

The implementation of WHO global strategies of reproductive health and prevention and control of sexually transmitted infections in the Eastern Mediterranean Region

Report of an intercountry meeting

Marrakech, Morocco
29 October-2 November 2007



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1. Introduction

An intercountry meeting on the implementation of WHO global strategies of reproductive health and prevention and control of sexually transmitted infections in the Eastern Mediterranean Region was held in Marrakech, Morocco, from 29 October to 2 November 2007. The meeting was organized by the WHO Regional Office for the Eastern Mediterranean (WHO/EMRO) and attended by participants from across the Region. WHO staff from headquarters, the Regional Office and country offices also attended.

The meeting was inaugurated by Dr Abdelwahab Zerrari, Acting Director of Population, Ministry of Health, who welcomed delegates to the meeting on behalf of Her Excellency Mrs Yasmina Baddou, Minister of Health.

Dr Said Salah Youssouf, WHO Representative to Morocco, read a message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. In his message, Dr Gezairy noted that sexual and reproductive health problems accounted for a high proportion of the disease burden among individuals, families and communities. For women in the Eastern Mediterranean Region this was estimated at 31%. Sexual and reproductive ill-health had a broader impact on social and economic development. Investments in sexual and reproductive health were essential to breaking the cycle of poverty and freeing up national and household resources. Unmet family planning needs, pregnancy, childbirth-related conditions and sexually transmitted infections, including HIV, directly affected the potentially most economically active segments of the population, including women who died during pregnancy in the prime of life.

Information on the major determinants of reproductive morbidity throughout the life span was still inadequate to enable evidence-based programme development and implementation. Moreover, several countries in the Region suffered from lack of political stability, inadequate financial

and human resources, restrictive regulations, poor socioeconomic conditions and sex-based discrimination, reduced access and use of reproductive health services, and scarcity of health-related data and information necessary to plan, monitor and evaluate reproductive health needs. Today, 53 000 mothers and 610 000 newborn babies died every year in the Eastern Mediterranean Region. By the end of 2006, the total estimated number of people living with HIV in the Eastern Mediterranean Region was 670 000. Sudan alone carried 75% of this burden.

The WHO global strategy on reproductive health, adopted by the 57th World Health Assembly in May 2004 (WHA57.12), recognizes the crucial role of sexual and reproductive health in social and economic development in all communities. Also in 2004, the Regional Committee for the Eastern Mediterranean passed a resolution (EM/RC51/R.4, Moving towards the Millennium Development Goals: investing in maternal and child health) urging Member States which had not already achieved the targets set by the Millennium Development Goals (MDGs) for improvement of maternal and child health, to develop the required national policy and strategy documents and expand upon the achievements already made by other Member States. In October 2007, the Regional Committee passed a resolution (EM/RC54/R.2) aimed at strengthening relevant national policies and strategies in order to improve neonatal health in the Region.

In 2000, the World Health Assembly (WHA53.14) requested the Director-General to develop a global health sector strategy for responding to the epidemics of HIV/AIDS and sexually transmitted infections (STIs) and to complement the reproductive health strategy. The subsequent global strategy for the prevention and control of sexually transmitted infections 2006–2015, adopted in 2006, reiterated that prevention and control of STIs were core aspects of sexual and reproductive health. The strategy offers four fundamental benefits of investing in STI control, namely: reduction in STI-related morbidity and mortality; prevention of HIV through a cost-effective intervention; prevention of long-term sequelae of STIs, such as cancer, especially in women; and reduction in adverse outcomes of pregnancy (in women infected with STIs). The strategy highlighted opportunities for scaling up an effective response to STI prevention and control and proposed

feasible evidence-based interventions for implementation at country level.

It was clear that achieving the Millennium Development Goals relating to reproductive health required strong political commitment and strategic partnerships at all levels, said Dr Gezairy: accelerated concerted efforts were urgently needed. Specific attention should be given to: strengthening health systems; improving knowledge and skills of health workers about early detection and management of complications in pregnancy and childbirth; and raising the awareness of individuals, families and communities about emergency preparedness and life-saving practices. Critical analyses of the current situation in countries, particularly those with high levels of maternal and neonatal death and prevalence of people with STIs, along with the use of available knowledge and technology, were expected to support national efforts towards achieving the Millennium Development Goals, so that women of childbearing age and their children have a chance to attain the highest possible level of health.

Dr Georges Georgi, representative of the United Nations Population Fund (UNFPA) told the meeting that reproductive health was a main focus of UNFPA and that the organization had many offices in the Arab world. Although maternal mortality was an important issue to be addressed, he noted that maternal morbidity was also a major focus, as this affected many aspects of women's life. The trend towards later age at first marriage also affected the reproductive and sexual health of women in the 18–30 age group. He noted that there were many synergies between the agencies represented at the meeting: WHO, UNFPA, the International Planned Parenthood Federation (IPPF) and the relatively new Eastern Mediterranean Network of STI Control (EMNOSTIC; see below).

Dr Abdelwahab Zerrari (Morocco) was elected chair and Dr Aziza Bennani (Morocco) rapporteur for day one of the meeting. The agenda, programme and list of participants are attached as Annexes 1, 2 and 3 respectively.

2. Objectives and methodology

The specific objectives of the meeting were to:

- share information and experiences on existing national programmes, strategies and approaches designed to address reproductive health and sexually transmitted infections issues in countries of the Region
- introduce the WHO global strategies of reproductive health and prevention and control of sexually transmitted infections, with specific focus on MDG priority countries
- identify appropriate mechanisms and actions in line with WHO global STI workplan and reproductive health framework.

The meeting methodology included regional overviews, country presentations and overviews of the WHO global strategies on reproductive health and the prevention and control of sexually transmitted infections. Following the presentations, delegates worked in groups in order to formulate national plans of action to implement the strategies in the Eastern Mediterranean Region and to identify priority areas, gaps, constraints activities and expected results.

The expected outcomes of this meeting were

- to have reviewed and discussed current national and Regional strategies of reproductive health and control and prevention of sexually transmitted infections, and share experiences and lessons learnt
- to have identified appropriate collaborative activities between reproductive health and sexually transmitted infections, and identified coordinating mechanisms
- to have identified priority areas, gaps, constraints, activities and expected results in reproductive health

and sexually transmitted infections in the Region and participating countries

- to have agreed on areas for regional focus in reproductive health and sexually transmitted infections and collaborative activities
- to have considered activities and future steps at national level; and identified support needed to operationalize strategies and activities in countries.

3. WHO global strategies on reproductive health and prevention and control of sexually transmitted illnesses

WHO global strategy on reproductive health

The WHO global reproductive strategy was adopted by the World Health Assembly in 2004 through resolution WHA 57.12. It was developed following consultation with key stakeholders in all WHO Regions.

The strategy aims to strengthen the capacity of health systems to achieve universal access to sexual and reproductive health in all Member States, and to make sexual and reproductive health an integral part of national planning and budgeting. The resolution calls on countries to ensure that all aspects of sexual and reproductive health, including *inter alia* maternal and newborn health and adolescents' reproductive health, are included in monitoring and reporting of progress towards attainment of the development goals of the UN Millennium Declaration.

The strategy aim to improved sexual and reproductive health in countries with respect to five core elements:

- improving antenatal, delivery, postpartum and neonatal care
- providing high-quality services for family planning, including infertility services
- eliminating unsafe abortion
- combating sexually transmitted infections, including HIV and reproductive tract infections (RTIs), and cervical cancer and other gynaecological morbidities
- promoting sexual health.

For each of these areas, the strategy calls for action to accelerate progress through a number of actions for

- strengthening health systems capacity
- improving the information base for priority setting
- mobilizing political will
- creating supportive legislative and regulatory frameworks
- strengthening monitoring, evaluation and accountability.

WHO subsequently developed an implementation framework to help accelerate implementation of the strategy and four policy briefs in the areas of:

- financing sexual and reproductive health care services
- integrating sexual and reproductive health care services
- creating supportive legislative and regulatory frameworks
- promoting and safeguarding the sexual and reproductive health needs of adolescents.

The WHO global strategy echoes both the International Conference on Population and Development goal of achieving universal access to sexual and reproductive health services and the commitment made by heads of state and governments in the 2005 world summit when they stated “ to this end ... we commit ourselves to ... achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration ...” (Figure 1).

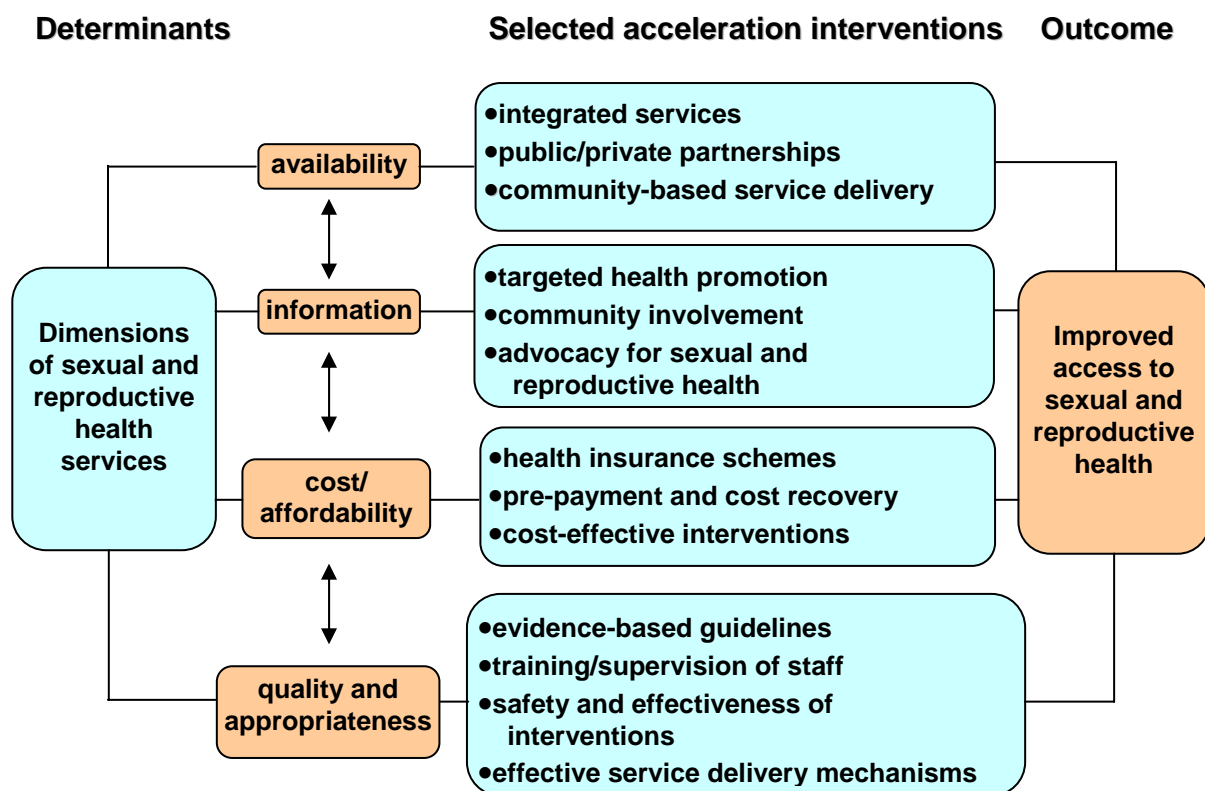


Figure 1: Pathways to improving access to sexual and reproductive health

This call was recently (October 2007) affirmed when the UN general assembly endorsed a new MDG:

- “Achieve, by 2015, universal access to reproductive health.”

Key actions suggested for achieving universal access to sexual and reproductive health services include:

- policy to strengthen health systems
- existence of a reproductive health task force
- inclusion of reproductive health within national development plans
- inclusion of reproductive health within proposals to the Global Fund
- human resource assessment—training needs

- improving data for quality of sexual and reproductive health care
- standards and guidelines for service delivery
- strengthening referral systems.

As part of monitoring the implementation of the strategy to the WHA, through WHO using the strategy for

WHO global strategy on prevention and control of sexually transmitted illnesses

The World Health Assembly in 2006 requested that a global strategy be developed on the prevention and control of HIV and STIs, and to complement the reproductive health strategy. The development of the strategy was a broad consultative process over a four-year period including internally with various WHO departments, regionally and externally. The strategy was then an agenda item for the WHO Executive Board in January 2006, which recommended that Member States further discuss the strategy electronically. The outcome of this discussion was incorporated, and the Strategy was endorsed by the Assembly in May 2006 (Resolution WHA 59.19). The global strategy for prevention and control of sexually transmitted illnesses is laid out in four chapters (STIs as a public health problem; aims and scope; technical strategy to be adapted at country level; and advocacy strategy) and an annex.

STIs are a global burden both directly and indirectly. There are four reasons to invest.

- Reduction in morbidity and mortality both directly on quality of life and reproductive health and indirectly through their role in facilitating HIV transmission and their impact on national and individual economies.
- Prevention of HIV infection. At the individual level, the STI cofactor effect on acquisition and transmission is clear. Services that offer STI care are an entry point for risk-reduction counselling and HIV testing and counselling.
- Prevention of serious complications in women.

- Prevention of adverse pregnancy outcomes including caesarean section and stillbirth due to syphilis; this is a cost-effective intervention even at low prevalence rates.

An expected benefit of these reductions is progress towards attainment of Millennium Development Goals 4, 5 and 6.

A number of opportunities exist to advance STI prevention and control; STI case management is a proven HIV prevention intervention which is cost-effective, even more so when targeted at groups with high likelihood of transmission. New partnerships have a renewed focus on prevention and accept STI control as a primary prevention strategy. New technologies can provide opportunities for care and surveillance. Successful results from diverse interventions in resource-limited settings (such as Thailand, Uganda and Sweden) demonstrate that STIs can be controlled.

Effective prevention and care can be achieved through a combination of responses, which include a public health package plus innovative interventions such as periodic presumptive treatment, which have been tried and could be implemented with evaluation.

Sufficient evidence exists that condoms are effective against most STIs. Condom promotion should be particularly targeted where there are high rates of STIs or unsafe sexual behaviour.

The strategy looks at major obstacles to prevention and control including stigma.

The second chapter describes the main goal of the strategy, which is to promote an accelerated global response to STI prevention and control and also to increase commitment and resources available and harness involvement of multiple partners. The guiding principles are described as well as essential elements that are based on well established experience. Countries will need to explore innovative ways to package their programmes.

The third chapter describes the technical strategy. Over the past 20 years much more knowledge has been gained on

the dynamics of STI epidemics. Most infections are not distributed evenly through the population, and early in epidemics infections are likely transmitted between and from persons at high risk with high rates of infection; these infections then spread to lower risk groups through bridging groups that link the core groups to the general population. STI prevention and control programmes need to have an understanding of which populations are at risk, what behaviour or circumstances put these populations at risk, and what the best approaches and interventions are. An effective prevention response starts by providing accurate and explicit information on safer sex, including condom use, and quality health care services must be available to provide early and effective treatment. Male and female condoms are a key component of comprehensive prevention strategies and should be readily and consistently available. Access to medicines and appropriate technologies is essential to break transmission.

Scaling up of effective interventions is essential. Small-scale and pilot projects provide limited coverage and cannot be expected to have an effect. Improving information through surveillance must be enhanced for the purposes of advocacy, programme design, monitoring and evaluation, and patient care. This includes basic components which must be enhanced: routine case reporting, prevalence assessment, assessment of etiologies of syndromes, antimicrobial resistance monitoring and special studies.

STIs are implicated in programmes that deal with adolescent health, family planning, women's health, safe motherhood, immunization, child survival and HIV prevention. These programmes are interdependent and should be strategically integrated or have interfaces, because this is indispensable for increasing coverage and reducing missed opportunities for prevention, detection and treatment.

Strengthening the capacity of health systems requires a focus on stewardship, including access to services, financing, including resource mobilization, and regulatory guardianship for quality and equity, such as national guidelines on care and supportive supervision. Priorities for immediate action are suggested and based on the principle of building on success. Countries should implement or scale up the provision of care for those with

STIs through key activities for which there is sufficient knowledge and evidence for impact and feasibility. These are interventions that have been implemented elsewhere with modest additional human and financial resources, but not been sufficiently scaled up. For interventions that require more resources, plans are needed for implementation in a stepwise fashion.

Good technologies and interventions will be of little benefit without the political will and resources to sustain implementation. Strong leadership with support from civil society is required. Advocacy will be enhanced by documentation, identifying key constituencies and creating multidisciplinary coalitions. The strategy addresses working with the media to promote goals, building effective partnerships for a broad-based approach and mobilizing financial resources for implementation.

WHO will prepare action plans at regional and global levels collaboratively with interested partners. Member States are urged to adopt and draw on the strategy in order to ensure that efforts include plans and action that address local problems, enhancing political will and improving programme linkages and access by populations at increased risk.

4. Eastern Mediterranean Network of Sexually Transmitted Infection Control

Background

During a meeting in Harare, Zimbabwe, in June 2005, eight experts on sexually transmitted infections from different countries of the Eastern Mediterranean Region suggested the establishment of an Region-wide STI network. In Alexandria, Egypt, in March 2006, during a side-meeting of STI network members at an STI workshop, an agreement was made to:

- establish a STI network secretariat at the WHO Mediterranean Centre for Vulnerability Reduction in Tunis, Tunisia
- name the network the Eastern Mediterranean Network of Sexually Transmitted Infection Control (EMNOSTIC)
- establish terms of reference for a secretariat coordinator
- prepare a draft constitution.

In Tunis in December 2006, during a training and planning workshop for STI network members:

- a constitution was adopted by all members
- executive committee members were elected
- a secretariat coordinator was recruited
- a work plan for the year was endorsed.

The Regional Office and WHO headquarters expressed their readiness to help the network to become functional and efficient and committed themselves to providing full support.

Mission statement

EMNOSTIC is a nongovernmental, non-profit and non-partisan organization whose mission is to support countries of the WHO Eastern Mediterranean Region in assessing and formulating a response to the challenges related to STI through sharing information and knowledge, supporting educational programmes and fostering networking, debates and discussion on STI.

Objectives of the network

- Advocating for the development or strengthening of national responses to STI in the region.
- Providing technical support and training to strengthen national responses to STI.
- Facilitating exchange of experience and information within and beyond the Region (including other similar networks).

Membership

Members are individuals who are committed to prevention, care and control of STI in their countries and to STI experts from governmental and nongovernmental institutions and organizations.

Executive committee

The executive committee is composed of seven members: the president, the vice-president, the secretary-general, the treasurer and three additional members.

Progress since December 2006

- An EMNOSTIC logo has been created; the web site www.emnestic.org is online; and an EMNOSTIC leaflet in Arabic, English and French is ready to be distributed.
- New membership: 10 new members (making a total of 21) from 11 of the countries of the Region have joined the network.
- Two meetings have been held, one in May and the other in July 2007, to follow up on EMNOSTIC and the secretariat's work plan.

Current activities

The main activity is the implementation of an STI prevention and response analysis in the Eastern Mediterranean Region, the goal of which is to contribute to the improvement of STI/RTI prevention and management in the Eastern Mediterranean Region.

The objectives of this project are to:

- collect data on the STI situation in selected countries of the Region by using the WHO STI assessment tool
- complete data through the implementation of STI prevalence and response studies
- analyse data, write reports and disseminate findings
- help decision-makers to implement effective programmes using the results of the data analysis.

A database of STI experts is being compiled gathering details of STI experts from the Region or outside, not necessarily members of EMNOSTIC, who could be requested to assist countries in planning and implementing projects or programmes for STI prevention and control.

Publications, activities, events, meetings and training related to STI and reproductive health are being identified. Information is disseminated through e-mail, a newsletter and the website www.emnestic.org.

Next steps for the network are to move the secretariat office into a national institution, to increase membership and to collect funds for EMNOSTIC functioning as well as for project implementation.

5. Regional situation

Reproductive health

Background

Reproductive health is fundamental to the development of individuals, families and communities in the Eastern Mediterranean Region. WHO recognizes that although there is no universal formula for programmes to achieve reproductive health, there are some basic principles that can be applied everywhere. One such principle is building on what already exists. Another basic principle is avoiding the creation of a parallel, vertical reproductive health programme.

Research is a strategic priority for improving the performance of reproductive health programmes. However, there is a need for close collaboration among national research institutes, the governmental sectors concerned, nongovernmental organizations and the researchers themselves in making practical use of the findings of their studies.

Focus has been placed on safe motherhood (including: antenatal, obstetric, postpartum and neonatal health care and family planning) as a priority component of reproductive health in all countries of the Region. It is estimated that 53 000 women still die every year of pregnancy-related complications in the Region. Furthermore, around 610 000 newborns die every year in the first month of life in countries of the Region. The total fertility rate is as high as four children per woman. Moreover, attention is being increasingly paid in countries of the Region to reproductive health in adolescence and post menopause. Other components are emerging as priority areas, including: practices harmful to reproductive health, reproductive tract infections, reproductive system cancers, premarital and preconception counselling, genetic counselling and neonatal screening for inherited disorders.

Nonetheless, the adoption of a holistic approach to reproductive health care is partially realized; but the

integration of existing services needs to be further supported in most countries of the Region. Available data on reproductive health is still inadequately disseminated, used and shared within and between countries of the Region. Thus the attainment of international development goals in some countries of the Region still faces challenges where lack of information on major determinants of reproductive morbidity is insufficient to enable evidence-based programme development and implementation. Moreover, the political instabilities, domestic conflicts, economic sanctions and recession affecting some countries in the Region, coupled with ever decreasing financial resources, pose a double burden that must always be taken into consideration while planning for promoting public health, including reproductive health throughout life.

Main activities

Emphasizing an evidence-based approach for strategic planning for promoting reproductive health, the Regional Office completed in 2004 the first phase of creating a reproductive health research directory in collaboration with the Reproductive Health and Research unit at WHO headquarters (<http://www.emro.who.int/rhrn>). The second stage will focus on gathering information on the research conducted in the research institutes identified in phase one over a specified period of time. This stage is expected to be completed in three countries in late 2007.

The Pan Arab Project for Family Health (PAPFAM) is a project of the League of Arab States, in collaboration with the Regional Office, AGFUND and other partners (<http://www.papfam.org>). PAPFAM surveys on reproductive health were completed in Algeria, Djibouti, Lebanon, Morocco, Syrian Arab Republic, Sudan, Tunisia and Yemen and are being prepared in Libyan Arab Jamahiriya, Mauritania and Somalia.

Training on ethical practices in reproductive health research has been organized by the Regional Office in collaboration with Reproductive Health and Research since 2001, both regionally and in Egypt, Oman, Pakistan and Syrian Arab Republic. A sub-Maghrebian workshop was conducted in Tunisia in 2007 with the participation of Algeria, Djibouti, Lebanon, Mauritania, Morocco and Tunisia.

The Regional Office has collaborated with other interested

UN agencies on the development of national reproductive health policy and strategy documents for Afghanistan, Bahrain, Iraq, Morocco, Pakistan, Sudan, Syrian Arab Republic and Yemen. The Regional Office has developed a regional framework entitled *Strategic directions for accelerating the reduction of maternal mortality in the Eastern Mediterranean Region*. The strategic directions are a guide to planning, implementing, monitoring and evaluating need-based interventions and programmes at country level.

The Regional Office has also developed a regional framework entitled *Strategic directions for promoting adolescent health and development in the Eastern Mediterranean Region*.

In order to ensure that training tools and standards used in this regard are in line with the sociocultural norms and values prevailing in the countries of the Region, an adaptation workshop on transforming health systems and gender and rights in reproductive health was established in the Institute for Women, Gender and Development Studies, Ahfad University for Women, Khartoum, Sudan. The workshop has been conducted on an annual basis since 2004, and has been attended by national health staff from Afghanistan, Ethiopia, Morocco, Nigeria, Sudan, Tanzania and Yemen. A specific training workshop was conducted in Afghanistan in October 2007.

The following components were used in the operational planning for reproductive health: 2008–09

Strategic Objective 4 Statement

To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps.

Organization-wide expected result (OWER)

Guidelines, approaches and tools available and technical support provided to Member States for accelerated action towards implementing the global reproductive health strategy, with particular emphasis on ensuring equitable access to quality sexual and reproductive health services, particular in areas of unmet need, and respect of human rights as they relate to sexual and reproductive health.

Regional expected result (RER)

Technical support is provided to countries in order to build national capacities for developing gender-responsive policies and strategies, and implementing and monitoring programmes for improving sexual and reproductive health and achieving health-related MDGs.

Indicators

- Number of countries implementing the global reproductive health strategy.
- Number of countries having reviewed their existing national laws, regulations and policies relating to sexual and reproductive health.

Financial status 2008–09 (US\$ 000)

Country budget			Regional budget			
Regular	Extra	Total	Regular	Extra	Total	Total
1740	5190	6930	580	1730	2310	9240

Areas of action in 2008–09

- Ensure skilled attendance during key stages of life and improve sexual and reproductive health for all individuals.
- Improve health systems to increase availability and accessibility of services for complicated cases.
- Improve reporting and information systems and enhance data use for planning, implementing, monitoring and evaluation of existing health care services.
- Improve quality of care by establishing standard protocols, setting up systems for monitoring and regulating quality, training and deploying skilled health professionals, as well as improving the managerial capacity at all levels.
- Raise the awareness of individuals, families and the community about the importance of health care during key stages of life, and the preparedness for appropriate life-saving practices (such as family

planning), as well as building capacities of health providers in interpersonal communication skills and counselling.

Planned activities in 2008–09

- Regional and country operations research training and field activities.
- Regional workshop on adolescent reproductive health research.
- Regional workshop on implementation of best practices in family planning programmes.
- Regional workshop on strengthening reporting, information and surveillance systems in the countries of the Region.
- Regional workshop on human papilloma virus and cervical cancer.
- Support to academic and technical institutions (e.g. Afghanistan Public Health Institute, Egyptian Fertility Care Society, Institute for Women, Gender and Development Studies, Lebanese National Collaborative Perinatal Neonatal Network).

Future directions

Resolution WHA57.12 called on Member States, as a matter of urgency, to make sexual and reproductive health an integral part of national planning and budgeting, and to strengthen the capacity of health systems to achieve universal access to sexual and reproductive health care. The overall current strategic framework for WHO's work in sexual and reproductive health is guided by the WHO global reproductive health strategy.

Prevention and control of sexually transmitted infections in the Eastern Mediterranean Region

Sexually transmitted infections are a considerable health threat to the Eastern Mediterranean Region—there are an estimated 10 million curable cases each year, and sexually transmitted infections are the fourth largest killer among communicable diseases.

However, possibly because of the sensitive nature of the

illnesses, there are few reliable data. Sexually transmitted infection rates vary widely from country to country, between urban and rural population groups and even within similar population groups. Usually, sexually transmitted infection rates are higher among urban populations, the unmarried, young adults and at-risk groups such as intravenous drug users. The main determinants of the differences are social, cultural and economic factors, and access to care.

Sixteen countries replied to a regional survey sent out by the Regional Office in 2005. Of these, seven reported that there was syndromic case reporting of sexually transmitted infections and five reported both syndromic and etiological case reporting. Syphilis screening during pregnancy occurred in ten countries, but only one reported HIV counselling and testing of patients with sexually transmitted infections.

Syndromic case management guidelines were available in 14 countries but included in medical school curricula in only one. Services were provided through primary health care providers in 14 countries, through nurses/midwives in two, by gynaecologists in ten and by sexually transmitted infection specialists in nine.

There are many challenges to the prevention and control of sexually transmitted infections in the Region. There needs to be more government, public and donor recognition of the problem; there is a stigma attached to suffering from a sexually transmitted infection; the understanding of the epidemiology of sexually transmitted infections and of effective public health approaches is poor; it is difficult to reach out to at-risk groups; and because of the nature of the problem, treatment, if pursued at all, may be sought through the private sector in a bid to retain confidentiality.

There are, however, new opportunities. New technologies, such as bedside tests, are becoming available, as are new and cheaper drugs. There is increasing attention and support being given to sexually transmitted infections, for example by the Global Fund to Fight AIDS, Tuberculosis and Malaria and by recent World Health Assembly resolutions. And countries are increasingly accepting the need to target at-risk groups.

6. Country presentations

Afghanistan

Afghanistan has a population of 24 million with women of childbearing age representing approximately 5.2 million of this figure. Average life expectancy is 46 years, and women's literacy rate is 14%, Maternal and infant mortality rates are 1600 per 100 000 live births and 140 per 1000 live births respectively, while under-5 mortality rate is 230 per 1000 live births. There have been 266 reported cases of HIV/AIDS in the country, detected through blood screening and from the Kabul voluntary counselling and testing centre report, although the actual number of cases may be far higher as there is no surveillance system in place. Action has been taken to reduce maternal and neonatal mortality, and the prevention and management of STI is now a national health policy priority. The national health system also includes the development and implementation of a basic package of health services (BPHS) and an essential package of hospital services (EPHS) in addition to the development of guidelines and protocols. BPHS coverage has increased from 9% in 2003 to 82% in 2007, and the percentage of facilities with at least one female doctor, nurse or midwife has increased from 39% in 2004 to 76% in 2006.

A reproductive health policy and strategy for 2006–09 and technical guidelines have been developed, approved and are being implemented. A reproductive health task force and a reproductive health training management committee; a newborn learning resource package; pilot projects for community-based post-partum haemorrhaging intervention; maternity waiting home; a referral system; a community-based DMPA programme, community midwife education programme; a midwifery accreditation board; a safe motherhood campaign; posters, brochures, and magazines for maternal and neonatal health, family planning; gender and reproductive rights; a capacity-building programme for central and provincial reproductive health officers; all these are recent approaches to reproductive health services. Supportive supervision for

the further improvement of reproductive health services central to provincial level is being carried out. Implementation of a quality assurance programme at BPHS facilities is planned.

The national HIV/AIDS strategic plan 2003–07 was approved in 2003, and HIV was included in the BPHS in 2005. National harm reduction and HIV/AIDS strategies were approved in 2005, and draft reproductive health and tuberculosis strategic plans including HIV/AIDS voluntary counselling and testing guidelines have been developed and are currently under review. There are just six voluntary counselling and testing centres in the country and one sexually transmitted infection centre.

Barriers to the adoption and implementation of the guidelines include the inaccessibility and unavailability of high-quality services, a shortage of female staff, lack of skilled birth attendants, security, illiteracy, sociocultural norms and traditions (presence of other married women in a household may suppress use of maternal health services), geographical factors and low income levels.

Egypt

Reproductive health

Overview

Responding to the Cairo conference declaration, the Ministry of Health and Population has merged family planning, maternal health and child health services into a broad-based women's health programme. It has expanded family planning and reproductive health services, particularly to low-income populations and rural Upper Egypt.

The most important indicators are total fertility rate, female age at first marriage, percentage of early pregnancy, percentage of consanguineous marriage, antenatal care and deliveries attended by trained health personnel, maternal mortality rate, infant mortality rate, contraception prevalence rate, unmet family planning needs, prevalence of female genital mutilation and attitudes towards female genital mutilation.

Activities

- Establishment of reproductive health coordinating and integration committee, for optimal use of the available resources for reproductive health services.
- Expanding of service provision outlets to cover all targeted beneficiaries (outlets increased from 4763 in 2002 to 5111 in 2005).
- Provision of safe and affordable contraceptives in order to cover the needs of all agencies working in family planning.
- Application of a quality improvement programme at each of public health unit so that services are delivered in accordance with standards of practice. This in addition to quarterly evaluation through supervisory teams at the governorate and district levels.
- Training of service providers to provide reproductive health services according to approved protocols.
- Training of Islamic and Christian religious leaders, as well as community leaders, to advocate for the concept of reproductive health.
- Women's clubs provide illiteracy classes, vocational training, and health awareness to women and young people, especially in family planning and reproductive health.
- Activate the role of outreach (*raedat refeyat*) through face-to-face communication through 13 000 *raedat refeyat* (women from the community trained in IEC and health issues) in order to raise awareness.
- Cooperation and coordination with the national population council in research and studies for prioritization and the implementation of research recommendations.
- Negotiating with donor agencies, and exploring means of support to family planning and reproductive health programme.

- Ensuring the sustainability and continuous flow of funds and services of the ongoing programmes after phasing out of donor agency support.
- Confronting the unmet needs of squatter and deprived areas through 590 mobile clinics, providing daily family planning and reproductive health services and free contraceptives.
- Establishing mobile teams, consisting of a female doctor and a nurse, to provide services to beneficiaries desiring the services of a female doctor.
- Medical campaigns rendering family planning/reproductive health services within a package of several medical specialties.
- Construction of friendly youth clinics providing health education and reproductive health services for young people and newly weds.
- Media coverage, using the state information services, which provide flyers, television and radio spots, and awareness seminars with special focus on:
 - university youth
 - military and police soldiers
 - squatter area inhabitants
 - newly wed, and pre-marriage couples
- Implementing a programme of “youth weeks” to cover all governorates with intensive IEC campaigns in areas of low population indicators.
- Population and reproductive health magazine.

Achievements

Birth rate reduced from 37.5 in 1980 to 25.8 in 2006; natural increase rate reduced from 27.5 in 1980 to 19.2 in 2006; contraceptive prevalence increased from 24.2% to 59.2% in 2005; total fertility reduced from 5.3 in 1980 to 3.1 in 2005; life expectancy for females increased to 73.6 and males 69.2; infant mortality rate has fallen from 60 in 1996 to 33 in 2005; medically assisted deliveries have increased from 40.7% in 1992 to 74.2% in 2005.

Constraints

- High growth rates represent one of the most dangerous obstacles and hinder efforts to raise the standard of living of the Egyptian people.
- Burden of combating illness associated with poverty, illiteracy, lack of education and outmoded thinking and traditions.
- Phasing out of donor agency support.

Sexually transmitted infections

Overview

- The cumulative total number of people living with HIV/AIDS starting from 1986 is 1106 persons.
- The cumulative total number of deaths starting from 1986 is 1021 persons.
- The highest mode of transmission is heterosexual with 49% of total reported cases.
- The lowest modes of transmission are intravenous drug users and mother-to-child transmission with 2% of total reported cases for each.
- Females constitute 18% of total reported cases.

STIs study

A total of 999 individuals was recruited with ages between 18 and 45 years of age from 15 sites in Greater Cairo (government and private hospitals and private clinics). Witnessed oral consent was obtained from each participant. The findings are presented in the table below.

	Prostitutes (n = 52) %	MSM (n = 80) %	Drug users (n = 150) %	ANC (n = 604) %	FP (n = 108) %
Syphilis (TPHA)	5.8	7.5	1.3	0	0
Gonorrhoea	7.7	8.8	2.7	2	2.8
Chlamydia	7.7	8.8	2.7	1.3	2.8
Trichomoniasis	19.2	1.3	0.7	0.7	2.8
Any STI	36.5	23.8	5.3	4	8.3

HIV/AIDS and STI national strategy

- Epidemiological surveillance to identify the extent and the trend of the problem.
- IEC to inform the public to avoid and reduce risk of exposure.
- Prevention of sexual transmission through avoidance of risk and, encouraging early and effective management of STIs.
- Prevention of transmission through blood through screening of all blood donations.
- Prevention of mother-to-child transmission.
- Reduction of the impact of HIV infection through supportive care for the infected and affected population.

Main achievements

- Establishing and improving STI clinics in pilot areas.
- Establishing national guidelines for the management of STIs.
- Capacity-building for the medical staff working in the STI clinics.
- Raising public awareness through IEC materials and orientation seminars.

- Establishing a national HIV/AIDS and STI surveillance plan.

Obstacles faced

- Insufficient STI clinics.
- Insufficient skills of medical staff working in skin and venereal clinics.
- Inadequate public awareness.
- STI surveillance system is not powerful and sensitive enough.

Future plans

- Establishing and improving STI clinics all over the country.
- Enforcing the implementation of the national guidelines for the management of STIs.
- Continue medical education and on-the-job training for medical staff working in STI clinics.
- Raising public awareness through IEC materials, orientation seminars and mass media campaigns.
- Improving the STI surveillance system.
- Establishing integration mechanisms between STI clinics and other health activities, including reproductive health.

Morocco

Reproductive health

Abstract

The Moroccan Ministry of Health is making considerable efforts to develop reproductive health activities in collaboration with other sectors and national and international organizations.

Several departments of the Ministry of Health are involved with provision of reproductive health services: the Directorate of Population, the Directorate of Epidemiology, the Directorate of Hospitals and Ambulatory Care, the

National Institute of Health Administration and the Directorate of Scheduling and Financial Resources.

Some indicators show improved performances: use of contraceptives has increased, the fertility rate has fallen, the age of first marriage is later and vaccination coverage has improved; but other indicators are below the Millennium Development Goals, such as the maternal and neonatal mortality rates.

The main activities of the reproductive health programme are:

- family planning
- pregnancy care
- immunization
- child care
- school and university outreach.

Constraints on the provision of reproductive health services in Morocco are:

- weak coordination between departments
- insufficient financial and human resources
- weak information, education and communication efforts towards women
- lack of accessibility and quality of care in some areas
- poverty and illiteracy
- reproductive health is not always considered as a woman's right.

Sexually transmitted infections

Epidemiology

Morocco has been little affected by the HIV epidemic, with less than 1% prevalence in pregnant women. The main route of HIV transmission is heterosexual. The proportion of AIDS cases in women is increasing, from 19% at the

beginning of the epidemic (1986–90) to 42% during 2001–05.

At the same time, sexually transmitted infections are a major public health problem because of their high incidence (370 000 reported cases per year), with actual numbers estimated at 600 000 new cases per year, taking into account undernotification and self-medication. But of these data, 73% of reported STIs are represented by vaginal discharge, and of these, about 50% are caused by vaginitis, which is not always of sexual origin.

National STI control strategy

Control of sexually transmitted infections in Morocco has been a national priority since 1995; and after the relationship between HIV/AIDS and other STIs was clearly demonstrated, the control programme was integrated with the national AIDS control programme. Syndromic case management of STIs, as promoted by WHO, has been adopted.

The first step was to set up a programme management structure, comprising a national STI control programme at the central level, within the Ministry of Health; staff responsible for STI control at provincial level; and a coordinating body involving public health specialists and academics.

The second step was to conduct a STI situation and response analysis, and three studies were conducted in 1996–97 to identify:

- the STI epidemiological profile (trends, most common clinical syndromes and most prevalent STI pathogens) and STI flowchart validity
- STIs patients' and health care professionals' beliefs and behaviour
- STIs quality case management and PI6–PI7 measure.

Three flowcharts were adopted for STI syndromic case management: urethral discharge; genital ulcer; and vaginal discharge and/or lower abdominal pain.

Specific training tools were elaborated, and the national

referral laboratory in the National Institute of Hygiene was strengthened: a molecular biology unit was created and human resources capacities improved.

At the same time, special information sessions were held for physicians and pharmacists from the private sector, in order to encourage them to use the syndromic approach for STI case management.

A monitoring and evaluation system has been defined:

- the information system has changed from monthly reports to one per trimester
- a benchmarking system and annual reviews have been set up
- many studies have been planned and conducted:
 - 1999: STI prevalence among antenatal and family planning clients
 - 2000: serological study on herpes
 - 2001: STI socioanthropological study on women
 - 2001: urethral discharge, drug sensitivity study
 - 2005: STI case management quality assessment study
 - 2007: STI prevalence and vaginal discharge flowchart validation study.

Common actions with reproductive health care

Syndromic case management of STIs has been an integral part of reproductive health services since the latter was implemented as part of primary health care (PHC) services in 1998. Training has involved PHC managers, medical doctors (public health specialists, venereologists, gynaecologists, etc.), information, education and communication experts, and nurses from family planning and mother and child health units. This training was generalized to cover all PHC services between 1998 and 2000.

In 1999, a cross-sectional study among antenatal and family planning clients was conducted to obtain baseline data on prevalence of reproductive tract infections (RTIs) in sexually active women, to identify their aetiology and pathogen frequency, to estimate rate of asymptomatic carriage and identify risk factors for cervical STIs.

In early 2007, a survey on STI prevalence among symptomatic women presenting a vaginal discharge and in sex workers was conducted in order to identify the most common pathogens, to review the vaginal discharge and/or lower abdominal pain flowchart and to validate and adopt a revised one.

The results of this survey will allow the adaptation of the WHO STI/RTI guidelines to the national context, which will be done in close collaboration between the STI control programme and the reproductive health department in the Ministry of Health. Also in 2008, specific training tools for STI case management in women will be elaborated, and training sessions will be held for health care professionals in the public and private sectors and for the staff of nongovernmental organizations.

Rapid tests for syphilis and HIV diagnosis will be implemented in primary health care services within the prevention of HIV mother-to-child transmission programme in two pilot sites.

Pakistan

Current situation

Pakistan is a densely populated country with a population 164 million. Key indicators follow:

- maternal mortality is estimated at 350 per 100 000 live births
- total fertility rate = 4.1 (4.5 rural, 3.3 urban)
- crude birth rate = 30.7
- contraceptive prevalence rate = 30%
- antenatal care (1 visit) = 61%
- tetanus toxoid coverage = 60%
- postnatal care (1 visit) = 32%
- delivery by skilled person = 39%
- median interval between births = 29 months
- prevalence of infertility in Pakistan is 21.9%:
primary infertility is 3.9%
secondary infertility is 18.0%
- age standardized incidence rate (ASIR) of cervical cancer is estimated at 6.8 per 100 000
- unsafe abortion: the national abortion rate is 29 per 1000 women of reproductive age (Population Council, May 2001–May 2003). About 890 000 unsafe induced

abortions occur annually, and about 200 000 women suffer from post-abortion complications each year.

There are no figures regarding breast and cervical cancer. There is no national adolescent health policy; although a draft national youth policy has been prepared it does not include adolescent health.

In recent decades the fertility rate has changed little at 4.1. There is very low postnatal care and almost no improvement in the neonatal mortality rate.

National strategy and achievements

Maternal and child health and reproductive health have been addressed in more than eight programmes/policy documents/projects but in a fragmented manner. The National Maternal and Neonatal Health Policy and Strategic Framework was endorsed in April 2005. A national maternal, neonatal and child health programme worth US\$ 333.3 million for 2006–2012 was approved in April 2007. A strategic partnership proposal was prepared and contains an STI component. National STI management guidelines have been developed, and health care providers are being trained.

Priority areas of the national maternal, neonatal and child health programme

- Provision of skilled birth attendants or community midwives.
- Provision of basic and comprehensive emergency obstetric and neonatal care services.
- Comprehensive family planning services.
- Nutrition interventions (including breast-feeding, appropriate and timely complementary feeding, severe malnutrition management).
- Child survival and development interventions, including neonatal care interventions.
- Integrated management of neonatal and childhood illnesses.

- Advocacy, community organization, social mobilization and health education.
- Strengthening of the health care delivery system (including functional referral system and essential drugs provision)
- Management and organizational reforms.
- Monitoring and evaluation mechanism.

Infertility is also being addressed by the Ministry of Population and Welfare, the Pakistan Family Planning Association and the Ministry of Health.

Constraints

- Delayed implementation of a maternal, neonatal and child health programme.
- Critical mass of skilled birth attendants required which does not match the fertility rate.
- Disintegrated family planning services (between the Ministry of Population and Welfare and Ministry of Health).
- Huge urban/rural disparities.
- Male/mother-in-law dominated society.
- Traditional beliefs.
- Very low male participation in reproductive health.
- Low capacity at provincial and district levels.

Future plans

- Implementation and scaling up of the maternal, neonatal and child health programme.
- Integrated family planning/reproductive health services.
- Development of an adolescent health policy.

- Strengthening and sustaining partnerships for maternal, neonatal and child health.
- More advocacy for reproductive health among politicians, policy-makers, influential groups and leaders.
- Community participation.

7. Group work

The participants carried out two sessions of group work. The first addressed collaborative activities with relevant national programmes on reproductive health and sexually transmitted infections. The second looked at formulating national plans of action for implementation of the WHO global strategies for reproductive health and sexually transmitted infections in the Eastern Mediterranean Region. The programme for the group work may be found in Annex 2a. The detailed results of the group work may be found on the CD-ROM issued to participants at the end of the meeting; the main outcome is presented in the Conclusions and Recommendations sections below.

8. Conclusions

The participants expressed their satisfaction with WHO global strategies on reproductive health and the prevention and control of sexually transmitted infections. These documents are expected to form the basis for developing and updating national strategies with the purpose of ensuring universal access to reproductive health care. However, it was noted that certain issues, such as the reproductive health of menopausal women and cancers of the reproductive system, have not been well addressed.

Sexual and reproductive health affects many different aspects of people's lives, and until now the approach has been piecemeal with little collaborative or multisectoral coordination among the parties concerned. The meeting provided an excellent opportunity for working together in order to develop a holistic approach to sexual and reproductive health as a priority issue that should be an integral part of public health care.

Surveillance, reporting and information systems on sexual and reproductive health have not been adequately developed in the countries of the Region to enable reliable evidence-based decision-making. Improved information will strengthen efforts to mobilize resources from donors such as the Global Fund and target action for community mobilization.

Countries of the Region have recognized the severity of the impact of sexually transmitted infections and reproductive morbidities on individuals, families and national economies, but until now, not enough has been done by countries to address them. The political will towards sexual and reproductive health issues gained over recent years has not been translated into effective and appropriate policy. The sensitivity of certain sexual and reproductive health issues, such as sex education, has been a barrier to further action.

Several countries have begun to implement integrated activities. For example, syphilis screening has been

introduced in antenatal clinics in some countries. There are many other opportunities available in Member States for building and sustaining partnerships, and countries can share their experiences and expertise through regional exchanges and networks such as the Eastern Mediterranean Network on Sexually Transmitted Infection Control.

9. Recommendations

For Member States

Success stories should be documented and reported for submission to the Regional Office so that positive experiences may be shared with other countries.

Countries should review available information and identify priority areas for research into feasible, action-oriented and cost-effective interventions.

National action plans for prevention and control of sexually transmitted infections should be finalized. Plans should be feasible, action-oriented and cost-effective and include a reporting requirement in order to monitor progress.

Countries should strengthen integration between sexual and reproductive health services using WHO global strategies and other supportive tools, building on current successful practices.

Countries should raise awareness of sexual and reproductive health issues amongst the community in order to reduce stigma and broaden access to sexual and reproductive health services. The role of nongovernmental organizations in support of community-based activity should be well recognized and actively solicited.

Groups most at risk should be identified and actively targeted for sexual and reproductive health intervention.

For WHO and other concerned partners

Technical guidelines should be developed to allow Member States to develop and update their national strategies for reproductive health and for prevention and control of sexually transmitted infections in line with WHO global strategies.

The Regional Office should finalize the regional action plan for prevention and control of sexually transmitted

infections.

WHO should continue to provide technical and logistical support for priority research into sexual and reproductive health issues using multicentred methodologies where necessary.

The Regional Office should hold a follow-up meeting within 12 months to review progress and exchange experiences.

Annex 1

Agenda

1. Inaugural session
2. Introduction of participants, election of officers
3. Adoption of the agenda
4. Objectives, mechanics and expected outcomes of the meeting
5. Reproductive health in the Eastern Mediterranean Region
6. Prevention and control of sexually transmitted infections in the Eastern Mediterranean Region
7. Country presentations on existing national programmes, strategies and approaches addressing reproductive health and sexually transmitted infections:
8. Introduction of the Eastern Mediterranean Network of Sexually Transmitted Infections Control (EMNOSTIC)
9. Overview of WHO global strategy on reproductive health
10. Overview of WHO global strategy for the prevention and control of sexually transmitted infections
11. Group work sessions on collaborative activities with relevant national programmes
12. Group work sessions on identifying areas of action for implementation the WHO global strategies on reproductive health and sexually transmitted infections in the Eastern Mediterranean Region
13. Identifying next steps for implementation in countries of the Region the WHO global strategies on reproductive health and sexually transmitted infections
14. Conclusions and recommendations
15. Closing session

Annex 2

Programme

Monday, 29 October 2007

Theme: review current strategies of reproductive health and prevention and control sexually transmitted infections in countries and the Eastern Mediterranean Region, and share experiences and lessons learnt in countries

8:30–9:00	Registration
9:00–10:45	Inaugural session Introduction of participants Election of officers Adoption of the agenda
10:45–11:15	Objectives, mechanisms and expected outcomes of the meeting <i>Dr Hamida Khattabi, Medical Officer AIDS and Sexually Transmitted Diseases, WHO/EMRO</i>
11:15–11:45	Reproductive health in the Eastern Mediterranean Region <i>Dr Ramez Mahaini, Regional Adviser, Women's and Reproductive Health, WHO/EMRO</i>
11:45–12:15	Prevention and control of sexually transmitted infections in the Eastern Mediterranean Region <i>Dr Gabriele Riedner, Regional Adviser, AIDS and Sexually Transmitted Diseases, WHO/EMRO</i>
12:15–12:30	Plenary discussion
13:30–15:30	Country presentations on existing national programmes, strategies and approaches addressing reproductive health and sexually transmitted infections: Afghanistan, Egypt, Morocco, Pakistan

16:00–16:30 Introduction of the Eastern Mediterranean Network of Sexually Transmitted Infection Control (EMNOSTIC)
Dr Amira Médimagh, EMNOSTIC Secretariat Coordinator

16:30–17:30 Plenary discussion

Tuesday, 30 October 2007

Theme: identify appropriate collaborative activities between reproductive health and sexually transmitted infections and identify coordinating mechanisms

9:00–9:30 Overview of WHO global strategy on reproductive health
Dr Heli Bathija and Dr Mike Mbizvo, Reproductive Health and Research, WHO headquarters

9:30–10:00 Overview of WHO global strategy for the prevention and control of sexually transmitted infections
Ms Julia Samuelson, Reproductive Health and Research, WHO headquarters

10:00–10:30 Plenary discussion

11:00–11:30 Briefing for group work sessions on collaborative activities with relevant national programmes

11:30–15:30 Group work

15:30–16:30 Group work presentations

16:30–17:30 Plenary discussion

Wednesday, 31 October 2007 (see Annex 2a below)

Theme: identify priority areas, gaps, constraints, activities and expected results in reproductive health and sexually transmitted infections in the Eastern Mediterranean Region

9:00–9:30 Briefing for group work sessions on formulating a plan of action for the implementation the WHO global strategies on reproductive health and sexually transmitted infections in the Eastern Mediterranean Region

9:30–17:30 Working sessions in two groups

Thursday, 1 November 2007

Theme: identify priority areas, gaps, constraints, activities and expected results in reproductive health and sexually transmitted infections in the Eastern Mediterranean Region

9:00–10:30 Group work (continued)

11:00–11:40 Group work presentations

11:40–12:30 Plenary discussion

13:30–14:00 Briefing for country work sessions on formulating national plan of action for the implementation the WHO global strategies on reproductive health and prevention and control of sexually transmitted infections in countries of the Region

14:00–15:00 Working sessions in country groups

15:30–16:30 Country group work presentations

16:30–17:30 Plenary discussion

Friday, 2 November 2007

Themes: 1) agree on areas for regional focus on reproductive health and sexually transmitted infections and collaborative activities; 2) consider activities and next steps at national level; and identify support needed to operationalize strategies and activities in countries

9:00–10:00 Plenary discussion

10:30–11:30 Major conclusions and recommendations

11:30–12:00 Closing session

Annex 2a

Group work

Theme: accelerating implementation of prevention and control of STIs to identify priority areas, gaps, constraints, activities and expected results

Wednesday, 31 October 2007

9:00–9:15	Action plan to implement global strategy for preventing and controlling STIs
9:15–9:30	Discussion
9:30–9:45	Identifying next steps in the region and the countries: introduction to group work

Strengthening support components; ensuring reliable supply of commodities and medicines

9:45–12:15	Group work on strengthening support components
12:15–13:00	Report back by rapporteurs and discussion

Access to good quality STI care

14:00–16:00	Group work on provision of good quality STI care
16:30–17:15	Report back by rapporteurs and discussion

Thursday, 1 November 2007

Promoting healthy behaviour, reviewing policies and regulations affecting STI control

9:00–11:30	Group work on promoting healthy behaviour, review policies and regulations affecting STI control
11:30–12:30	Report back by rapporteurs and discussion

Advocacy at the regional and national level; promote and facilitate coordinated programming and collaborative action

12:30–15:30 Group work on advocacy at the regional and national level; promote and facilitate coordinated programming and collaborative action

15:30–17:00 Report back by rapporteurs and discussion

Annex 3

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