EM-WHO/WRH/056/E

Report on the Intercountry Meeting of National Managers of Making Pregnancy Safer Programmes in the Eastern Mediterranean Region

Sana'a Yemen
5-8 November 2006

World Health Organization
Regional Office for the Eastern Mediterranean

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1. Introduction

An intercountry meeting of the national managers of Making Pregnancy Safer programmes in countries of the Eastern Mediterranean Region was held in Sana'a, Yemen, from 5 to 8 November 2006. The meeting was organized by the WHO Regional Office for the Eastern Mediterranean (WHO/EMRO) and attended by the managers of making pregnancy safer programmes in Egypt, Iraq, Morocco, Sudan, Syrian Arab Republic, United Arab Emirates and Yemen. Representatives of the Pan Arab Project for Family Health (PAPFAM) at the League of Arab States, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), United States Agency for International Development (USAID) Basic Health Services Project/Pathfinder, International Planned Parenthood Federation (IPPF), Royal Netherlands Embassy, Yemeni Midwives Association, and the Yemen–German Reproductive Health Programme also participated. WHO staff from headquarters, the Regional Office and country offices also attended, along with temporary advisers from Lebanon and the United Kingdom.

The meeting was inaugurated by Dr Arwa Al Rabe'e, Deputy Minister, Population Sector, Ministry of Public Health and Population, on behalf of His Excellency Dr Abdulkarim Rasa'a, Minister of Minister of Public Health and Population. Dr Al Rabe'e highlighted the considerable progress Yemen had made over the past years in the provision of reproductive health services, and maternal and newborn health in particular. Yemen continued to exert extended efforts towards achieving the MDGs. There was strong political commitment and a supportive environment for reducing maternal and neonatal deaths. This had been well expressed in the reproductive health strategy set out in the national five-year plan, 2006–2010. The government had increased financial support for reproductive health, and supportive legislation was currently under discussion by parliament.

Dr Ghulam R. Popal, WHO Representative, Yemen, delivered a message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. In his message, Dr Gezairy noted that the meeting came at a time when the promotion of maternal and neonatal health was high on the health agenda, at both the international and country levels.

The current efforts in the Region were still insufficient to achieve the fifth Millennium Development Goal for improving maternal health. To address this challenge, the Fifty-first Session of the Regional Committee for the Eastern Mediterranean had passed, in October 2004, resolution EM/RC51/R.4, which focused on moving towards achieving the MDGs through investing in maternal and child health. The Regional Office had developed a regional framework, "Strategic Directions for Accelerating the Reduction of Maternal Mortality in the Eastern Mediterranean Region" to guide countries of the Region.

The Regional Office had also embarked on developing appropriate strategies and interventions aimed at improving neonatal health in countries of the Region. The next step would be reviewing and exploring the feasibility of implementing the developed strategies through the existing health care systems in countries of the Region.

Dr Gezairy stressed that too many women in the Region suffered and died as a result of pregnancy-related conditions, most of which could be prevented. Strong commitment, intensive efforts and effective national policies and strategies were now urgently required in order to translate vision into action. Members States, with support from WHO and other concerned partners, had a unique opportunity to make pregnancy safer, decrease maternal mortality and make the achievement of the MDGs a reality.

Dr Arwa Al Rabe'e (Yemen) was elected Chair. Ms Laura Maxwell served as Rapporteur. The programme was modified to include an update on the prevention of postpartum haemorrhage. The agenda, programme and list of participants are attached as Annexes 1, 2 and 3 respectively.

2. Objectives and methodology

Dr Ramez Mahaini, Coordinator, Family and Community Health, WHO/EMRO, briefed participants on the objectives, mechanisms and expected outcomes of the meeting. The last formal meeting with national managers of making pregnancy safer programmes in the Region took place in 1999, and the Regional Office was relying on the current meeting to develop action points and realistic future steps Regardless of country situation, countries should focus on identifying cross-cutting issues. The regional framework entitled *Strategic directions for accelerating the reduction of maternal mortality in the Eastern Mediterranean Region* should be the basis for future plans. The specific objectives of the meeting were to:

- share information and experiences on existing national programmes, strategies and approaches designed to address safe motherhood issues in countries of the Region;
- introduce the recently developed Regional Framework of the Strategic Directions for Accelerating the Reduction of Maternal Mortality, with specific focus on MDG priority countries, and
- identify appropriate mechanisms to operationalize the existing national strategies for making pregnancy safer in line with the Regional Framework.

He explained that the meeting methodology included technical presentations, country presentations and group work. Country presentations would focus on the main strategies, achievements, constraints and existing solutions for making pregnancy safer. For group work, participations would be divided into three groups. The first would examine approaches to political commitment and policy development. The second would identify strategies for partnership and resource mobilization. The third group would devise information, education, and communication strategies for increasing community awareness.

3. Technical presentations

3.1 Global overview on making pregnancy safer: monitoring and evaluation of maternal and perinatal health

Ms Archana Shah, WHO headquarters

The WHO Making Pregnancy Safer Initiative was introduced in 2000, and the Department of Making Pregnancy Safer was established at WHO headquarters in January 2005. The departmental mission is to provide accelerated country support to scale up access to essential interventions to reduce maternal and newborn morbidity and mortality and improve newborn health.

The role of WHO headquarters is to gather evidence and manage knowledge; develop and update norms and tools; provide information, advocate and mobilize resources; foster partnerships within and outside the organization; monitor progress and evaluate programmes; and coordinate technical support.

Regional offices coordinate regional policy and strategy within the global framework; support knowledge management; provide technical support to countries; build regional and national capacity; promote and coordinate intercountry cooperation; advocate; and mobilize resources. The role of country offices includes providing direct, evidence-based support to countries; fostering intercountry and interagency cooperation; and contributing to global and regional normative work.

Support to regions and countries by the Department of Making Pregnancy Safer involves the development of regional and national strategies, and national standards and guidelines on maternal and neonatal health. It also builds capacity in improving skilled care; emergency obstetric and neonatal care; audits in maternal and perinatal health care; integration of malaria and HIV care in maternal and neonatal health

services; and costing of maternal and neonatal health interventions and services.

Technical guidelines produced by the department have included managing complications in pregnancy and childbirth and managing pregnancy, childbirth, postpartum and newborn care.

Recently developed tools have included the MPS Essential Health Technology Package (EHTP) costing tool and the Service Availability Mapping tool. The latter is a decision-making tool which quantifies, estimates, and maps key services and resources. It can be used in monitoring scale up, in informing service and resource planning, and in national monitoring and evaluation.

Other monitoring and evaluation activities have included the WHO global survey on maternal and perinatal health which focuses on the mode of delivery of services, and maternal and perinatal health outcomes. The survey has so far been implemented in 17 countries in Africa and the Americas and will be expanded to other regions.

3.2 Essential health technology package: costing tool for maternal and neonatal health interventions

Dr Matthews Mathai, WHO headquarters

The Essential Health Technology Package (EHTP) is a database of software for general health planning. The EHTP addresses integrated health resource planning and management, optimizing responses to resource needs. It is based on consensus and evidence-based clinical practice guidelines.

The EHTP has four components: clinical guidelines or "scenarios", procedures, techniques and technologies. For maternal and neonatal health, the four scenarios are antenatal care, labour and delivery, post partum care and newborn care (both normal and with complications). Within a given scenario, the software links each procedure (e.g. measuring blood pressure) to a number of associated techniques (e.g. a non-invasive method), and each technique to database of

associated technologies (human resources, medical devices, pharmaceuticals and facilities)

The system allows modelling of resources based on the integration of interventions and health care technologies, and also based on workload, constraints, costs, health and demographic data Both ideal and real scenarios can be modelled

Typical EHTP applications are: health care technology lists; staff norms, skills and competency requirements; costing of interventions; and strategic planning and operational activities, including GAP analysis.

Country implementation is initiated with a preparation phase which consists of sensitization; identification of a core team for training; formulation of objectives and goals; and data collection on costs, resources, and epidemiological profiles. This is followed by training of a core team on use and adaptation of the tool.

Implementation begins in selected districts with support from the core team, and is then gradually scaled up to the national level WHO will continue to provide technical support in the form of training of trainers, training materials, trouble shooting and update of the generic database and software.

3.3 Overview on making pregnancy safer in the Eastern Mediterranean Region

Dr Ramez Mahaini, WHO Regional Office for the Eastern Mediterranean

The Millennium Declaration adopted by the United Nations General Assembly on 8 September 2000 set eight goals known as the Millennium Development Goals. Three of these goals (4, 5 and 6) are health focused. The fifth goal aims to "improve maternal health" The target set for this goal is to "reduce maternal mortality ratio by three-quarters, between 1990 and 2015". For this target, two indicators have been selected to help track progress: maternal mortality ratio; and percentage of deliveries assisted by skilled birth attendants.

Due to the intensified efforts made by Member States, in collaboration with the Regional Office and other partner agencies, maternal health care delivery indicators have been significantly improved since 1990. The percentages of pregnancies and deliveries attended by skilled health personnel increased during this period from 28% to 60% (a 114% increase) and from 36% to 54% (+50%), respectively.

However during the 1990–2005 period, the average maternal mortality in the Region only declined from 465 to 377 per 100 000 live births, a reduction of only 18.9%. If this trend continues, the maternal mortality ratio in the year 2015 will be around 300 per 100 000 live births, while the target of the MDGs is 116 per 100 000 live births.

The main challenges to quality implementation and sustainability of safe motherhood programmes are: insufficient financial and human resource allocations; weak health systems; the current tendency to fund vertical programmes; inadequate pre-service education and in-service training of health providers, coupled by high turnover of the recruited staff; scarcity and poor utilization of reproductive health related data and information; inadequate investment in, and poor recognition of, community-based approaches; and finally, the devastating implications of sanctions, civil conflicts and wars on health.

The document *Strategic directions for accelerating the reduction of maternal mortality in the Eastern Mediterranean Region* was developed by the Regional Office to support national efforts aimed at improving maternal health through formulating appropriate and effective strategies in countries of the Region. The central objective of this regional framework is to ensure safe pregnancy and childbirth through the availability, access and use of quality skilled care for all women and their newborn babies.

The strategic directions highlight the importance of certain operational principles: a continuum of care from the household to higher level facilities; quality of care; integration with primary health care; partnerships between governments, civil society, professional groups, international agencies and donor groups; and good governance, peace and security.

Priority actions highlighted in the regional framework are: achieving political commitment; promoting a favourable policy and legislative environment; ensuring adequate financing, strengthening delivery of health care services; empowering individuals, families and communities; and strengthening monitoring and evaluation (M&E) for better decision-making.

The Regional Office has planned numerous activities for 2006–2007 in support of maternal and neonatal health, with specific focus on Member States with low health indicators (sometimes called MDG priority countries). These involve developing and operationalizing national workplans; provision of technical support for the implementation of MPS strategy (including provision of guidelines and training); and strengthening political commitment to MPS-related issues.

3.4 National Collaborative Perinatal Neonatal Network in Lebanon

Dr Khalid Yunis, WHO Temporary Adviser

The National Collaborative Perinatal Neonatal Network (NCPNN) is a non-profit, multi-disciplinary voluntary collaboration of health professionals in Lebanon, created in 1998. The network was initially restricted to Beirut but was expanded in 2003 and currently includes 17 hospitals in various regions, with a database on over 77 000 newborn infants and their mothers.

The NCPNN's objectives are to improve perinatal, and neonatal health in Lebanon by developing accurate, scientific systems for routine data collection, capable of identifying health problems and inappropriate health practices.

Trained research assistants, nurses and midwives collect data prospectively on all live and stillborn (≥20 weeks) admissions at NCPNN centres. Data are collected on sociodemographics, maternal characteristics, delivery characteristics, and newborn characteristics. Data sources are maternal and neonatal medical charts, and interviews with mothers. Information is uploaded to a website.

Research activities have included a study on consanguinity, medical surveillance (on the prevalence of congenital malformations) and intervention studies/policy making (on the prevalence of caesarean section, on the preconceptional use of folic acid, and on the prevalence and risk factors of group B streptococcus in pregnant women).

Consanguinity is associated with adverse child health outcomes (morbidity and mortality) because it increases homozygosity of recessive alleles. A study, *Consanguinity and congenital malformations: a study of prevalence and association in the Lebanese population* is ongoing. Its objectives are to assess the prevalence and social correlates of consanguinity in Lebanon; the incidence at delivery of overall and specific types of congenital malformations; and the effect of consanguineous marriages on overall and specific types of congenital malformations among newborns. According to preliminary results, the rate of congenital malformation is 4.2% for consanguineous parents, and 2.6% for unrelated parents.

A January 2005 study, *Implementation of an intervention to reduce the caesarean section rate: a collaborative study in Beirut,* examined the documentation status of caesarean sections at two major hospitals in Beirut, using international clinical guidelines. It assessed the impact of the implementation of these guidelines and of confidential provider feedback on the documentation status and on the caesarean section rate. It also assessed the impact of this intervention on perinatal morbidity and mortality.

Other research projects include a follow-up study on the causes of morbidity and mortality during the first year of life, and *Epidemiology of cytomegalovirus in Lebanon: a multicenter study.*

The network publishes two annual scientific reports, holds a weekly perinatal neonatal journal club, and a hosts number of workshops and meetings. Future plans include the consolidation of the perinatal care system in Lebanon, with more centres from the rural underserved areas joining the network. There are also plans to expand the NCPNN concept to other countries in the Region.

3.5 Prevention of post partum haemorrhage: an update

Dr Matthews Mathai, WHO headquarters

Post-partum haemorrhage (PPH) (vaginal bleeding in excess of 500 mL following childbirth) is a major cause of maternal mortality (25% of maternal deaths worldwide). WHO recommends prevention of PPH by active management of the third stage of labour, with use of the drug oxytocin. Oxytoxin must be injected and requires refrigeration. Misoprostol, an alternative drug, can be administered orally and is more stable. There is currently an interest in promoting misoprostol as the drug of choice for prevention of PPH. Small-scale, uncontrolled studies have been done where non-skilled providers have administered this drug. However, there are concerns about the safety of this powerful drug, including the possibility of uterine rupture.

WHO held a technical consultation in Geneva in October 2006 to develop guidelines and recommendations for the prevention of PPH. Based on an extensive process of review and grading of evidence, the expert group recommended that oxytocin should remain the drug of choice for active management of the third stage of labour by skilled birth attendants. There is no evidence to support the practice of active management by non-skilled providers. The guidelines will be published in the near future.

4. Country presentations

4.1 Egypt

The Ministry of Health and Population has implemented a complete health services package for women and children. The integrated package targets high risk areas in Upper Egypt, including rural, non-educated and low socioeconomic areas, where the incidence of mortality and morbidity for mothers and children are particularly high.

The main strategies have been implementing the Integrated Management of Child Illness (IMCI) programme at the national level; competency-based training for health providers; improving the quality, effectiveness and use of family planning services; and information, education, communication (IEC) activities, including building community awareness of danger signs during and after pregnancy. Specific inputs have included implementing an effective essential obstetric care system in Upper Egypt; developing and upgrading the national heath information system (HIS); and implementing a maternal mortality surveillance system.

Between 1992 and 2005, maternal mortality dropped from 174 to 63 per 100 000 live births. Neonatal mortality declined from 39 to 20 per 1000 live births. Infant mortality declined from 73 to 33 per 1000 live births, and under-five mortality decreased from 103 to 41 per 1000 live births.

Multilevel political and administrative support was a key factor in producing these results. Safe Motherhood Committees were supported by a ministerial decree and established at all levels, and there was investment in the development of a strong national maternal morality surveillance system. Future challenges include substituting *dayas* with trained licensed nurses to cover all villages in Egypt and to encourage delivery in a health facility, and

expanding quality services through standardizing and disseminating national competency-based clinical protocols.

4.2 Iraq

In June 2004, the Ministry of Health, in collaboration with WHO, UNICEF and UNFPA, developed a maternal and child health and reproductive health strategy for 2005–2008 in line with the Millennium Development Goals.

Current strategies include the provision and upgrading of basic and emergency obstetric and neonatal care services, and training of staff throughout the health system. Family planning is also being targeted, with better provision of contraceptive services. Improvements are being carried out in the HIS (including registering of births and maternal deaths) and monitoring of the quality of maternal health services.

The changes in government and governmental focal points have resulted in significant constraints to implementation, while the unstable political, economic and security situation has further undermined the services for women and children. Supervision and monitoring of various activities by programme managers are not feasible. In remote areas, social and cultural factors impede use of reproductive health services. Some supplements such as vitamin A are not currently available.

Future activities will include establishing an effective health information and surveillance system and improving monitoring of services to ensure optimal implementation. Activities will also focus on increasing community awareness of the health needs of women, mothers and newborns.

4.3 Morocco

Morocco's maternal and neonatal mortality and morbidity reduction strategy has five components: establishment of quality emergency obstetric care (EmOC) nationwide; promotion of skilled birth attendance; reinforcement of family planning service provision; focused antenatal and postnatal visits; and a MNH-related IEC campaign.

Between 1980 and 2004, the contraceptive prevalence rate among married women aged 15–49 years increased from 36% to 66% in urban areas and from 9% to 60% in rural areas. Between 1987 and 2004, total antenatal coverage increased from 25% to 68% and deliveries attended by skilled birth attendants increased from 26% to 61%.

The shortage and high turnover of staff, inequitable distribution of resources between urban and rural areas, and the under-utilization of MNH services in remote areas are all major challenges. Despite professed political commitment, national budget allocation for health remains low and partnership building is progressing very slowly.

4.4 Pakistan

The situation of maternal and newborn health in Pakistan has steadily improved, but is still falling short of the MDG targets. The current five-year programme is aimed ensuring the MDGs are reached by strengthening, upgrading and integrating ongoing interventions, and introducing new strategies.

Implementation strategies include: strengthening district health systems by improving technical and managerial capacity, and by upgrading institutions and facilities; streamlining and strengthening emergency obstetric and newborn care (EmONC); integrating all MNCH-related services at the district level. Other strategies include introducing a cadre of community-based skilled birth attendants, and increasing demand for health services through targeted, socially acceptable communication strategies.

Challenges have included the recent change in government, the lack of human resources, and the need for better integration with other programmes.

4.5 Somalia

The national goals for maternal mortality reduction are not currently being reached. Challenges have included the lack of human resources in rural areas, and the lack of accountability of the public health system.

There are three main strategies to meet these challenges. Local communities are being involved in managing health institutions at regional, district and village level, including managing budgets. Contracts for local health workers are being made more flexible to improve motivation. Funding is also being increased, along with more timely procurement of equipment.

Recommendations for the future include improving the skills of health workers at all levels of the health care system by adapting guidelines and standards for the management of pregnancy and childbirth. District level management of health services, including the provision of adequate staffing, logistics and equipment should be improved. Family and community education to change attitudes and practices is also recommended.

4.6 Sudan

Sudan was the first country in the Region to implement the MPS initiative (with pilots in two districts in two states). In August 2001, federal and state ministers of health signed the Sudan Declaration on Making Pregnancy Safer. Recent activities have included the development of standards and standard operating procedures based on integrated management of pregnancy and childbirth (IMPAC) guidelines, the midwife services rehabilitation project which upgrades midwifery training and schools, and the development of a Road Map for Maternal and Neonatal Health Reduction.

Priority interventions of the Road Map include upgrading the midwifery cadre to skilled birth attendants; supporting rural hospitals to provide EmOC services; raising awareness of individuals, families and communities on risk signs; strengthening family planning services and developing effective partnerships with the relevant sectors. A MNM reduction council, chaired by the president, has been established, along with a steering committee chaired by the Federal Ministry of Health. Establishment of a MNM reduction council and support teams at state and local levels is in progress.

The size of the country, the scattered population and limited resources are major constraints to implementation of programmes. Sudan is prone to natural and man-made disasters: war has resulted in death, disability, displacement, destruction of health facilities, and migration of human resources. There are high levels of illiteracy and poverty. The health system lacks good management, infrastructure and human resources.

4.7 Syrian Arab Republic

The 2005 study on causes of maternal mortality among Syrian women aimed at investigating the (direct and indirect) medical causes of deaths of women of reproductive age and identifying priorities for intervention based on avoidable factors The study was a retrospective community-based study covering deaths that occurred in 2003.

According to the study findings, 88.4% of maternal deaths had direct causes. Haemorrhage was the most common direct cause of maternal death (66%) followed by hypertension in pregnancy (11%). Wrong diagnosis or mismanagement was the primary cause of death by post partum haemorrhage.

Existing national strategies and programmes for promoting maternal health include: expanding antenatal care particularly in underserved areas (establishing new maternity homes and hospitals and providing equipment); preparing comprehensive national protocols and guidelines for emergency obstetric care; capacity building for service providers (from physicians to midwives) through continuous training based on national protocols and guidelines; increasing community awareness of the importance of antenatal care and obstetrics; coordination between the Ministry of Health and other ministries; and improving maternal mortality data collection.

4.8 Yemen

Strong political commitment to improving maternal and neonatal health has led to the development of a poverty reduction strategy and the establishment of a council for the mother and child. Recent achievements have included the

introduction of needs assessment survey tools for the implementation of EMOC services starting in seven governorates. There has been an ongoing process of discussion between national and developmental partners to update and coordinate the reproductive health strategy and to ensure equity of coverage. Over 2000 community midwives have been trained in the past 2 years.

Maternal and newborn health and family planning are priority components of the 2006–2010 reproductive health strategic directions. Strategies include upgrading health services, building capacity of human resources through the introduction of new qualifications, developing clinical protocols and guidelines, and training community midwives and traditional birth attendants. Health education and community awareness will be improved.

Challenges include high levels of illiteracy. Governmental health expenditure (5.2%) is low and health services are dependent on external funding. Institutional capacity is weak. There is inadequate pre-service training and high turnover of qualified staff. The national MPS information system is weak and there is poor recognition of the role of family and community in health promotion.

5. Group work

The participants were divided into three groups and asked to identify mechanisms for making pregnancy safer in line with the regional framework, according to the following guidelines:

- Group A: Discuss the challenges hindering political commitment and policy development in making pregnancy safer, and identify ways through which these challenges can be addressed and overcome. Elaborate on the manner through which policy development, combined with political commitment can manifest itself in decreasing maternal mortality.

- Group B: Identify ways through which effective partnerships can be developed and resources mobilized. The role that effective partnerships and resource mobilization can play in decreasing maternal mortality in MDG priority countries in the Eastern Mediterranean Region.

- Group C: Identify the required information, education and communication strategies for increasing community awareness and changing behaviours to achieve better pregnancy outcomes, with special attention to suitable mechanisms for delivery in the appropriate key settings.

Group A: political commitment and policy development

The group identified a number of major challenges for political commitment and policy development in MPS in the Region, including: political instability and the high turn over of ministry officials; lack of resources and unfair allocation of budget to the health sector; lack of adequate data to support advocacy; and the socio-cultural environment.

The group stressed that the first stage in overcoming the challenges would be advocacy by all stakeholders

emphasizing legal commitments to the MDGs and drawing comparisons with other countries. The private sector and professional bodies would be involved in developing a strong national health policy, which would result in change in legislation. The ministry of health would coordinate allocation of donor and public resources.

Community education activities in the media and local health facilities would raise awareness of the new policies and facilities and promote women's empowerment.

Group B: partnership and resource mobilization

The group suggested that partnership mobilization should start with a mapping of partners working in maternal and newborn health. This would include existing and potential, and national and local partners. Partnerships between donors, between ministries, and within local communities would be included, and partnership roles clearly defined.

Reliance on local resources would ensure sustainability and avoid duplication of funds. Private-public partnerships should be developed. Ownership by partners would ensure their effective participation and improve sustainability.

National committees on maternal and neonatal health should be re-examined to ensure the involvement of all stakeholders, and similar sub-committees at district and local levels should be established. National and regional networks should be created and would be useful in documenting and sharing success stories and challenges.

Group C: Information, education and communication strategies

Group C pointed to the regional framework as a useful tool in defining, identifying and analysing problems, and in advocacy. All stakeholders should be involved in designing and implementing the IEC process. Local communities should participate in planning; targeting audiences; and designing and testing materials.

Health workers should be involved in advocacy within the community and trained on communicating appropriate messages during service provision. The media and schools could also deliver key messages. Challenges of poverty and illiteracy in local communities could be addressed through using interpersonal communication, simple messages and pictures, involving community and religious leaders, delivering culturally appropriate messages at community gatherings and ceremonies, and making use of social networks.

6. Conclusions

- The participants expressed appreciation for the efforts of the Regional Office in developing and disseminating the regional framework and recognized it as an important strategic tool for strengthening national policies in maternal and newborn health.

- Substantial progress has been achieved by some countries of the Region through translating political commitment and policy development into action.

- If the current trend of maternal mortality in some countries continues, they may not achieve Goal 5 of the Millennium Development Goals. Action is therefore urgently required in these countries.

- There are opportunities that should be utilized for implementing MPS programmes at the national level: the national commitment to achieve the MDGs and the corresponding international and UN efforts for achieving the MDGs with specific focus on Goal 5 (improving maternal health) and Goal 4 (reducing child mortality); Regional Committee resolution EM/RC51/R.4 (2004); the extensive research, known evidence and cost-effective interventions in this area; the establishment of a new department at WHO headquarters to support MPS, and the corresponding increased resources geared towards maternal and newborn health.

- Essential areas recognized as effective in improving maternal and neonatal health are partnerships, advocacy and resource mobilization, all of which can be expanded and strengthened.

- Awareness-raising activities aiming at changing behaviour and empowering individuals, families and communities, specifically those aimed at recognizing danger signs in pregnancy and childbirth and making timely decisions to provide necessary care, have a major impact on maternal and neonatal morbidity and mortality. In addition, underlying (non-medical) causes of maternal mortality should be considered.

- In some countries the limited reporting and information systems are impeding the availability of essential and basic information required for evidence-based planning, implementing, monitoring and evaluation of maternal and newborn health programmes and activities.

- A continuum of quality care from individuals, families and the community to primary and referral level health facilities, and through pregnancy, childbirth, postpartum and newborn care, is recognized as a key approach to improving maternal and newborn survival.

- Operational research and human resources capacity-building in managerial skills are cost effective interventions for strengthening maternal and newborn health care delivery systems in countries of the Region.

7. Recommendations

To Member States

1. Develop or strengthen existing national policies and strategies for making pregnancy safer using the regional framework document *Strategic directions for accelerating the reduction of maternal mortality in the Eastern Mediterranean Region.*

2. Build on the expressed political commitment to improving maternal and newborn health by allocating the necessary budgetary resources at national level and in collaborative plans with WHO.

3. Guide and coordinate donor inputs in maternal and neonatal health based on the mandates of donors and in accordance with national plans and strategies in order to avoid duplication of efforts and ensure optimal utilization of available resources.

4. Report success stories and emerging challenges to the Regional Office for sharing with other countries and interested parties and for advocacy purposes

5. Establish or strengthen the existing health information systems for maternal and newborn health to ensure effective planning, implementation, monitoring and evaluation.

6. Include operational research and human resources capacity-building in managerial skills as integral components of national maternal and newborn health programmes.

7. Report to the Regional Office every six months on maternal and neonatal health activities, using the format agreed in the meeting.

8. Support partnerships at national and sub-national levels that encourage the effective and coordinated involvement of civil society, the private sector, donors, international organizations and UN agencies in the promotion of maternal and newborn health.

9. Utilize existing community-based activities to promote the role of the community in maternal and newborn health and provide the necessary support through evidence-based interventions.

For WHO EMRO

10. Continue to advocate with concerned agencies the need to support the implementation of MPS strategies, especially in countries with low health indicators.

11. Support the piloting of MPS tools in selected countries with a specific focus on the Essential Health Technology Package (EHTP) and other tools for monitoring and evaluation of maternal and newborn health, such as mapping maternal and newborn health services availability.

12. Build country capacity to empower individuals, families and communities to improve maternal and child health and provide countries with the relevant technical guidelines and tools.

13. Continue to build country capacity to implement the Integrated Management of Pregnancy and Childbirth (IMPAC) guidelines and other tools and provide technical support for their adaptation, where necessary, at the national level.

14. Strengthen networks for sharing information, encourage communication between Member States and establish linkages at the country, regional and global levels in support of maternal and child health.

15. Continue to support operational research to build national capacity in evidence-based planning and monitoring of MPS programmes.

16. Advocate with ministers of health to allocate the financial resources required for MPS activities in order to accelerate the reduction of maternal mortality in countries with high maternal mortality ratios.

17. Organize intercountry meetings for national MPS managers on an annual basis to follow up progress and plan the way forward.

Annex 1

Agenda

1. Welcome and opening remarks

2. Introduction of participants, election of Chairperson and Rapporteur

3. Adoption of the agenda

4. Objectives and mechanics and of the meeting

5. Global overview on making pregnancy safer: monitoring and evaluation of maternal and perinatal health

6. Essential health technology package: costing tool for maternal and neonatal health interventions

7. Overview on making pregnancy safer in the Eastern Mediterranean Region

8. National Collaborative Perinatal Neonatal Network in Lebanon

9. Prevention of post partum hemorrhage: an update

10. Country presentations of existing national programmes and strategies for promoting maternal and neonatal health: Egypt, Iraq, Morocco, Pakistan, Somalia, Sudan, Syrian Arab Republic and Yemen

11. Working sessions in three groups:
    A) Political commitment and policy development
    B) Partnership and resource mobilization
    C) Information, education and communication strategies for increasing community awareness

12. Group presentations and plenary discussion

13. Major conclusions and recommendations.

14. Closing session

Annex 2

Programme

Sunday, 5 November 2006

8.30-9.00	Registration
9.00-10.30	Inaugural session
10:30-10:45	Introduction of participants Election of Chairperson and Rapporteurs Adoption of the Agenda
10:45-11:00	Objectives and mechanisms of the meeting Dr Ramez Mahaini, WHO/EMRO
11:00-11:30	Global overview on making pregnancy safer: monitoring and evaluation of maternal and perinatal health, Ms Archana Shah, WHO/HQ
11:30-12.30	Essential health technology package: costing tool for maternal and neonatal health interventions Dr Matthews Mathai, WHO/HQ
12:00-13.30	Plenary discussion
13:30-14:30	Overview on making pregnancy safer in the Eastern Mediterranean Region / Dr Ramez Mahaini, WHO/EMRO
14:30-15:00	National Collaborative Perinatal Neonatal Network in Lebanon / Dr Khalid Yunis, WHO Temporary Adviser
15:00-16:00	Prevention of Post Partum Haemorrhage: an update / Dr Matthews Mathai, WHO/HQ
16:00-16:30	Plenary discussion

Monday, 6 November 2006

09:00-10:30	Country presentations of existing national programmes and strategies: achievements, constraints, future directions for promoting maternal and neonatal health: Egypt, Iraq, Morocco, Pakistan, Somalia, Sudan, Syrian Arab Republic and Yemen.
11:00-11:30	Briefing for group work sessions
11:30-17:30	Working sessions in three groups A: Political commitment and policy development B: Partnership and resource mobilization C: Information, education and communication strategies for increasing community awareness

Tuesday, 7 November 2006

9:00–13:30	Group work
13:30-15:30	Group presentations
15:30-16:30	Plenary discussion
16:30-17:30	Finalizing the group work input

Wednesday, 8 November 2006

9:00– 10:30	Plenary discussion
10:30-11:30	Major conclusions and recommendations
11:30-12:00	Closing session

Annex 3

List of participants

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