

SEA-MCH-231
Distribution: General

Reducing Unsafe Abortion

*Report of an Intercountry Workshop
Bangkok, Thailand, 30 May – 2 June 2005*

WHO Project: ICP MPS 002



Regional Office for South-East Asia
New Delhi

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February 2006

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1. INTRODUCTION

At the Millennium Summit in 2000, countries committed themselves to achieving the Millennium Development Goals by 2015. The MDG-5 on Maternal Health, which calls for a 75% reduction in MMR compared to its 1990 level, cannot be achieved without addressing the issue of unsafe abortion as it constitutes one of the important causes of maternal deaths. Women die because they seek to end unwanted pregnancies but lack access to appropriate services. Globally, some 45 million unintended pregnancies are terminated each year, of which an estimated 19 million are terminated in unsafe conditions. Asia accounts for 10.5 million of these cases.

What is most disconcerting is the fact that unsafe abortion in some countries affects young women and teenagers. Approximately 40% of all unsafe abortions are performed on young women aged 15 to 24. It kills an estimated 68 000 women every year globally, of which Asia contributes 34 000, accounting for 13% of all pregnancy-related deaths. This is just the tip of the iceberg, as most unsafe abortions are provided in a clandestine manner and are almost never reported. They are associated with considerable morbidity.

Unsafe abortions and unwanted pregnancies go hand-in-hand. One of the main reasons for unwanted pregnancies is the lack of knowledge about and limited access to family planning services. In addition, contraceptive failure is a significant cause of unwanted pregnancy. Other important factors include early marriages and teenage pregnancies, out-of-wedlock pregnancies especially among adolescents, and coercive sexual relationships. All of this can be prevented irrespective of the legal settings – whether permissive or restrictive, for abortion services.

To address this important issue, an intercountry consultation was organized by the WHO Regional Office for South-East Asia in collaboration with WHO Headquarters and *Ipas*, USA. There were 13 countries represented at the consultation from Member States in the South East Asian and Western Pacific Regions. The country participants included representatives

from the Ministry of Health, non-governmental organizations working in the area of maternal health as well as professional organizations and institutions.

2. OBJECTIVES

The main objectives of the meeting were to:

- (1) Demonstrate an understanding of the clinical, health systems and policy considerations and recommendations contained in the WHO guidance document and related materials, including the essential elements of safe, high quality abortion/post-abortion care based on current evidence.
- (2) Describe legal and policy factors that facilitate or constrain access to safe abortion and post-abortion care.
- (3) Identify strategies for integrating safe abortion – in circumstances where it is legally permitted – and addressing/responding to unsafe abortion within national and local initiatives, and develop plans of action.

The expected outcome was to develop a framework of national action plans for preventing unsafe abortion at country level.

Day 1

3. INAUGURAL SESSION

On behalf of the Regional Director for South East Asia, Dr Samlee Plianbangchang, Dr Somchai Peerapakorn, NPO from the WHO Representative's office in Thailand delivered the inaugural speech. In his address the Regional Director said that to improve maternal health and achieve the MDG targets required actions on several fronts. Women die because complications during pregnancy, childbirth and the postpartum period go unrecognized or are inadequately managed. Since complications as a result of unsafe abortion constitute one of the important causes of maternal deaths and unwanted pregnancies constitute the main reason for seeking abortion, efforts should be focussed more on preventing unwanted pregnancies, he added.

The Regional Director further mentioned that WHO has assisted governments, international agencies and nongovernmental organizations to plan and deliver maternal health services in the broader context of reproductive health, including managing complications of unsafe abortion and providing high quality family planning services. At the Special Session of the UN General Assembly in June 1999, Member States agreed that: "in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible". In countries where abortion is legally restricted, post-abortion care services should be made available to those who need it, so that maternal death due to complications of abortion can be reduced significantly.

Before moving on to the technical sessions, Chairperson and Rapporteur were assigned for the day. To set the stage for the meeting Dr Ardi Kaptiningsih, Regional Adviser, Reproductive Health and Research, provided a brief overview of the situation in the Region and presented a framework for action. She highlighted the magnitude of the problem and the contribution of unsafe abortion to the global maternal mortality burden. The exact burden in the Region was not known due to paucity of data. As many countries in the Region had legally restrictive settings, it was difficult to obtain data on unsafe abortion. Even where the settings were more permissive, data on abortion and unsafe abortion in particular were limited.

Dr Kaptiningsih said that, unwanted pregnancies, which precede abortion, were a result of unmet need, inability of the system to reach vulnerable population groups, such as adolescents, sexual abuse victims, etc. The framework for addressing the issue of unsafe abortion could be implemented at three levels: primary prevention, which focuses on prevention of unwanted pregnancy, secondary prevention which includes emergency contraception and tertiary prevention which focuses on services and would depend on legal settings.

Dr Khine Sabai Latt presented an overview from the Western Pacific Region. The main challenges in the Region included high levels of maternal mortality, low contraceptive prevalence rates, unwanted pregnancies and unsafe abortions as well as inadequate programmes to address the needs of adolescents. The Region accounted for 40-50 million pregnancies every year;

more than 14 million of which ended in induced abortions. Almost 30,000-50,000 women died each year from complications related to pregnancy and childbirth. More than 40% of all maternal deaths occurred in Cambodia, Laos, Papua New Guinea, Philippines and Viet Nam, which accounted for one-tenth of the Region's population.

Major activities in the area of maternal health in the Region included regional workshops on improving quality of care in family planning, development of a framework for family planning service standards and guidelines, a training plan on improving and strengthening competency, skills and capacity for family planning, family planning fellowships, regional strategy on adolescent reproductive health and training on gender and rights in reproductive health.

In the discussions following the two presentations participants felt that the framework presented by WHO/SEARO on the three levels of prevention of unsafe abortion – primary, secondary and tertiary – was a useful starting point. A number of additional points were raised to elaborate on these levels.

- In Nepal, where the law has recently changed, there is still a large unmet need for abortion services, because the cost of abortion in the government hospitals is still very high.
- In Bangladesh and some other countries, one of the barriers to women accessing needed services is the lack of skills of providers; they are not adequately trained. There is a need to build capacity at different levels.
- There is a need to focus on the broader social determinants of unintended pregnancies and unsafe abortion, i.e. it is important to address the root causes of early marriage and of violence against women. Ideally, the estimates of the global burden of disease should include these dimensions also, so that the real burden of disease for women can be clearly seen.
- The introduction of new technologies for inducing abortion should also be an area for action, along with a strategy to ensure access to services for adolescents, many of whom are restricted in using services.

- Based on recent evidence indicating how abortion is due to psychosocial factors, such as abuse, violence, poverty, lack of women's decision-making power, WHO should encourage governments to pay much greater attention to these factors.
- An important way to prevent unintended pregnancies is to ensure that emergency contraception (EC) is widely distributed and available. This has been done in Bangladesh through health providers at community level: the family welfare visitors. However, more information about EC needs to be made available so that people know and they can ask for it.
- Another key intervention in relation to primary prevention is expanding target-oriented community education about menstrual regulation. The need for well-targeted education and information for young women and men was also stressed.
- In the Philippines, using a gender and rights-based approach at local government level has found some receptivity in a situation where abortion is often a taboo subject. NGOs working at the local level start the discussion on primary prevention - universal access to family planning - and manage to push the discussion further from there.

4. POSTER SESSION

As a preparatory exercise, participants were requested to bring a poster (one for each country) highlighting the situation of unsafe abortion in their respective countries including the burden, legal status, service availability, enabling factors and constraints. A framework for the poster presentation was shared well ahead of the workshop. All the participating countries brought posters which were exhibited during the last session on the first day. They were given key questions to answer while looking at the posters, which included common challenges across the Region, examples of success that would be worth replicating, policy issues, service quality and access issues.

Day 2

A chairperson and rapporteur for the day were nominated. The chairperson reviewed the previous day's proceedings and laid out the roadmap for the day. In the first session, Ms Wendy Darby, Dr Peter Fajans and Dr Bela Ganatra followed up on the poster session feedback. Participants were asked

to discuss, in small groups, several questions related to the posters. Each group then presented one key issue from their discussion.

The issues presented included reforming abortion laws taking a rights-based approach, ensuring the right to choice for all women, use of data on unsafe abortion and the health impact of law, how to ensure safe and legal access to abortion services, focussing on quality of abortion services, and the need to highlight sex selective abortion in countries where this constitutes a major problem. Currently, there is some degree of opportunity in countries that can be used, such as ensuring that where abortion is legally permitted on health grounds, it is being interpreted and implemented in the widest possible way.

5. WOMAN-CENTERED CARE

The first technical session for the day was on woman-centred care. Dr Bela Ganatra introduced the subject, including the core elements of choice, access, quality and sustainability. She led the participants in a discussion of the challenges in providing high-quality services without increasing barriers by over-medicalising them. A comprehensive, woman-centred abortion care project in Vietnam was presented next by Dr Thuy. She shared experiences in Vietnam in introducing a comprehensive high-quality abortion care model into the health system. Abortion is legal in Vietnam and in the project areas abortion care is available from the highest level to the grassroots and is widely accessible. Confidentiality, privacy and needs of women are taken into consideration while providing services. She noted that the changes at project sites are sustainable only when decisions are made by facilities' staff and activities are implemented by themselves. Therefore, a performance improvement/problem-solving approach was applied for the project.

In a pilot project on friendly services for adolescents, health providers were invited to see a drama developed by young people. Later, both sides discussed what contributed to developing a friendly service. In counselling for Special Clients Training, providers had a chance to talk with women living with HIV in a very friendly atmosphere. Women living with HIV told very moving stories about their lives, their feelings of being discriminated against, and their experiences while receiving health services. These helped providers

to better understand these special clients, become more sensitive and develop positive attitudes towards them.

In the ensuing discussion various issues were raised. These included dealing with long queues, repeat abortion clients, ensuring 24-hour service availability, affordability, role of mid-level providers, demand generation and improved knowledge of women seeking/needing services, and changing provider attitudes.

6. TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS ON SAFE ABORTION

Ms Jane Cottingham, RHR Department, WHO/HQ, presented an overview of the WHO technical and policy guidance document on safe abortion. WHO's technical guidance over the past decade or more has focused on the management of the complications of unsafe abortion, on post-abortion family planning, on studying the problem of unsafe abortion, and on developing and providing guidance on non-surgical – or “medical methods” – of terminating pregnancy. However, in 1999, a landmark consensus agreement was reached at the follow-up conference to the International Conference on Population and Development (ICPD), popularly known as ICPD+5.

ICPD+5 reaffirmed the conclusions of ICPD with regard to abortion not being considered as a family planning method, and the need for abortion to be safe where it was legalized. As per the ICPD recommendation, “in circumstances where abortion is not against the law, health service providers must be trained and equipped to provide such abortion safely. Additional measures must be taken to protect women's health. Since ICPD+5, governments have agreed on a Millennium Declaration for which, in 2001, they agreed on 8 Millennium Development Goals with targets to be reached over the next 10-15 years. It is clear that eliminating unsafe abortion is one critical way to help reduce maternal mortality in many countries where the rate is high.

In nearly all countries, abortion is permitted to save a woman's life, and in some, it is allowed to preserve the woman's health. Safe abortion services, as provided by law, therefore need to be accessible and available, provided

by well-trained health personnel supported by policies, regulations and a responsive health systems infrastructure. Ms Cottingham noted that this guidance is for a wide range of health professionals, and others inside and outside the governments who are working to reduce maternal mortality and morbidity. The purpose of the guidance is to provide a comprehensive overview of the many actions that can be taken to ensure access to good quality abortion services as allowed by law. She concluded by saying that large numbers of women in all parts of the world seek abortion, both safe and unsafe.

When they go to clandestine providers or undertake self-induced abortion, they often suffer serious health consequences and sometimes death. Technical, service-related and regulatory barriers prevent eligible women from accessing services. There are still a lot of challenges in improving quality of abortion care in countries, where such service is permitted.

In the afternoon Session, Chapter 4 of the guidance document, dealing with legal and policy considerations was presented by Ms Jane Cottingham. International consensus on safeguarding the basic human rights of women has been building since 1974 when the World Population Plan of Action concluded that all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.

The 1984 Mexico City World Population Plan of Action recognized as one of its principles, the basic human right of all couples and individuals to decide freely and responsibly the number and spacing of their children. For this right to be realized, couples and individuals must have access to the necessary education, information and means to regulate their fertility, regardless of the overall demographic goals of the Government. ICPD 1994, in Cairo, declared advancing gender equality and equity and the empowerment of women and ensuring women's ability to control their own fertility as cornerstones of population and development-related programmes. The Women's Conference in Beijing considered reviewing laws containing punitive measures against women who have undergone illegal abortions. ICPD +5 reiterates previous agreements and concludes that in no case should abortion be promoted as a method of family planning.

All governments, relevant intergovernmental and nongovernmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. International, regional and national laws and courts have considered and applied human rights to the issue of abortion. All governments have ratified at least one legally-binding international treaty that protects human rights. When a pregnancy threatens a woman's life, almost all countries permit abortion to save her life.

The following are examples from countries of the South-East Asian and Western Pacific Region with regard to being permitted legally:

- For saving a woman's life: Bangladesh, Bhutan, Indonesia, Myanmar, Sri Lanka, Philippines.
- For saving a woman's life and preserving health: Maldives, Thailand (and in cases of rape).
- For economic/social reasons: India.
- Without restriction as to reason: DPR Korea, Nepal, Cambodia, Mongolia, Viet Nam.

Research indicates that women eligible under the law are often unable to obtain services, the reasons for which include: lack of knowledge of the law, lack of training for providers, provider unwillingness, government restrictions on types of facilities, and complex authorization procedures. Many women seek abortion because they cannot afford to look after the child. In addition, there are many women – particularly young, single women – for whom continuing a pregnancy would be socially difficult or impossible. There is considerable scope to review and promote wider understanding of the relevant laws and policies, design and implement comprehensive policies to ensure access to services to the extent the law allows and to identify and remove unnecessary regulatory and administrative barriers to services.

7. GROUP DISCUSSION ON LEGAL AND POLICY ISSUES

Following the presentation, the participants were divided into three groups to discuss legal and policy issues. Each group was given a task and terms of

reference. The following are the reports from the group work on legal and policy considerations.

Group 1: Barriers in national laws and policies

The group highlighted a number of ways in which these barriers might be addressed. These include the importance of removing misconceptions at all levels, from women and service providers to donors. Evidence-based advocacy as well as increased accountability is essential at all levels. They also proposed advocating for a rights-based approach, in which the woman has the right to choose and the right to the highest attainable standard of health. Women should be able to question why they are not getting the services they need, but for this they need information and empowerment. Fees for abortion also need to be regulated so that abortion is affordable for all eligible women and that no one is rejected for economic reasons. The importance of using paramedical personnel for providing abortion was underlined, since there is good experience of this in Bangladesh and Viet Nam.

In the discussion following the group report, there were some questions about how paramedics are monitored. In the countries where they are providing menstrual regulation (MR) services, there is a clear monitoring and supervisory mechanism, and – as with any health personnel – there is administrative discipline for performing services outside the designated health facilities. It was emphasized that, in Bangladesh, for instance, paramedics are extremely skilled and experienced in providing manual vacuum aspiration (MVA).

Group 2: Barriers related to implementation of laws and policies

This group focused on the lack of information for women and service providers. Information and accessibility are interlinked. Because of the different legal/policy situation in different countries, different approaches are needed. Among the points covered were:

- Providers do not necessarily know about the methods of abortion available, or about complications. Practice in providing abortion is often not given during pre-service training.
- Implementation of the law may or may not be strictly monitored. This has both positive and negative consequences on women and

providers. In a situation where abortion is criminalized, providers may often try to help women and protect them from prosecution, but then they also put themselves in danger. In situations of a liberalized law, providers may insist on providing abortion out of hours and charging much higher fees yet, there is no control over this practice.

- To overcome these barriers, building the demand for services at the community level is essential. This needs to involve a multi-pronged awareness campaign on both contraception and abortion, on the management of complications and on costs. Families need to be addressed in this regard, with adolescents being particularly in need of information. Community-based organizations are key actors in this respect, especially women's groups and organizations.
- Funding for NGOs is a crucial factor in being able to do this work as some donors do not support abortion services, which poses a major barrier.

Group 3: Barriers related to providers' skills and attitudes

Among the key problems discussed by this group were:

- Health is not a priority for many governments, and therefore, there is little financial support for aspects like in-service training for menstrual regulation or abortion. There are also objections related to paramedical personnel being used in this area of activity.
- Providers' attitudes include the fact that if a woman does not suffer pain, she will keep coming back for an abortion. Providers may also feel a sense of guilt, especially for second trimester abortions. Some providers sympathise with women, but do not have the courage to take a stand in their favour. Providers may also protect women from the adverse consequences of a punitive law.
- There is a need for research on the barriers, in order to be able to use this information for advocacy.
- Training of providers is much less of a problem than monitoring and supervision, along with adequate logistical and financial support. Training could also include "values clarification" as done in South Africa after the liberalization of the law, because many providers did not want to perform abortion.

- Stigma and discrimination on the part of providers, leading to judgemental attitudes, tends to be high in situations where abortion is considered to be a religious and moral issue, but low in situations where abortion is seen as a public health issue and one related to women's rights.

The group rapporteur, summarized by emphasizing three points: (a) it is important to create, and use, a political grounds well in favour of changing a restrictive situation; (b) the role of the judiciary needs attention; and (c) account needs to be taken of the political power of those speaking in the name of religion.

Day 3

After the chairperson and rapporteur were nominated for the day, the chairperson reviewed the previous day's proceedings and charted out the course for the day. Clinical issues were presented and discussed. In the first session there were a series of presentations on various clinical aspects of abortion services.

8. COUNTRY EXPERIENCES ON DIFFERENT METHODS OF ABORTION

In her presentation on medical abortion in India, Dr Suneeta Mittal shared her experience at the All India Institute of Medical Sciences, New Delhi, where they use a sequential regimen of mifepristone and misoprostol. It has a success rate of almost 95% and is associated with fewer side effects if it is given in combination, and results in more complete abortion. The process of termination of pregnancy with drugs differs from surgical procedures in that the exact time of pregnancy expulsion is not clear and is often not obvious to the woman.

Advantages of medical methods include high acceptability among women, usage at an earlier stage, the fact that it is more private, feasible with insufficient trained manpower, and a lower overall complication rate as there is no risk of perforation/cervical/bowel injury and no anesthesia complications. These drugs do not affect on future fertility. However, as with other

medication, they do have drawbacks, which include longer abortion duration, multiple visits to the health facility, less predictability, higher failure rates, and potential risk of fetal malformation in a pregnancy continuing after a failed abortion.

Ms Sudha Tiwari then made a presentation on vacuum aspiration. She noted that it is the preferred surgical technique for abortion and treatment of incomplete abortion through 12 weeks since the last menstrual period (LMP). She highlighted the advantage of manual vacuum aspiration (MVA) over dilatation and curettage (D&C). She concluded that MVA is a proven technique excellent for low-resource settings. It provides high quality care for women and constitutes an essential part of comprehensive abortion or post-abortion care.

Dr Hinh from Viet Nam made a presentation on second trimester methods and shared the Viet Nam experience. It is important to think about second trimester methods to meet the needs of women. In many countries, it is second-trimester abortion where services are the least safe, because outdated or unsafe methods are used that put women at risk. In some countries there is a gap in services. For example, in Viet Nam, before introduction of dilatation and evacuation, women who were more than 12 weeks pregnant had to wait until they were 18 weeks pregnant – a gap of 5 weeks – to have an abortion. With dilatation and evacuation (D&E), women can now access services very early in the second trimester. The Viet Nam Ministry of Health asked *Ipas* and Johns Hopkins Bay-View Medical Centre to assist them to fill the gap between 13 and 18 weeks by introducing D&E to Viet Nam. The study results concluded that D&E using buccal misoprostol for cervical preparation, MVA and forceps for evacuation is a safe and effective method to terminate pregnancies between 13 and 18 weeks. Buccal misoprostol with an average dose of 400mcg is effective for cervical preparation and based on the results, this method may be appropriate for other low-resource settings when providers are properly trained. The medical methods used for second trimester terminations include 200 mg mifepristone, followed , after 36-48 hours, by 400 mcg misoprostol orally every 3 hours up to 5 doses *or* 800 mcg vaginal misoprostol followed by 400 mcg oral misoprostol every 3 hours up to a maximum of 4 doses.

9. PLANNING AND MANAGING SERVICES FOR ABORTION OR POST-ABORTION CARE

Ms Traci Baird from *Ipas* presented issues related to services, norms and standards as outlined in the WHO guidance document. The document acknowledges that planning and managing services for abortion or post-abortion care require specific thought and attention. The first requirement was an assessment of the current situation. Besides offering clinical services, another key aspect of making safe abortion services available within the law involves establishing or clarifying national norms and standards. Without clear standards, health care providers and others often feel unsure of their obligations and rights under the law. Health care managers and providers should understand and comply with norms and standards. Norms and standards should protect the rights of clients and providers, and specify providers' legal and ethical obligations.

It is important that norms and standards detail the "where, who and how" of any service. Other issues that specifically relate to abortion services include possible third-party authorization procedures (that is, whether other health care providers, judges, parents, spouses or others must agree to the procedure). National norms and standards should also protect women's reproductive rights in line with international human rights standards. These include the right to make fully informed decisions, free of violence or coercion, and the right to autonomy in decision-making, as well as the rights to confidentiality and privacy. Policies regarding abortion services may also need to include mechanisms to take into account health care providers' personal views. Women should not be denied the services they need because of providers' personal beliefs.

An important issue for many countries in Asia is the involvement of mid-level providers. This is because in the South-East Asia and the Western Pacific Regions there are only 13 doctors for every 10,000 people, compared to 38 per 10,000 people in Europe. Even in settings with a higher proportion of doctors, they may be concentrated in urban areas or in the private sector. Research has clearly shown that midwives and other mid-level health professionals can provide high quality manual vacuum aspiration. Both MVA and medical methods of abortion can be used at primary levels of the health

system, with adequate back-up and referral. Bangladesh leads Asia in training and authorizing paramedical professionals to perform uterine evacuation.

Training is likely to be a major focus for many programmes and service delivery sites. The content and type of training should be based on the findings of the needs assessment and the skills and service standards set out in the national norms and standards. The service system must also include training for supervisors, so that they can support and assist staff in ensuring high quality services.

Monitoring should be used as a tool for decision-making – hence it is ongoing. Monitoring can help managers and supervisors identify weaknesses before they become big problems. Monitoring also provides key stakeholders with data needed to lend support to the programme. Evaluation looks at the effectiveness, sustainability, and impact of services using monitoring data and other data collected specifically for the purpose. An evaluation might look at whether the quality of services has improved, whether women are achieving access to services, or whether the number of service delivery points has increased. Monitoring and evaluation should both include attention to women’s experiences and opinions, as well as those of providers.

Financing is an important area for programme planners and managers to address and needs to be considered from both the systems’ as well as from the woman’s perspective. As one puts services into place or improves existing services, it is important to be careful to reduce barriers to access, and to make sure not to create new barriers. Ms Baird concluded that everyone, from the policy makers, service providers, professional organizations to civil society, families and communities, have a role to play. It is possible to reduce the tragic toll of unsafe abortions on women, families, communities and nations worldwide.

10. GROUP DISCUSSION ON SERVICE DELIVERY ISSUES

Participants were divided into three groups and three concurrent sessions were held where they discussed with facilitators various service delivery issues. The first session covered service delivery and sustainability – how to assess needs, set up and monitor services, and ensure availability of

instruments and drugs. The second session discussed various training modules and methodologies, including pelvic models, training curricula, and training strategies. The third session focussed on the key steps in developing national norms and guidelines and included a review of examples and the opportunity for participants to practice identifying issues using the various guidance tools. In each of these three sessions, participants were provided resource materials on a CD.

Day 4

The nominated chairperson reviewed the previous day's proceedings. Dr Peter Fajans provided a brief overview of the WHO Strategic Approach. He explained that this was initially used to address issues related to expanding contraceptive choice and improving the quality of care in family planning services, but countries have since adapted the process to address issues related to abortion and post-abortion care, as well as to a broad range of reproductive health issues. It has three stages: the first is a participatory strategic assessment designed to assist countries in making decisions about how best to increase equitable access and to improve the quality of care; the second stage involves policy development and action research to pilot-test interventions, based on recommendations from the strategic assessment; and the third stage involves policy change and the scaling-up of successful interventions, utilizing the results and lessons learned in the second stage for implementation on a broader scale.

The Strategic Approach is based on a systems framework that examines the relationships between:

- People, including their reproductive health needs and their perspectives.
- The capacity of the service delivery system (including policies and programmes, and issues of access, availability, equity and quality of care), and
- The characteristics of available technologies. The strategic approach tries to understand the interactions between these components, as well as how they are influenced by the broader social, cultural, resource and health reform context. It is based on the idea that appropriate decisions concerning policy and programme development

should be based on an understanding of this complex set of relationships. These relationships ultimately suggest how quality services, meeting the needs of individuals and communities, can best be provided within the existing context.

The strategic approach has been used in Mongolia, Romania and Viet Nam to address issues related to preventing unwanted pregnancy and improving access to and the quality of abortion services.

Dr Davaadorj Uranchimeg, in her presentation on the strategic assessment in Mongolia, said that abortion is legal for first and second trimester terminations of pregnancy. UNFPA currently provides nearly all of the contraceptives in Mongolia. Stock-outs are common. The key findings of the strategic assessment were that women are being driven to the private sector by bureaucratic requirements for seeking abortion in the public sector; underreporting is common in both the public and the private sector; transport is a major problem in rural areas; youth-friendly services are supposed to exist but usually don't meet the real needs of youth, and in-service training for abortion is non-existent outside of the Marie Stopes International clinics.

The key recommendations from the strategic assessment in Mongolia stressed the need for: national standards and guidelines, pre- and in-service training in MVA and medical abortion for all providers, special attention for training in second trimester abortion; streamlining contraceptive commodity ordering and distribution; simplifying and reducing bureaucratic requirements for abortion; implementing and improving post-abortion contraceptive services; and improving community outreach services. Follow-up activities have included the development of national norms and standards, establishing a model of comprehensive abortion care services at the national women's hospital, and training of trainers to introduce MVA and medical abortion as part of the new model of care to be scaled up nationally.

11. COUNTRY GROUP DISCUSSION ON FRAMEWORK FOR ACTION TO REDUCE UNSAFE ABORTION

At the last session of the workshop, participants in their own country groups discussed and presented the framework for action to reduce unsafe abortion

at country level within their existing legal framework. The tasks given to the country teams were to:

- Identify the current situation, barriers to access quality family planning services (including emergency contraception) and strategic actions that can be implemented in countries to prevent unwanted pregnancies.
- Identify barriers to access safe abortion services and/or post-abortion care, and develop plans of action for improving access to and quality of such services (based on the legal framework of each country), including division of responsibilities among MoH, professional organizations, relevant NGOs and other stakeholders.
- Identify necessary information for programming in preventing and management of unsafe abortion and how to get such information.

The following are some of the highlights from the country framework for action presented by SEAR and WPR Member States:

(1) Bangladesh

- Advocacy for expanding services for menstrual regulation (MR) up to 12 weeks.
- IEC campaigns for raising awareness in communities and families on the issue of unsafe abortion.
- Improving the reach of the family planning programme, especially emergency contraception.
- Strengthening post-abortion care services.
- Introduction of medical menstrual regulation.
- Needs assessment including expansion of the duration of MR services, medical MR, cost of services.

(2) Bhutan

- Gather data on unwanted pregnancies and unsafe abortions.
- Improve FP services through refresher training.

- Inform women through RH clinics and media on emergency contraception and make it more accessible.
- Update the manual on post-abortion care (include MVA and medical abortion).
- Train doctors, including obstetrician/gynaecologist in use of MVA and medical abortion.
- Obtain MVA equipment.
- Develop a manual on adolescent reproductive health and give in-service training to all levels of providers.

(3) India

Legal and policy issues:

- Need to lower the age for consent for abortion from 18 years to 16 years (legal age for sex is 16 years).
- Further modifications required in rules of MTP Act to include training on medical abortion and MVA and advocacy for delegating the services to mid-level providers.
- Regulation regarding the need for the opinion of two doctors for second trimester abortion needs to be modified.
- Simplification of the certification process.

Service delivery issues:

- Demand generation for legal, safe abortion, and sensitization for rights of clients.
- Increasing service delivery outlets in the public and private sectors.
- Specify the reporting for medical abortion and all methods in all sectors (public, private, civil society).
- Explore availability of medical abortion drugs in public health facilities.
- Sensitization of judiciary/IAS/media on reproductive health issues, including medical termination of pregnancy.
- Expansion of training.

(4) Indonesia

- Increase the promotion of reproductive health education through formal and in-formal education.
- Empower the community with FP information and knowledge.
- Improve quality of FP (through supervision and regular monitoring and evaluation).
- Provide information and counselling on emergency contraceptives and provide accessible services.
- Accelerate the process of endorsement of the revised health law which may expand access to abortion services.
- Promote scaling-up of provision of FP (including emergency contraception) and post-abortion care.
- Reorientation/advocacy to decision makers from various sectors on the issues of unsafe abortion and lessons learnt from other countries.

(5) Myanmar

- Initiate discussions with the Director of Public Health to propose a nationwide study on the cost and socio-economic burden of unsafe abortion with Department of Medical Research .
- Develop a proposal for UNFPA/WHO to increase availability of MVA training/supplies/ equipment to township-level in 100 post-abortion care (PAC) townships.
- Advocate that NGOs be permitted to work with Department of Health (RHC) in order to provide IUD and other FP services in rural communities outside established project sites.

(6) Nepal

- Decentralize comprehensive abortion care (CAC) training centres.
- Expand CAC/PAC services at PHC level in a phased manner.
- Scaling up IEC/BCC (behaviour change and communication) advocacy programmes through public-private partnership.
- Encourage private sector to introduce CAC/PAC services in rural and peri-urban areas.

- Intra/intercountry exposure of providers and policy makers to learn best practices.
- Enhance and expand information, recording, reporting and monitoring system through improved health monitoring information system (HMIS).
- Introduce a compensation system for clients in PAC/CAC in case of complications.
- Award letter of appreciation/incentives to CAC public service providers.
- Conduct monitoring, supervision and evaluation, as well as research on implementation of the CAC/PAC programmes.

(7) Sri Lanka

- Conduct a strategic assessment on the degree and nature of unsafe abortions.
- Organize advocacy seminars for different levels of stakeholders.
- Carry out strategic assessment of current status of unmet needs and prevalence of traditional methods of family planning and the current status of post-abortion care.
- Develop pilot strategies for a selected district.
- Develop a pilot project for improving post-abortion care in a district.

(8) Thailand

- Educate women and adolescents regarding the use of contraceptives and emergency contraception.
- A project focusing on youth, "Friends' corner", is already implemented using the peer-to-peer approach.
- Develop guidelines on safe abortion and use of MVA.
- Training of doctors and nurses on legal and safe abortion and post-abortion care.
- Generate funds, procure and supply MVA kits to the trained doctors.

- Develop and implement awareness programme on the complications of unsafe abortion.
- Conduct nation-wide unsafe abortion survey in the public and private sectors every five years.
- Conduct more research on the effectiveness of MVA over D&C and client satisfaction.

(9) Viet Nam

- Review and upgrade national standards and guidelines by 2006 to:
 - Provide medical abortion at district level, and make it possible to be provided by midwives.
 - Provide home-based administration of misoprostol.
 - Extend gestation for medical abortion service (56 or 63 days).
 - Remove outdated techniques: D&C and Kovacs method.
 - Disseminating the national standards and guidelines 2007-2008.
- Standardize private sectors.
- Scale up CAC in the whole country: 2006-2010.
- Provide dilatation and evacuation (D&E) services at provincial level: 2005-2010.
- Introduce MVA Plus and bring it into use: 2005-2008.
- Train providers for improvement of attitudes and behaviours: 2005-2010.
- Refresher training for private providers.
- Make contraceptive methods available at hospitals: 2005-2008.

12. FEEDBACK ON THE WORKSHOP

Feedback on the workshop was sought from the participants through evaluation forms. Some of the participants also shared their views on the meeting in the open forum. The general feedback was encouraging with most

participants satisfied with the meeting content and methodology. The general feeling was that a very important and sensitive issue was discussed effectively.

The poster session was much appreciated. Some participants felt that more time should have been devoted to sharing country experiences and one way could have been country presentations in addition to the posters as there is a lot to learn from each other. The group discussions were appreciated, as it made the workshop more participatory and less didactic. The clinical sessions proved to be heavy for participants who were not from the clinical stream. The parallel sessions were liked by most participants as they allowed maximum sharing of information in a limited time frame. Most of the background materials for the meeting were given as electronic copy on a CD and this was highly appreciated as it saved on paper and also reduced the "carry-home" weight.

Ms Jane Cottingham and Ms Traci Baird thanked the participants for their contributions. Dr Ardi Kaptiningsih gave the vote of thanks. She urged the country teams to act on the action plan they had formulated and promised full support from WHO for implementation at the country level.

Annex 1

PROGRAMME

Monday, 30 May 2005

- 3:00 – 3:45 Panel presentation: Setting the stage
Unsafe abortion. A framework for prevention.
Dr Ardi Kaptiningsih
Unsafe abortion. Overview of situation in West Pacific Region.
Dr Sabai Khine Latt
- 3:45 – 5:00 Poster session: Country situation related to abortion and contraception
Dr Bela Ganatra, IPAS
Dr Peter Fajans, RHR Department, WHO-HQ

Tuesday, 31 May 2005

- 8:30 – 8:45 Overview of previous day and preview of today's sessions
- 8:45 – 9:30 Follow up discussion from poster session
Dr Bela Ganatra
Dr Peter Fajans
- 9:30 – 10:30 Woman centered and comprehensive care
Dr Phan Bích Thuy, Ipas Viet Nam
Dr Bela Ganatra
- 11:00 – 11:45 Overview of WHO guideline:
Safe Abortion: Technical and policy guidance for health systems
Ms Jane Cottingham, WHO-HQ
- 11:45 – 12:00 Discussion
- 12:00 – 12:30 Overview of Chapter 4: Legal and Policy Considerations
Dr Sharad Iyengar, Director, ARTH, Udaipur
Ms Jane Cottingham
- 1:30 – 3:00 Group discussion: Case studies on legal and policy issues
Dr Sharad Iyengar
Ms Jane Cottingham

- 3:30 – 4:15 Plenary: Report on group discussion
Dr Sharad Iyengar
Ms Jane Cottingham
- 4:15 – 4:30 Wrap up/evaluation of the day

Wednesday, 1 June 2005

- 8:30 – 8:45 Review of previous day and preview of today's sessions
- 8:45 – 9:15 Panel discussion: Overview of Chapter 2: Clinical considerations
Dr Nguyen Duc Hinh, Vice Director, National Hospital of Obstetrics and Gynecology, Viet Nam
Dr. Suneeta Mittal, Professor and Head of the Department of Obstetrics and Gynaecology, All India Institute of Medical Sciences, New Delhi
- 9:15 – 10:00 Clinical methods after the first trimester
Dr Nguyen Duc Hinh
Dr. Suneeta Mittal
- 10:30 – 12:00 Clinical issues and discussion
Dr Nguyen Duc Hinh
Dr. Suneeta Mittal
- 12:00 – 12:30 Overview of Chapter 3: Services, norms and standards
Introduction to group work
Ms Traci Baird, Director, Asia, Europe, US Region, IPAS
- 1:30 – 2:15 Group work: Service Delivery and Sustainability: Setting up services, monitoring services, instrument and drug sustainability
Ms Traci Baird
Dr Nguyen Duc Hinh
- 2:15 – 3:00 Group work: Training: In/pre-service, competency-based, curricula, trainers' networks, assessment
Ms Traci Baird
Ms Jane Cottingham
- 3:30 – 4:15 Group work: Norms and guidelines: Work in groups to review examples and identify issues using tools for guidance
Dr Peter Fajans
Dr Davaadorj Uranchimeg
Public Health Institute, Mongolia

4:15 – 4:30 Wrap up/evaluation of the day

Thursday, 2 June 2005

8:30 – 8:45 Review of previous day and preview of today's sessions

8:45 – 9:45 Introduction to the Strategic Approach

Dr Peter Fajans

Dr Davaadorj Uranchimeg
Public Health Institute, Mongolia

9:45 – 10:00 Introduction to group work: Framework for action plans on preventing unsafe abortion

Dr. Razia Pendse, Short-term Professional, RHR, WHO/SEARO

10:30 – 12:30 Group work: Framework for action plans on preventing unsafe abortion

1:30 – 2:30 Report on group work

2:30 – 3:00 Wrap up and evaluation of the day

Evaluate consultation

Next steps for region

Closing

Annex 2

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