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SCALING UP HIGH-IMPACT FP/MNCH BEST PRACTICES IN THE ASIA/NEAR EAST REGION

TECHNICAL MEETING: BANGKOK, THAILAND
SEPTEMBER 3-8, 2007

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DISCLAIMER

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CONTENTS

ACRONYMS.....	iii
ACKNOWLEDGEMENTS	v
EXECUTIVE SUMMARY.....	1
I. OPENING SESSION.....	3
II. ORGANIZATION OF THE CONFERENCE	5
III. TECHNICAL PLENARIES: GATEWAYS TO THE MDGs	7
IV. COUNTRY ACTION PLANS TO SCALE UP EVIDENCE-BASED BEST PRACTICES	19
V. EVALUATION	21
VI. BEYOND THE TECHNICAL MEETING	23

APPENDICES (separate volume)

1. LIST OF PARTICIPANTS
2. COUNTRY TEAM FACILITATORS
3. SUMMARY OF COUNTRY ACTION PLANS
4. EVALUATION INSTRUMENTS
5. EVALUATION RESULTS

ACRONYMS

AIIMS	All India Institute of Medical Sciences
ANC	Antenatal care
ANE	Asia and the Near East
CHW	Community health worker
DHS	Demographic and Health Survey
EmOC	Emergency obstetric care
EmNC	Emergency newborn care
ESD	Extending Service Delivery
FP	Family planning
IMCI	Integrated management of childhood illnesses
IMNCI	Integrated management of newborn and childhood illnesses
LAM	Lactational amenorrhea method
LAPM	Long-acting and permanent methods
M&E	Monitoring and evaluation
MAT	Maternal health session
MDG	Millennium Development Goals
MOH	Ministry of Health
NIC	Newborn, infant, and child health session
MNCH	Maternal, newborn (neonatal), and child health
MOHP	Ministry of Health and Population
NGO	Nongovernmental organization
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
RH	Reproductive health
SBA	Skilled birth attendant
SDM	Standard days method
USD	United States dollars
WHO	World Health Organization

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- World Health Organization (WHO)
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- MotherNewBorNet
- White Ribbon Alliance for Safe Motherhood
- Quality Assurance Project
- Health Policy Initiative
- Implementing Best Practices in Reproductive Health
- Extending Service Delivery Project (ESD)

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EXECUTIVE SUMMARY

This report summarizes the proceedings of the technical meeting, Scaling Up High-Impact FP/MNCH Best Practices in the Asia/Near East Region, which took place in Bangkok, Thailand, September 3–8, 2007. The 450 participants represented more than 15 countries and came from governments, donors, and nongovernmental and other organizations.

This meeting report describes the opening session, highlights of the daily plenaries, country consultations, and evaluations of the plenaries and technical sessions. It also provides information on activities that participating countries have since undertaken.

The plenary sessions covered three technical topics—newborn, infant, and child health; maternal health; and family planning (FP)—and three themes that crossed technical boundaries—scaling up, integration, and cross-cutting areas, such as financing, monitoring and evaluation, nontraditional linkages, and advocacy and policy.

Key messages in the newborn, infant, and child health plenary related to the need to focus on neonates as a target population within the broader spectrum of child health; the role of trained community health workers in closing access gaps; leveraging donor resources and building upon donors' respective manageable interests; and rigorous monitoring and evaluation.

The maternal health plenary reviewed the epidemiology of maternal deaths, findings and recommendations from the Lancet Series on maternal survival, and evidence-based interventions such as emergency obstetric care; skilled attendance at birth; narrowing the equity gap between the rich and poor; providing quality services at the facility level while recognizing the need to address home birth care; and improving the tracking and monitoring of pregnancies and deliveries.

The family planning plenary presented successful strategies and recommendations to improve FP programming and examined how public and private sector strategies address quality, informed choice, and access to contraceptives. In this plenary, USAID technical priorities for the Office of Population and Reproductive Health were presented and the link between pregnancy spacing and lower mortality rates, based on evidence-based data were presented. The data showed a dramatic reduction in infant and child mortality rates when women space their births two years apart. The uptake of FP at the individual level was stressed, as well as the contribution of FP towards improving the economy and environment, alleviating poverty and improved health of newborns and children.

The scaling-up plenary discussed factors that influence scaling-up and the use of improvement collaboratives as a methodology for helping health personnel overcome barriers to scaling-up. This plenary also served as a reference point for prioritizing best practices learned at the meeting so participants could judge which might be relevant for scaling-up in their home settings.

In the integration plenary, speakers synthesized the technical themes of the meeting by describing their experiences with integration models and their successes and struggles. The session delineated three distinct models for integrating FP and maternal, newborn, and child health services.

An important part of the meeting was the opportunity for participants from the same country to meet as a team and develop plans for applying and adapting best practices for use in their country's unique circumstances. USAID and the ESD project will facilitate and support implementation of the action plans. The country consultation process is discussed in this report, and the 13 country action

plans drawn up as a result of the meeting are discussed in Appendix 3.

Additional detailed information on the meeting, including the nearly 150 technical presentations, an analysis of the country action plans and the ANE technical meeting report, are available at the ESD project web site, [www.esdproj.org/site/PageNavigator/Conf ANE Meeting](http://www.esdproj.org/site/PageNavigator/Conf_ANE_Meeting).

I. OPENING SESSION

Gary Cook, Senior Health Advisor, USAID Bureau for Asia and the Near East (ANE), opened the meeting with an eloquent speech describing the current state of the world's children. He acknowledged each of the ANE country delegations and introduced the panel of speakers:

- Dr. Sapon Mekthon, Government of Thailand
- Dr. Daisy Mafubelu, Assistant Director-General, Family and Community Health, WHO
- Dr. Ian Pett, Senior Advisor, Child Survival and Development, Regional Office of South Asia, UNICEF
- Dr. Giri Giridhar, D.Sc., UNFPA
- Mr. Dan Pellegrom, President, Pathfinder International
- Dr. James D. Shelton, Senior Medical Advisor, USAID Washington
- Ms. Milka Dinev, Project Director, ESD
- Mr. Richard W. Whelden, Acting Mission Director, USAID Regional Development Mission for Asia

Mr. Cook then gave an overview of the progress in child survival and maternal health, focusing on the importance of hope. He discussed the variables working against aspirations and goals in international health: (1) lack of funding for programs; (2) political upheaval and unrest in some countries; (3) lack of trained health personnel; (4) ignorance and illiteracy; (5) crushing poverty in target groups; (6) lack of coordination among agencies; and (7) insufficient time. Despite these challenges, there is promise for the future:

- Global communication has improved with the Internet and telecommunication technologies.
- Monitoring and evaluation (M&E) techniques have improved much faster in the health sector than in other sectors.
- Scientific breakthroughs have placed new tools at the disposal of the international health community (e.g., new oral rehydration salts, vitamin A, zinc, and improved contraceptive technology).
- A large body of evidence supports the use of new best practices.
- More is known today about what does and does not work.

After highlighting current challenges and progress in this field, Mr. Cook then turned to the goal and objectives of the Bangkok Technical Meeting:

Goal: To disseminate high-impact maternal, newborn, and child health (MNCH) and family planning/reproductive health (FP/RH) best practices for scaling up in the ANE region to achieve the Millennium Development Goals (MDGs).

Objectives:

- To increase participants' knowledge of and capacity to implement proven, high-impact FP/MNCH best practices in the ANE region (**learning opportunities**).
- To allow health practitioners to participate in field-directed presentations, discussions, and

skill-building sessions so that country teams can learn from each other and apply the lessons at home (**South-to-South learning**).

- To strengthen relationships within country teams and forge relationships with other country teams (**working as efficient teams to accomplish more**).
- To build new networks and strengthen existing networks of people and organizations throughout the region (**getting to know each other**).

II. ORGANIZATION OF THE CONFERENCE

Approximately 450 participants attended the conference from 15 countries in the ANE region and the United States (U.S.). Representatives came from national and local ministries of health, universities, foundations, local and international nongovernmental organizations (NGOs), United Nations (UN) agencies, and the donor community (including USAID/Washington, USAID missions, and their contractors and independent consultants). There was also broad representation among disciplines; senior management, programmers, and researchers alike attended.¹ The presenters were global health leaders from an array of professional disciplines affiliated with premier institutions.

The five-day technical meeting was organized into six thematic sessions that covered both technical topics and issues that applied to all technical areas.² The three technical themes were:

- neonatal, infant, and child health (NIC)
- maternal health (MAT)
- family planning (FP).

Themes that stretched across technical areas were:

- scaling-up as a policy model
- integration of the technical areas
- cross-cutting themes, including, among others:
 - financing
 - M&E (three sessions)
 - nontraditional linkages (such as with religious leaders and men)
 - advocacy and policy.

A plenary was convened for all themes except cross-cutting. These plenary sessions were well attended by the vast majority of meeting participants.

Because many technical areas had subcategories or tracks, presentation times were varied so that participants interested in particular tracks could attend all the related presentations. The schedule was also adjusted to accommodate presentations in high demand, some of which were given more than once.

Many participants learned about new interventions tested in the region, such as the use of misoprostol to prevent postpartum hemorrhage; community health worker (CHW) administration of oral gentamycin to reduce infections in the first week of life; newborn dosing with vitamin A after the first week of life; village preparedness to address obstetric emergencies (such as the Alert Villages in Indonesia); application of healthy timing and spacing of pregnancies interventions to promote and increase FP use; and financing tools and methods for measuring the cost of scaling-up. In general, the NIC and MAT sessions drew the most participants; those marked with an asterisk (*)

¹ For a full list of participants and their affiliations, please see Appendix 1.

² For a complete list of sessions and abstracts, please see the meeting information at www.esdproj.org/site/PageNavigator/Conf_ANE_Meeting.

were repeated:

- NIC-1: Essential Care for All Newborns
- NIC-2: Let the Low Birth Weight and Preterm Babies Live!
- NIC-3: Newborn Infection Prevention and Management in Resource-Poor Settings
- MAT-2*: Enabling Women to Protect Themselves from Postpartum Hemorrhage During Home Births
- MAT-5: Empowering Communities for Improved Maternal and Newborn Health Outcomes
- FP-1*: Family Planning Through the First-Year Postpartum
- SCL-1: Scaling-up Community-based Skilled Birth Attendants
- SCL-4*: Improvement Collaboratives: An Approach to Spreading Best Practices
- CC-3*: Nontraditional Linkages with High Impact Results: Involving Religious Leaders and Men in Family Planning and Maternal, Newborn and Child Health

The e-Learning room proved to be very popular and successful. Equipped with 15 computers, it was open around the clock. During the day, most computers were in use and in the late evening hours about half were. Many members of country delegations diligently completed most of the modules, and all members of the Jordan and Pakistan teams completed the entire course.

At the end of each day, country team meetings were held. The 13 country teams met to review the technical presentations of the day and to discuss applying and scaling-up of appropriate FP/MNCH best practices in their individual country settings. Based on the learning and new information about the evidence-based best practices and each country need, the country teams developed action plans for scaling-up country-specific best practices. The action plans were then presented in 3-4 groups of country team presentations for peer review on the last day of the conference. Action plans are presented in Annex 3.

III. TECHNICAL PLENARIES: GATEWAYS TO THE MDGs

Each morning the conference was launched with a plenary featuring global experts—policy makers, clinicians, technical leaders, advocates, and donors—who presented their perspectives on best practices based on lessons learned across the region.³

SCALING-UP NEWBORN, INFANT, AND CHILD PROGRAMS:

THE GLOBAL MANDATE

Panelists at the NIC Plenary represented India's Premier All India Institute of Medical Sciences (AIIMS), UNICEF, the Bill & Melinda Gates Foundation,⁴ USAID, the World Health Organization (WHO), and the Ministry of Health (MOH) of Nepal. The objectives were to identify state-of-the-art NIC interventions and to describe how the institutions represented are working to scale up these interventions.

Vinod Paul, Neonatologist, AIIMS, laid the foundation for the plenary by citing such startling statistics as:

- 40 percent of newborn deaths occur by the end of their first day of life.
- 73 percent of newborn deaths occur within the first week—the vast majority of them at home.
- Sepsis and pneumonia account for some 74 percent of all deaths, followed closely by asphyxia.
- The number of deaths due to neonatal tetanus has been reduced to less than 40 percent, but the path is still uphill in some hard-to-reach populations.
- Colostrum has a dramatically beneficial effect on newborn survival. The risk of neonatal death among children who were breastfed within one hour of birth was only 0.7 per 1,000 live births, compared to 4.2/1,000 when breastfeeding was initiated only after three days.

Dr. Paul advocated for deliveries at subdistrict primary health centers that have access to referral care when needed, citing the 2005 Lancet Series on Maternal Health: “A health centre intrapartum-care strategy can be justified as the best bet to bring down high maternal mortality.” Good clinical care can prevent 23 to 50 percent of all neonatal mortality, particularly emergency care for sepsis and pneumonia particularly in low birth weight newborns; basic care during childbirth (breastfeeding, hygiene, and warmth, especially instituting Kangaroo Mother Care); and administration of medicines. Dr. Paul emphasized the importance of CHWs in encouraging increasing coverage, but pointed out if they are to be successful, CHWs need to be given (a) focused tasks, (b) training, (c) remuneration, (d) supervision, and (e) community support. Dr. Paul concluded that the hope for newborn survival is contingent on close community linkages to the formalized health system.

Nancy Terreri, Senior Advisor and Team Leader, UNICEF, discussed “Strategies and

³ Refer to the program guide for abstracts and a complete listing of the panelists for each plenary. For references to data cited in this report, please see the specific presentation. All documents and presentations related to this meeting are available at www.esdproj.org/site/PageNavigator/Conf_ANE_Meeting.

Programming for Newborn & Child Health.” The talk was framed by the five core areas for UNICEF action: (1) getting results for children and women; (2) strengthening the evidence base; (3) measuring results; (4) partnerships and leveraging; and (5) program communication and advocacy. Ms. Terreri pointed out that in integrated management of childhood illnesses (IMCI), practitioners now have two algorithms to work with—one for the neonate and one for the infant (2-11 months). Similarly, emergency obstetric care (EmOC) has been transformed into emergency obstetric and neonatal care (EmONC). Another recent innovation has been the Community Model, which addresses home-based maternal and newborn care and offers a birth plan to be used during home visits. Ms. Terreri highlighted the benefits of UNICEF’s training package for CHWs that facilitates the assimilation of pregnant women into the community health system and prepares them for healthy births.

Al Bartlett, Senior Advisor for Child Survival, USAID/Washington, took stock of the final proceedings of the 2004 ANE State-of-the-Art (SOTA) Meeting, which provided program continuity and directions by identifying the best mix of system strengthening, demand creation, and community and public-private approaches. Dr. Bartlett’s chief concern was the mortality reduction that can be achieved by scaling-up interventions based on epidemiological evidence. Since 1983, there have been substantial decreases in postneonatal mortality (1-11 months) but much less progress in reducing neonatal deaths (0-28 days), which have dropped only a few points.

Dr. Bartlett cited Bangladesh, Cambodia, Nepal, and Afghanistan as having significantly reduced child mortality. Newborns have benefited greatly from such interventions as essential newborn care, sepsis prevention and treatment, and special care for low birth weight babies, soon to be supplemented by others on the horizon like neonatal vitamin A supplementation and chlorhexidine washes. Nonetheless, breastfeeding is the single most important intervention for reducing mortality. Babies who are not breastfed have an almost six times greater risk of dying before two months of age than those who are breastfed.

Dr. Bartlett structured his presentation in terms of what *has* changed and what *has not*. Using the new USAID Foreign Assistance Framework, at the field level delivery and integration of interventions along the continuum of care have changed. However, from an access perspective MNCH services are still not reaching many of the poor. Only 63 percent of sick children are taken for care and of these only a scant minority goes to public health facilities. Most sick children under 5 are seen by private practitioners, formally organized or not. In Bangladesh, for example, 40 percent of those who are seen for care go to untrained providers, and another 12 percent go to traditional healers, so that over half of all sick children are treated outside the formal health sector.

He concluded that USAID’s comparative advantage is to create and evaluate innovative MNCH program approaches at the country level. The donor community should set targets for decreasing mortality rates and link systems to outcomes. This can be done in part by involving the private sector along with the public. Donors continue to learn how to complement their contributions.

Jose Martines, Coordinator, Newborn and Child Health, WHO, presented “From Global Recommendations to Implementation Strategies for NIC Health.” He first described WHO’s role in achieving universal coverage: To support an evidence-based cycle, WHO is assisting countries to generate science and based on the findings to develop implementation guidelines and tools. WHO values measuring and evaluating impact to help identify and resolve global health problems.

WHO works hands-on in the field with partners to prepare and implement country work plans. It also helps to adapt regional strategies to country circumstances. A mutually agreed framework for

strategy development includes tools for analyzing situations, prioritizing interventions, packaging, and planning. Beyond strategy, WHO's support includes developing human resources and instruments for delivering services at different levels and promoting accountability. Assessments of country progress are based on survey data and qualitative outputs from sound M&E systems.

Y.V. Pradhan, Director, Child Health Division, Department of Health Services, Ministry of Health & Population (MOHP), Nepal, presented his government's strategies. Nepal's public health program is built upon female CHWs who are responsible for, among other functions, vitamin A distribution, community-based management of pneumonia and diarrhea, and involvement with immunization and FP programs.

One of Nepal's more innovative and positive programs is the National Skilled Birth Attendant (SBA) Policy, which sets SBA training targets and gives a cash incentive for facility-based delivery. Two projects—the Morang Innovative Neonatal Intervention and the Mother Infant Research Activities Project—that focus on CHW management of neonatal sepsis are being tested for scaling-up. Nepal is targeting the neonate with a community-based neonatal care package that increases the emphasis on the newborn in its safe motherhood and child survival programs. Dr. Pradhan described Nepal's successful child health approach as a three-step process: (1) introduction of policies and strategies; (2) tests of scalable models; and (3) refinement of the models for gradual scaling-up, giving special attention to quality and coverage.

The consensus of the plenary session was that though great strides have been made to reduce post-neonatal deaths (1-11 months), newborns continue to die. However, innovations in child survival interventions have helped reduce newborn deaths at least modestly. Evidence-based interventions such as vitamin A, chlorhexidine, and adaptation of management tools like EmONC and Integrated Management of Newborn and Childhood Illnesses (IMNCI) are also helping newborns survive. At base, however, breastfeeding is the mainstay for newborn and infant survival. Meanwhile, systems management tools promote forward thinking through informed and balanced strategic planning.

During the NIC plenary, donors spoke often of the importance of leveraging their resources to build upon their interests, and of measuring progress through rigorous M&E. Access to services is a perennial challenge; the poorest of the poor, who would benefit the most, have least access. Respect for the role of CHWs in connecting the community with the system was also a recurring theme. With the right training and skills, CHWs can be essential in closing access gaps between socio-economic quintiles.

Another central message was the importance of neonates as a target population within the broader spectrum of children under 5. Promising interventions are continually being tested as possible reinforcements for such mainstays as breastfeeding promotion, support for CHWs, and better M&E.

MATERNAL HEALTH PLENARY: Catalyzing and sustaining change: strategies for improving maternal health and achieving Millennium Development Goal 5

The objectives of the maternal health plenary were to identify strategies to increase maternal survival and to describe initiatives supported by major donors and the government of India. Speakers also reviewed the epidemiology of maternal deaths and recent findings and recommendations from the Lancet Series on maternal survival. All speakers underlined the importance of skilled attendance at birth.

Marge Koblinsky, Director, Public Health Sciences Division, International Centre for Diarrhoeal Disease Research, Bangladesh, a longtime leader in the international effort to reduce maternal mortality, opened the plenary with a petition to change the strategic focus of maternal health programming: “All women should deliver in health facilities with midwives working in teams.” Evidence has shown that home births, whether with CHWs or traditional birth attendants, have not been as effective as expected. Dr. Koblinsky argued that the health facility is more efficient because it achieves higher coverage rates than attendance on either end of the care continuum—home and hospital. (Health facilities include health centers, birthing centers, and maternity homes.) This strategy has the greatest impact on mortality. As skilled attendants, midwives can provide a package of proven interventions known to avert mortality and morbidity.

Unfortunately, Dr. Koblinsky pointed out, in the ANE region (excluding China and Israel), only 43 percent of women have a professional attend their deliveries. This is one explanation for why almost half of all maternal deaths in the world (47%) occur in the ANE region. Maternal mortality is the public health indicator that draws the line between rich and poor countries.

Josephine Sauvarin, CST (Country Technical Services Team), Adviser on Reproductive Health and Family Planning Programmes, East and South East Asia, UNFPA (speaking on behalf of Vincent Fauveau), explained that UNFPA-supported programs emphasize building maternal care capacity, particularly for those with midwifery skills. Ms. Sauvarin focused on such opportunities as interagency coordination as manifested by UN partnerships. Increased funding demonstrates UNFPA’s commitment to integrating maternal health into RH programs. The agency emphasizes internationally recognized evidence-based technical interventions and increasing knowledge, which in turn generates political commitment. She outlined recent UNFPA accomplishments: (1) building national consensus for planning and management (the “Three Ones”: one national plan, one national coordinating mechanism, and one national M&E system); (2) costing national health plans and scaling up; and (3) indicator refinement (e.g., EmOC process indicators and sampling approaches for measuring maternal mortality).

UNFPA’s strategic vision of reducing maternal mortality emphasizes access to contraceptive services and FP, skilled attendance at birth supported by functional health systems, and EmOC. Ms. Sauvarin concluded by emphasizing challenges that remain, such as getting agreement on strategies (e.g., the role of communities and home vs. facility births), raising the status of midwives, division of responsibilities and accountability, ensuring funding for scaling up, exploring financing mechanisms to improve equity, and testing new indicators.

Continuing with the skilled birth attendants theme, **Monir Islam, Director, Department of Making Pregnancy Safer, WHO/Geneva**, presented data from the Demographic and Health Surveys (DHS). Dr. Islam posited that the plethora of DHS data are not used to their optimal potential. He presented an array of slides representing all regions of the developing world. At 44.3 percent of skilled attendance at birth South and Southeast Asia are barely above the 42.5% total for sub-Saharan Africa.

He also presented data to demonstrate wide urban-rural disparities: Up to 91 percent of all rural births in South and Southeast Asia are not attended by skilled care (DHS 2001–06). In addition to urban-rural differences, there are large inequities between the highest and lowest income quintiles. Bangladesh, for instance, is one of the three countries with the highest discrepancy in skilled attendance at birth between well-off and poor women. He also presented other interesting maternal health indicators for individual countries. For example, Indonesia’s teenage pregnancy rates have fluctuated little since 1987; the 2002/03 DHS recorded 12.1 percent.

Nahed Matta, Senior Maternal and Newborn Health Advisor, USAID/Washington, reported on USAID priorities for MNCH relative to funding for other topical areas. The ANE Region receives 22 percent (\$379 million USD in 2005) of all USAID health funding other than that for the Global Fund. USAID's MNCH priorities are focused on (1) SBAs, (2) prevention of postpartum hemorrhage, (3) newborn and postpartum care, (4) focused antenatal care (ANC), and (5) fistula prevention and repair. One of USAID's strategic approaches is development and dissemination of a basic package for MNCH that delineates the minimum activities needed at the facility and community levels. This basic package, known as "MAMAN," has been incorporated into USAID's Child Survival and Health Grants Program in 18 ANE countries. Specifically, USAID's approaches incorporate the following:

- Scale-up high-impact best practices.
- Mainstream newborn health into all maternal health programs
- Encourage synergies with other programs (prevention of mother-to-child transmission of HIV (PMTCT), Malaria in Pregnancy), and incorporate MNCH components into FP/RH programs
- Emphasize community-based approaches for MNCH care (with links to health facilities)
- Encourage comprehensive EmONC and the continuum of care
- Provide a basic MNCH package of care developed through USAID Missions and NGOs

Dr. Matta concluded by reviewing how MNCH interventions relate to other health topics in 18 ANE countries. She left the audience with hope, noting that over the past 10 years maternal mortality has fallen in 11 ANE countries, with declines ranging from 21–52 percent.

H. Bhushan, Assistant Commissioner, Maternal Health Division, Ministry of Health and Family Welfare, Government of India, concluded the maternal health plenary with a country-specific perspective. Dr. Bhushan gave a brief overview of indicators that underscore the global impact of India's maternal deaths. Every year in India there are approximately 28 million pregnancies, followed by 25 million deliveries. As is common, 15 percent of the pregnancies develop complications that cannot be predicted. This translates into 77,000 maternal deaths a year. Indian data confirm the inequities in maternal outcomes described by previous panelists: The maternal mortality ratio is 301/100,000 live births, but this masks vast differences between states—Kerala's ratio is 110/100,000 live births but Uttar Pradesh's is 517/100,000 (data source: SRS). Still, the national maternal mortality ratio has been on a steady decline since 1960, when it was estimated at 1,231/100,000 live births. Hemorrhage accounts for 38 percent of the deaths, followed by "other conditions" (34%) and sepsis (11%).

The main strategies guiding India's maternal health program are (1) provision of critical services in government facilities, with an emphasis on EOC and EmOC that includes skilled attendance at birth (home or facility) and strong referral systems; (2) management of sexually transmitted infections at the facility level; (3) decentralized planning; (4) targeting rural and underprivileged groups; (5) basic skills training; (6) national, state, and district Quality Assurance Cells; and (7) preservice and inservice training for doctors, nurses, and midwives. Beyond the national strategies there are a variety of promising innovations at the state and local levels, such as village delivery huts; use of private obstetricians; free transport for pregnant women; birth companions; monitoring services through a "central control room"; and outsourcing management of primary health facilities.

All maternal health plenary panelists emphasized evidence-based technical interventions such as EmOC and skilled attendance at birth. The ANE region has enjoyed successes in reducing the

number of maternal deaths, but it is still very important to narrow the equity gap between the rich and poor. While there is a movement to provide quality services at the facility level, the need to address home birth care is also recognized. Improving the tracking and monitoring of pregnancies and deliveries calls for new ways to identify women who fall into service delivery gaps.

FAMILY PLANNING PLENARY: Past progress and promising directions for FP in Asia and the Near East

The FP plenary presented successful strategies and recommendations to improve FP programming. The panelists reviewed public and private sector strategies, examining how they address quality, informed choice, and access to contraceptives. The commentary was illuminated by both micro and macro perspectives.

James Shelton, Science Advisor, USAID/Washington, began by giving an overview of the benefits of FP, including data showing that longer birth intervals are associated with lower mortality rates. There are dramatic differences in neonatal and child mortality rates when women space their births two years apart or less rather than three years apart. Sadly, most women living in ANE countries (about 60 percent) report spacing their births less than three years apart. For example, in Jordan 76 percent of women space their births less than three years apart and 45 percent space them less than two years apart. Indonesia offers the most promising data, with 36 percent of births spaced less than three years apart, and only 15 percent less than two years.

Dr. Shelton then presented USAID's technical priorities for family planning and reproductive health:

- Healthy timing and spacing of pregnancies (HTSP)
- Long-acting and permanent methods (LAPM)
- Community-based FP services (both public and private, with an emphasis on injectables)
- Integration of FP and HIV programming
- Integration of FP and MCH programming, especially postpartum FP, postabortion care, and immunization services
- Contraceptive security

Dr. Shelton also discussed specific categories of contraceptive methods (the standard days method [SDM] and LAPM) and tools. He described the benefits of long-term use of SDM. Typically, pregnancy rates of SDM users drop from 12 percent after one year of use to five percent after two years and three percent after three. Dr. Shelton attributes LAPM successes to (1) nurturing champions at all levels; (2) a focus on the benefits of FP as perceived by clients and providers; (3) tailoring programs to early adopters and client satisfaction; (4) building scale-up in during the planning and design phases; and (5) realistic program goals and schedules.

Dan Pellegrum, President, Pathfinder International, spoke passionately to the point that FP is actually a euphemism having different meanings for different people. Perspectives range from the personal (micro) to the societal (macro). He believes there is general agreement on the importance of FP even though not all might prioritize the benefits the same way. While FP is important to an individual woman's life, on a population scale FP improves economies and the environment, which alleviates poverty and improves the health of newborns and children.

For the first time in history, Mr. Pellegroni said, this year more people will reside in urban areas than rural. Asia's urban population will double between 2000 and 2030. Of the 13 countries that account for 67 percent of all maternal deaths, six are in Asia; India is first and Pakistan is third.

Mr. Pellegroni submitted that what matters most is not what we do to contribute to women's right to manage their own fertility, but how well we do it.

Rehana Ahmed, Reproductive Health Specialist, MDG Center, Nairobi, Kenya, answered the question: "Can the Private Sector Assist in Meeting National Needs for Family Planning?" She offered evidence from 38 countries on the use of out-of-pocket payments for private health providers. Preference for private providers is based mostly on client perceptions that they provide better care than the public sector does. Yet the private sector is made up of diverse groups, and there are pronounced differences in the quality of services. Private providers have the advantage of being flexible but as a group they have weaknesses—the most prominent being their lack of continuing education. Dr. Ahmed cited the Pakistan Greenstar social marketing program as a private sector success that accounts for 30 percent of government FP services.

One of Dr. Ahmed's key messages was to divert patients to the private sector who are willing to pay a fee, however nominal, since that is the expectation of those providers. The role of the government should be to provide services to people living in abject poverty. She hopes the private sector would be proactive and demonstrate a commitment to collaborating with the public sector. She advised the public sector to consider the whole system (including the private sector) in their plans. She also urged donors to integrate private sector components into their development portfolios and advocate for public-private collaboration.

The plenary offered participants a broad view of the current state of FP. An outline of USAID technical directions, espousing FP's significance within the global context, and a call for increased attention to the role of the private sector were among the highlights of this session.

SCALING-UP PLENARY: Using effective change processes for scaling up FP/MNCH practices

The basic tenet of this plenary was that change processes are pivotal to sustainable scaling-up of each best practice. The panel discussed considerations that would increase the likelihood of successful scaling-up and factors that influence it. The intent was for participants to use the criteria presented to determine the potential for scaling-up a best practice in their own country. Improvement collaboratives were presented as a management methodology for helping health personnel overcome barriers to scaling-up and sustain the change process.

Jonathan D. Quick, President and CEO, Management Sciences for Health, opened the session by giving a report card on ANE country-specific progress on the MDGs. Of the 29 ANE countries discussed, 10 are moving ahead, but the rates are highly variable. Most of the ANE countries are at risk of, or already are, falling behind in achieving their targets.

Dr. Quick explained a new paradigm in international development that encompasses (1) forceful advocacy at all levels; (2) local leadership and partners; (3) a focus on measurable results; (4) performance-based funding; (5) public-private participation/partnership; and (6) an emphasis on funding of medicines and other health products.

Engaging a wide range of stakeholders was a theme woven throughout Dr. Quick's presentation. In the Philippines, he said, local government works with local health personnel to reduce the unmet

need for FP. The involvement of religious leaders in Afghanistan has increased contraceptive prevalence rates. And in Africa as a whole, treatment with antiretroviral drugs for HIV/AIDS has been scaled-up within just five years: people with access to antiretrovirals rose from about 100,000 in 2002 to about 1.3 million in 2006 (WHO, 2006).

Timothy R. Allen, Deputy Director, Center for Leadership and Management, Management Sciences for Health, discussed a theory of effective change that involves “diffusion of innovation.” He posited that there are three main “clusters of influence” in the diffusion of innovations: (1) the perceptions of an innovation; (2) the characteristics of adopters; and (3) contextual factors. Mr. Allen ranked the perceived benefit of an innovation to be the most crucial perception, followed by compatibility, complexity, “trialability,” and observability. When the conventional bell curve is used to lay out the characteristics of adopters, the innovators are found at one end, accounting for only 2.5 percent of all adopters, and only 13 percent are early adopters. The laggards at the other end add up to 16 percent. Thus the majority of adopters (68%) come on board mid-way through the change process.

Communication, incentives, and leadership comprise the context that surrounds diffusion of innovations. For learning more about the scaling-up process, Mr. Allen recommended *A Guide for Fostering Change to Scale-Up Effective Health Services*, a publication of the Implementing Best Practices in Reproductive Health Initiative supported by USAID and WHO. Mr. Allen concluded by summarizing the principles of a practical approach to scaling-up based on change theory:

1. Change must matter most to those making the change.
2. Credible and committed change agents require support.
3. There must be support at all levels for the change process.
4. There must be clarity on the purpose, benefits, and results of change.
5. Motivation must be maintained throughout the process.
6. Roles and responsibilities must be clear.
7. “Start where you can, and start now.”

Richard Kohl, Technical Director, Management Systems International, described the ExpandNet/WHO framework for scaling up, which gives a step-by-step methodology for assessing, developing, and implementing a scaling-up strategy. This model helps the user to identify specific action steps and devise the needed tools. It can be used by donors, governments, NGOs, and technical assistance agencies. Goals for scaling-up can be made clear using the mnemonic “REESE”:

- (1) expanded **Reach**—geography, population type, percentage of population;
- (2) ensuring and maintaining program **Effectiveness**;
- (3) **Efficiency**—cost per beneficiary;
- (4) **Sustainability**—funding, continuity, and ownership; and
- (5) **Equity**—reaching the hardest to reach.

There are five main considerations in choosing an intervention to be scaled-up:

1. Ensure that the innovation offers a solution to the problem.
2. Choose innovations that are easily scaled-up or adapt the model to improve its scalability.
3. Ensure that the innovation and the user organization are compatible or be prepared to do substantial capacity building.
4. Assess the environment, especially political, and plan for advocacy for the issue, solution, and implementation.
5. Politics and implementation capacity are just as important as technical aspects.

David Nicholas, Director, Quality Assurance Project, University Research Co., LLC, has adapted for less developed countries the Breakthrough Series work that the Institute for Health Care Improvement in Boston, Massachusetts, has been using to scale-up best practices in community health care in industrialized countries. The Quality Assurance Project has adapted the methodology into improvement collaboratives for developing countries. An improvement collaborative is an organized network of a large number of sites (e.g., districts, facilities or communities) that work together for a limited period to rapidly achieve significant improvements in a single area. The basic principle of the collaboratives is to form a network of participating organizations/sites that share learning. At each site there is a quality improvement team focused on one clinical or public health topic. The collaborative works to find better ways to implement best practices and achieve better results through regular communication between sites, which report on common indicators monthly.

There are two stages to the process. In the initial stage, a demonstration collaborative of 15-60 sites works intensively for 9-24 months to adapt a model of care to the local situation. In the next phase, a spread collaborative of 40-150 sites again works for 12-24 months to scale-up the best practices and solutions produced by the demonstrative collaboratives. The model for making these changes is called the PSDA Cycle: **Plan, Study, Do, Act**. This continuous feedback system allows for reflection and adaptation during the scaling-up process. Dr. Nicholas described his project's accomplishments in scaling-up EmONC in Niger and Russia. He outlined the steps in planning and organizing a collaborative and walked the participants through the change process.

The scaling-up plenary, a critical part of the technical meeting, started by framing the context for scaling-up in global health, described change theory, and then gave a detailed description of a renowned WHO model for scaling-up. The session ended by demonstrating how a management methodology can be used to bring about broad-based and sustainable change. This plenary provided reference points for prioritizing best practices gleaned at the meeting so participants can decide which might be scaled-up in their home setting.

INTEGRATION PLENARY: Where is the “I” in FP/MNCH?

The purpose of this session was to synthesize the technical themes of the meeting with a focus on “Integration.” Panelists described their own experiences with integration models, noting both successes and struggles.

Koki Agarwal, Director, ACCESS Program, JHPIEGO, suggested that the key to integration is to maintain a balance. Clients have opportunity costs when they decide to seek health services. Accessing comprehensive care is a challenge for clients when specific services are segregated by day of the week (e.g., immunizations offered only on Mondays, prenatal care only on Wednesdays). In turn, providers have to structure services within resource-poor settings that do not always make it possible to optimize client time. One model JHPIEGO has adopted is “focused antenatal care,” which provides a platform for effective interventions for mothers. Services bundled into ANC visits include provision of micronutrients, malaria prophylaxis, tetanus toxoid vaccination, nutrition counseling, deworming medications, PMTCT, and counseling for FP and breastfeeding. The strategy has been successful because ANC coverage is quite high in many settings, and the series of visits allows time to deliver all the services.

JHPIEGO also promotes integration of postnatal and postpartum care because the same health personnel can provide both services. It is currently working on the timing and content of the package so as to optimize the impact for both mother and newborn. Integrated packages of care

minimize missed opportunities, and clients receive more comprehensive care with each visit.

Dr. Agarwal clearly laid out the challenges of integrated care, such as ensuring that policies, norms, and guidelines reflect the integration of services and the transition from policy to implementation. Integration creates the expectation that providers will respond to different management units, which might meet with resistance. Record-keeping needs to be more fluid and less linear. Integration also places demands on the capacity of providers who previously specialized. In the end, Dr. Agarwal recommended merging what makes sense, ensuring integration at various levels, and eliminating redundancies in health service delivery.

Stephen Wall, Senior Newborn Health Advisor, Saving Newborn Lives, concentrated on the need for integrating postnatal care (PNC). To deal with the vulnerability of mothers and newborns subject to high rates of mortality, Dr. Wall advocated for a focused PNC assessment before they are discharged from facilities. This is an opportunity to relay health promotion messages, such as breastfeeding and the lactational amenorrhea method (LAM), hygiene, workload and nutrition, thermal care of the newborn, and—most important—recognition of danger signs. For community PNC visits for the home-born, timing is critical. The first visit should occur as soon as possible after delivery—preferably at one day but at the very least within three days postpartum, when the risk of mortality is highest. Optimally, PNC visits should follow at the end of the first week of life and again at six weeks (see Table 1 for the content of these visits).

Table 1: Content Focus of Integrated Postnatal Care

Content Focus of Integrated Postnatal Care		
Timing	Baby	Mother
Day 1	Breathing, warmth, feeding, cord care, danger signs, Vitamin A, immunization	Blood loss, pain, blood pressure, danger signs, advice
Early PNC	Feeding, cord, infection, danger signs	Early breast care, infection, lochia, mood, FP including LAM
Late PNC	Weight, feeding, danger signs, immunization	Recover, anemia, FP and birth spacing

While the technical evidence for integrated PNC is not in question, any PNC, however nominal, is rare in most developing countries. Country policies often do not support provision of optimally timed PNC, and regulation of existing policies is often sporadic. Dr. Wall suggested that the following is needed to achieve integrated PNC:

- In-service and pre-service curricula integrating PNC content that distinguishes between facility and community deliveries
- Clear PNC linkages and referral pathways between facility providers and community caregivers
- Guaranteed PNC for mothers in postnatal packages that also aim to improve newborn survival
- Common postpartum indicators for mothers and newborns
- Evaluation of processes and outcomes to provide high coverage with quality PNC

- Refinement of national and global standards and guidelines for integrated PNC

Maged Sayed, Field Operations Team Leader, TAKAMOL Project, reported on this integrated USAID FP/RH/MCH health project in Egypt, launched in March 2006 by Pathfinder International and partners. The objectives are to (1) improve health outcomes of mothers, newborns, and young children by lowering fertility and mortality rates; and (2) strengthen program planning and implementation capacities at different levels within the health system. The target groups reach beyond the formal health system. They range from policy makers to agricultural extension workers. TAKAMOL also targets schools and universities, local media, and religious leaders, among others. The project works within existing venues to disseminate health messages that promote behavior change and improve the quality of care. The aim is to sustain the quality and delivery of integrated health services. To optimize chances that the model will be sustainable, the project builds the capacity of the MOHP through an integrated national supervision system and training packages and integrated district planning and supervision. It also trains facility managers. TAKAMOL has already achieved many successes, such as establishing Community Development Associations that make home visits and referrals and offer seminars and awareness sessions.

The integration plenary thus delineated three distinct models for integrating FP/MNCH services. A clearly thought-out process lays a solid foundation for integrated PNC. The models improve access to FP/RH services by opening up the definition of the system to additional services.

IV. COUNTRY ACTION PLANS TO SCALE UP EVIDENCE-BASED BEST PRACTICES

An important purpose of this meeting was to stimulate country teams to adapt evidence-based best practices to the unique circumstances of their own countries. The planning committee began the process in January 2007. The committee—comprised of technical advisors from USAID Office of Population and Reproductive Health and Office of Health, Infectious Diseases, and Nutrition, USAID partners, consultants, and the ESD team—met regularly. They contacted a wide range of host-country counterparts and field staff to ensure that state-of-the-art and evidence-based FP/MNCH best practices would be presented. To launch country team partnerships, committee members worked through USAID mission staff. This groundwork was integral to the success of the formation of country teams: by the time most participants arrived in Bangkok, they were prepared to glean lessons from the meeting with an eye to their application at home. Another strategy employed to encourage country team interest to bring best practices to scale was a request for proposals: ESD managed a procurement to provide seed grants to country teams interested in scaling up FP/MNCH best practices.

The country teams convened each day after the technical sessions were completed. Team leaders and USAID liaisons were identified on the first day and worked with the teams to maintain the momentum, internalize and apply the learning, and help identify potential funding sources for implementation where needed.

Planning committee members trained in facilitation guided daily team meetings using a specially prepared guide, and the country teams followed a template that outlined the elements of an action plan. The result was that action plans were produced by 13 country teams for presentation on the last day of the conference. Groups of three to four countries presented action plans to each other for peer review. Eight countries will scale up FP/RH best practices (Bangladesh, Cambodia, Egypt, India, Jordan, Pakistan, and Yemen); five will scale up best practices for healthy timing and spacing of pregnancies (Bangladesh, Egypt, India, Nepal, and Philippines); seven will scale up newborn care best practices (Afghanistan, Bangladesh, Cambodia, Egypt, Indonesia, Nepal, and Yemen); and all thirteen will scale up maternal health best practices.⁵

WHO gave considerable support to the work of the country teams, and is still working with them and the planning committee through headquarters and field offices to maintain momentum. WHO has also set aside a small amount of funds to implement the action plans.

ESD will provide technical assistance to the country teams as they scale-up best practices and will coordinate support from other donors and partners to facilitate scaling-up.

The Bangkok meeting was thus the impetus for learning to scale-up. The planning committee helped to identify best practices and facilitate the formation of country teams several months before the meeting. USAID/W, USAID field missions, WHO Geneva, and WHO field offices and ESD continue to support the country teams so their action plans can be realized.

⁵ For summaries of the country action plans, see Appendix 3 to this report and the following link: http://www.esdproj.org/site/DocServer/ANE_Action_Steps_Analysis_2_26.pdf?docID=1702 .

V. EVALUATION

Daily evaluations were used to understand the learning process from the technical sessions and to assess the relevance of the best practices offered and their potential for adaptation. There were four different survey forms for each day (see Appendix 4). The forms were made available at each plenary and at survey return boxes. Participants were reminded at the end of each plenary to complete the forms, and reminder signs were placed in the e-Learning Lab.

RESULTS

The evaluation survey results are presented in tabular form in Appendix 5. Key points are summarized here:

- Responses of the participants were generally very positive.
- They suggested, however, that the objectives for each session could have been made more explicit. Though these were clearly presented in the program guide, apparently few of the moderators stated the objectives at the sessions.
- Several comments requested better time keeping, shorter presentations, and giving more thought to how much information can be absorbed in a given time.
- Some comments highlighted the need for more innovative information to be presented in the plenary sessions.
- A majority of responses indicated agreement with the statement that the participant would explore adapting one of the best practices learned in the session.

The evaluation results should not be over-interpreted. Sample sizes for the individual sessions were very small; people with stronger opinions—positive or negative—might be more inclined to report them; and language may have been a barrier for some participants.

VI. BEYOND THE TECHNICAL MEETING

Anecdotal evidence suggests that the meeting's objectives of country-level applications are already being met in some countries. Communications with meeting participants from Indonesia and Yemen indicate that, indeed, South-to-South learning was fostered by the meeting and in-country teams are working efficiently to scale up the best practices they gleaned. For example, the deputy of a large USAID/Jakarta project reported that

As a result of the USAID regional meeting in Bangkok, the Indonesia country team set an objective to implement [kangaroo mother care] as the standard protocol in at least three teaching hospitals in Indonesia. USAID and [our project] are looking into ways to fund this objective. USAID [is] seeking funds for a study tour to Capetown or Mumbai, and [our project is] considering funds for follow-on activities to the study tour. This meeting was to discuss (1) learning objectives of the study tour; (2) criteria for participant selection and (3) methods to follow up the study tour to ensure that best practices are implemented. The objective of the study tour would be to give practitioners from the neonatal intensive care units of the three teaching hospitals the skills and confidence to implement kangaroo mother care as the protocol for all low birth weight babies, including those under 1,500 grams. Within a year it is envisioned that these facilities would be able to serve as training locations for Perinasia [the neonatologist association].

The new Indonesia team is also working to scale up other best practices learned from the meeting, as reported by the leader after the team met with the MOH's Maternal and Child Health Directorate:

- JHPIEGO is currently supported by the subdirectorate for FP to develop a strategy for FP services. JHPIEGO now plans to include postpartum FP in its strategy and adopt the best practice of LAM.
- Perinasia will work with the infant health subdirectorate to strengthen its objectives and draft the action plan needed to achieve those objectives.
- APPI (the local chapter of the White Ribbon Alliance) will be looking for more support for develop the KIBLA model at Desa Siaga ("Alert Village") and will discuss this initiative with Desa Siaga Team leader at the MOH.

The Yemen team has also met the fourth meeting objective of building new networks and strengthening existing networks in-country. The team leader sent a communiqué to the entire team asking them to summarize their participation in the meeting with highlights and results, and a meeting report was circulated. A special emphasis was a call for team members to continue using the e-Learning modules, and there is an offer of rewards to the three to five people who complete the most modules.

A White Ribbon Alliance member in Yemen also reported:

I was one of the participants in the conference on scaling-up high-impact best practices for making pregnancy safer... which was very good and interesting. During that [meeting] I met more new important persons, I obtained new knowledge and skills. and received presentations. [I have distributed] all that to my students and many doctors who could not participate in the conference. I am starting to make proposals to study many problems related to maternal health problems and I am still [working] with Global Health e-Learning every day and obtaining more certificates.

These examples are just a few of the responses the planning committee has had the pleasure of hearing about since the meeting. Informal input from Washington colleagues echoes the conclusion that the meeting successfully met its objectives of providing a learning opportunity, encouraging South-to-South learning, promoting working as efficient teams, and launching the scale-up of FP/MNCH best practices.

An update on where the countries are in implementing the action steps is provided in Appendix 3.

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