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Strategic Partnership Programme: Countries of Intensified Focus in the Asia and the Pacific Region

*Report of the Implementation Review and Planning Workshop
Bangkok, Thailand, 24-27 April, 2006*



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1. Introduction

The Strategic Partnership Programme (SPP) Implementation Review and Planning Workshop for Countries of Intensified Focus in the Asia and the Pacific Region held in Bangkok, Thailand, 24-27 April, 2006 was a collaborative effort between WHO and UNFPA under the Strategic Partnership Programme. The overall objectives of the Programme are to promote adaptation and implementation of evidence-based norms, standards, guidelines and tools in the area of reproductive health, with special attention to family planning (FP), reproductive tract and sexually transmitted infections (RTIs/STIs) and maternal and newborn health (MNH). The programme was initiated in 2003 at WHO-UNFPA headquarters level, and introduced to the regional/Country Technical Service Team level of the two UN organizations later the same year.

Following the initiation of the collaboration, a workshop was organized in each Region to introduce evidence-based guidelines and tools, mainly in the areas of FP and RTIs/STIs. For the Asia-Pacific Region, two SPP workshops were organized in 2004 involving countries from the South-East Asia and the Western Pacific Regions respectively. Two FP guidelines and a tool (Medical Eligibility Criteria for Contraceptive Use, Selected Practice Recommendations for Contraceptive Use and Decision Making Tool for Family Planning Clients and Providers), as well as two RTIs/STIs guidelines (Sexually transmitted and other reproductive tract infections: a guide to Essential Practice and Guidelines for the Management of STIs) were introduced during the workshops. As a follow-up to the workshops, countries were encouraged to submit proposals for adaptation and implementation of the guidelines. A number of countries sent proposals, which were then approved and funded by the WHO-UNFPA SPP. These countries of intensified focus (CIF) are implementing their workplans and the current workshop was organized to review the achievements, to share experiences and lessons learnt and to develop follow-up plans. The programme of the workshop and the list of participants are included as Annexes 1 and 2.

2. Inaugural session

The opening address by Dr Samlee Plianbangchang, Regional Director, WHO/South-East Asia Region was delivered by the WHO Representative to Thailand, Dr William Aldis, on behalf of the. The Regional Director welcomed the participants and stressed the importance of reproductive health in social and economic development and for achieving the MDGs. In the Asia-Pacific Region there was a need to improve access to and quality of FP and RTIs/STIs services, including prevention of HIV infection. Many countries in the Regions had high MMR and neonatal mortality rates, compounded by low utilization of skilled care at birth, high fertility rates and unsafe abortion. The SPP focused on systematic introduction of selected practice guidelines for family planning, sexually transmitted infections and maternal and newborn health, particularly promotion of skilled care at birth, in the countries of intensified focus.

This was followed by the opening address by Ms Yegeshen Work Ayehu, Technical Advisory Programme Manager, UNFPA/HQ. Ms Ayehu described the objectives of the SPP which included development of products to improve the efficiency of national population and reproductive health programmes and promoting a partnership that draws on the comparative advantages of each agency. This meeting provided a unique opportunity for national counterparts, UNFPA and WHO to conduct a joint assessment of (i) the effectiveness of the modality of the partnership at global, regional and national levels to respond to the technical assistance needs of countries and (ii) the progress in the adoption of the guidelines and tools by countries. She added that as the current Technical Advisory Programme will come to an end in 2007 and a new proposal would need to be submitted in September 2007, the identification of effective modalities to support countries was critical. The analysis of progress from all regions would provide inputs for the recommendations for technical assistance for 2008-2011.

Opening remarks were also made by Dr Michael Mbizvo, Senior Scientist, Office of the Director, Department of Reproductive Health and Research, WHO/HQ. Dr Mbizvo gave an overview of reproductive health issues globally and in the Asia and Pacific regions specifically, where there are more than 200,000 maternal and two million newborn deaths annually. The SPP had linked WHO and UNFPA as development partners concerned with sexual and reproductive health. The SPP aimed to improve the quality of reproductive health care through utilization of normative guidance/tools. The process included: systematic dissemination guided by a global response; regional orientation workshops; translations; in-country

awareness, orientation workshops, technical backstopping; building partnerships; adaptation/adoption of guidelines; monitoring and evaluation; and up-scaling of interventions. Currently, SPP has being implemented in 60 countries worldwide, he added.

Dr Josephine Sauvarin, Reproductive Health Adviser, UNFPA CST East and South-East Asia, introduced the objectives and expected outcomes of the workshop. The general objective of the workshop was to review, plan and improve implementation of the work on specific aspects of reproductive health within countries of intensified focus under the collaborative WHO-UNFPA Strategic Partnership Programme. The specific objectives were: (i) to review progress in SPP in-country implementation, including sharing of adaptation products, lessons learned, constraints encountered and monitoring and evaluation plans; (ii) to provide technical updates on the in-country implementation of FP and RTI/STI guidelines and promotion of Skilled Care at Every Birth and (iii) to develop workplans for 2006 and 2007. The expected outcomes were (i) development of a framework for country plans of action for activities under SPP in 2006-2007 elaborating on how to adapt and utilize evidence-based guidelines and tools for FP and STIs and how to put them into practice, as well as to address critical issues for promoting Skilled Care at Every Birth for further action based on country situations and needs and (ii) plans for technical backstopping for countries in implementing the action plans identified.

Dr Katherine Ba-Thike, the Area Manager for the Asia and Pacific Region, Department of Reproductive Health and Research, WHO/HQ, reviewed the programme of the workshop. This was followed by the introduction of participants by Dr Ardi Kaptiningsih, Regional Adviser for Reproductive Health and Research, WHO/SEARO and Dr Wame Baravilala, UNFPA CST Advisor, Reproductive Health from Suva, Fiji. Dr Supanee J Apimas, the representative of the local organizer, Siriraj Hospital, made the administrative announcements.

3. Country presentations: Progress on activities under SPP

Representatives from countries of intensified focus made presentations on in-country activities related to adaptation and implementation of guidelines supported by the SPP. The session was chaired by Mr Garimella Giridhar, Director, UNFPA CST for East and South-East Asia and Country

Representative, UNFPA Thailand Office, and Dr Pang Ruyan, Regional Adviser, Reproductive Health, WHO Regional Office for the Western Pacific.

China has achieved significant progress in the translation and adaptation of the Decision Making Tool for Family Planning Clients and Providers (DMT) and Sexually transmitted and other reproductive tract infections: Guidelines for Essential Practice (RTI/STIs GEP), as well as translation of the two FP guidelines (MEC and SPR) and the WHO Reproductive Health Library (RHL) No. 8. This has been achieved through advocacy meetings, involvement of stakeholders and consultations with Chinese experts. Many partners have been involved including NPFPC, CDC China, MOH and Peking University. Six counties/cities in five provinces have been selected to implement the integrated RTI Project. Challenges to implementation include the lack of access to services in the rural areas, particularly in the western provinces and low coverage of medical insurance for certain population groups. Quality of services is also an issue, as well as lack of community awareness on prevention of RTI/STI. Recommendations from China included that reproductive health should be placed as a WHO country priority and activities supported through SPP integrated in the UNFPA country programme. Further adaptation of the RTI/STI guideline is required due to the various region-specific situations within China. There is also a need to develop and print health education materials.

Viet Nam reported on achievements which include progress on introduction, translation, adaptation and implementation of the DMT and the RTI/STIs GEP. DMT will be implemented in five provinces under the Viet Nam Population and Family Planning Project and there are plans to implement DMT and RTI/STIs GEP in three additional provinces in 2006. Recommendations include the provision of continued support from SPP to scale up the implementation of FP and RTI/STI guidelines. Viet Nam also requested additional technical assistance from WHO-UNFPA to update the national RH standards including those on FP, STI, comprehensive abortion care (CAC) and adaptation and implementation of Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC).

Vanuatu, Tonga and Solomon Islands have used a similar approach of consensus building to reviewing, updating and utilizing the updated FP guidelines at national, provincial and service delivery levels through collaboration between the governments and WHO/UNFPA country offices. Significant progress has been made despite some delays due to political

problems and natural disasters in one of the islands. In each country, a nationally developed FP manual has been produced with the assistance of a National FP Manual Task Force and disseminated. A regional FP wheel was also developed as a job aid, and some countries developed a pocket manual, IEC material and posters to support the updated FP manual. A rapid needs assessment tool was designed and has been utilized in Tonga and the Solomon Islands. Plans have been made for monitoring the related quality of care and utilization of the FP guidelines which include supervisory visits. Recommendations included development of a strategy for the introduction of DMT, as well as STI and adapted obstetric protocols. Closer collaboration among WHO, UNFPA and MOH was recommended, to be facilitated by WHO at the country level for the development of plans and proposals.

Indonesia has done considerable work in the field of family planning prior to the implementation of SPP: Recommendations from the MEC, SPR and the Handbook for FP Providers have been included in the Practical Manual for Contraceptive Use, which was developed through collaboration between the MOH and National Family Planning Coordination Board (NFPCB/BKKBN). The RTI/STIs GEP was translated, adapted and field tested in 2005-2006. The adaptation process was intensive as discussions included adjustment with national standards and a list of STI medicines while taking cultural issues into consideration. The constraints identified included lack of laboratory facilities and reagents, trained technicians, STI drug supply, and counseling rooms and as well as the cultural barriers. A simpler document is required for providers at the primary health care level with additional pictorial information.

Under the SPP in Myanmar, the Obstetricians and Gynaecologists Society in has updated sections of specialist hospital service delivery guidelines on reproductive health academic institutions. The content of FP and RTI/STIs modules in undergraduate and postgraduate courses in obstetrics and gynaecology has been updated and its use in undergraduate and post-graduate training has been initiated. The DMT was translated and adapted to the local context, followed by a dissemination workshop and training of trainers in the use of DMT. The cost of producing the DMT for dissemination in colour is high, so at present many copies are in black and white. The challenges identified included coordinating with the DoH that will utilize the SPP products such as the Myanmar version of DMT and its inclusion in in-service training.

Dr Josephine Sauvarin and Dr Katherine Ba-Thike summarized the country reports in a presentation *Overcoming the Challenges*. It was clear from the country reports that there have been enormous achievements with respect to FP and STIs guidelines introduction, adaptation and implementation in the Asia and Pacific regions. This has included updating of national guidelines and development of job aids. Additionally, there has been development of a rapid needs assessment tool in the Pacific Island countries and update of undergraduate and post-graduate curriculum. China and Viet Nam have also established a translation system for RHL.

There have been several challenges in implementing SPP activities in the Asia and Pacific regions. Translation and adaptation was time-consuming and was delayed where responsible individuals had competing priorities. The move from SPP to a national programme is also a challenge, with a need for national institutionalization. The separation of MNH, FP and STIs Departments in the MoH structure is a particular challenge for integration of relevant services. Additionally, broader issues regarding the health service structure, human resources and equipment have been identified as obstacles for implementation of programmes, as well as lack of access to services by some communities, particularly the poor and migrants. As funding is limited under the SPP, the need for additional resources for scaling up is seen as a major challenge. Monitoring and evaluation of the implementation of the guidelines is also an issue that is emerging as a challenge, which needs adequate attention.

There have been many positive moves to overcome the challenges in implementation. Consensus building has been very strong in the Region, with stakeholder meetings being held to bring partners with different focus areas together to discuss the activities. The issue of National ownership has been raised, particularly by the adaptation process where the local context has been analyzed and changes made accordingly. National commitment has been strong, with the national governments providing counterpart funding for SPP activities in some countries. It was noted that WHO/UNFPA expertise was useful, particularly for advocacy for reproductive health issues and coordinating partnerships between new partners in the country, i.e. FP and STIs Departments. SPP activities have also been seen as a catalyst for increased motivation to strengthen broader RH interventions within the countries.

4. Panel discussions on young people and STIs

The session was chaired by Dr Hans Troedsson, WHO Representative in Viet Nam and Dr Win Win Mya, Associate Professor/Consultant Obstetrician and Gynaecologist from the North Okkalapa General Hospital, Yangon. Dr Nathalie Broutet from the Controlling Sexually Transmitted and Reproductive Tract Infections Team, Department of Reproductive Health and Research, WHO/HQ presented Strengthening Health Services for STIs amongst Adolescents. In this presentation, she defined adolescents, youth and young people and also provided a global overview of STIs among adolescents.

The increasing number of street children is making them vulnerable to STIs and other problems. The average age of initiating sexual experiences is between 15 and 16 years, with boys more likely to experiment before marriage. Globally, 11.8 million of those in the 15-24 year age group are HIV positive, with 1 million in South Asia. STIs are most common amongst the 20-24 year age group, followed by the adolescent group (10-19 years). African data indicate high levels of Chlamydia infection among sex workers (40%) followed by fairly high levels among FP and antenatal care clients (10-25%). Gonorrhoea is less prevalent (less than 10%) with increasing HIV and HSV-2 among young women, who are more likely to be affected than young men.

She pointed out that adolescents and young people have poor conventional health seeking behaviour for a number of reasons, i.e. the nature of the presentation of symptoms (most are asymptomatic in girls), affordability of screening and inaccurate risk assessments, poor case management (shortage of drugs as well as incorrect dosage, follow up, partner notification, etc.). The general by low level of awareness about the disease, where to go for treatment, fear of examination, lack of confidentiality and limited access to services are important factors. Specific barriers to health care for young people include the attitude of health service providers, inconvenient timing, cost and restrictive policies. In general, a youth-friendly health service for young people needs to provide services for adolescents who are healthy as well as those who are ill. It should be easily accessible, have low costs for services (or is free) and served by providers with positive attitudes about youth. The need for

involvement of youth in the design of programmes, providing comprehensive services (contraception, treatment of STIs) along with other health facilities (rather than stand-alone adolescent health clinics), as well as the need for better data and positive changes in policies were emphasized.

Dr Pachara Sirivongrangson, Chief of STIs Cluster Bureau of AIDS, TB and STIs Department of Disease Control, MoPH Thailand, gave a presentation on STIs in Young People: Thailand Experiences. It was noted that people between the ages of 15-25 years comprise 17% of the population, but are at a significantly higher risk for acquiring STIs. A massive reduction in the national prevalence of STIs from more than 250,000 cases (1989) to only 12,000 cases (2005) was demonstrated and attributed to the 100% Condom Use Programme (CUP), although it was felt that the latter figure represented under-reporting. Like youth in the rest of the world, young Thais were becoming more sexually active younger with more males than females reporting having had intercourse. To underscore the point that the 100% CUP was probably not as effective as it used to be, data on condom use amongst selected youth populations were presented. Young commercial sex workers (CSWs) were reporting condom use between 30.8%-73.9% of the time, while for casual sex partners the figures ranged from 16.7%-38.9%. There was a gender difference in condom use amongst males (33%) compared to females (22%).

Dr Wame Baravilala made a presentation on STIs in Young People in the Pacific. The situation in the Pacific mirrors that of young people in other parts of the world: there are many youth who are becoming sexually active at younger ages and are a significant risk group for contracting STIs. Data from the few studies conducted on young people in selected settings, including antenatal clinics, show significant rates of chlamydia infection, syphilis and gonorrhoea in the Pacific. Studies repeated over 5-6 years show similar prevalence rates for STIs. Most Pacific countries do not appear to have responded to previous data. The only exception is Vanuatu where presumptive treatment of antenatal women has led to a significant reduction in chlamydial infections. Information was presented on how UN agencies had launched the Adolescent Sexual and RH Programme in the Pacific with the objective of meeting the needs of young people. Essentially, the few successful sites that had been set up were very youth-specific and were centered around gymnasiums and NGO facilities. Previous experience had shown very little utilization of traditional RH facilities by young people.

5. Panel discussions on interventions for sex workers with STIs

Dr Zhao Pengfei, Programme Officer for HIV/AIDS and STIs and the Focal Point for RH of the WHO China Office, made a presentation on 100% Condom Use Programme (CUP): Experience from China. He explained the status of sex workers and the goal of the 100% CUP to prevent sexual transmission of HIV in the general population. Ensuring high level of condom use among sex workers and their clients was highlighted. The importance of preventing transmission in the bridging population was stressed. The benefit of the 100% CUP was a decrease in STIs and HIV incidence as exemplified in Thailand, where data illustrate decreased STIs infections; and in Cambodia, where decreased STI infections among young sex workers was observed.

In China, new infections in HIV are primarily through sexual transmission. An increasing number of HIV infections was found especially among sex workers. Condom use in sex workers continues to remain low. Programme components include advocacy at the highest level, policy formulation, mapping establishments, enforcing condom supply and accessibility, monitoring use and enforcing compliance of sex establishments. Multi-sectoral coordination is a key component for the success of 100% CUP. Scaling up of current pilot projects in entertainment workers in low prevalence sites has shown that while there has been a decrease in STIs, a concomitant HIV decrease is less evident.

Dr R R Gangakhedkar, Assistant Director Clinical Science, National AIDS Research Institute (NARI), India, presented STIs among Sex Workers and their Implications: Experience from India. There is an increasing trend of HIV infections in India, although not as high as one would expect had there been no interventions. It appears that there continues to be an emerging epidemic and that it has not yet reached the reversed epidemic stage. Initiation of programme support occurred in 1998 and there are currently 600 focused interventions in 77 districts. Key elements include quality STI services and syndromic management, quality condoms, behavioural change communication, peer education, enabling environment, advocacy with stakeholders and empowerment of women. Of concern is data that suggest that although condom use is increasing in sex workers, condom use in regular partners is decreasing. Sustaining changes

in behaviour in sex workers is very difficult and acceptability of services continues to be a problem. While genital ulcer disease is decreasing, HIV decreases are slight. Chancroid has almost disappeared, syphilis has decreased but candidiasis continues. This suggested low health-seeking behaviour among sex workers. The increase in hidden sex workers poses significant challenges to STI services. The importance of STI protocols was highlighted.

Ms Wassama Im-em, Assistant Representative, UNFPA Thailand Office, presented Women's Health Approach: Strategies for Sex Workers and STIs in Thailand. There is an overall decreasing trend of STI prevalence, against a backdrop of increased sex workers over time. From 2002, there appears to be a decrease in the number of sex workers but an increase in the number of sex worker establishments. There is a diversification of sex work in the last decade and many sex workers are not reached for interventions, thus maintaining 100% CUP is difficult. The majority of sex workers enter the trade through friends and many have dependents to look after. For them, the work is transient.

In comparison, while a decrease has been observed in brothels and food gardens over time, there has been an increase in sex workers in beer bars and karaokes, which makes it difficult to reach them. Key linkages between HIV/AIDS and RH were discussed and the women's health approach was highlighted as the entry point for sex workers' interventions. A major barrier has been the lack of attention to promote SRH for sex workers. This approach primarily includes increasing access and utilization of client-friendly services, encouraging women's support groups and self-help support groups, strengthening female condom utilization and collaborating with sex workers' networks for 100% CUP.

Common themes in all presentations and discussed subsequently related to the difficulty in sustaining the 100% CUP due to the changing profile of sex workers i.e. an increased number of "hidden" sex workers. The difficulties of reaching such informal sex workers, especially transactional sex workers, forces programme managers and policy makers to explore other means of enforcing 100% CUP and using a different entry point for interventions, namely the Women's Health Approach. A key to sustaining interventions ensuring community-led interventions are well supported. A summary of the session was made by Dr Annette Sachs Robertson, CST Adviser, Reproductive Health, UNFPA CST, Suva, Fiji.

Dr Rosanna Peeling, TDR, WHO/HQ introduced and demonstrated the Rapid Diagnostic Tests in Management of STIs. Most of the participants were interested in the tests, which can be used at health facilities at the primary care level.

6. Country experiences on the adaptation and implementation of STI guidelines

The session was chaired by Dr Dinesh Agarwal, Technical Adviser, Reproductive Health, UNFPA India Office and Dr Trisnawaty Loho, Head, Subdirectorate of Reproductive Health, Directorate-General of Community Health, MoH Indonesia. The overall objective of this session was to have an update on the introduction, adaptation and implementation of the STI/RTI GEP in countries. Three countries were selected to present, two from the Asia-Pacific Region (Indonesia and China) and one from Africa (Kenya).

Dr Melania Hidayat, UNFPA National Programme Officer for Reproductive Health in her presentation on Indonesia said the programme falls under the responsibility of the Directorate-General of Community Health, while all technical assistance is provided by the Directorate-General of Communicable Disease Control (CDC). Some preliminary pre-field implementation was done in four health centres in two provinces. Two rounds of national expert reviews have been conducted on the translated version followed by reviews at district level of the field-test locations. A draft guideline was prepared by consultants. At the same time, CDC received funding for training of health providers on the STI syndromic approach from the Global Fund. The Training of Trainers model is being used for health providers training.

It was noted that the decentralization process currently underway is impacting the implementation of policies and programmes. Therefore, the adoption of the RTI/STIs GEP at the national level does not automatically ensure buy-in at district level, as districts make independent decisions. The nature of support from the national level needs to be clarified in this regard. Currently, there are 400 districts in 33 provinces. Each district has district managers for various programmes including RH, STI, MCH and laboratory. The future plan is to implement the STI/RTI GEP in various districts using UNFPA's country-programme budget for supported provinces.

Pilot testing identified the need to strengthen counseling services related to RTI/STIs. As the translated STI/RTI GEP cannot be used at the grass-roots level, there are plans to develop job aids and counseling manuals for RTI/STIs. Support to identify mechanisms for integration of FP and maternal and newborn care with STIs in the context of decentralization is required.

Dr Wang Bin, Director, Women's Health Division Department of Maternal and Community Health, Ministry of Health Presented The introduction of the RTI/STIs GEP in China. This was facilitated by the prior implementation of the Programme Guidance Tool (PGT), based on the strategic approach in introducing RTI/STIs programme within reproductive health services. The RH Programme of the MoH leads the process in collaboration with MCH and the Communicable Disease Control programmes.

The guidelines have been translated into Chinese and reviewed by a national committee of experts that has been providing oversight to the adaptation process. The committee developed an accompanying pocket guide. National training workshops have been organized for the provincial health care providers from the Health Bureau, MCH and FP programmes from six pilot sites in six counties from five provinces (Hebei, Shandong, Shanxi, Jilin and Shenzhen). Providers come from FP, MCH and general hospitals and clinics. Implementation has been started at county level and training has been cascaded to other professionals. Evaluation of the first phase has been planned for 2006.

Provincial training workshops are planned for health professionals from additional counties. Other national training workshops are planned to train professionals from other provinces. Health education materials are being developed and advocacy with local government sectors to promote the guidelines is being undertaken.

Attention needs to be paid to:

- Strengthen training, using provincial teaching resources and revision of training materials;
- Address health education and health promotion; and
- Integrate national and international projects.

The Kenya experience was presented by Dr Saiqa Mullick, Programme Associate, Frontiers in Reproductive Health, Population Council, South Africa and Dr Nathalie Broutet. The process of adaptation has been led jointly by two programmes of the MoH, the Division of RH and the National AIDS Control Programme. A national working group and task teams have been set up to address adaptation, training and implementation issues. The guidelines have been adapted and endorsed by the Director for Medical Services. The control of RTIs has also been included in the new national RH policy. A national training manual has been developed and an accompanying trainee handbook has also been produced.

The guideline adaptation process was also used as an opportunity to review the national syndromic management algorithms. Job aids for antenatal and postnatal care have also been developed and are in the process of being reviewed and finalized. Accompanying training manuals and student handbooks for the use of the job aids have been developed.

The MoH has included the pilot testing of the adapted materials and job aids in two UNFPA-supported districts in Kenya. UNFPA will support pilot implementation through the annual business plan with the MoH, which will be administered by Population Council. A parallel process to build capacity through technical support to the national process and to assist the national task teams to support the provincial and district level has also been planned. Lessons learnt will be documented and the results will disseminated at the national level.

Following the three presentations, the participants highlighted the importance of looking at the adaptation of RTI/STIs guidelines in a broader perspective, as it is related to improving the health systems, including human resources, training, setting up health facilities and its referral, provision of drugs and other logistics, strengthening laboratory capacity, etc. On the issue of integration among RTIs, although the RTI/STIs GEP has been developed to focus on non-HIV RTIs, integration of HIV-related issues could be considered in the development of job aids. The participants also noted that development of training manuals suitable for cascading training need to be developed to minimize loss of information.

It was generally agreed that the guidelines need to be piloted within various health services (FP, antenatal clinic, etc.) and that demand creation for the integrated service is important. RTIs surveillance data is lacking and

surveillance systems need to be strengthened for programme evaluation, guideline adaptation and planning. It was felt that there is a need for advocacy and support to policy makers on integration of RTI. Consensus building in countries through the establishment of strong partnerships among programmes and stakeholders needs to be encouraged.

7. The role of rapid diagnostic tests in management of RTI/STIs

The session was chaired by Dr Nathalie Broutet and Mr Suthon Panyadilok, Senior Public Health Technical Officer, Reproductive Health Division, Department of Health, Thailand. Dr Rosanna Peeling gave a presentation on the Sexually-transmitted Diseases Diagnostic Initiative (SDI) which has evaluated a number of rapid diagnostic tests.

She stressed that there is a need to increase availability of rapid diagnostic tests in countries where laboratory facilities are scarce. Rapid tests have the potential to improve treatment and care of RTIs. The impact of rapid tests has been evaluated and showed an increased proportion of women infected with chlamydia and gonorrhoea who were diagnosed and treated. The evaluation also showed a decrease in the number of women with pelvic inflammatory diseases (PID).

Among the rapid tests evaluated, syphilis tests seem to be the most promising, combining high sensitivity and specificity with user friendliness. Chlamydia and Gonorrhoea Rapid Tests evaluated by SDI did not perform as well as the syphilis test and are not affordable. Better tests may be available in the next few years.

Discussions following the presentation highlighted the issue of validation of these tests. It was agreed that the validation needs to be conducted in low STI-prevalence settings. The tests should also be validated in pregnant women.

8. Support to implementation and scale-up: Potential partner contributions

Three presentations were made by Family Health International (FHI), JICA and IPPF. FHI and IPPF are partners in the Implementing Best Practices

(IBP) initiative. Dr Graham Neilsen, Associate Director, Prevention, Care and Treatment, FHI Thailand Office, presented a range of targeted interventions for HIV/STI prevention and care in high-risk population such as groups of men having sex with men (MSM), transgender and mobile populations in the Region.

The agencies are involved in advocacy activities based on the coordination of available HIV surveillance data to influence policy and programmes. The common elements of these projects were government support, outreach peer education, STI clinic service delivery, standardized management, supervision, recording and reporting, capacity building, STI and VCT. Discussions following the presentation raised the issue of impact evaluation of the programmes. Technical partnership for support of the SPP was discussed particularly in the field of training and capacity building.

Dr Noriko Fujita, Chief Advisor, JICA, Afghanistan, presented the Reproductive Health Project that supports countries through bilateral funding, multilateral funding and technical cooperation. JICA supports long-term projects as well as south-to-south cooperations. JICA also currently runs two large programmes in Cambodia and Afghanistan and cooperates with other countries in the Region. The national RH programmes in training and supervision with a focus on maternal health in Afghanistan are also supported.

Dr Pratima Mittra represented IPPF, South-Asia Regional Office. She stated that IPPF is working in 182 countries and with FP associations in selected countries. They work on improving the quality of care and on the integration of STI/RTI services into FP. They highlight client rights and provider needs. IPPF develop plans with countries based on gaps identified through an assessment process. Financial and technical assistance is provided, particularly in cascade training and dissemination of guidelines. They have translated the DMT in different languages, i.e. Nepali, Hindi and Bangla and shared the documents with WHO Nepal, India and Bangladesh through WHO/SEARO.

During the discussions, it was noted that it is important to develop mechanisms for inter-agency and partners within countries. It was agreed that communication among agencies needs to be improved. The session ended with a review of the overall objectives of the SPP and a presentation on the monitoring checklist and evaluation tool by Dr Katherine Ba-Thike.

The monitoring checklist would be used by WHO and UNFPA staff on a six-monthly basis during site visits to countries while the evaluation tool will be used for evaluation of the implementation of SPP activities in countries in 2007. Country representatives were requested to complete the monitoring tool which would serve as a baseline. Feedback from countries on the two instruments was requested.

Introduction to Group Work was made by Dr Ardi Kaptiningsih, who guided the participants to develop SPP workplans for 2006-2007 by countries. The participants were grouped by countries to review their plans and revise and/or develop plans for 2006-2007.

9. Presentation of group work: Workplans for 2006-2007

The session was chaired by Ms. Yegeshen Work Ayehu and Dr Michael Mbizvo. All the ten countries of intensified focus, i.e. China, Viet Nam, Mongolia, the Pacific Islands (Vanuatu, Solomon Islands, Tonga), Indonesia, Myanmar, Bangladesh and Nepal presented their planned activities for 2006 and 2007.

In general, all the countries are planning a systematic adaptation and adoption of guidelines based on best experiences, with the emphasis on monitoring and implementation for impact and sustainability. The following are the specific issues for each country workplan.

- China: the workplan consists of four parts: overall coordination and management of SPP activities, FP services, RTI/STI activities, and RH Library-related activities. New approaches to ensure integration of RH and STI/RTI prevention and management were discussed, as well as consideration of distance education mode for training.
- Viet Nam: the workplan was refined to specify the roles of all participating partners. A follow-up meeting will be undertaken to define the linkage with the UNFPA Country Programme, in addition to the current WHO and Government plans.
- Mongolia: the plan for 2006-2007 will concentrate on institutionalizing FP and STI/RTI guidelines into undergraduate

and in-service training, with exploration of new approaches for implementation and supervision and involvement of key counterparts.

- Vanuatu will focus on completing implementation of the 2005 workplans and initiating introduction of STI protocols including GEP and development of job aids in 2006.
- Tonga will aim at completing SPP activities outlined in the 2005 proposal and initiating new activities for introducing STI protocol development in 2006-2007. It was also highlighted that the monitoring and evaluation mechanisms are already in place and mechanisms for ensuring assessment of progress are being given due attention.
- Solomon Islands will be undertaking the completion of SPP activities as outlined in the proposal, as well as initiating development and introduction of STI guidelines. Current activities include the updating of FP guidelines, FP “wheel” and its nationwide introduction. They have also included the updating of the nurses’ curriculum and distance education curriculum using Medical Eligibility Criteria (MEC) and Selected Practice Recommendations (SPR). The increase in demand for FP as a result of the introduction of the revised evidence-based guidelines in FP and FP “wheel” was not anticipated and led directly to an increase in demand for contraceptives. Concern was expressed about the postponement of provincial workshops because of delay in release of funds at the country level.
- Indonesia has a complete set of FP and STI manuals including GEP with support from SPP and other sources. From 2006, a person to coordinate and manage the SPP programme will be designated, using existing UNFPA funds. Indonesia is considering the introduction of rapid diagnostic tests, upgrading the training of lab technicians, integrating STI treatment in care of sexual violence and violence against women, undertaking advocacy and conducting operations research.
- Myanmar: the Departments of Obstetrics and Gynaecology of the Universities of Medicine plan to develop RTI/STI training materials and to adapt the management algorithms from RTI/STI GEP. Activities include a stakeholder meeting of RH/STI

programme managers and academic staff followed by a meeting of academic staff of the Ob Gyn Department to review reference materials (GEP, national standard treatment guidelines and flowcharts and job aids from Kenya). A second workplan on strengthening maternal and newborn health care includes a national workshop, review of manuals and building skills of providers and volunteers in maternal and newborn health care and communication.

- Bangladesh will undertake development of FP guidelines through review of the existing guidelines, adaptation of DMT, holding a consensus workshop of experts and programme managers and will disseminate revised FP guidelines. Technical assistance will be needed for orienting stakeholders on RTI/STI management guidelines. The next phase will include orientation of trainers and service providers on guidelines, formulation of a monitoring and evaluation framework and development of pocket manuals and IEC materials. A follow-up proposal on STI guidelines focusing on STI/RTI GEP will be submitted later.
- Maldives: MEC and SPR were used for preparation of national FP guidelines. A RH technical working group will be set up to discuss introduction of STI management guidelines and STI/RTI GEP, with a view to adapt STI guidelines. Development of job aids, training of health service providers, field testing, and monitoring and evaluation activities were discussed.
- Nepal: WHO, UNFPA and the Family Health Bureau will update FP guidelines and will involve several donor agencies. Consultants will be recruited to review and update FP guidelines and adapt DMT. A consensus-building workshop is planned during which DMT, GEP and STI guidelines will be introduced.

Following the presentations and discussions on workplans for 2006-2007 the following issues were highlighted.

- Mechanisms for integration of STI/RTI into FP and MNH services need to remain as a major focus.
- A national workshop to introduce the guidelines was held in Tonga and subsequently the Tonga FP Task Force was developed and the SPP proposal written and approved. Thus, while some

activities are not necessarily funded directly by SPP, these activities should be considered SPP-related as they contribute to introduction of SPP guidelines, using WHO-UNFPA collaborative strategies, technical resources and advisers.

- The issue of adequate contraceptive supply was discussed. The introduction of guidelines in Solomon Islands triggered increased demand in contraceptives and the RH division is currently re-adjusting procurement projections for contraceptives.
- Operations research is needed in evaluating the integration of essential RH services at health centres to determine the short and long-term impact. From the last assessment, there were four components in integration: MCH, FP, STI and Adolescent Reproductive Health. The last two components were most difficult to integrate.
- Clarification on the process of improving providers' skills on newborn health was provided. The first step should be to explore national capacity of trainers in newborn care before extending to national basic health providers. Training of health care providers using the Pregnancy, Childhealth, Postpartum and Newborn Care should be combined with activities for improving the health system, which is conducive for providing quality maternal and newborn health (MNH) service. While upgrading protocols contributes to improving the quality of services, broader health system issues need to be considered. As funding through the SPP is limited, therefore, there is a need to include different development partners and the private sector. It was noted that in preventing perinatal mortality and morbidity, maternal and newborn health should be seen as a dyad.
- In Bangladesh, the FP guidelines were translated in 2005 with the assistance of EngenderHealth. The review of the national guidelines will be undertaken in 2006 to see if they are in line with recommendations in the MEC and SPR. This work is led by the MoHFW. It was noted that the STI programme is under the Directorate-General of Health Services while FP is under the Directorate-General of Family Welfare. The mechanism collaboration between two-line DGs involvement in this activity was raised.

- WHO/SEARO and UNFPA CST-SAWA has promoted evidence-based FP guidelines using other resources, i.e. in Maldives and Thailand. The DoH of Maldives felt that it was very important to develop a national FP guideline because of the high turnover of staff and the high percentage of expatriate staff. For the sustainability of programmes there is a need to find resources from all sources. Technical assistance was provided by WHO for the first meeting on introduction of FP, STI management and GEP guidelines. It was noted that although the adaptation of those guidelines in countries is not funded by the SPP, they should be considered equally as important as those supported by SPP funds. It was suggested that countries that had implemented similar work should be kept on the mailing list for publications. Obtaining support from the UNFPA Country Programme was discussed as one of the options to maintain sustainability of the programme.

10. Next steps

At the end of the presentations, Dr Michael Mbizvo and Ms. Yegeshen Work Ayehu emphasized the following issues in planning for the next steps.

- While countries are at different stages of implementation, the key to sustainability and success is through incorporating efforts into on-going national plans and programmes.
- It is very impressive that even with the small budgetary support, significant progress has been made. Efforts have been made to mobilize funds from MoH, other WHO and UNFPA programmes and various partners.
- Collaboration between WHO and UNFPA at country level in assisting government counterparts should be strengthened.
- The critically important issue is how to articulate a long-term vision, to develop a plan for a longer period and to integrate it into long-term national plans.
- In terms of costs, human life cost should be looked at rather than just the financial cost of new programmes. By preventing unwanted pregnancies which could lead to maternal deaths, the cost effectiveness of the programme can be determined among other contributing factors.

- For countries, the challenges now are to incorporate into national programmes, to identify key indicators for monitoring progress and achievement, to plan for nationwide scaling-up and to document lessons learned to share with other countries.
- SPP will be evaluated in terms of outcomes and results, which will be reported to the WHO and UNFPA Executive Boards in 2007. If the SPP is continued, the benefits and progress of the partnership interventions may be observed by 2012, as well as by expansion to other countries.

Discussions on the following issues were noted.

- The three advantages emanating from the partnership between WHO and UNFPA through the SPP are: (i) using limited resources in a very strategic way and using evidence-based and sound technical interventions; (ii) a phased expansion of technical areas, and (iii) complementarities and avoidance of duplication and making optimal use of limited resources.
- Plans for the next steps for expansion at country level: it is unclear how this will be worked out at the global level. There are options, i.e. bringing in other partners and/or expanding SPP financial resources. There are also issues to be addressed, such as how to prioritize technical areas. Are we going to expand geographically or expand in countries of intensified focus?
- The overall RH programmes, including MCH programmes in countries are often under-funded. The global challenge is to advocate for sexual and reproductive health programmes at all levels. Activism for universal access to treatment in HIV ensured resource allocation at the global level. UN Executive Board and member states have a vision for complementarities. There is a need for the grassroots to put pressure on advocating for RH.
- In terms of garnering increased support, the need is to properly document the progress made, lessons learned and share the experiences globally.
- Global partnerships are important and expanding. However, there is some concern regarding competition among partners and between programmes for funds. The WHO and UNFPA partnership is very important with demand coming from countries.

- Because of pressure from countries, the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) is more amenable now to funding other RH programmes and development of health systems. In the 6th round of the GF proposals, studies in sexual and RH interface linkages are being considered.
- There was acknowledgement of the work of Implementing Best Practices to bring in 21 partners into supporting implementing evidence-based best practices.

11. Session on skilled care at every birth

The session was chaired by Dr Wame Baravilala and Dr Junilyn Pikacha, Director, Reproductive and Child Health, Ministry of Health, Solomon Islands. The first presentation was made by Dr Jelka Zupan, Coordinator, Norms and Country Support Cooperation, Department of Making Pregnancy Safer, on "Integration of FP, STI Prevention and Control into Maternal and Newborn Health Services and Ensuring Skilled Care at Every Birth". She highlighted the situation in the Asia-Pacific regions, and said the proportion of deliveries attended by skilled birth attendants is very low in some countries. Skilled care at every birth is important for achieving MDGs 4 and 5. She stated that the Department of Making Pregnancy Safer is striving to promote integration of relevant programmes into maternal and newborn health services. There was collaboration with the Departments of Reproductive Health and Research, Child and Adolescent Health and Gender and Women's Health.

She also pointed out that the Integrated Management of Pregnancy and Childbirth (IMPAC) guidelines provide guidance on essential care for maternal and newborn health, which is comprehensive as it promotes integration of relevant services. Countries are recommended to adapt the guidelines and use them in developing national guidelines. Based on interventions in the national guidelines, costing of MNH services can be further calculated.

She stressed the importance of a balance between basic and referral care, as well as a mix of interventions for MNH in order to prevent maternal and newborn morbidity and mortality. It would take many years for countries with a very low proportion of deliveries attended by skilled birth

attendants to achieve universal skilled care at birth. A very strong commitment from the government and concrete long-term plans for human resources for MNH, which include midwives/nurse-midwives at primary care level (usually a priority issue in countries with a low proportion of deliveries attended by skilled birth attendants), as well as ob/gyn specialists and neonatologists (or medical doctors with relevant essential skills) at referral level would be required. The challenges would be in educating, employing or deploying new/upgraded health workers which would need long-term strategies, team work, integration and complementarities of skills, and services close to families and individuals.

She also stated the importance of making most of the existing workforce by addressing the entire work cycle in both the public and private sectors. For a short-term strategy, safe work environments for midwives to ensure safety and more flexible work arrangements would be necessary. She recommended the World Health Report 2006 on health workforce as a good reference document for programme managers and policy makers for better planning and programming for human resources for MNH.

11.1 Framework and progress in achieving skilled care at every birth

Dr Ardi Kaptiningsih highlighted key issues that were presented at the SEAR Consultative Committee for Programme Development and Management (CCPDM) in 2005, which was attended by Health Secretaries from 11 Member countries in the Region. She explained the scope of skilled care at birth, which consists of essential care for mothers and their newborns during childbirth and the immediate postpartum period. It includes: (i) routine care in normal birth, (ii), management of obstetric complications and newborn problems and (iii) special care for those with underlying health problems. The focus is given to the childbirth period because most complications and deaths occur during birth and immediately after birth. Skilled care at birth highlights the most critical period, although emphasis should always be made on the continuum of care during pregnancy, childbirth and the post-partum period.

An overview on the proportion of births attended by skilled attendants in SEAR countries was presented. Less than 50% of births were conducted

by skilled attendants in Bangladesh, Bhutan, India, Nepal and Timor-Leste. Some countries had achieved universal skilled care at birth a long time ago, such as Thailand, Sri Lanka and DPR Korea. It was noted that the key to success in countries with universal skilled care at births includes: (i) high commitment to provision of maternal and child care with established long-term strategic plans; (ii) promoting community-based midwifery care at the early phase to improve coverage of MCH service; (iii) a functioning health system, including referral back-up; (iv) regulation of skilled attendants to ensure quality of services; and (v) strong management teams for maternal and newborn health, including an effective monitoring system.

She explained that countries in the Region are at different stages of development. For countries with a very low proportion of births attended by skilled attendants (less than 50%), the major problem is lack of skilled attendants at the community level. The main challenge is to ensure availability of skilled attendants in adequate numbers. For countries with 50-80% of births attended by skilled attendants, there was a need to ensure that all components of skilled care at birth are in place, basic equipment and supplies are adequate, referral back-up services are effective, quality of care is maintained; outreach to the poor is well in place and skilled attendants are based close to the community they served. For countries with a high proportion of births attended by skilled attendants, there are still pockets of areas with low access and a growing tendency for over-medicalization of normal pregnancy and childbirth, such as overuse of ultrasound and high rates of caesarean section. It was pointed out that each country should address its specific problems in order to achieve universal skilled care at birth.

Dr Saramma Mathai presented progress in promoting universal skilled care at birth in the South and West Asia (SAWA) regions. She highlighted the results of a workshop organized by UNFPA CST-SAWA in Islamabad, Pakistan, in 2004. Among others, the main recommendation of the workshop was the need to develop strategies in countries to improve access to skilled birth attendants. This should be done through training, changes in policy and regulations on human resources for maternal and newborn health, including production issues, establishing appropriate job description, strengthening the accreditation process, supervision, deployment and retention mechanisms. Progress in countries was highlighted showing that many challenges still need to be addressed, including those at policy and implementation levels.

Recommendations of joint WHO/UNFPA workshop on Accreditation of Community-based Skilled Birth Attendant (SBA) held in Behror, India, in 2005 were highlighted. These included the need to set up regional midwifery training institutions and development of standard guidelines for curriculum, regulation and accreditation for reference. Further, it was recommended that Member countries should develop their community-based SBA according to set standards and strengthen the regulatory bodies for nursing and midwifery. It was proposed that WHO and UNFPA should collaborate in the development of a regional framework for accreditation of midwifery education. In this context, the WHO Maternal and Newborn Health guidelines would serve as reference.

11.2 Country initiatives in achieving universal skilled care at birth

Bangladesh, China and Viet Nam presented their country initiatives in achieving universal skilled care at birth. Bangladesh, with 13% deliveries assisted by skilled attendants in 2005 is committed to increase the figure to 50% by 2010. Bangladesh decided to train the community-based MNH providers in midwifery skills to enable them to provide MNH care, especially delivery and newborn care. A six-month competency-based training programme was initiated with WHO support in mid-2003, which was implemented by the Ob-Gyn Society and expanded further with UNFPA financial support. The Ministry of Health and Family Welfare involved the Bangladesh Nursing Council to develop and implement an accreditation mechanism for the training. So far, the programme has been expanded to 28 districts involving more than 1,300 MNH providers. It will be expanded to all the 64 districts in the country.

China, with an MMR of 120 per 100,000 live births, is implementing a national programme for reducing maternal mortality and elimination of neonatal tetanus through multi-sector collaboration involving all stakeholders. China is improving lower-level facility infrastructure, improving access for delivery and emergency MNH care for the poor, improving capacities and skills of health providers, building incentive mechanisms and documenting achievements, while ensuring stable financial support. An initial cooperation medical scheme (CMS) was initiated for rural residents, including provision of MCH service, covering 600 counties with approximately 80% of the total population. As a result, the hospital deliveries have increased rapidly from approximately 50% in 1995 to 80% in 2005.

Viet Nam, with 70% of deliveries by skilled attendants of 70% and MMR at 165 per 100,000 live births, is committed to further the MMR and NMR to 70 per 100,000 live births and 18 per 1,000 live births respectively. Actions include revision of national standards and guidelines on MNH as part of the reproductive health guidelines. The government has also disclosed action plans for Safe Motherhood, newborn care, adolescent reproductive health and prevention and management of RTIs/STIs/HIV-AIDS. At the local level, on-the-job and in-service training is carried out, and pre-service midwifery training is being strengthened. Piloting of pre-service midwifery training for ethnic minority groups in mountainous areas is on-going and is planned to continue till 2010. Advocacy to local government and other sectors are among other local interventions.

11.3 Group work on skilled care at birth

An introduction to the Group Work was made by Dr Ardi Kaptiningsih. Countries were grouped according to the level of proportion of deliveries by skilled attendants (three country groups: low level – less than 50%, medium level – 50-80% and high level – above 80%). They were requested to identify a few priority areas for achieving universal skilled care at birth and to select a specific issue of the priority areas and develop a draft plan of action. The outcomes of the Group Work were presented on the last day of the workshop.

A special session on cervical cancer prevention was conducted by Dr Nathalie Broutet. Most country participants were interested and attended the session.

The session was chaired by Dr Pang Ruyan, who invited country representatives to present the outcomes of their group work. The following are the summaries of the country presentations.

From countries with a low proportion of deliveries assisted by skilled attendants, i.e. Bangladesh, plans were: (i) to strengthen policies and plans for human resources for MNH; (ii) to strengthen midwifery training; (iii) to strengthen supportive supervision and management of community-based SBA; (iv) to upgrade health infrastructure at community level; (v) to strengthen referral systems and (vi) to establish mechanisms to raise public awareness. These are actions to achieve a proportion of SBA to 50% in 2010 from the current proportion of 13%.

From countries with a medium proportion of deliveries assisted by skilled attendants, Myanmar, with approximately 60% deliveries assisted by SBA aims to improve the quality of MNH service. They would invest on pre-service and in-service training of community-based MNH providers using evidence-based WHO guidelines and monitor their skills. They would also identify key MNH issues and find solutions.

Indonesia, with almost 70% of deliveries assisted by skilled attendants, addressed the issue of retention of community midwives, especially in rural areas. It was estimated that only 40% of the total villages in the country have a midwife, while in the past it was intended that each village would have an assigned midwife. It was proposed that a plan for retention of human resources for MNH be developed, which would include a deployment mechanism, development of a career path and implementation of structured in-service training. Advocacy to local government is also necessary to provide rewards to the community midwives, i.e. provision of proper housing, incentives, adequate protection/security during travel to remote areas.

Viet Nam focused on the issue of newborn care and lack of SBA in villages in mountainous areas. Some activities were proposed for improving newborn care, i.e. training of health providers at all levels, provision of necessary equipment, etc. For improving availability of SBAs in mountainous areas, midwifery training for local females aged 17-25 years with 12-year basic education for 9 months was proposed to be implemented in 2006-2007.

From countries with a high proportion of deliveries assisted by skilled attendants, Thailand aims to expand integrated MNH practice guidelines nationally. They also proposed to strengthen maternal and perinatal death reviews and conduct studies on maternal and neonatal deaths in remote and poor setting areas, especially among the hill tribes.

Tonga and Vanuatu, with 95% institutional deliveries and 88% of deliveries assisted by skilled attendants respectively, basically proposed the same activities on expansion of improving quality of MNH service through implementation of evidence-based WHO MNH guidelines. The results of EmOC assessment will be used as a basis for improving the service. Both countries proposed supervision visits to monitor implementation of the guidelines. Vanuatu also proposed maternal death reviews.

12. WPRO experiences

A presentation was made on experiences of the WHO Western Pacific Regional Office (WPRO) in two areas, ARH and gender and reproductive rights. Dr Pang Ruyan presented two topics: (i) Investing in Our Future: A framework for accelerating action for the sexual and reproductive health (SRH) of young people and (ii) Workshop on Gender and Rights in Reproductive and Maternal Health.

The first presentation highlighted the importance of adolescent sexual and reproductive health. A literature review was made by eight countries in response to World Health Assembly Resolution WHA 55.19. A framework for accelerating action for the SRH of young people was developed in collaboration with UNICEF and UNFPA. The objectives of the programme are to reduce: (i) pregnancy before maturity of young people aged 15-19 years by 20%; (ii) the unmet need for contraception among young people aged 15-24 years by 30%; (iii) STIs/HIV infection rate of young people aged 15-24 years by 25%; (iv) sexual violence and exploitation of young people aged 15-24 years by 25%, all between 1990 and 2015. The components of the framework include: (i) promoting healthy behaviours through life-skill based information and education; (ii) ensuring access to reproductive health for young people; (iii) creating a supportive and enabling environment; (iv) accelerated actions.

The second presentation was on WPRO's experience in promoting the WHO guideline on gender and rights in reproductive health, especially for maternal health. A workshop was held in December 2005 with the following objectives: (i) to understand the gender and rights framework for SRH issues in policy analysis and health systems; (ii) to familiarize participants with the use of tools and concepts in gender and rights; (iii) to discuss selected national efforts for reducing maternal and newborn mortality and identify priorities for action, from a gender and rights perspective. Contents of the short course and a user-friendly manual were highlighted.

13. Closing

Dr Michael Mbizvo and Ms. Yegeshen Work Ayehu concluded the workshop by thanking all participants, resource persons and the organizers.

Annex 1

Programme

Day 1: Monday, 24th April 2006

- 08:00–09:30 Registration and Inauguration
- 09:30–10:00 Group photograph and Tea/Coffee break
Chairpersons: *Dr Garimella Giridhar and Dr Pang Ruyan*
- 10:00–10:45 Country presentation and discussion: China and Viet Nam
- 10:45–11:30 Country presentation and discussion: Solomon Islands, Vanuatu, Tonga
- 11:30–12:15 Country presentation and discussion: Indonesia and Myanmar
- 12:15–12:30 Summary: Overcoming the challenges
Dr Josephine Sauvarin and Dr Katherine Ba-Thike
- 12:30–13:30 Lunch
Chairpersons: *Dr Hans Troedsson and Dr Win Win Mya*
- 13:30–14:15 Summary and overall recommendations for strengthening SPP implementation and future modalities
Dr Josephine Sauvarin and Dr Katherine Ba-Thike
- 14:30–15:30 Panel discussions on: Young People and STIs.
Moderator: *Dr Saramma Mathai*
- Strengthening health services for STIs among adolescents
Dr Nathalie Broutet
 - Selected country experiences: Thailand
Dr. Pachara Sirivongrangson, MoPH, Thailand
 - Selected country experiences: East Asia and the Pacific
Dr Wame Baravilala, UNFPA CST, Suva
- 15:30–16:00 Tea/Coffee break

- 16:00–17:00 Panel discussions on: Interventions for Sex Workers with STIs – Breaking the Silence.
Moderator: *Dr Annette Robertson*
- The 100%-Condom Use Programme: Experiences from China.
Dr Zhao Pengfei
 - STIs among sex workers and their implication: Experiences from India: *Dr RR Gangakhedkar*
 - Women’s health approach: Strategies for sex workers and STIs in Thailand: *Ms Wassana Im-em*
- Summing up and recommendations
- Special session** (for interested participants):
- 17:00–18:00 Demonstration of Rapid Diagnostic Tests in Management of STIs
Dr Rosanna Peeling, TDR
- Facilitators’ meeting

Day 2: Tuesday, 25th April 2006

Chairpersons: *Dr Dinesh Agarwal* and *Dr Trisnawaty G. Loho*

- 08:00–09:00 Experiences on use of WHO STI/RTI care guidelines in Indonesia, China and Kenya: Presentation and discussion.
Dr Saiqa Mullick and *Country Representatives*
- 09:00–10:00 The process of adaptation: An Adaptation Guide for STI guide-lines: Presentation and discussion.
Dr Saiqa Mullick and *Dr Nathalie Broutet*
- 10:00–10:40 Planning implementation: Presentation and discussion.
Dr Saiqa Mullick and *Dr Nathalie Broutet*
- Products of the Kenya experience: guidelines, training manuals and handbook and job aides.
Dr Saiqa Mullick
- 10:40–11:00 Tea/Coffee break
- Chairpersons:** *Dr Nathalie Broutet* and *Mr Suthon Panyadilok*
- 11:00–11:30 Role of Rapid Diagnostic Tests in Management of STIs.
Dr Rosanna Peeling
- 11:30–12:00 Support in implementation and scale-up: Potential partner contributions – *Representatives of IBP Partners.*
- 12:00–12.30 Monitoring and Evaluation Tools: Presentation and discussion.
Dr Katherine Ba-Thike

12:30–13:30	Lunch
13:30–13:45	Challenges to SPP implementation <i>Dr Saramma Mathai</i>
13:45–13:50	Introduction to Group Work: Work Plans for 2006-2007. <i>Dr Ardi Kaptiningsih</i>
13:50–15:30	Group Work: Plans for 2006-2007
15:30–16:00	Tea/Coffee break
16:00–17:00	Group Work: Plans for 2006-2007 (continued).
17:00–17:45	Facilitators' meeting
19:00	Reception

Day 3: Wednesday, 26th April 2006

Chairpersons: *Ms. Yegeshen Work Ayehu and Dr Michael Mbizvo*

08:00–08:10	Review of Day 2
08:10–08:55	Presentation of Work Plans: China, Viet Nam, Mongolia
08:55–09:40	Presentation of Work Plans: Pacific Island countries
09:40–10:10	Presentation of Work Plans: Indonesia, Myanmar
10:10–10:30	Presentation of Work Plans: Bangladesh, Nepal
10:30–11:00	Tea/Coffee break
11:00–11:30	Next steps <i>Ms. Yegeshen Work Ayehu and Dr Michael Mbizvo</i>
	<i>Chairpersons:</i> <i>Dr Wame Baravilala and Dr Junilyn Pikacha</i>
11:45–12:05	Integration of FP, STIs prevention and control into MNH services and ensuring Skilled Care at Every Birth
12:05–12:30	Framework and progress in achieving Skilled Care at Every Birth <i>Dr Ardi Kaptiningsih</i> <i>Dr Saramma Mathai</i>
12:30–13:30	Lunch
13:30–14:30	Country initiatives in achieving Skilled Care at Every Birth: <i>Country representatives from Bangladesh, Nepal, China and Viet Nam</i>
14:30–14:35	Introduction to Group Work on Skilled Care at Every Birth: Development of: i) framework for achieving Skilled Care at Every Birth; ii) framework of country plan of action for SPP in 2006-2007

14:35–15:30	Group work on Skilled Care at Every Birth
15:30–16:00	Tea/Coffee break
16:00–17:00	Group work on Skilled Care at Every Birth (continued)
17:00	Facilitators' meeting
	Special session (for interested participants):
17:30–18:30	Cervical cancer prevention <i>Dr Nathalie Broutet</i>

Day 4: Thursday, 27th April 2006

Chairpersons: *Dr Pang Ruyan*

08:00–08:10	Review of Day 3
08:10–09:30	Group work on Skilled Care at Every Birth (continued)
09:30–10:30	Presentation of Group Work on Skilled Care at Every Birth
10:30–11:00	Tea/Coffee break
11:10–11:30	Presentation on Gender and Rights in Reproductive Health course <i>Dr Pang Ruyan</i>
11:30–12:00	Investing in the future: A Framework for accelerating action for the Sexual and Reproductive Health of young people <i>Dr Pang Ruyan and Dr Annette Robertson</i>
12:00–12:30	Conclusion and closing <i>Ms. Yegeshen Work Ayehu and Dr Michael Mbizvo</i>
12:30–13:30	Lunch
13:30–15:00	WHO/UNFPA Discussions

Annex 2

List of participants

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