epidemiology, and experience with the management of vaginal discharge syndromes were reviewed at a consultation of STI experts. The main change to the GUD management flowchart was to include Herpes Simplex type 2 (HSV2) treatment where prevalence was 30% or higher.

Dr Ndowa explained that several problems were associated with vaginal discharge syndrome. The symptom of abnormal vaginal discharge was more indicative of vaginal infection, and was a poor predictor of cervical infection. In addition, there was a significant over-diagnosis and over-treatment for Gonorrhoea and Chlamydia in some settings. The currently proposed flowcharts for "vaginal discharge" were neither

sensitive nor specific enough for the diagnosis of cervical infection, especially in settings where the prevalence of cervical infection was very low, for example in Matlab, Bangladesh. A low prevalence led to a low positive predictive value and a high cost of unnecessary treatment.

Existing rapid diagnostic tests for *Neisseria gonorrhoea*/*Chlamydia trachomatis* (NG/CT) were not simple, as they required a number of steps to obtain results, and were costly, at approximately US\$7 per test. Furthermore, their sensitivity was 60-70% compared to amplification tests. However, in high prevalence areas, a woman's contact with the health services offered a good opportunity for her to be treated and cured of NG/CT.

(3). STI/RTI: A guide to essential practice (GEP)

Dr Sibongile Dlodlu presented the STI/RTI: A Guide to Essential Practice (GEP) on its guidance categories and structure. This guide provided an evidence-based comprehensive approach to STIs and RTIs, including counselling, prevention, screening, case-finding, and management. It addressed ICPD goals and the need to expand STI/RTI prevention and care.

GEP was developed for use in resource-limited settings and can be used in diverse ways:

- It aims to get providers for reproductive health in primary health care settings to think about STI/RTI prevention and care.
- It can also be used by managers to better understand approaches to STI Management in their service delivery setting and implementation needs.
- It can serve as a reference or resource guide for clinicians, providing evidence-based practical information concisely.

GEP includes recommendations from other WHO guidelines, such as IMPACT, and complements other guidelines developed by WHO. It was developed based on evidence and a desk review in four countries. The evidence was compiled through the review of current research, including Cochrane Reviews. Over 30 international experts also reviewed and debated aspects of this document, based on best available evidence and what are considered favourable public health outcomes. The document has been reviewed by practitioners and programme managers in Brazil, China, Jamaica, Kenya and Latvia.

Pilot introduction has not occurred. Key issues to consider in a pilot include:

- how countries can use the guide lines;

- what technical assistance is needed, including for adaptation and training;
- where should the guidelines be implemented initially; and
- what are some of the issues to be considered for Operational Research.

Dr Dlodlu pointed out that GEP was divided into sections, each of which had three to four chapters. Each chapter covered:

- (1) Key points: a summary of the information and recommendations for different levels based on established approaches, accepted practices and recommended approaches.
- (2) Background information/rationale on key recommendations presented.
- (3) A simplified approach to problem solving, including steps in decision-making process, flow-charts, and treatment tables

She noted that Section I, where STI and RTI Basics are elaborated, included:

- (1) infections of the male and female reproductive tract and their consequences;
- (2) prevention of STI/RTI and their complications;
- (3) detecting infections; and
- (4) STI/RTI Education and counselling.

Dr Dlodlu said that STIs prevention and case management included effective treatment to reduce STI transmission in the community, and safer medical procedures to reduce iatrogenic infections. Community education and outreach as a means to promote prevention of infection and use of health care services, and reduce further transmission, was considered an accepted practice. STI prevention involved reducing exposure, through the correct and consistent use of condoms, reduction in the number of sexual partners as well as a comprehensive approach to STIs and support to adolescents to delay sexual activity.

Strategies and opportunities for screening of syphilis, cervical and vaginal infections, PID, HIV, and cervical cancer were highlighted. These include evidence regarding how to identify signs and symptoms of RTIs and STIs, screen for syphilis in ANC, and screen for bacterial vaginosis and *Trichomonas vaginalis* in women with previous spontaneous abortion or preterm delivery. Regular Pap smears starting at around 40 years of age were recommended, as was maximizing opportunities for speculum exams and lab tests for cervical infections.

It was important to note the difference between education and counselling as they served different purposes and required different resources. The Health Education Training module in GM STI included more details for developing competencies in education and counselling. STI GEP added content regarding the community level, partner counselling and positive sexuality.

Dr Dlodlu also highlighted Section II of the STI GEP, which focuses on addressing STIs and RTIs through clinics, and improving services for prevention and treatment. It also looks at ways to reach other groups who do not typically use reproductive health services, such as men and adolescents. Opportunities for STI/RTI prevention, detection and management for women seen by providers for other reasons, such as family planning and pregnancy related care are promoted.

The last section covers STI/RTI management, diagnosis and treatment. One of the chapters under this section is wholly based on the Guidelines for the Management of STI (GM STI), presented earlier. Syndromic management flowcharts and treatment tables are presented, including management of STI/RTI-related problems that occur during or following pregnancy. It also includes important issues of sexual violence, such as needs for survivors of assault, emergency contraception, PEP of STI, and other legal/support issues.

Dr Dlodlu finally explained that the GEP Pocket Guide for Essential Practice was developed as a companion to the GEP guide. It was designed specifically for health care providers for use in their day-to-day work. Essential information was clearly presented in charts and tables, with section tabs for easy reference.

5. KEY ISSUES ON SKILLED BIRTH ATTENDANCE IN ACHIEVING THE MDGS

5.1 Workforce for Maternal and Newborn Health Services

Ms. Della Sherratt, Department of Reproductive Health and Research, Making Pregnancy Safer Team, WHO/HQ, gave a presentation on the workforce needs for maternal and newborn health services. She explained that the use of a skilled birth attendant was the key intervention for reducing maternal and peri-natal mortality. Human resource planning was therefore crucial to making pregnancy safer.

Lessons learned from different countries indicated that access to skilled attendance at birth had a strong correlation with MMR reduction. Available data showed that most pregnancy-related deaths and the majority of the complications, which resulted in severe morbidity in both women and newborns, occurred at and around the time of birth. In other words, a skilled attendant at each birth was a priority.

Ms. Sherratt described the framework for skilled attendance at birth. Skilled attendance (a process of care) required both skilled attendants (a person - accredited health provider) and also an enabling environment (addressing both health systems and community issues). Effective skilled attendance at birth (and care before and after birth) required skilled health providers *plus back up*; it needed a functioning health system, a supportive community, and ready access to, and support and supervision from, a facility that provided quality care for management of pregnancy and birth-related complications that were beyond the capacity of the skilled attendant to deal with in the place where they worked.

She explained that the definition of *Skilled Attendant* is "an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns". This definition was agreed on by WHO, ICM and FIGO, and endorsed by UNFPA and the World Bank. Thus, the term; *Skilled (Birth) Attendant* was a description of an appropriate health worker for maternity, a category rather than a title for a specific cadre. The new WHO document, *‘Making Pregnancy Safer: The critical role of skilled attendants’* (2004) provided a list of core competencies that countries could use to assess if their health workers for maternity met the established definition. "In many countries there will be more than one cadre who falls into the *Skilled (Birth) Attendant* category. Defining the category of worker is important and helps provide consistent and accurate information regarding the 'proportion of births attended by a skilled attendant', for which countries now have to report on" she added.

Ms. Sherratt also outlined the established framework of quality care for skilled birth attendance. She explained that it could be used for developing a Human Resource Plan with country specific data. She pointed out that key issues in quality of care included the deployment of skilled personnel, matching training sites with sufficient clinical load and trainees, modifying the medical curriculum, and monitoring and evaluation.

5.2 Report from the UNFAP CST SAWA Regional Workshop on Skilled Birth Attendant, Islamabad

Dr Saramma T. Mathai, presented findings from a workshop, which served as a situational analysis for the countries in the Region on Skilled Birth Attendants (SBAs). During the workshop, a consensus was reached on the definition of SBAs, their tasks, the competency required, and implementation-related issues. The consensus included the tasks to be carried out by a skilled attendant working in the community and those working in institutions.

Dr Mathai also provided information on the follow-up to the workshop, which included deliberations and subsequent workshops in India and Nepal. She pointed out that some national level workshops were planned for other countries in the Region to facilitate country-specific work and planning, which should focus on country consensus regarding:

- Who is a skilled birth attendant?
- The definition of Skilled Birth Attendance
- Life saving skills during home and institutional deliveries for SBA as agreed at the Islamabad workshop
- Implementation issues
- Moving forward and continuing to build on established consensus.

5.3 Overview of Country Reports on Maternal and Newborn Health

Dr Ardi Kaptiningsih presented an overview of country reports on maternal and newborn health in the Region. She highlighted that in 2000, approximately 174,000 maternal deaths occurred in the Region, almost 70% in India alone. Other countries with a large number of maternal deaths were: Bangladesh, Indonesia, Nepal and Myanmar. However, the highest maternal mortality ratio (MMR) was found in Timor Leste and Nepal. The high number of maternal deaths in countries was consistent with the high number of neonatal deaths.

She pointed out that the proportion of deliveries attended by skilled health personnel were low in those countries with high MMR, i.e. it was less than 20% in Bangladesh, Nepal and Timor Leste; while above 90% in Thailand and Sri Lanka. She reminded that countries had agreed to achieve the targets of the Millennium Development Goals (MDGs) and other international development targets by 2015, Among others these included 90% deliveries globally attended by skilled health personnel, and for countries with high MMR: at least 60%.

Highlighting country reports from Indonesia and Bangladesh, she said that in Indonesia, more than 54,000 community midwives (nurse graduates plus 1-year midwifery education) were deployed at the village level during 1990-1996. The government was currently training D3-level midwives (3-year midwifery training for high school graduates) to ensure that they could provide better midwifery services, including life- saving skills for managing and provide first aid during maternal and newborn complications. The proportion of deliveries attended by skilled health personnel was 66% and 15% of Emergency Obstetric Care needs were being met. In Bangladesh, the government was initiating the training of a new cadre of skilled birth

attendant by training (6 months) community health workers (10-year basic education and some years of work experience in public health): Family Welfare Assistant and female Health Assistant. This programme would be expanded to achieve the MDGs target. The proportion of deliveries attended by skilled health personnel was 12% and 27% of Emergency Obstetric Care needs were being met. The target in the national strategy was that by 2010, the proportion of deliveries attended by skilled health personnel should reach 50%.

Observations by participants on updating data on MMR and the proportion of deliveries attended by skilled health personnel, were noted. Issues were raised on the terminology used by the Government of Bangladesh: for the 6-month training as "SBA", while SBA is a category rather than a title for a specific cadre.

6. GROUP WORK: PUTTING WHO GUIDLINES INTO PRACTICE

6.1 Family Planning

Participants had an opportunity to practice using the MEC and SPR. Dr Huezo presented 12 case studies which had to be analyzed based on the question, "According to the Medical Eligibility Criteria, is the method the client wants to use among the safest choices for her?" Participants were divided into four groups, where Group I and III worked on half the cases and Group II and IV worked on the other half. Participants were also divided into groups in order to practice the SPR, based on another set of case studies. Dr Huezo suggested that participants should not only address the issues in the practice cases, but also consider how relevant this guidance is for use in their countries. Feedback from participants confirmed that the process of reaching a consensus among group members and other participants, and using the guidelines for reference, served as a good introduction to these materials and their use, and increased participants' interest in the guidelines.

6.2 STIs and RTIs

(1) Practice of guidelines for the management of STIs

Dr Ndowa asked participants to work in groups to answer questions based on the Guidelines for the Management of STIs, as follows:

- (1) Describe the key components of identifying an STI syndrome (Section 5 of the guideline).

- (2) Describe the advantages and disadvantages of a laboratory-based diagnosis for STI management.
- (3) Describe the advantages and disadvantages of using the syndromic approach for STI management.
- (4) What are the recommended practices to improve treatment compliance for STIs (Section 4)?
- (5) Recommended practice for management of partners.

(2) Practice of STI GEP

In order to carry out familiarization exercises for the STI GEP, participants were divided into five groups and given specific questions corresponding to particular chapters (see Annex 1 for a list of questions).

6.3 SBA: Group Discussion and Reports

Working in country groups, participants were asked to look at Human Resources Planning for SBA based on the following terms of reference:

- Complete as much as possible the country profile for human resources required for maternity care using a format on Mapping Midwifery Services.
- Using the Quality Assurance Framework and the completed Mapping Midwifery Services Form data sheet, consider the following:
 - What additional data is required to make your human resources for Making Pregnancy Safer? How could you obtain this data?
 - If applying the QA Framework in your own country, what is currently missing so far in your country plan regarding human resources? What can you do/suggest to address the missing issues/components?
 - What are the human resource constraints in your country for MPS? What solutions can you suggest that address these constraints in your own setting?

Key issues that emerged during group plenary presentations included:

- Mapping of available human resources is critical
- Distribution of providers in public and private sectors is important
- Pre- service training, education audit, re certification and continuing education are needed

- Career path and promotional avenues are useful
- Regular updating of curriculum and monitoring is necessary.

7. COUNTRY-SPECIFIC ACTION PLANS FOR IMPROVEMENT OF QUALITY OF FAMILY PLANNING SERVICES, AND PREVENTION AND MANAGEMENT OF STIS

Using the information they had received on evidence-based materials and methods to improve the quality of family planning services, and to prevent and manage STIs, participants identified ways to apply what they had learnt to programming in their countries.

They were asked to identify programming needs in order to implement these guidelines in their context. Participants worked in country groups to list out general programme issues, current activities, desired activities, obstacles and challenges, activities required and key stakeholders.

Using the identified key activities, participants were also asked to develop action plans in order to implement the guidelines. They identified responsible persons, the time frame, and the resources needed. The plans were focused and practical, based on the needs of the respective countries and consistent with existing programming.

All countries were interested in using the three family planning and two STI/RTI tools introduced during the workshop. It was decided that these could be used as they are, after adaptation, or as reference material for revision of national guidelines. In countries which had recently revised their family planning guidelines, the focus would be more towards the adaptation and implementation of the STI guidelines, and the integration of family planning and STI/ RTI services.

(1) Bangladesh

The following interventions were required to implement the guidelines:

- *Policy and Programme:* To enforce policies that support programmes, involvement of professional bodies like the British Medical Association, and the Obstetrical and Gynaecological Society of Bangladesh, etc. in training health care providers from the private sector is needed.
- *Training:* To train Health and Family Planning providers in STIs/ RTIs/ HIV at all levels of the health system, it is necessary to sensitize members of the pre-service curriculum review board, and streamline mechanisms for change.

- *Supervision:* To ensure that quality services for family planning, SBA, and STIs/ RTIs are available, accessible, and affordable to all sub-populations, it is necessary to provide training to providers to sensitize them, facilitate transportation for clients, make supervision transparent, and provide training for evidence-based planning to all senior health functionaries.
- *Service Provision:* To ensure that necessary tools and resources (such as contraceptives, vaccines, lab tests, equipments and medicines) are available in adequate quantity at any given time, appropriate training institutions need to be established. To ensure that safe delivery services are available at all times to all women, and that facilities and mechanisms for referral are established, it is important to sensitize donors, senior health care functionaries, NGOs, and communities.
- *Monitoring and Evaluation:* To provide quality monitoring of all programme activities periodically, and to utilize periodic reviews of monitoring and evaluation activities in order to make mid-course programmatic changes, it is necessary to include policy makers and bureaucrats.

In their action plan, Bangladesh gave more focus on the adaptation and implementation of the STIs guidelines.

(2) Bhutan

The following interventions were required to implement the guidelines:

- *Policy and Programme:* To ensure political commitment, the formation of committees is needed. To ensure financial support, funding proposals are required. To ensure human resources, there is a need to increase training, skilled manpower, and provide incentives.
- *Training:* To provide regular, in-service training and refresher courses on family planning, and STIs/RTIs, there is a need for an external consultation for training, with financial assistance.
- *Supervision:* To ensure that an effective supervision system is in place, development of supervisory guidelines and training of personnel is necessary.
- *Service Provision:* To make family planning services accessible, acceptable, and affordable, there is a need for ongoing, high-level advocacy and awareness campaigns, an increase in visits, training, and setting up of good referral systems in districts. To integrate STI/RTI services with family planning services, a policy change is necessary, as is the improving coordination between the two national programmes.

- *Monitoring and Evaluation:* To establish systematic monitoring and evaluation tools, guidelines need to be developed. To have competent health care providers in monitoring and evaluation, training in relevant tools is needed.

In their action plan, Bhutan focused on the adaptation and implementation of both family planning and STIs guidelines.

(3) Indonesia

The following interventions were required to implement the guidelines:

- *Policy and Programme:* To ensure that identified policies are approved and implemented at all levels, and that advocacy is carried out with relevant stakeholders and local governments, the implementation of Minimum Service Standards must be strengthened and effective facilitation, monitoring and technical assistance put in place.
- *Training:* To incorporate guidelines into the pre-service curricula, consultation mechanisms among related institutions must be established. To ensure that the capacity of health providers is maintained and improved, regular meetings need to be held in order to develop and update training plans.
- *Supervision:* To establish effective and efficient supervision mechanisms, there is a need to prioritize issues, hold regular meetings to analyze results, recommend follow up action, and strengthen capacity.
- *Service Provision:* To review and update integrated protocols, SOP, coordination mechanisms need to be strengthened, integrated planning developed, and capacity should be strengthened.
- *Monitoring and Evaluation:* To establish effective monitoring and evaluation mechanisms there is a need for skills strengthening. To carry out appropriate research, regular meetings to analyze results must be carried out with recommendations for follow-up actions.

In their action plan, Indonesia focused on the adaptation and implementation of STI guidelines.

(4) Myanmar

The following interventions were required to implement the guidelines:

- *Policy and Programme:* To ensure a favourable environment and political commitment of the programme as well as nationwide coverage, it is

necessary to have collaboration and cooperation between UN agencies, NGOs, and INGOs, and revolving funds through community cost sharing.

- *Training:*
 - To have up-to-date in-service curricula in all health training institutions, it is necessary to promote advocacy resource mobilization, and develop problem and task-oriented curricula in training institutions and schools.
 - To ensure that all health providers are up to date on current guidelines, it is necessary to provide refresher training within and outside the country.
- *Supervision:* To ensure close supervision at all levels and appropriate support, it is necessary to have management training for supervisors.
- *Service Provision:* To ensure nationwide quality services on reproductive health and STIs, it is necessary to acknowledge achievements, recognize dedicated health workers, especially in remote areas, raise community awareness, and conduct outreach programmes.
- *Monitoring and Evaluation:* To ensure close monitoring and regular evaluation at all levels, it is necessary to provide management training for supervisors. To ensure an adequate MIS system, it is important to provide MIS training, refresher training, and a rewards system.

In their action plan, Myanmar has focused on the adaptation and implementation of both family planning and STI guidelines.

(5) Nepal

The following interventions are required to implement the guidelines:

- *Policy and Programme:* To establish and implement family planning policies and strategies and the implementation of new guidelines, it is necessary to adapt and disseminate guidelines. It is also necessary to formulate STI policies and strategies.
- *Training:* To ensure inclusion of guidelines within pre-service training curricula, it is necessary to coordinate with training institutions, and review and update existing curricula and training manuals. To provide training to different categories of health workers, public and private, on evidence-based guidelines on a regular basis, resource mobilization is needed, as is training of trainers and different categories of health workers.

- *Supervision:* To ensure continuous, supportive, quality supervision at all levels of health service delivery, it is necessary to strengthen capacity and management, and provide adequate budget and logistics.
- *Service Provision:* To be able to use evidence-based guidelines at all service outlets, the WHO guidelines must be adapted to the local context.
- *Monitoring and Evaluation:* To have an effective and efficient monitoring and evaluation system in place, the current system needs to be strengthened and improved.

In their action plan, Nepal has focused on adaptation and implementation of both family planning and STI guidelines.

(6) Sri Lanka

The following interventions are required to implement the guidelines:

- *Policy and Programme:* To have an integrated approach in the adoption of the guidelines, regular stakeholders meetings need to be held. To ensure emphasis on STIs and not only on HIV, review and follow-up at different levels is necessary (central, provincial, district). To strengthen the collaboration between the directorates at the central and provincial levels, review of existing policies in relation to STIs and family planning is necessary to strengthen the development of a comprehensive reproductive health programme.
- *Training:* To identify the content of training required for different categories of providers, it is necessary to adapt guidelines as appropriate for different categories of providers, review curricula, provide re-orientation, monitor implementation, and assess performance. It is also necessary to look at training programmes to determine areas of overlap, gaps, and where changes are needed, as well as monitor effectiveness of programmes.
- *Supervision:* To ensure a systemic plan for monitoring and supervision which is linked with a good information system and follow up, it is necessary to review the ongoing system and identify areas that could be addressed at different levels of the health care system, and improve logistics.
- *Service Provision:* To ensure that guidelines are used optimally to benefit the community, it is necessary to review the existing situation at MbH level, develop a mechanism to monitor the extent to which defined responsibilities are carried out, strengthen regular reviews, link continuing educational

programmes for all categories with re-accreditation, ensure equipment and drugs, and improve management capacities.

In their action plan, Sri Lanka has focused on the adaptation and implementation of both family planning and STI guidelines.

(7) Thailand

In the action plan, the participant from Thailand focused on improving the quality of integrated family planning, MCH and RTI/STI based on the evidence-based guidelines introduced during the workshop, with special attention being paid to adolescents.

8. NEXT STEPS

In the Closing Session, Dr Ardi Kaptiningsih explained that the next step would be finalizing the country plans of actions developed during the workshop. She encouraged countries to submit proposals reflecting the final country plans of action for possible support from the WHO-UNFPA Strategic Partnership Programme.

Funding would be available for countries that submitted a proposal which was relevant to the objectives of SPP, following a review by HQ, RO and CSTs. The UNFPA and WHO Country Offices will also need to be fully involved in the implementation. In addition, technical support could be provided from WHO and UNFPA on request.

Annex 1

AGENDA

Inaugural Session

Monday, 2 August 2004

0800 – 0830	Registration
	Welcome remarks:
0830 – 0840	- Dr Denham Pole, Ag WHO Representative for Sri Lanka, on behalf of the Regional Director, WHO/SEARO
0840 – 0845	- Ms. Malathi Weerasooriya, Ag Representative, UNFPA Sri Lanka
0845 – 0850	- Dr Katherine Ba-Thike, RHR Department, WHO/HQ
0850 – 0900	Opening remarks:
	- Mr Ranjith Maligaspe, Secretary, Ministry of Health, Nutrition and Welfare – Sri Lanka
0900 – 0905	Introduction to the objectives of the meetings:
	- Dr Ardi Kaptiningsih, Regional Adviser for Reproductive Health and Research, WHO/SEARO
0905 – 0920	Introduction of the participants
	- Dr Saramma T Mathai and Dr Josephine Sauvarin RH Adviser, UNFPA CST for South and West Asia, Kathmandu, RH Adviser, UNFPA CST Bangkok
0920 – 0925	Nomination of Chairperson, Co-Chairperson and Rapporteur
	- Dr Denham Pole
0925 – 0930	Administrative announcement
	- Secretariat/local organizer, Family Planning Association, Sri Lanka

Programme

Monday, 2 August 2004

08:30 – 10:00	Inauguration session
10:00 – 10:30	Overview of the Strategic Partnership Programme:
	- Dr Katherine Ba-Thike, RHR Department, WHO/HQ
10:30 – 11:30	Situational analysis:

- Overview of country reports on FP and STI
- *Dr Ardi Kaptiningsih*
Overview on quality of family planning services in selected countries
- *Dr Saramma T Mathai*
- 11:30 – 13:00 Overview of latest WHO FP and STI guidelines
The Four Cornerstones of evidence based guidance for FP
- *Dr Carlos Huezo, RHR Department, WHO/HQ*
The WHO STI/RTI Guidelines
- *Dr Francis Ndowa, RHR Department, WHO/HQ*
- 14:00 – 15:30 Introduction to Medical Eligibility Criteria for Contraceptive Use: Highlights of content and followed by practice (in groups)
- *Dr Carlos Huezo*
- 16:00 – 17:30 Introduction to Selected Practice Recommendations: Highlights of content and followed by practice (working groups)
- *Dr Carlos Huezo*
- 19:00 Welcome reception and display of family planning/STI/RTI and Making Pregnancy Safer guidelines, posters and leaflets.

Tuesday, 3 August 2004

- 08:30 – 10:00 Introduction to Decision Making Tools on Family Planning: Highlights of content and followed by practice (working groups)
- *Dr Katherine Ba-Thike*
- 10:30 – 12:00 Key issues on skilled birth attendance in achieving the MDGs target:
Work force for maternal and newborn health services
- *Ms Della Sherratt, MPR/RHR Department, WHO-HQ*
Reports from Islamabad meeting on Skilled Birth Attendant
- *Dr Saramma T Mathai*
- 12:00 – 12:30 Overview of country reports on Maternal and Newborn Health
Introduction to country group discussion on SBA
- *Dr Ardi Kaptiningsih*
- 12:30 – 14:30 Country group discussion on SBA
- 14:30 – 15:30 Plenary: Country group reports on SBA

16:00 – 17:30 Introduction to Guidelines for the Management of STIs:
Brief overview on what is new and followed by practice
(working groups)
- *Dr Francis J Ndowa*

Wednesday, 4 August 2004

08:30 – 10:00 Introduction to RTI/STI Guide to Essential Practice:
Brief overview on what is new and followed by practice
(working groups)
- *Dr Sibongile Dlodlu*

10:30 – 11:30 Plenary - Working group reports:
Issues to be addressed on FP and STI guidelines

11:30 – 11:45 Introduction to group discussion: Worksheet to identify
required interventions

- *Dr Josephine Sauvarin, RH Adviser, UNFPA CST Bangkok*

11:45 – 13:00 Country group discussion I: Identifying required interventions:
FP and STI

14:00 – 15:30 Plenary - Country group reports:
Identifying required interventions: FP and STI

16:00 – 16:10 Introduction to group discussion II: Action Plan Forms
- *Ms Antigoni Koumpounis*

16:10 – 17:00 Country group discussion II: Development of action plans for
improvement of quality of FP services and prevention and
management of STI.

Thursday, 5 August 2004

08:30 – 09:30 Country group discussion II: Development of action plans for
improvement of quality of FP services and prevention and
management of STI.

10:30 – 11:30 Plenary - Country group reports: Draft action plans

11:30 – 12:30 Backstopping needs and next steps: Discussion in plenary
- *Dr Josephine Sauvarin*

12:30 – 13:00 Workshop evaluation
Closure of the workshop

Annex 2

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