Making Pregnancy Safer

Review of the early implementation phase - 2002-2003

Report

Chisinau, Republic of Moldova
22-24 March 2004
Abstract

The Making Pregnancy Safer (MPS) Global Initiative was developed by WHO with the objective of providing governments and partner agencies with guidance and technical support to ensure optimal outcome at birth for both mothers and infants. The Republic of Moldova is the pilot country for MPS in the European Region, where the Initiative was launched in January 2002; the early implementation phase was from February 2002 to February 2004. In order to review implementation and plan for the expansion phase, a review meeting was organized to analyze experiences, lessons learned, and decide on MPS expansion and scaling up. It was the opinion of participants at the review meeting that the MPS experience in MDA has been positive and successful and that the original plan of action was fully implemented. It was the consensus of the meeting that MPS should be further implemented in the Republic of Moldova.

Keywords

PREGNANCY
MATERNAL HEALTH SERVICES - organization and administration
MATERNAL WELFARE
PROGRAM EVALUATION
REPUBLIC OF MOLDOVA

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Glossary

BCA  Biennial Collaborative Agreement
CDC  Centre for Disease Control
EOC  Essential Obstetric Care
ENC/BF Essential Newborn Care/Breastfeeding
EBMN Evidence-Based Mother and Newborn
FPS  Family Planning Society
HIS  Health information systems
HIV  Human immuno-deficiency virus
HSR  Health sector reform
ICM  international Confederation of Midwives
MAV  Manual Vacuum aspiration
MCH  Mother and child health
MCHCRI Mother and Child Health Care Research Institute
MDA  Republic of Moldova
MPS  Making Pregnancy Safer
MPS WG Making Pregnancy Safer Working Group
MoH  Ministry of Health
MoE  Ministry of Education
NAF  National Abortion Federation
NGO  Non-governmental organization
NPO  National Professional Officer
NPSPHC National Program of Strengthening of Perinatal Health Care
OSI  Open Society Institute
PAT  Planning for Appropriate technologies
PEPC Promoting Effective Perinatal Care
PHC  Primary health care
PMTCT Prevention of mother-to-child transmission of HIV
RH  Reproductive health
STI  Sexually transmitted infection
ToT  Training of trainers
TQM  Total quality management
UNAIDS United Nations AIDS Programme
UNFPA United Nations Population Fund
UNICEF United Nations Children’s Fund
WB  World Bank
WHO/HQ World Health Organization, Headquarters (Geneva)
WHO-Europe World Health Organization, Regional Office for Europe
1 Executive summary

The Making Pregnancy Safer (MPS) Global Initiative was developed by WHO to provide governments and partner agencies with guidance and technical support for optimal outcome at birth for both mothers and infants. MPS focuses on strengthening the capacity of countries to address human resource development, quality of care, health system planning and management, and family and community participation. MPS also contributes to coordination of national and international partnerships and resource mobilization.

The Republic of Moldova is the pilot country for MPS in the European Region, where the Initiative was launched in January 2002 with an introductory orientation and planning meeting, during which a plan of action for the early implementation phase of MPS was developed (February 2002 to February 2004).

In order to review implementation and plan for a possible expansion phase, WHO Regional Office for Europe, and the Moldovan MPS national working group organized a review meeting to analyze experiences, summarize lessons learned, and decide whether and how MPS is to be expanded and scaled up. The review was seen as an essential step to bridge the early implementation and expansion phases.

It was the opinion of participants at the review meeting that the MPS experience in MDA has been positive and successful and that the original plan of action was fully implemented. Additionally, MPS undertook other tasks not foreseen in the original plan, such as capacity building through pre- and in-service training of health care providers, quality of reproductive care and assessment, operational research in the area of pregnancy and birth, assessment of how to implement cervical and breast cancer screening, and the development of recommendations for updating evidence-based interventions.

2 Background

The purpose of the MPS strategy is to provide strategic directions to countries for accelerating the reduction of maternal and perinatal mortality and morbidity. MPS suggests priorities for action – and, in doing so, intends to contribute to dialogue amongst all key stakeholders at the country level, as well as to the development of national and local strategies. The main causes of maternal and perinatal deaths are well known and could be avoided if appropriate care was available throughout pregnancy, childbirth and the post-natal period. Maternal and perinatal mortality are indicators of disparity and inequity between rich and poor, urban and rural populations, gender, and can be a sign of women’s place in society and their access to social, health and nutrition services and to economic opportunities.

MPS was launched in 2000 and builds on the experience of more than a decade of the Safe Motherhood movement. Interventions that can prevent maternal and perinatal mortality from the major causes are known and can be made available even in resource-poor settings. So that all births are positive and fulfilling experiences, support in pregnancy and childbirth needs to focus on adequate preparation in the household, support to the woman and her baby, early detection and management of complications, ensuring that quality services are available and accessible close to where women live.

Moldovan children and women (1.3 million of the population is under 18 years of age) continue to feel the impact of a health care system in transition. MDA is one of the poorest
countries in the European region, with per capita income\(^1\) of US$ 380 (2001), with 35% of the total population of 4.3 million living below the poverty line. Social development is hampered by unemployment, inequality in the distribution of income and inflation. Reduced budgets for the social sector have resulted in the worsening of major social indicators and to the deterioration of quality of and access to social services.

The poor status of mother and child health is reflected in perinatal mortality\(^2\) of 14 per 1 000 live births and maternal mortality ratio\(^3\) of 34 per 100,000. Maternal mortality is mainly due to pregnancy-related pathologies (haemorrhage and hypertension) and puerperal infections. Almost 28% of children under five and 20% of women of reproductive age suffer from anaemia.

Following the 1\(^{st}\) National Conference of Perinatal Medicine in 1997, a national program of strengthening of perinatal health care for 1997-2003 was developed and launched as a response to the critical health status of women and children. MDA was also selected as the global MPS Initiative European pilot country, and was introduced in January 2002\(^4\). MPS in MDA has included a series of evidence-based activities, such as training courses in evidence-based mother and newborn care for guideline makers and the strengthening of midwifery through training courses in essential obstetric care and consultations to upgrade the curricula for midwifery schools (Ref. 7). Close collaboration with partners – especially UNICEF – has been key to successful implementation.

### 3 Review meeting recommendations

In order to meet existing challenges, it was agreed that the activities of all partners be complementary (and avoid overlapping); their various roles and responsibilities have been clearly defined. Government commitment to cost-effective interventions within a supportive environment is essential; the creation of synergies between partners should be identified and enhanced, as should the comparative advantages of each partner.

A number of recommendations express the joint commitment of MoH, WHO and other partners towards achieving the MPS goals.

1. For effective coordination of implementation, a coordination committee should be set up at central level to periodically evaluate the programme and recommend adjustments to the plan of action developed by the orientation and planning meeting\(^5\). Responsibility for implementation of interventions should include district level (rayons), who would also participate in coordinating action plans; all levels of the health system should have full access to the action plan, training materials, information leaflets, etc.

2. A crucial component will be updating laws, norms and regulations related to mother and newborn care based on MPS/WHO recommendations, with special focus on MoH Decree 165. Dissemination of MPS/WHO principles and recommendations should be promoted at all levels of the health system.

In view of the limited funding available for health, there is a need to make the most effective use of existing resources:

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\(^1\) Source: HFA Database. WHO Regional Office for Europe, Copenhagen, 2003.

\(^2\) 2000-2002 data. HFA WHO-Regional Office for Europe

\(^3\) 2000-2002 data. HFA WHO-Regional Office for Europe


10/06/2005
3. All levels of health care should be involved in allocating funds; while families and the community need to support the promotion of effective interventions. The basic health package should be updated and reflect the officially approved clinical guidelines in line with the MPS strategy and recommendations.

4. In order to scale up maternal and newborn care activities, estimated budgeting of interventions would be important for MoH decision makers and partners. It is recommended that the WHO Mother and Baby Package costing spreadsheet be used at all referral levels as a tool for developing cost effective interventions.

5. Recognizing that maternal and perinatal health and access to safe delivery and care services are not equally distributed within the population, special attention should be given to reaching the most vulnerable groups with limited access to services. Financial and other mechanisms should be identified to achieve equal coverage and be part of the planning for scaling up MPS.

There is a close link between the health of mothers and children that need to be addressed in an integrated manner by all levels of the health sector.

6. Responsibilities at different levels of care should be revised to reflect up-to-date clinical guidelines; funding mechanism should support these various levels of responsibilities.

7. Coordination needs to be ensured among all the different levels of care, especially primary care and hospitals.

A number of interventions have proven effective in pilot sites in improving quality of care, with a major impact on maternal and perinatal health outcomes. Scaling up of such interventions to the national level is essential for achieving full coverage and ensuring improved health status.

8. Optimal use of available human resources, equipment and drugs (for instance, a clear definition of services provided by the primary health care team in antenatal care, and monitoring essential drug availability) is basic for successful implementation. The Midwifery School will be further developed and supported.

9. Training in relevant areas linked to MPS should be scaled up; training should be linked to the approved clinical guidelines, including such issues as full access to antenatal care. Course participants should include health care providers (obstetricians, midwives, neonatologists, nurses, community health workers, family doctors), health managers and sanitary epidemiologists.

10. Plans for 2004-5 will include introduction of selected components of audit of maternal and perinatal mortality and morbidity at MoH and district levels, based on a participatory approach, confidentiality and evidence-based. The mechanism of continuous development and revision of evidence-based clinical guidelines, supporting the audit process, will be established.

Working with communities and individual families is critical to ensure continuum of appropriate care during pregnancy, childbirth and the post-partum period. Improving family and community practices will be key to successful implementation.

11. An assessment of access to health services from a family and community perspective (plan of birth, family support, availability of transportation, financial constraints, domestic violence, etc.) should be carried out, including assessment of the role of local social and other services in mother and child health protection.

12. Women and families should be involved in the decision-making process through promotion of the family-friendly maternity concept.
13. Key messages on appropriate care seeking should be consistent and compatibility with WHO/MPS recommendations.

14. An effective interaction process between the health system, the family and community in the area of MPS should be developed.

Documenting successful project implementation is essential to mobilize political and financial support. In the area of epidemiological data and statistics, continuous improvement of data quality is essential for monitoring implementation outcomes and reducing maternal and perinatal mortality rates.

Local research – especially operational research – on maternal and perinatal issues to serve as models of successful interventions and a basis for scaling up both at national and regional levels will be key to the success of MPS.

4 Review meeting

4.1 Objectives

The objectives of the review meeting were (a) to assess the implementation of the action plan developed in January 2002; (b) to evaluate the experience gained and lessons learned during the early implementation phase (2002-2003); and (c) to identify ways of strengthening and sustaining further expansion of MPS.

4.2 Outcomes

The outcomes of the review were (a) an assessment of the early implementation phase – both planned and additional (see Annex 3-1, 3-2); (b) Working Group recommendations for 2nd phase activities (Annex 6); and (c) the present report, which summarizes the findings on which the recommendations are based.

4.3 Participants

The review meeting brought together participants from various groups, including high-level officials from the MoH, members of the MPS working group, representatives from national programmes, rayons and institutions involved in the early implementation phase or that may become involved in the expansion phase, as well as partner organizations and UN Agencies.

4.4 Preparing for the review

Prior to the review, a report was developed which summarized the plans, activities and results from the early implementation phase; documents 1-8 (Section 5) were also used for the review. Other background documents available are those numbered 9 to 22.

The composition of the working groups, including chairpersons and rapporteurs matched the main areas of responsibility or interest of participants; in each group there was a balance of MoH staff, institutions and partners.

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5 See Annex 2 – List of participants
4.5 Proceedings

The review took place over a three-day period. The first two and half days were dedicated to the review process itself and the last half-day to development of recommendations.

On the first day, the MoH gave an overview of early implementation; WHO HQ and WHO Regional Office for Europe made plenary presentations on MPS at regional and global levels. This “setting the scene” format enabled participants to develop an understanding of the MPS plan action and its achievements in MDA.

On the second day, an overview of partnership activities was made providing an opportunity for different stakeholders to present their experiences or views. This was followed by the working groups desk review.

The desk review covered three major areas:

1. Organization and management: improving the health system
2. Improving health worker skills
3. Improving family and community practices

During the review, participants completed the following steps:

− Step 1: Assess what has been achieved in each major area, identifying constraints and specifying resources required for the expansion phase;
− Step 2: Identify feasible solutions for constraints;
− Step 3: Assess how the MPS strategy should be expanded and developed recommendations of how this should be done.

A checklist, Issues relevant to the status and quality of MPS implementation organized according to major areas was provided to help participants identify issues for consideration.

The findings and the recommendations of the three groups were presented during a plenary session and is attached as Annex 5.

Consensus was achieved on recommendations for the next implementation phase. These are reflected in Section 3, Summary of working group recommendations.

5 References


6 See Annex 1 – Programme
7 See Section 5, Document 7
8 See Annex 4
11. MPS Assessment Mission on Cervical and Breast Cancer Screening, 09-15 March 2003
18. Evaluation of the Perinatal Programme study, 2001
19. Evaluation of the Perinatal Programme study, 2002
21. KAP study, UNICEF, 2001
22. Reproductive Health Survey, 1997(21)
Annex 1 – Programme

22 March 2004

11.00 -11.15 Welcome Ministry of Health
11.15 -11.30 Speech of greetings WHO/UNICEF
Introduction of participants
Administrative arrangements during the review

Setting the scene: Making Pregnancy Safer in regional and global context

11.30 -12.00 The situation of MCH in The Republic of Moldova. Rationale for implementing the MPS strategy Maria Tarus

12.00 -12.20 MCH in the European Region Mikael Ostergren

12.20 –12.50 MPS in the European region Alberta Bacci

12.50-13.00 Discussion

14.00 – 14.20 Global status of MPS implementation, and future directions. Luc de Bernis

Making Pregnancy Safer in the Republic of Moldova: what has been learned from the early implementation phase

14.20 – 14.30 Discussion
14.30 – 15.00 Overview of the early implementation phase Petru Stratulat
15.00 –15.20 Clinical guidelines – strengths and weaknesses Valentina Baltag
15.20 –15.40 Strengthening midwifery and maternities practices (achievements and constraints) Vasile Rotaru
15.40 –16.00 The Orhei maternity experience in essential obstetric care Minodora Cucu
16.20 – 16.40 Pre-service training. MPS component implementation process into medical colleges curriculum Tatiana Buzdugan
16.40 – 17.00 Maternal mortality audit: a new strategy to review maternal deaths Valentina Baltag
17.00-17.30 Discussion

23 March 2004

Making Pregnancy Safer related activities
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter(s)</th>
</tr>
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<tbody>
<tr>
<td>09.00-09.30</td>
<td>Relation of the MPS strategy to health sector reforms: PHC WB project.</td>
<td>Ghenadie Turcanu</td>
</tr>
<tr>
<td>09.30-09.50</td>
<td>Trends in maternal mortality in MDA safe abortion</td>
<td>Valentin Friptu</td>
</tr>
<tr>
<td>09.50-10.10</td>
<td>Overview of UNICEF activities in MDA from the MPS prospective: the NPSPHC and PMTCT of HIV project</td>
<td>Viorica Berdaga</td>
</tr>
<tr>
<td>10.10 – 10.30</td>
<td>NPSPHC: assessment of maternity practices using WHO follow up tools.</td>
<td>Ala Curteanu</td>
</tr>
<tr>
<td>10.50 – 11.00</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>11.00-11.20</td>
<td>Overview of UNFPA activities in MDA in relation to MPS</td>
<td>Boris Galca</td>
</tr>
<tr>
<td>11.20-11.40</td>
<td>Activities to improve HIS in MDA in maternal and perinatal health</td>
<td>Petru Crudu</td>
</tr>
<tr>
<td>11.40 -11.50</td>
<td>Reforms in the pre-service training system</td>
<td>Olga Cernetchi</td>
</tr>
<tr>
<td>11.50 -12.00</td>
<td>Pre-service training: MPS component implementation process into university curriculum</td>
<td>Larisa Spinei</td>
</tr>
<tr>
<td>12.00-12.30</td>
<td>Discussions, information</td>
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**Group working**

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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>13.30-14.00</td>
<td>Group work: introduction</td>
<td>WHO</td>
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<td>14.00-17.30</td>
<td>Group work</td>
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**24 March 2004**

<table>
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<tr>
<td>09.00-13.00</td>
<td>Group work</td>
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<tr>
<td>14.00-16.00</td>
<td>Group work presentations</td>
<td></td>
</tr>
<tr>
<td>16.00-16.30</td>
<td>Consensus (plenary session)</td>
<td></td>
</tr>
<tr>
<td>16.30-17.00</td>
<td>Closure</td>
<td></td>
</tr>
</tbody>
</table>
Annex 2 – List of participants

Participants

Ion Bologan
   Obstetrics and Gynecology Department, Medical University

Tatiana Buzdugan
   Medical College, Mother and Child Health Care Research Institute

Olga Cernetchi
   Head, Methodical Department, State Medical University

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   Midwife, Perinatal Center Cahul

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Olga Osadcii
   Information Unit, Ministry of Health

Victor Petrov
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Lilia Prisacari
   Midwife, Perinatal Center Balti

Vasile Rotaru
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Galina Scerbacova
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Larisa Spinei
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Petru Stratulat
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Petru Stirbate
   Ob-gyn Director, Perinatal Centre Orhei

Maria Tarus
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Raisa Tulbu
   Midwife, Mother and Child Health Care Research Institute

Ghenadie Turcanu
   Head, Department of Medical Care and Health Insurance

Natalia Zarbailov
   Chair, Family Medicine, State Medical University

Oxana Zavtoni
   Chief Midwife, Mother and Child Health Care Research Institute, President of Association of Midwives,

   Partners

Angelina Ursu
   Public Health Programme, SOROS Foundation

   UN Agencies

   UNICEF

   Viorica Berdaga
   Programme Officer, Health Systems
Ala Curteanu
Program coordinator

UNFPA

Boris Galca
Programme coordinator

Oxana Gavrilita
Project logistics

World Bank

Andrei Mosneaga
Health programme coordinator

World Health Organization

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WHO Regional Office for Europe

Valentina Baltag
NPO Making pregnancy Safer Initiative WHO Regional Office for Europe, Republic of Moldova

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Mikael Ostergren
Regional Adviser, Child and Adolescent Health and Development WHO Regional Office for Europe

Pavel Ursu
Liaison Officer, Republic of Moldova, WHO Regional Office for Europe
Annex 3 – Review of early implementation

3. 1 – Assessment of implementation of planned activities (2002-3) and plans for expansion phase (2004-5)

<table>
<thead>
<tr>
<th>Priority area/Activity</th>
<th>Partners</th>
<th>Evaluation</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td></td>
<td>2002-3</td>
<td>2004-5</td>
<td></td>
</tr>
<tr>
<td>Clinical guideline (Guide C)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish scientific documentation centre on MCH at Perinatal Centre</td>
<td>WHO-Europe</td>
<td>Centre established</td>
<td>Centre activities to be continued</td>
</tr>
<tr>
<td>Training professionals in evidence-based mother and child care</td>
<td>WHO-Europe</td>
<td>3 EBM courses for decision-makers and professionals (49)</td>
<td>Involvement of professional associations in continuous clinical guideline development, revision process</td>
</tr>
<tr>
<td>Finalization of clinical guidelines (Guide C) by MDA professionals</td>
<td>OBGYN Dept, Medical University, CMHCRI, Municipal Hospital N1, Professional Association OBGYN, Professional Nurses Association</td>
<td>Guide C completed</td>
<td></td>
</tr>
<tr>
<td>External expertise for clinical guideline making support, MDA consensus</td>
<td>WHO-Europe, UNICEF</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>Clinical guideline formalization process</td>
<td>MoH</td>
<td>Approved by MoH</td>
<td></td>
</tr>
<tr>
<td>Continuous revision of clinical guidelines</td>
<td>MoH, WHO-Europe</td>
<td></td>
<td>Working group set up.</td>
</tr>
<tr>
<td>Technical working group on clinical guideline implementation and monitoring</td>
<td>OBG Chairs, Medical University, CMHCRI, Municipal Hospital N1, Professional Association OBGYN, Professional Nurses Association</td>
<td>Implementation of clinical standards ongoing</td>
<td>Set up national working group for implementation, monitoring</td>
</tr>
<tr>
<td>Performance improvement measurement</td>
<td>WHO/HQ</td>
<td>WHO assessment of maternity practices tools adapted; 11 maternities assessed,</td>
<td>Continuous assessment (10 maternities</td>
</tr>
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## Strengthening Midwifery

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Organization/Entity</th>
<th>Details</th>
</tr>
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<tbody>
<tr>
<td>Participation in regional EOC, ENC/BF capacity building in</td>
<td>WHO-Europe</td>
<td>Training course in Bishkek, KGZ Apr 2002 (4 MDA facilitators) ToT follow-up to training, Nov 2002, Samara, RUS (4 MDA participants)</td>
</tr>
<tr>
<td>Curricula revision</td>
<td>WHO, MDA working group</td>
<td>Completed: Midwifery Educational Programme developed based on WHO &amp; ICM recommendations approved by MoH &amp; MoE</td>
</tr>
<tr>
<td>Support to Midwifery School (pre service training)</td>
<td>WHO-Europe, Orhei Midwifery School</td>
<td>ToT EOC course in Orhei &amp; two cascade courses (Balti, Cahul). Follow up to training in Orhei</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ToT ENC/BF; follow-up to 2 cascade courses, scaling up. Swiss Development Agency</td>
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### Monitoring, evaluation and research

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Organization/Entity</th>
<th>Details</th>
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<tr>
<td>Definition of risk assessment methodology</td>
<td>MoH, MCHCRI, UNICEF, WHO-HQ, CDC Atlanta</td>
<td>Not done</td>
</tr>
<tr>
<td>Definition of indicators, revision of routine data collection</td>
<td>MoH, UNICEF, WHO-HQ, MCHCRI, CPHM, OSI</td>
<td>Working group established. Draft document (in ROM) of definitions, indicators for MCH developed based on Canadian document plus MPS.</td>
</tr>
<tr>
<td>Preparation of materials for training on monitoring, evaluation</td>
<td>CDC Atlanta, CMCHCRI, Medical University, UNICEF, WHO-Europe</td>
<td>Training modules, including EBM developed in framework of TQM course for health managers</td>
</tr>
<tr>
<td>Training of trainers for health managers</td>
<td>CDC Atlanta, CMCHCRI, Medical University, CHN1, UNICEF, WHO</td>
<td>Training course on TQM completed</td>
</tr>
<tr>
<td>Training of field staff</td>
<td>CDC Atlanta, CMCHCRI, Medical University, CHN1, UNICEF, Professional Association of OBGYN</td>
<td>Training courses on TQM completed</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Professional Association of Nurses</th>
<th>Young people’s health and development knowledge, attitude, behavior, and practice study. Completed</th>
</tr>
</thead>
</table>
| Reproductive health survey, with special attention to adolescents | CDC, UNICEF, WHO, UNFPA | WHO international consultancy Nov 2001: assessment, workshop and recommendations:  
- implementation of MVA  
- training health professionals on MVA, counseling  
- training materials for providers, drafts of MVA clinical guideline, abortion counseling guidelines developed  
- information, education, communication activities for MVA  
- established national working group for revision of national abortion policy |
| Decreasing unsafe abortion | Approval of MVA clinical guideline by MoH  
Updating national abortion policy  
Information, education, communication activities for safe abortion |
| Standards for preventing unsafe abortion and management of complications  
Training of professionals | WHO, UNFPA, OSI, NAF, FPS, Medical University | WHO international consultancy Nov 2001: assessment, workshop and recommendations:  
- implementation of MVA  
- training health professionals on MVA, counseling  
- training materials for providers, drafts of MVA clinical guideline, abortion counseling guidelines developed  
- information, education, communication activities for MVA  
- established national working group for revision of national abortion policy |
| Maternal and perinatal audit | WHO-Europe, Medical University, WHO-Europe | National working group set up, project proposal developed together with National Perinatal Program and MCHRI |
| Maternal, perinatal deaths audit at national level | MoH, MCHCRI, CPHM, Medical University, WHO-Europe | National working group set up, project proposal developed together with National Perinatal Program and MCHRI |
| Introduce audit methodology at providers team level to improve quality of care | WHO-Europe, MoH | National working group set up in maternal/perinatal mortality audit. Conceptual framework, data collection forms for confidential enquiries in maternal mortality and near miss cases analysis |
| Maternal, perinatal deaths audit at national level | WHO-Europe, MoH | National working group set up, project proposal developed together with National Perinatal Program and MCHRI |
| Introduce audit methodology at providers team level to improve quality of care | WHO-Europe, MoH | National working group set up in maternal/perinatal mortality audit. Conceptual framework, data collection forms for confidential enquiries in maternal mortality and near miss cases analysis |
| Implement audit of maternal, perinatal deaths at national level | Improve confidential enquiry into maternal deaths, near miss cases concept analysis according to WHO recommendations  
Establish mechanism for near miss case audit at facility level |
Primary health care and maternal and newborn health

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsible Parties</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support preparation of clinical guidelines for essential package of interventions for maternal and newborn health</td>
<td>WHO, UNICEF</td>
<td>Hospital level guidelines approved, implemented (national perinatal guidelines (Guide C)), modules developed for antenatal care course for family doctors, based on clinical guidelines. Further development of clinical guidelines especially for PHC in collaboration with Association of Family Medicine of Moldova.</td>
</tr>
<tr>
<td>Establishment of working group to support PHC:</td>
<td>MOH, WHO, UNICEF, UNFPA, Professional organisations</td>
<td>Draft document developed to reintroduce midwives into PHC team. Follow up, capacity building for midwifery care at PHC level.</td>
</tr>
<tr>
<td>- human resource strategy for PHC</td>
<td></td>
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<tr>
<td>- access and quality of care, health insurance</td>
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<tr>
<td>- community participation in maternal and newborn health.</td>
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</tbody>
</table>

3.2 – Assessment of additional activities in the early implementation phase (2002/3)

MPS has generated interest in evidence-based which goes behind the field of MCH to other medical specialties as well as basic medical training and research issues. Updating of curricula to include evidence-based modules has taken place in the Midwifery School, in the School of Public Health and the State Medical University. Interest has developed in more operational-focused research (as against clinical research). The concept of an evidence-based model of care was used to assess f.e., cervical and breast cancer.

1. Capacity building in pre- and in-service training

- State Medical University, Chisinau, and School of Public Health, Chisinau: 36 didactic staff trained in EBM content and training methodology
- EBM teaching modules developed
- Didactic materials developed on appropriate technologies for medical students

10/06/2005
• Curricula development
  − School of Public Health curricula now includes EBM module
  − State Medical University curricula under revision to incorporate EBM topics in a systematic way
  − Ob&Gyn Department, State Medical University pre-service obstetric & gynaecology curricula updated

2. Research development and research training

• WHO international consultancy assessment of national capacity and research in the field of MPS: 27 February to 4 March 2003. Staffan Bergström, Professor and Chair, Division of International Health. Karolinska Institutet, Sweden
• MDA participation in training course on operational research in reproductive health, 14-25 April 2003, Almaty, Kazakhstan
• MDA participation in training course on evidence-based research in perinatal care with limited resources, 14-24 August 2003, Gotland, Sweden.
• MCHRI, Chisinau, applied to become a WHO Collaborating Center for Mother and Newborn Care (March 2004)

3. Assessment of cervical and breast cancer screening

Annex 4 - Issues relevant to the status and quality of MPS implementation organized according to major areas

MPS Organization and management, and improving the health system

<table>
<thead>
<tr>
<th>Area</th>
<th>Issues</th>
<th>Information needed</th>
<th>Information source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization, management at central level</td>
<td>Capacity of MoH to coordinate, support MPS strategy</td>
<td>What kind of structure has been established at central level to coordinate, implement MPS activities?</td>
<td>MPS WG membership list</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are relevant programmes, institutions all represented in MPS WG?</td>
<td>MPS report (8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is manpower sufficient to complete tasks required at national level? How many full and part-time staff are assigned to MPS?</td>
<td>Description of organization of MoH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does MPS WG have necessary authority to enact decisions?</td>
<td>Interviews with MPS WG members (including coordinator or focal person)</td>
</tr>
<tr>
<td></td>
<td>Policy support</td>
<td>How has MoH expressed its commitment to MPS strategy?</td>
<td>BCA document</td>
</tr>
<tr>
<td></td>
<td>Forma support of MoH for MPS as key strategy</td>
<td>How does MPS strategy fit into national health policy framework?</td>
<td>National health policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have health authorities at all levels, partners, been informed where MPS is included in national health policy?</td>
<td>Reproductive health strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do existing programmes include MPS into their policies?</td>
<td>National perinatal program policy documents</td>
</tr>
<tr>
<td></td>
<td>Central-level support to pilot sites (Orhei, Balti, Cahul)</td>
<td>Do districts selected for early implementation meet essential characteristics? (availability of training site, referral facilities, drugs, committed staff, good physical access by central-level staff)</td>
<td>MPS reports (7, 8)</td>
</tr>
<tr>
<td></td>
<td>Readiness of district health teams to implement MPS strategy</td>
<td>Have district orientation, planning meetings been held?</td>
<td>Interviews with district health team, MPS WG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have district health managers been trained in MPS as part of orientation and planning process?</td>
<td>Section 5, Ref 3,5,7,8,10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What else was done to prepare district health teams for MPS planning, implementation?</td>
<td></td>
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</tbody>
</table>
| Health sector reform | Relationship of MPS to health sector reform (HSR) efforts | What is status of HSR in country?  
Is MPS strategy included in HSR policy? Is package of activities promoted under HSR?  
What are implications of HSR for implementing MPS strategy? (manpower, resource decentralization, cost-sharing systems, community health boards, health information systems) | MoH reports on implementation of health sector reforms  
HSR documents (1,12,13,14)  
MPS Reports (3,5,6,7,10) |
|----------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| Organization, management at district level | Commitment of district health authorities  
Budget commitment  
Capacity of district health team to plan, implement, monitor MPS strategy | Is MPS part of district health plan?  
Is district health team fully involved in creating conditions in health facilities to help MPS implementation?  
What action has district health team taken in response to results of follow-up visits?  
Have district authorities allocated resources to MPS activities?  
Is there pool of district-level staff trained in MPS facilitation, follow-up skills? Are they able to implement training and follow-up without central-level support? | Interview with district focal person, MPS WG  
District health plan  
MPS reports (3, 7) |
| Monitoring of MCH Care | Relationship of MPS and existing monitoring, evaluation system | Have supervisors been trained in MPS, follow-up skills?  
Have supervisory visits been made to follow-up on aspects of MPS? Which aspects were included?  
Were existing supervisory checklists adapted to include MPS related tasks? | MPS reports (3, 7)  
Assessment of maternity services in MDA Draft report, NPSPHC/UNICEF, 2003 |
| Linkage of MPS and HIS | Compatibility of MPS classifications. HIS categories | What are discrepancies between MPS classifications, HIS categories?  
What has been done to overcome these discrepancies? | WHO Europe report  
Indicators and definitions for reproductive health  
NCPHM Reports |
| Documentation of early implementation phase | Capacity to monitor quality of activities, overall progress | Was plan developed specifying areas, activities to document; who should be responsible for collecting information?  
Was adequate follow-up made? If not, what were problems?  
Were tools developed to facilitate documentation?  
Can they be used in future or is further adaptation needed? | MPS reports  
Interviews with MPS WG members |
## Partners

<table>
<thead>
<tr>
<th>Issues</th>
<th>Information needed</th>
<th>Information Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement of, coordination with partners</td>
<td>What is interest of partners in MPS strategy? Have any potential partners not yet been involved? Are results of follow-up, supervision used to generate support for MPS strategy?</td>
<td>Interviews with representatives of partner organizations</td>
</tr>
<tr>
<td></td>
<td>Is support for MPS from WHO and other partners sufficient?</td>
<td>Financial records of support from partners</td>
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<tr>
<td></td>
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<td>Interview with MPS WG coordinator or focal point</td>
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<td>MPS report (7)</td>
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</table>

## Human resources development

### Area

<table>
<thead>
<tr>
<th>Area</th>
<th>Issues</th>
<th>Information needed</th>
<th>Information Source</th>
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<tbody>
<tr>
<td>Adaptation of MPS materials</td>
<td>Appropriateness of local terms, recommendations from EBM, EOC courses Further adaptation required Capacity for carrying out further adaptation</td>
<td>Did course content cover relevant subjects for country? Were MPS training materials helpful during training (guidelines, modules, local terms, recommendations)? Are MPS recommendations widely accepted? Were participants able to apply recommendations after return to their own facility? Do training materials need to be revised? Is adaptation needed for other regions or districts? What adaptations are required? Is national expertise, capacity available for further adaptation?</td>
<td>Training modules, WHO EOC course Training modules, EBMNC course MPS reports (3, 5, 7, 10) Interviews with trained health workers Interview with facilitators</td>
</tr>
<tr>
<td>MPS training courses</td>
<td>Quality of MPS training courses Capacity, feasibility for continuing in-service training Coordination of MPS, other training programmes Pre-service training</td>
<td>Were courses conducted as planned? How many? Had national trainers been trained before? Did they meet quality criteria? (facilitator, course duration, time spent in different types of activities: clinical sessions, formal presentations, group work, completion of course modules, follow-up visit planned, action plans) Were participants selected appropriately?</td>
<td>MPS reports (3, 5, 7, 10) Interviews with trained health workers Discussions with MPS WG members, representatives of district health team</td>
</tr>
<tr>
<td>How did participants perform during training?</td>
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<td>Was methodology appropriate? Did course meet needs?</td>
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<td>Were training sites appropriately selected? (sufficient case load, access to patients, acceptable quality of care, director and staff interested in MPS)</td>
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<td>Were training materials available in sufficient quantities?</td>
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<tr>
<td>Were there any specific problems with training courses?</td>
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<tr>
<td>How many suitable training sites are available in each rayon?</td>
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<td>Have provisions for procurement or reproduction of training materials been made to continue training process in-service?</td>
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<td>Did course participants share knowledge, skills with colleagues who did not benefit from courses?</td>
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<tr>
<td>Has core trainers team been established at national level (to help districts get started)? How many, who are they? Are they appropriately skilled? (currently active in clinical care, previous training experience, previously trained in MPS, facilitation skills, speak participants’ language, include qualified course directors, clinical instructors and facilitators). Were there any specific problems?</td>
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<tr>
<td>Have core trainer team been established at rayon level? Are they appropriately skilled? (currently active in clinical care, previous training experience, previously trained in MPS, facilitation skills, speak participants’ language, include qualified course directors, clinical instructors, facilitators). How many trained course directors, clinical instructors, facilitators are available in each rayon?</td>
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<tr>
<td>Any specific problems with training at district level?</td>
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<tr>
<td>Did MPS WG receive complete reports after each course? Was feedback provided to district?</td>
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<tr>
<td>Is staff from different programmes involved as trainers?</td>
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<tr>
<td>Is MPS being coordinated with other trainings, i.e, ante- intra-natal care courses within perinatal programme?</td>
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<tr>
<td>Any plans made or activities undertaken to train future health</td>
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</tbody>
</table>

Interviews with trained health workers
Interview with facilitators
Discussions with MPS WG members, representatives of district health team
Interview with other programmes coordinators (UNICEF, perinatal programme)
Perinatal programme reports on training activities
Reports MPS (3, 7)
| Follow-up visits after training | Quality of follow-up after training  
Capacity, feasibility to sustain follow up after training  
MPS perinatal practices in assessed facilities (effectiveness of training)  
Coordination with other programmes in conducting follow-up after training | Number, proportion of participants visited for follow-up?  
Proportion of participants visited within 6–8 weeks after MPS course?  
Were any additional visits conducted?  
Did follow-up visits meet quality criteria? (WHO recommendations for use of follow up questionnaires)  
Was staff conducting follow-up visits trained? How? (in MPS plus facilitation skills, follow-up procedures?)  
Were data collected during follow-up used for feedback, action at all levels (health facility, district and national level?)  
How many staff has been trained in each district, available for follow-up?  
Was there any relationship between follow-up visit and regular supervision? (e.g., were multiple visits conducted? were same people doing them? Were district supervisors involved in visits?  
How did health workers perform during visit? (knowledge, skills, implementation of action plan developed after EOC training course)  
Did actual situation in facility permit all trained staff to implement changes? If not, what are barriers at national /rayon/institutional level for MPS implementation?  
Was central staff from different programmes involved in follow-up? Was district-level staff responsible for different programmes involved in follow-up? | MPS reports (3, 7)  
Assessment of maternity services in MDA. Draft report, NPSPHC /UNICEF, 2003  
MPS reports (3, 7)  
Interview with perinatal programme (UNICEF) coordinators |
| Development of human resources through participation at regional/global activities | Domains where human resources have been trained  
Critical mass of human resources  
Continuity of activities after participation in regional/global activities | Which domains were covered through MPS regional/global activities? Were these relevant to country needs? Where all relevant domain human resources able to implement MPS activities?  
Is number of training capacities per domain sufficient to disseminate activities? | Reports MPS (5, 6, 7, 10) |
**Improving family and community practices**

<table>
<thead>
<tr>
<th>Area</th>
<th>Issues</th>
<th>Information needed</th>
<th>Information source</th>
</tr>
</thead>
</table>
| Defining content, scope           | Selection of key practices, effective interventions to address these    | Was assessment of key family practices in relation to main health problems conducted?  
Which practices were selected for intervention?  
Was assessment of ongoing interventions, available community resources carried out? At what levels (national, district, community)?  
Which interventions or resources were selected for strengthening or support? | MPS reports (1, 7)  
Reproductive Health Survey, 1997(21)  
Evaluation of Perinatal Programme study, 2001-2002 (16, 17)  
*Situation of children and women in MDA 2000. UNICEF Moldova, Chisinau, 2001 (18).*  
KAP study (UNICEF) (20)  
Children care family practices study, UNICEF, 2002 (19)  
Interviews with MPS WG  
Interviews with district health team |
| Health education, counseling by health workers | Consistency of existing messages targeted at caretakers, community with MPS principles?  
Effectiveness of health workers in teaching caretakers about MPS home care, timely care-seeking | Were existing health education, promotion messages reviewed, revised for compatibility with MPS recommendations (to include local terms, feeding recommendations, etc.)?  
Were MPS-specific health education messages developed? If so, were messages from different programmes reviewed, utilized to guide development?  
Was perinatal card field-tested with assistance of expert?  
Was caretaker’s knowledge assessed; what was knowledge about | MPS WG  
WG partners programmes  
Evaluation of perinatal programme study, 2001 and 2002(16, 17)  
Reproductive health survey, 1997(21)  
Assessment of maternity |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Activity</th>
<th>Questions</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing the linkage between health facilities and community</td>
<td>Participation of community health workers in MPS strategy</td>
<td>Were community-based health workers used to provide a link between MPS-trained health workers in health facilities and community? What is their profile? How were they trained? What tasks did they perform? What were the resulting experiences?</td>
<td>Interviews MPS WG Interviews with MPS-trained health workers, community based health workers Community health worker training materials</td>
</tr>
<tr>
<td>Community interventions</td>
<td>Quality of the community interventions</td>
<td>Were any family and community interventions implemented? Who participated in planning, implementation? How was community staff trained? How was progress monitored? Were activities implemented according to plan? How many families or persons were contacted? Were there any problems?</td>
<td>Interviews with MPS WG rayon team Interviews with NGOs representatives involved in family, community activities in selected rayons</td>
</tr>
</tbody>
</table>
Annex 5 - Working group review of MPS early implementation phase

1 Group 1 - Health system organization and management

- Participants:
  - Maria Tarus
  - Valentina Diug
  - Victor Petrov
  - Iurie Dondiuc
  - Oxana Zavtoni
  - Svetlana Ciobanu
  - Petru Stirbate
  - Pavel Ursu
  - Mikael Ostergren

- Issues:
  1. Organization and management
  2. MPS and the health system
  3. Sustainability of the MPS in relation to Health System
     - Health services financing
     - Health services delivery
     - Health system resources
     - Health system management

1. Organization and management

- Achievements:
  - Documentation Centre on Mother and Child Health strategically well placed
  - MPS is a component of the National Mother and Child Health Policy
  - There is a full time person coordinating MPS activities
  - MPS is part of the WHO BCA 2004-2005
  - Good partnership experience

- Constraints:
  - Territorial-administrative reform, inconsistent responsibilities at territorial-administrative units of Gagauzia and Transdniestria
  - Communication barriers (Internet, informational bulletins)
  - Different level of coverage with MPS (EBM, EOC, others) within the new territorial-administrative units because of limited resources
  - Mid-term evaluation has not been done
  - In some cases, MoH has not be fully informed about benefits and steps taken from MDA participations in international events
  - SanEpi regulation still a constrain
  - “Stereotype” barriers
  - External constrains – social problems
Recommendations:

- More efficient coordination:
  - Set up a coordination committee at central level for periodical evaluation of the programme and adjustment of the plan of action, if necessary – information about international visits, etc.
  - Include districts in responsibilities for the MPS – perinatal programmes
  - Identify the ways to detect communications barriers, to set up a well-established network of communications (sharing information and materials)
  - Develop and update SanEpi norms related to MPS according to WHO requirements for essential care; update MoH Decree 165
  - Identify training needs with the help of district MPS coordinators
  - Continuous promotion of MPS at central and local level

2. MPS and the health system

- Achievements:
  - It is part of the National Mother and Child health policy
  - Strategic and political support from the MoH
  - Included in the basic package of health services - good perspectives for the future development
  - Acceptance of interventions by health providers and society
  - State provision of essential drugs, f.e., in health facilities
  - EBM training – updating of protocols
  - EOC trainings with midwifery involvement – team work built up to facilitate organizational aspects
  - National protocols exist – standards for quality assessment

3. Sustainability of MPS in relation to the Health System

- Health services financing
  - Constraints:
    - Limited resources for universal access to services
    - Direct payment (drugs, others)
    - Lack of drugs needed to follow clinical protocols
    - Limited experience in contract based finance (level I, II, III)
    - Lack of financial incentives to provide appropriate technologies in perinatal care
    - Local public administration
  - Recommendations:
    - Identify a clear mechanism for protection of vulnerable population
    - Finalize costing of the Mother and Baby package for referral levels I, II, III
    - Update the basic package of health services according to clinical protocols
    - Contract based finance
    - Establish providers initiatives for use of appropriate technologies
    - Involve local public administration in fixed expenditures

- Health services delivery
  - Constraints:
    - Ongoing health services reform, with special focus on PHC and rural areas
    - Functioning of the referral system in the new administrative reform framework
Insufficient coordination between PHC and hospital care
Insufficient implementation of new clinical protocols
Unequal training of health providers
Limited managerial skills at health providers’ level
Out-of-date and inflexibility in terms of efficient infrastructure

Recommendations:
- Define list of responsibilities according to referral levels, including family doctor; update guidelines, if necessary
- To build up coordination between PHC and hospital care (head specialist on MCH)
- Continue training in relevant areas (EBM, EOC, others)
- Institutionalization of clinical protocols
- Continue to train health managers

Health system resources

Constraints:
- PHC in rural areas – doctors, midwives, nurses
- Lack of specially trained person in antenatal care – midwife
- Insufficient training of the family doctors in antenatal care
- Insufficient investment to maintain up-to-date technologies and costs
- Limited access to essential drugs
- Inappropriate use of drugs and over-medicalization

Recommendations:
- Clearly define the list of services provided by the family doctor within antenatal care
- Identify partner initiatives active in areas of difficult access
- Train staff involved in antenatal care to broaden access to quality antenatal care
- Training courses based on clinical protocols
- Monitor essential drugs listed in protocols
- Use investment opportunities for renovation and maintenance of hospitals/wards/clinics

Health system management

Constraints:
- Lack of clarity on responsibilities at central and local level
- Unequal managerial capacities of health authorities
- Data collection system being set up

Recommendations:
- Revision of responsibilities and their reflection on administration and infrastructure
- Continue to train decision makers in health system/services management
- Monitoring and information of the national center of preventive medicine in the implementation status
- Continue to improve data collection system
Partnership

- MoH
- WHO-UNICEF
- WB
- Soros
- NGOs
- Swiss Development Agency
- Other partners

2 Group 2 - Human resources development

Participants

- Spinei Larisa
- Buzdugan Tatiana
- Cucu Dora
- Friptu Valentin
- Corcimaru Vera
- Şerbacova Galina
- Chirilenco Irina
- Tulbu Raisa
- Prisăcaru Lilia
- Curteanu Aia

Issues discussed:

- Activities within MPS for human resource development during 2001 – 2003 and identification of major problems, constraints and future plans:
  - EBM training courses
  - EOC courses
  - Follow up visits after EOC courses
  - Planning for appropriate technologies course
  - Development of the new midwifery educational programme

- Priorities for human resources development for 2004-2006
## Results – Group 2

### Activities within MPS for human resource development 2001-03 and identification of major problems, constraints and future plans

#### Evidence Based Mother and Newborn Care courses

<table>
<thead>
<tr>
<th>Area/Achievements</th>
<th>Problem statements</th>
<th>Constraints</th>
<th>Recommendations: future plans</th>
<th>Partners</th>
</tr>
</thead>
</table>
| I. Adaptation of MPS materials for EBMNC courses (distributed to course participants handouts for all presentations + folder with course materials) Used CD with Cochrane Library, WHO Reproductive Health Library | A. All the manual content important, but courses have not covered all relevant topics | Modules do not include national data on existing evidences | - I. Local adaptation of materials  
- II. Adaptation of EBM course for PHC | Dept of Family Medicine  
Association of Family Medicine |
| | B. Course manual in Russian, half of presentations in Romanian. | Translation of materials from English to Russian inadequate, difficult to understand | - I. Translation of materials (needs special sources, efforts)  
- II. Use of national protocols as didactic materials | |
| | C. Electronic sources only in English | Language barriers. Need for translation | Some systematic reviews translated in advance | |
| II EBMNC ToT course (1 course, 16 persons trained) | | Limited time because of consecutive translation | | |
| III. EBMNC cascade courses (2 courses, 33 persons trained)  
IV. Cascade courses for health managers (total 37 persons trained) | A. Short duration of courses | **Too short time for clinical protocols authors on clinical guidelines development and grades of recommendations** | More time allowed for this subject | |
| | B. Participants insufficiently familiar with statistical terms, other course materials | | Analyze existing clinical guidelines in advance for their adaptability to country needs | |
| | C. Limited time dedicated to the audit | Local materials were not used | - Assess university curricula according to EBM requirements | State medical University |
| D. Searching for evidences too short | I. Centres have no computers  
II. No on line access to Internet, often also through modem (no telephone)  
III. Cochrane Library not accessible | - I. Ensure centres have computers  
- II. more CD's with Cochrane Library  
- III. Train medical staff in use of computer |
| E. Participants insufficiently familiarized with different types of epidemiological studies, insufficient critical appraisal skills | Participants don’t understand, don’t believe and don’t accept study methodology and EBM principles | - Continuous training of researchers and didactic staff  
- II. Familiarize students with EBM principles |
| F. EBMNC courses provided only for doctors | Physicians works together with midwives/nurses; will not be supported by them if trained separately | - I. Train midwives/nurses in EBM  
- II. OR train physicians + midwives/nurses + epidemiologists + psychologists + social workers together |
| I. Representatives from SanEpi have not participated in courses | Medical staff in maternities dependent on SanEpi rules (restrictions to technologies implementation) | - I. Train SanEpi staff in EBM  
- II. Update SanEpi regulations in line with EBM |
| K. Difficulties with implementing promoted technologies when trained providers returned to their facility | - I. Small number of staff (2) trained from one facility  
- II. Out-of-date SanEpi orders | - I. increase number of staff trained from one facility  
- II. train staff based on territorial principle to facilitate implementation  
- III. involve local decision makers in |
<table>
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<tr>
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<th>Recommendations: future plans</th>
<th>Partners</th>
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</thead>
</table>
| I. Adaptation of MPS materials for EOC courses  
WHO-Europe, EAPPC training manual, MPS global material, MCPC, Essential Care Practice Guide, Guide to Effective Care in Pregnancy and Childbirth (Enkin et al), and WHO Reproductive Health Library. | A. Didactic materials in Russian | No local video on EOC | - I. Need for local video  
- II. Add modules actually developed within perinatal programme (UNICEF) | Check consistency of WHO EOC messages and perinatal programme antenatal care course |
<p>| | B. Short time to study literature in cascade courses Cahul and Balti | | Keep course duration of 2 weeks (1 theoretical and 1 clinical) | |
| | C. Insufficient attention to antenatal interventions | Lack of continuity among ante- intra- and postpartum care | Extend antenatal part of course | WHO Europe, State Medical University; Medical Colleges |
| II. 3 EOC courses, 50 providers trained | A. Oreo and Balti SanEpi representatives were not included | SanEpi staff will object to some appropriate technologies due to lack of knowledge | Train SanEpi staff | Local SanEpi representatives |
| | B. Neonatologists not included | Neonatologist to be included in trainings as he/she needs to | Include neonatologists in trainings | |</p>
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<tbody>
<tr>
<td>in training courses</td>
<td>know principles of essential care of newborn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Auxiliary staff not involved in essential care</td>
<td>Cleaners may put barriers to some technologies</td>
<td>Auxiliary staff to be trained by physicians/midwives/nurses</td>
<td>Rayon maternities administration</td>
</tr>
<tr>
<td>D. Neonatal units nurses not included in training courses</td>
<td>Nurses lack knowledge to follow appropriate technologies for newborn care</td>
<td>Provide training courses for neonatal unit nurses</td>
<td></td>
</tr>
<tr>
<td>E. Participants from rayon maternities not decision makers, even if number of providers sufficient to represent maternity</td>
<td>Barriers against implementing changes when trainees returned to the home facility</td>
<td>Include maternity decision makers (chief midwife, chief of the delivery unit, head of the maternity)</td>
<td></td>
</tr>
<tr>
<td>F. providers don’t share information with colleagues</td>
<td>Changes do not occur if number of trained providers too small</td>
<td>Use national, local conferences, meetings to share knowledge, train colleagues (order)</td>
<td></td>
</tr>
<tr>
<td>J. Too small a number of facilitators in each rayon</td>
<td>Dissemination did not occur</td>
<td>I. Train more facilitators II. Include sharing of knowledge in list of medical staff responsibilities</td>
<td></td>
</tr>
<tr>
<td>H. EOC insufficiently reflected in pre-service and in service curricula</td>
<td>Young providers lack knowledge of new appropriate technologies</td>
<td>- I. Update pre-service, in service curricula - II. Use model sites for clinical practice of young physicians, midwives/nurses</td>
<td></td>
</tr>
<tr>
<td>I. WHO MPS EOC courses have to be integrated into other trainings funded trough different projects</td>
<td></td>
<td>- I. Integrate EOC course, ante-natal-intranatal-care courses, perinatal programme - II. Develop single course based on country needs</td>
<td></td>
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State Medical University, Medical Colleges, pilot maternities
WHO EURO, Donors: UNFPA, UNICEF, SDC, State Medical University, medical colleges, pilot maternities
### Follow up visits after EOC courses

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</thead>
<tbody>
<tr>
<td>I. Tools for follow up visits: WHO 11 questionnaires</td>
<td>A. Translation of questionnaires not very good</td>
<td>Misunderstandings</td>
<td>Check quality of translation</td>
<td>Partner programmes</td>
</tr>
<tr>
<td></td>
<td>B. Questionnaires do not have questions about each course participants contribution to implementation</td>
<td>Not all barriers to implementation can be detected</td>
<td>Include these questions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Questionnaires do not permit evaluation of technologies impact on quality indicators</td>
<td></td>
<td>Include questions to evaluate technologies impact on quality indicators (for ex. pain relief with drugs)</td>
<td></td>
</tr>
<tr>
<td>II. Follow up visit (Orhei only)</td>
<td>A. Short duration for observation of delivery</td>
<td>Wrong conclusion about implementation</td>
<td>Increase duration of follow up visit to 2-3 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Team included only obstetricians</td>
<td></td>
<td>Have mixed follow up team (neonatologist, nurse, midwife)</td>
<td></td>
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<tr>
<td></td>
<td>D. Only one visit after 6 months not enough</td>
<td>One visit does not assure sustainability</td>
<td>Practice repeated follow up visits</td>
<td></td>
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<tr>
<td></td>
<td>E. Local staff not involved in follow up</td>
<td>Local staff feels controlled</td>
<td>Practice self assessment using follow up tools</td>
<td></td>
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<tr>
<td></td>
<td>F. Maternity staff not informed by administration of follow up</td>
<td>Existing gaps cannot be</td>
<td>Maternity administration to share findings</td>
<td></td>
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### Planning for appropriate technologies

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<tbody>
<tr>
<td>Course materials: presentations, translated materials on planning, healthy newborn manual, CD Cochrane Library</td>
<td>Too short duration of Babies, TQM component (2 days) Babies, TQM components not integrated with planning part of course Practical part too short</td>
<td>- I. Train national trainers in planning for appropriate perinatal care - II. Provide training courses with Babies and TQM components integrated in planning for appropriate perinatal care</td>
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### Development of human resources through participation at regional/global activities

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<tbody>
<tr>
<td>Participation of local providers in regional/global trainings, meetings</td>
<td></td>
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</tr>
<tr>
<td>A. Small number of facilitators trained by participation at regional/ global trainings</td>
<td>Financial</td>
<td>Invite external expert to MDA Invite local providers to regional/ global trainings</td>
<td>WHO + other donors</td>
<td></td>
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<tr>
<td>B. Implementation of acquired knowledge/skills</td>
<td>Barriers to carrying out scientific research financial, etc. Research - no direct impact on quality of life</td>
<td>Conduct multidisciplinary research (medicine+economy; medicine+social care, culture, psychology) in priority areas Find external donors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Medical facility not involved in regional/ global research projects</td>
<td>Do not know where and how to find partners/donors</td>
<td>Select national institution to become WHO Collaborating Centre</td>
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### Priorities for human resource development for 2004–06

- New/updated training courses:
  1. Planning for appropriate technologies + Total Quality Management + BABIES matrix + EBM
  2. EBMNC courses for guidelines authors
  3. Extension of the EBMNC training courses for obstetrical + neonatal
  4. Train local staff on quality assessment and follow up of implementation of appropriate technologies
  5. Essential newborn courses for neonatologists and medical assistants
  6. Develop the maternal and perinatal audit methodology
  7. Build up audit teams in health facilities (hospital and university’ clinics)
  8. Form audit teams dealing with specific problems (deaths, near miss cases)
  9. Assessment of the quality of technologies implementation at the PHC level: use 4 questionnaires (medical staff, mothers, antenatal visit observation, health facility)
  10. Home care of mother and newborn for PHC staff
  11. Incorporate elements of MPS into the „Life skills education” manual, with MoH and Ministry of Education partners
  12. To incorporate MPS hours into the university and medical Colleges curricula
  13. Carry out of scientific obstetrical and neonatal researches based on appropriate study methodology
  14. Train a team of midwives as national trainers
3 Group 3 - Improving Family and Community practices

Participants:

- Petru Stratulat
- Petru Nedelciuc
- Ludmila Chitic
- Vasile Rotaru
- Ion Bologan
- Natalia Zarbailov
- Valentina Baltag

Issues discussed

1. List of key family and community practices from the MPS perspective:
   - existing sources
   - assessed practices
   - need’s assessment
   - recommendations 1, 2

2. Consistency of existing messages targeted at caretakers and community with MPS principles:
   - Existing sources of messages
   - Review of existing health education and promotion messages for compatibility with MPS recommendations.
   - Problems with delivering messages
   - Recommendation 3

3. Human resources
   - participation of community health workers in MPS activities
   - constraints
   - recommendation 4

Discussion results

1. List of key family and community practices from the MPS perspective:

   - Existing sources about key family and community practices from the MPS perspective:
     - Reproductive Heath Study, 1997
     - Perinatal Programme evaluation studies, 2001 and 2002
     - The situation of children in MDA, UNICEF
     - Family care practices, UNICEF, 2002

   - Assessed practices:
     - Early start of antenatal care
     - Number of antenatal visits
     - Participation in psycho-emotional preparation of pregnant woman and family
- Knowledge about danger signs during pregnancy
- Birth control
- Diet and nutrition during pregnancy
- Work and life conditions
- Risk behaviour during pregnancy (alcohol, drugs, smoking)
- Participation in decision making process during pregnancy, childbirth and postpartum
- Use of the Perinatal Card
- Family support in labour
- Skin-to-skin contact, early breastfeeding, rooming-in
- Exclusive breastfeeding, duration, time of supplement addition
- Post-partum contraception

- Needs assessment, women’s and family’s practices:
  - Was pregnancy wanted or not? Expected or not? (by one parent or both)
  - Use of drugs during pregnancy without medical prescription
  - Family and community attitudes to particular situations (adolescent, single, etc)
  - Danger signs during pregnancy (where to go, whom to call, who is a referral person and who informed her about plan in case of danger?)
  - Knowledge and practices about HIV and STIs
  - Attitude towards Fe, folic acid and iodine supplementation
  - Hygiene and sexual behavior of pregnant women
  - Knowledge about rights of pregnant women and mothers
  - Knowledge about place where childbirth will take place
  - Knowledge about signs of labor onset
  - Violence in pregnancy and post-partum
  - Knowledge about care of baby at home
  - Access to medical services (antenatal care, family planning, abortion)

- Needs assessment, community practices:
  - Knowledge of local public administration about situation of mother and child health
  - Local public administration’s attitude towards pregnant women – social support, opportunities of help in case of emergency
  - Community support to socially vulnerable families
  - Problem discussions at local administration meetings
  - Existing links between community and medical facility
  - Knowledge of local public administration regarding legal framework on mother and child health
  - Health education in schools

- Recommendation 1
  - Assess key practices
    - Access to health services from the family and community perspective (domestic violence aspects, financial constraints, family support, etc; perinatal care, family planning, abortion)
    - Participation of local public administration in mother and child health protection

- Recommendation 2
Promote messages with behavioural impact concerning:
- Knowledge and action if signs of danger during pregnancy occur (emergency plan)
- Planning childbirth and use of medical services
- Community involvement in mother and child health protection

2. **Consistency of existing messages targeted at caretakers and community with MPS principles**

- **Existing sources of messages:**
  - The guide for the future mother
  - Pregătirea psihoemoțională a gravidei și membrilor familiei ei
  - Guide for parents: *Our child*
  - Posters breastfeeding
  - Educational materials on safe abortion

- **Review of existing health education and promotion messages for compatibility with MPS recommendations**
  - Perinatal Card (official statistics form) has been tested in judet Orhei
  - Revision of the Perinatal Card:
    - Added detachable pages *Information about the post-partum* and *Information about the newborn*
    - Content messages about HIV, iodate salt

- **Problems with delivering messages**
  - Insufficient MPS educational materials (sources, lack of coordination, chaotic character)
  - Too many messages
  - Messages not prioritized

- **Recommendation 3**
  - Prioritize messages
  - Coordination and cooperation with partners in delivering messages
  - Integration (revision) of messages in Perinatal Card and *Guide for future mother*

3. **Human resources - participation of community health workers in MPS activities:**

- **Participation of community health workers in MPS activities**
  - Antenatal care training courses for family doctors, nurses, rayon obstetricians, coordinators of centres of family medicine
  - Duration of the training: 6 days
  - Interactive learning, topics:
    - RH in MDA
    - STIs and pregnancy, HIV
    - Hygiene, nutrition, sexual behaviors of pregnant woman, travels, smoking, alcohol consumption during pregnancy, etc., harmful behaviors
    - Minor problems in pregnancy
    - Emergency situations in pregnancy, labor and post-partum
    - Violence in pregnancy
Psycho emotional preparing of the pregnant woman and family

- Constraints:
  - No specialists trained to interact with family and community, lack of counseling skills
  - Absence of national concept of interaction with family and community in the field of mother and child health

- Recommendation 4
  - Development of a national concept for interaction between family and community in the field of MPS
Annex 6 - Summary of working group recommendations

1 Group 1 - Health system organization and management

1. Coordination of MPS
   - Set up coordination committee at central level for periodical evaluation of the programme and adjustment of working plan as necessary.
   - Set up responsibility for implementation of MPS interventions at rayon level.
   - Ensure that key stakeholders at all levels have access to full information regarding implementation of the action plan, materials, etc.
   - Update laws, norms and regulations related and mother newborn care based on MPS/WHO recommendations, with special regard to Ministry of Health decree 165.
   - Identify training needs in coordination with rayons
   - Promote and disseminate of MPS principles and recommendations at central and local levels.

2. Finance
   - Identify mechanisms for protecting vulnerable population.
   - Implement the WHO Mother and Baby Package costing tool at referral levels I, II, III.
   - Update the basic health services package based on officially approved clinical protocols.
   - Analyse whether the current contract-based finance provides enough incentives for providers to apply evidence-based and cost-effective intervention.
   - Stimulate family and community involvement in promoting the use of appropriate technologies.
   - Involve local public administration in exploiting (fixed) expenditures

3. Health services delivery
   - Define responsibilities according to referral levels to include family doctor, updating guidelines where necessary.
   - Ensure coordination between PHC and hospital care.
   - Continue training in relevant areas (EBM, EOC, ENCBF, others).
   - Ensure implementation of approved clinical protocols.
   - Continue training of health managers.

4. Health system resources
   - Clearly define services provided by family doctors in antenatal care.
   - Identify partners initiatives in difficult areas
   - train staff to increase access to antenatal care
   - Ensure training of health care providers according to clinical guidelines.
   - Ensure monitoring of essential drug availability based on clinical protocols.
   - Use investment opportunities for renovation and maintenance of institutions.

5. Health system management
   - Revise responsibilities at different levels of care and their reflection on administrative structures.
   - Continue training decision makers in health system/services management.
   - Monitor implementation status through the National Information Center for Perinatal Care
   - Continue improvement of data collection and information system.
2 Group 2 – Human resources

   - New/updated training courses
     - PAT + TQM + BABIES matrix + EBM
     - EBMN courses for guideline developers
     - Extension of EBMN training courses to obstetricians + neonatologists
     - Quality assessment and follow up of implementation of MPS PAT course for local staff
     - ENC/BF courses for neonatologists and nurses
     - Team of midwives trained as national trainers for EOC
     - Incorporate MPS components into University and Medical Colleges curricula
     - Home care of mother and newborn training for PHC staff

2. Maternal and perinatal audit introduction
   - Develop maternal and perinatal audit methodology
   - Build up audit teams in health facilities (hospitals and university’ clinics)
   - Form audit teams for specific problems (deaths, near miss cases)
   - Assessment of quality of technologies implementation at PHC level

3. Incorporate elements of MPS into the Life skills education manual together with MoH and MoE

4. Carry out of scientific obstetrical and neonatal research based on appropriate study methodology

3 Group 3 – Improving family and community practices

- Assessment of key practices
  - Access to health services from a family and community perspective (in cases of domestic violence, financial constraints, availability of transportation, family support, etc.)
  - Participation of local public administration in MCH protection

- Action
  - Promote messages with behavioral impact concerning:
    - Knowledge and actions if signs of danger during pregnancy occur (emergency plan)
    - Planning for childbirth and use of medical services
    - Community involvement in protection of MCH
  - Ensure consistency of existing messages targeted at caretakers and community with MPS principles
  - Review of existing health education and promotion messages to ensure compatibility with MPS recommendations
  - Address problems with delivering messages:
    - Prioritize messages
    - Coordination and cooperation with partners in delivering messages
    - Integration (revision) of the messages in the Perinatal Card and Guide for future mothers
• Human resources
  − Participation of community health workers in MPS planning, implementation and follow-up activities
  − Antenatal care training courses for family doctors, nurses, rayon obstetricians, coordinators of centres of family medicine

• Policy framework
  − Development of the national concept of interaction with family and community in the area of MPS
Annex 7 – Guide for review of MPS early implementation phase

- **Step 1 - Assess what has been achieved in each of the major activity areas, identify constraints, and specify the resources required**

  - **Tasks**
    1. List specific objectives, if any, for the component or area under review
    2. List activities that were planned
    3. Assess status of implementation of planned activities and their quality
    4. Examine resources that were required to implement activities and specify capacity built for implementing the various activities
    5. Identify achievements (specific objectives met, planned activities completed with good quality)
    6. Identify constraints
    7. Present findings in plenary and revise as necessary

  - **Methods to complete tasks**
    - Review documents, such as the report of the early implementation phase and specific documents related to the area under review
      - Use questions listed in checklist *Issues relevant to the status and quality of MPS implementation* according to major areas to assess quality of activities and capacity building
      - Discuss within group and draw upon individual experiences to complement available information.

  - **Guidance for completing the tasks of Step 1**
    - Take some time for every group member to read the report *Implementation of Making Pregnancy Safer 2002-2003* (7). Distribute other available documents among the group and ask one person to read each document and take note of the content so that this can be referred to during discussions
    - For the area or component under review, decide what the specific objectives were. They may be stated in the report or you may have to define them based on your knowledge of what the MPS WG intended to achieve.
      - **Example:** Specific objectives for the area *organization and management* might be:
        - to create a management structure which enables all relevant programmes, institutions and partners to contribute to implementation of MPS
        - to ensure consistency with policies relevant to MPS
        - to build capacity at national and district levels for planning, coordination, and supervision of MPS activities
    - Review questions relevant to the area under review on the checklist:
      - *Issues relevant to the status and quality MPS implementation* according to major areas. Use the questions as a guide to help you complete the subsequent tasks.
    - Identify the activities that were planned in the area under review.
      - For some areas, such as ‘Training of first-level health workers’, there may be a clear plan, which lays out specific activities.
      - For other areas, there may be no specific plan. The questions in the checklist will help you define the activities that are relevant.
− For all activities, assess their implementation status (whether they were implemented fully, partially or not at all) and their quality. The checklist provides you with criteria of good practice.
− Identify the resources that were needed to implement the planned activities, both financial and human. Identify the capacity that was built to implement future activities.
− Identify achievements in terms of (i) completed activities of good quality, (ii) progress towards the specific objectives, (iii) capacity built. To identify progress towards specific objectives, use the data that were collected as part of documentation of the early implementation phase provided in the MPS reports. Data from follow-up after training (and if available, from routine supervision) are particularly relevant to assess improvements in health care delivery.

Example 1: The specific objective of training health workers on Evidence Based Medicine was to improve their skills of clinical guidelines development.

   Considerable progress has been made towards this objective as AGREE appraisal of developed guidelines demonstrated that (7):

   − the score per Domain 1 increased by….%
   − the score per Domain 2 increased by….%
   − the score per Domain 3 increased by….%
   − the score per Domain 4 increased by….%
   − the score per Domain 5 increased by….%
   − the score per Domain 6 increased by….%

Example 2: A specific objective under ‘organization and management’ was to create district ownership for MPS. At the end of the early implementation phase, district health authorities had allocated a budget for MPS and included MPS activities into the district health plan for the next year. There is a clear commitment on their part to ‘own’ the MPS strategy.

• Identify constraints that impeded implementation of planned activities or progress towards the objectives.

   Example: Some SanEpi regulations are contradictory to the MPS message of “home like” delivery rooms. This fact creates skepticism at some health providers about the possibility to build “home like” delivery rooms.

• Present the findings in the plenary meeting. Discuss them with other groups and be prepared to receive feedback and comments.

• Complete or revise the findings before moving to the next step.

➢ Step 2 Identify feasible solutions for the constraints

• Tasks for Step 2

  – Review the list of constraints and summarize them in main problem statements
  – For each main problem, discuss the causes
  – Brainstorm on possible solutions to overcome the problems
  – Select realistic solutions based on relevance, efficiency and feasibility
  – Present the findings in a plenary session.
• Methods to complete the tasks
  − Group discussion
  − Application of criteria to select realistic solutions
• Guidance for completing the tasks
  − Look at the list of constraints identified in Step 1. You may find that some constraints are similar in nature or related. Try to define a limited number of problem statements which capture the most important constraints. This will help to find the most relevant, efficient and feasible solutions.
  ▲ Example: In the area of ‘organization and management’, the list of constraints include:
    • no formal MPS Working Group established
    • limited interest among programmes to contribute to MPS
    • no adequate manpower to plan, coordinate and monitor activities
    • no budget line for MPS
    • limited support from key decision-makers
    • limited involvement of district health team in implementation of activities
    • no district budget for MPS
    • MPS not included in district plans
The constraints can be captured in the following problem statements:
  − decision-makers are not well committed to the MPS strategy
  − the MPS strategy has not yet been institutionalized in the MOH
  − district health authorities have not yet taken ownership of the MPS strategy
• For each problem statement, discuss the causes.
  − Example: Decision-makers are not well committed to the MPS strategy. It is noted that few of them have participated in an orientation meeting. They were not kept informed as activities were planned. Results from follow-up have not been presented to them to illustrate the progress that has been made.
• Brainstorm freely on possible solutions to overcome the problems.
  − Example: Conduct an orientation and coordination meeting involving key officials in the Ministry of Health, and representatives from partner organizations, with the aim to reach a common understanding about the MPS strategy and to reach consensus about the place of the MPS strategy in the national health development plan. Organize periodic meetings involving senior staff in the Ministry of Health and partner organizations, to brief them about the findings of follow-up after training and routine supervision, and to discuss mechanisms for concerted action to solve problems.
• Review the list of possible solutions and select those solutions that are most relevant, efficient and feasible.
  − to assess relevance, examine whether the solution is directly related to the cause of a problem and intended to remove that cause.
  − to assess efficiency, examine whether the solution is likely to be successful in removing or decreasing the cause of a problem.
to assess feasibility, decide whether the solution can be implemented with available personnel, funds and other resources. If not, can additional resources be obtained? Discuss whether these solutions alone have a significant impact on the problem, or whether certain other solutions must be linked to them.

Example: Referral presents a problem for health workers in many health centres.

Limited data indicate that a minimum delay of two hours can be expected. The referral hospital is badly equipped and the quality of care is low. Pregnant women have little confidence to go there. As part of the solutions, it is not enough to train health workers at referral care level. The management of referral centres should be strengthened through management support training that is part of health sector reforms. Also, community-based activities should aim to involve communities in facilitating transport of people requiring it. All these solutions are feasible, but require a long-term effort.

• Present the main problems (or problem statements) and the solutions that are relevant, efficient and feasible in the plenary meeting.
• Discuss the solutions in light of the findings of other groups. Complement and revise the list of solutions according to the feedback and comments provided by other participants.

Step 3 - Assess how the MPS strategy should be expanded and develop recommendations for what should be done

• Tasks of step 3
  – Decide on activities that are critical as a prerequisite for expansion
  – Decide on the relative emphasis of activities in each of the three components
  – Decide on the pace of expansion
  – Develop recommendations for what should be done.
• Methods to complete the tasks
  – Optional:
    ▲ Presentation in plenary session to introduce the objectives and implications of expansion (by MPS coordinator or external facilitator)
    ▲ Group discussion
    ▲ Plenary discussion to reach common conclusions and coherent recommendations

Preamble to the tasks

The aim of the final step is to decide how and at what pace the MPS strategy will be expanded. This is a critical step, which forms the basis for developing an implementation strategy and a plan of action during the planning meeting for the expansion phase. Participants will work in their original groups to answer these questions. Each group should not only focus on their area but also take into consideration other findings of the review. The plenary session at the end of the step will help to arrive at coherent conclusions.

Generally speaking, the approach for expansion (how and at what pace it should take place) can be captured in one of the following scenarios:
1. The findings of the previous steps have indicated that the MPS strategy meets the needs of the country. However, basic conditions to make its implementation successful are lacking. They need to be put in place before implementing a broader range of activities.

- Examples:
  - There is no clear management structure for MPS, and responsibilities for future implementation have not been allocated. This problem needs to be solved as a matter of priority. Only a functioning working group and a designated MPS coordinator will make it possible and feasible to implement the MPS strategy.
  - There are hardly any drugs at health facilities due to an acute breakdown in the central procurement and delivery system. This problem needs to be addressed, prior to implementing training of health workers.

2. The early implementation phase has been successful. It has been shown that the MPS strategy is suitable for the country. There is a strong central-level working group and districts are able to plan, implement and monitor activities. The recommendations can focus on expansion of the MPS strategy to other districts and on increasing the range of interventions, in line with national and district capacity and available financial resources.

- Example: During the early implementation phase, considerable capacity was built to implement MPS activities, particularly training and follow-up after training. There is a strong commitment to MPS at all levels. District authorities have initiated activities to improve drug availability and supervision. As care seeking is low, there is a need to focus more clearly on improving family and community practices in future. In this scenario, there is scope to expand the MPS strategy in line with existing capacity to other districts and to expand the scope of activities to include more interventions in all three components. When the group works on Step 3, the conclusions are likely to meet one of the above scenarios.

➢ Guidance for completing the tasks of Step 3

Look at the list of problems and realistic solutions developed in your group and consider the findings of the review overall. Decide how each problem will affect expansion. Specify whether there are any critical problems that should be solved prior to expanding other activities. Specify whether there are realistic solutions to solve these problems.

- Example 1: The MPS strategy has not yet been institutionalized in the Ministry of Health.

  Feasible solutions include the appointment of a full-time MPS focal point in the maternal and child health unit of the Ministry of Health and the establishment of an MPS Working Group. The implementation of these solutions is critical for expansion. They should be implemented as a priority, before proceeding to other activities. Without this, the MPS strategy can not be expanded successfully.

- Example 2: There are major differences in recording and reporting requirements for HIS and MPS. The MPS Working Group will discuss possible solutions and the current differences need not hinder expansion.

- Example 3: Referral care of pregnant women has proved to be inadequate in most places implementing MPS. The problems include reduced confidence in quality of
care at referral centres, difficulties in transport, and financial and social constraints of caretakers. The overall solutions to the problems will require inputs from various sectors and are unlikely to be achieved in a short time. The referral possibilities and potential for improving them need to be considered as criteria for expansion into new areas.

Decide on the relative balance of activities in the three components. Indicate how activities in the area under discussion should relate to activities in other components.

- Example 1: Training of health workers has been successfully implemented, but care seeking behavior is low. Only 20% of pregnant women needing specialized care are brought to health facilities. The group dealing with improving family and community practices recommends that in districts with MPS-trained health workers, community-based efforts should be undertaken to improve care-seeking behavior. The planning of intervention in this area should be balanced with planning the expansion of training.

- Example 2: The commitment and capacity of district health teams to the MPS strategy is low. It is important to allocate sufficient time and resources to conduct district orientation and planning workshops. National staff should also be available to help district authorities initiate key MPS activities and also sustain their quality.

Decide on the pace of expansion. Considering what would be needed at district and national level to make future implementation a success, assess what a feasible rate of expansion would be. Take into account existing capacity at all levels, including human, financial and other resources.

- Example: Considering that central-level input is required in at least the first two courses in each district and there is limited availability of central-level trainers, expansion of training should not exceed five rayons per year during the next two years.

Develop recommendations for what should be done in your area under review, based on the solutions to problems and your assessment of how and at what pace expansion should take place. State clearly:

- the activities that are critical for any future success of MPS implementation and should have priority
- activities that were implemented well and should be sustained
- what else should be done to overcome current constraints or expand into new areas of activity
- the emphasis on interventions in one area relative to other areas
- the recommended pace of expansion into new districts.

Present the findings in a plenary session. Make revisions in light of other groups’ findings. Work towards achieving a coherent set of recommendations that describe what should be done in future, balancing activities in all three components and setting clear priorities for immediate action.