



3rd Task Force
Making Pregnancy Safer/
Promoting Effective Perinatal
Care

From evidence to practice

Verona, Italy, 22 - 24 October 2003

Abstract

The reduction of maternal and infant morbidity and mortality rates has been a WHO priority for a number of years. In order to share experiences in the field and introduce new tools, WHO-Europe, through its programme on Child and Adolescent Health and Development, has organized a number of task forces over the years. The first one, which had the objective of reinforcing perinatal care strategies, was organized in Venice in April of 1998, in collaboration with the Department of Health of the Veneto Region of Italy. The second, in January 2000 in Bologna, organized in cooperation with the Emilia-Romagna Region of Italy, followed up on the recommendations of the 1998 meeting. The third task force was held in Verona in October 2003, organized jointly by the Department of Health of the Veneto Region, the WHO-Regional Office for Europe programme on Child and Adolescent Health and Development and the European Making Pregnancy Safer Initiative.

Keywords

PREGNANCY
QUALITY OF HEALTH CARE
MATERNAL HEALTH SERVICES
PERINATAL CARE
MIDWIFERY
GUIDELINES
EUROPE

© World Health Organization 2004

All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation “country or area” appears in the headings of tables, it covers countries, territories, cities, or areas. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

The World Health Organization does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use. The views expressed by authors or editors do not necessarily represent the decisions or the stated policy of the World Health Organization.

Contents

1	Introduction	2
2	Recommendations from the Task Force.....	2
3	Background	3
4	Objectives of the 3 rd MPS/PEPC Task Force.....	4
5	Opening session of the Task Force	4
6	Summary of previous task force meeting recommendations – Gian Paolo Chiaffoni ..	5
7	How the WHO-Europe Family and Community Health Unit works – Mikael Ostergren.....	5
8	MPS/PEPC in European Region: report on activities, future plans – Alberta Bacci....	6
9	Session 1 - Update on tools and manuals.....	6
9.1	MCPC, EOC and ENC/BF – Gelmius Siupsinskas.....	6
9.2	WHO/HQ: Essential newborn care course and other recent tools – Jelka Zupan.	7
9.3	Evidence-based mother and newborn care course – Tengiz Azatiani.....	7
9.4	Beyond the numbers – Alberta Bacci.....	7
9.5	MPS Planning for appropriate perinatal care course – Fabio Uxa.....	8
9.6	Preventing HIV infection in infants– Mikael Ostergren	8
9.7	Follow up tools – Dalia Jeckaite	8
9.8	Standards of care – Gianfranco Gori.....	9
9.9	MPS and research – Giovanni Zanconato	9
9.10	Implementing communication through telemedicine – Gian Paolo Chiaffoni	9
10	Session 2 – Working on clinical guidelines and protocols	10
10.1	Introduction – Alberta Bacci.....	10
10.2	Country experience in using scientific evidence to develop guidelines – Valentina Baltag.....	10
11	Session 3 – Quality of care.....	10
11.1	Quality of care: keeping birth normal – Alberta Bacci	10
11.2	Psycho social aspects of perinatal care – Beverley Chalmers.....	11
11.3	Human management of the sick child – Adik Levin.....	11
11.4	The challenge of keeping birth normal in the European region – Gelmius Siupsinskas and Gianpaolo Chiaffoni	11
11.5	Normality in childbirth: the role of midwifery – Polli Glatleider	12
11.6	Quality of hospital paediatric care – Giorgio Tamburlini.....	12

11.7	Quality of maternal and newborn care – Alberta Bacci	12
12	Closure	13
	Annexes 1 - Programme.....	14
	Annex 2 – List of participants.....	17
	Annex 3 – Working Group outcomes	19
1	Group work on manuals and training: EOC, ENC/PBF, Follow-up after training, EBMN	19
1.1	Group 1	19
1.2	Group 2.....	20
1.3	Group 3.....	21
2	Group work: Prototype structures for guidelines	21
2.1	Group 1 - Obstetric haemorrhage.....	22
2.2	Group 2 –Newborn asphyxia.....	23
2.3	Use of the partograph	25
3	Group work on quality of care	27
3.1	Group 1 – eight steps to improve quality of care	27
3.2	Group 2 – MPS/PEPC principles and values	27
3.3	Group 3 – recommendations for midwives caring for women in labour: meeting physical and emotional needs.....	30
	Annex 4 – Principles for MPS/PEPC in the European Region.....	30
	Annex 5 – Pre-meeting: brainstorming on quality of mother and newborn care.....	30

Glossary

BFHI	Baby friendly hospital initiative
BTN	Beyond the numbers
CAH	Child and Adolescent Health and Development
EAPPC	Essential antenatal and post-partum care
EBMN	Evidence-based mother and newborn care
ENC/PBF	Essential newborn care promotion of breastfeeding
EOC	Essential obstetric care
IMPAC	Integrated management of pregnancy and childbirth
MCPC	Managing complications in pregnancy and child birth
MDG	Millennium development goals
MoH	Ministry of Health
MPS	Making Pregnancy Safer
MTCT	Mother-to-child transmission of HIV
NICU	Neonatal intensive care unit
PAPC	Planning for appropriate perinatal care
PAT	Planning for appropriate technologies
PCPNC	Pregnancy, childbirth, postpartum and newborn care
PEPC	Promoting Effective Perinatal Care
PHC	Primary health care
ToT	Training of trainers
UNICEF	United Nations Children's Fund
WHO/HQ	World Health Organization, Headquarters (Geneva)
WHO-Europe	World Health Organization, Regional Office for Europe

1 Introduction

The reduction of maternal and perinatal morbidity and mortality rates has been a WHO priority for a number of years. In order to share experiences acquired in the field and introduce newly developed tools, WHO Regional Office for Europe, through its programmes on Making Pregnancy Safer (MPS) and Child and Adolescent Health and Development (CAH), has organized a number of task forces over the years. In April of 1998, the first workshop¹ – to reinforce perinatal care strategies – was held in Venice in collaboration with the Department of Health of the Veneto Region of Italy. In January 2000, the second task force² was held in Bologna, in cooperation with the Emilia-Romagna Region of Italy, to follow up on the recommendations from the 1998 Venice meeting.

With the objective of reinforcing perinatal care strategies – from evidence to practice in implementing maternal and perinatal care – a third task force was held from 23 to 25 October 2003 at the Regional Centre for Health Promotion, in Verona, Italy. This activity was organized jointly by the European MPS Initiative, the WHO-Europe CAH programme and the Health Department of the Veneto Region of Italy.

Participants included European experts from a number of countries, who have over the past two years been involved with implementation of mother and child health interventions, as well as Italian professionals from the fields of paediatrics, obstetrics and neonatology.

Amongst other recommendations, the Verona Task Force added a tenth item to the MPS/PEPC principles, that care should respect the privacy, dignity and confidentiality of women.

2 Recommendations from the Task Force

It was concluded that the training courses and training material are basically good for topics, methodology, focus on an inter-active approach, have an adequate clinical component, are flexible, and consider both regional experience and that of practicing healthcare providers.

Taking into consideration the principles for MPS/PEPC in the European Region, it was decided that a 10th principle should be added (the Verona Principle: *Care should respect the privacy, dignity and confidentiality of women*)³ to the nine already existing.

As an example of how a multi-disciplinary group can develop clinical guidelines and protocols, three evidence-based *prototype structures*¹¹ for guideline-making was prepared.

Participants made the following recommendations:

1. Training manuals and materials:

¹ Workshop on Perinatal Care. Report on a WHO meeting. Venice, Italy, 16-18 April 1998. WHO-Regional Office for Europe, Copenhagen, Denmark, 1998

² Second Meeting of the Perinatal Care Task Force. Report on a WHO Meeting. Bologna, Italy, 26-29 January 2000. WHO Regional Office for Europe, Copenhagen, Denmark, 2001

³ See Annex 4

1. Update manuals both in *format* (more user friendly) and *content*, taking into consideration recently published scientific evidence and emerging issues such as prevention of HIV in infants.
2. Expand the *clinical* (practical) course *component* (including ENC/PBF).
3. Strengthen the *psycho-social* approach.
4. Increase the number of teaching and training tools.
5. Consider partner support in *translating manuals* and *materials* into local languages.
2. Training courses:
 6. *Multidisciplinary training* should be reinforced to ensure that care involves key professionals through participation of an appropriate varied choice of professionals, with more than one participant from each institution.
 7. Added emphasis on *pre-service* rather than *in-service* training.
 8. Target the *PHC family team* (doctors, midwives, nurses) as course participants.
3. Trainers/facilitators
 9. The role of the *midwife* as a *trainer* should be enhanced.
 10. Trainers should visit the *local health facility* where clinical part of course will take place prior to training.
 11. Ensure *progressive monitoring of trainees* (consider awarding trainer certificates after follow-up to verify changes in clinical practice).
4. Set up national *centres of excellence*
5. *Women, family and community* should be educated to ask for evidence-based care.
6. Assessment of hospital based *quality of mother and newborn care* using the existing example⁴.

3 Background

Motherhood is a positive and fulfilling experience for most women; however, pregnancy and childbirth can also be associated with suffering, ill health or even death. In the European region, wide differences still exist between and within countries in mothers' and newborn babies' morbidity and mortality, as well as in access to and the quality of care.

Over the past decade, WHO-Europe has implemented a number of interventions in perinatal care and reproductive health within the framework of the Safe Motherhood Initiative. In particular, perinatal strategies were developed to make these applicable to the European Region Member States. The main principles were to demedicalize maternal and perinatal care, ensure care is based on appropriate technologies, takes a holistic approach and is family-centered. This regional approach, known as Promoting Effective Perinatal Care (PEPC), addresses the health system, community and family practices. The PEPC tools, developed to update knowledge and skills of health care providers, have been extensively used in the region.

The MPS global initiative was launched in 2000 and was built on more than a decade's experience of the Safe Motherhood movement. Interventions that can prevent maternal and perinatal mortality from 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

⁴ Assessment of quality of hospital-based paediatric care. Republic of Moldova, Kazakhstan, the Russian Federation. WHO Regional Office for Europe, May-June 2002.

baby, early detection and management of complications and ensuring that quality services are available and accessible close to where women live.

The regional initiative PEPC was incorporated into the MPS strategy at the workshop *MPS essential tools for training* (December 2001)⁵, with participation of key regional experts from the area of perinatal care. Participants agreed that the PEPC principles and framework continue to be relevant to the European Region and should be combined with the MPS strategy and tools.

4 Objectives of the 3rd MPS/PEPC Task Force

The objectives of the 3rd meeting of the Task Force were to:

- Introduce new tools: Managing Newborn Problems: *Pregnancy, childbirth, postpartum and newborn care* (PCPNC), follow-up after training, *Beyond the numbers*: (BTN) audit of maternal and newborn deaths, standards of care, telemedicine;
- Discuss updating and integration of training materials and optimization of training courses;
- Develop prototypes for clinical guidelines (obstetric haemorrhage, newborn asphyxia, use of partograph); and
- Discuss issues of quality of care.

5 Opening session of the Task Force

Collaboration between the Health Department of the Veneto Region and WHO-Europe started in 1997 in the area of public health, when the Veneto Region supported technically and financially the CARAK⁶ project, which targeted reduction of maternal and infant mortality and morbidity in the central Asian Republics. The present Task Force aims of developing strategies to reduce mortality and improve the quality of perinatal care is a natural next step in the collaboration between WHO and the Veneto Region.

The Task Force was opened by Ms Maria Luisa Coppola, Regional Minister for International Cooperation, on behalf of the President of the Veneto Region. Ms Coppola said she felt that the Task Force was in line with other activities where the Veneto Region collaborates with WHO and other UN agencies. Veneto is the first region in Italy to have enacted a specific law on international cooperation on health and development.

In his opening for WHO-Europe, Dr Mikael Ostergren said that this is not the first time that a meeting has been organized together with the Veneto Region. The Veneto Region's collaboration at this meeting and in various other activities is highly appreciated by WHO. Maternal and child health is one of the major priorities not only in Europe but world wide; the UN's Millennium Development Goals (MDGs) include a specific goal on maternal and child health⁷. At the WHO-

⁵ Workshop Making Pregnancy Safer Essential tools for Training, 03-07 December 2001. WHO Regional Office for Europe, Copenhagen, Denmark, March 2002.

⁶ Strengthening maternal and child health in the Central Asian Republics, 1997-2000.

⁷ To reduce, by the year 2015, maternal mortality by three quarters, and under five mortality by two-thirds of their 1990 levels.

Europe Regional Committee held in September this year, the Member States approved a Resolution emphasizing child and adolescent health⁸.

The challenge for participants will be to meet the goals the Task Force has set itself on how to improve and implement MPS/PEPC strategies, and how to follow-up on the recommendations made by participants of previous Task Force meetings. WHO-Europe feels privileged by the close collaboration of WHO in Geneva and especially the Veneto Region.

6 Summary of previous task force meeting recommendations – Gian Paolo Chiaffoni

The MPS/PEPC Task *Force from evidence to practice* builds on the following previous activities:

- MPS/PEPC training of trainers, Copenhagen, Denmark, February 2002.
- MPS/PEPC Workshop, MPS essential tools for training, Copenhagen, Denmark, December 2001
- 2nd meeting of the PEPC Task Force, Bologna, Italy, January 2000
- 1st meeting of the PEPC Task Force, Venice, Italy, April 1998

The Venice meeting (1998) set out nine basic principles for effective perinatal care (see Annex 4), and recommended that these principles and values be widely disseminated. Recommendations included the development of needs assessment and monitoring and evaluation tools. The Bologna meeting (2000) recommended that management of perinatal care programmes focusing on planning, monitoring and evaluation be implemented.

Both Task Force meetings also attempted to identify indicators that would evaluate the outcome of care, and recommendations included proposed process indicators for management of ante-partum haemorrhage, management of labour and exclusive breastfeeding.

7 How the WHO-Europe Family and Community Health Unit works – Mikael Ostergren

In an overview of MCH in the European Region, Dr Ostergren spoke of the maternal and infant mortality rates and the trends in neonatal deaths. There continues to be a wide gap in the outcomes of care not only between but within countries as these relate to the 20% richest and 20% poorest of the population. The differences between countries in total expenditures for health and the way health care resources are utilized in a number of setting was also shown. In closing, Dr Ostergren said it was necessary to bring essential components together to improve MCH: policy and health system support, appropriate case management and good family and community practices.

⁸ Regional Committee for Europe, Fifty-third session, Vienna, Austria, 8-11 September 2003. Resolution: the health of children and adolescent in WHO's European Region

8 MPS/PEPC in European Region: report on activities, future plans – Alberta Bacci

MPS is a health sector strategy for reducing maternal and perinatal morbidity and mortality being implemented by WHO and its partners. The strategy assists the health sector focus on the prevention and management of unwanted pregnancies and unsafe abortions, ensuring availability of skilled care during pregnancy and childbirth and the widest possible access to referral care when complications arise.

MPS concentrates on the training of providers using global tools adapted to the European Region at courses with both theoretical and clinical components. MPS also builds capacity through identifying centres of excellence as a basis for scaling up implementation to the highest level. To ensure up-to-date and evidence-based care, a course for guideline makers creates local capacity for changing both guidelines and practices and as a basis for pre-service training. A course on planning for appropriate perinatal care supports identification of priorities and plans for maternal and perinatal care based on scientific evidence.

9 Session 1 - Update on tools and manuals

9.1 MCPC, EOC and ENC/BF – Gelmius Siupsinskas

In an overview of the MPS/PEPC training packages, Dr Siupsinskas said that the main areas for training are case management, communications and counselling. Each package is made up of manuals for participants and facilitators, visual aids (slides, videos) and selected additional reading material. Training activities include formal presentations, video, slide sessions, clinical exercises and case studies, role play sessions, field visits, auto evaluation and planning for implementation. The methodology is supported by evidence-based materials and specifically addresses multidisciplinary team work.

Following the expert meeting in December 2001⁵, a module was added to the ENC/PBF training package on infections, including MTCT (piloted in Samara, the Russian Federation, in December 2002⁹), and neuro-behavioural assessment of the newborn. At this time, the global MCPC (IMPAC) manual was adapted to conditions in the European Region and field tested in Kyrgyzstan (April 2002).

Participants from past training courses have proposed that, to improve training, there should provide longer periods set aside for exchange of experiences, additional practical sessions and clinical exercises, and an expanded coverage of topics. Future revisions and updating of course material should focus on an evidence-based orientation, building regional and local capacity, promoting changes in attitudes, increased midwifery participation in the multidisciplinary team, and pre-service, rather than in-service, training.

⁹ Improving infant and child health in the Russian Federation. A joint DFID and WHO-Europe project. The Samara oblast. Final Outcome Report 2000-2003. WHO Regional Office for Europe, Copenhagen, April 2003.

9.2 WHO/HQ: Essential newborn care course and other recent tools – Jelka Zupan

The latest addition to the global MPS initiative tools is a manual for *Managing newborn problems*, targeted at doctors and nurses in small hospitals with limited resources who do not have specific training in neonatology but work with newborn infants. A guide to antenatal care, *From research to action*, is based on the WHO antenatal care randomized trials. Work is ongoing in the areas of prevention of hospital acquired infections and the clinical use of blood. In the area of reproductive health, social science has become a method for research.

An area prioritized by WHO/HQ is working with individuals, families and communities to improve maternal and newborn health. The objectives are to increase empowerment and access to and utilization of health services through developing capacities, increasing awareness and improving quality of services.

9.3 Evidence-based mother and newborn care course – Tengiz Azatiani

The main challenges in the European region to achieve full implementation of MPS/PEPC recommendations are, firstly, the rigid legislation and vertical centralization within the health care system; and, secondly, limited motivation among providers, limited access to the international scientific environment and little possibility of participating in service quality improvement. Among clients, there is a lack of awareness of the rights and duties inherent in the health care system and low involvement in decision making.

A key requirement for appropriate care is the availability and use of updated clinical guidelines. To support professionals in developing such guidelines, MPS, in partnership with Scotland, Georgia and the Republic of Moldova, developed the training course *Evidence-based mother and newborn care*. This tool has been used in the Republic of Moldova, Ukraine and Uzbekistan and is planned for implementation in other countries.

9.4 Beyond the numbers – Alberta Bacci

Beyond the numbers (BTN) is a new tool developed to review maternal deaths and complications in order to make pregnancy safer. Maternal mortality rates do not give the real reasons why mothers die, who these women are, or an insight into avoidable or remedial factors. The underlying BTN principles are that, in order to reduce maternal mortality, a clear understanding of the factors leading to women's deaths is needed; that preventing maternal deaths is possible, even in resource-poor countries. Each maternal death has a story to tell and can provide indications on practical ways of addressing the problem.

BTN recommends a surveillance cycle: identify cases, collect information, analyse the results, recommend action, evaluate, refine ... and restart. A pre-requisite for the success of BTN is a commitment to act upon the findings of reviews.

9.5 MPS Planning for appropriate perinatal care course – Fabio Uxa

Many countries has seen widespread introduction of expensive technologies without prior cost evaluation or effectiveness assessments, availability of adequate technical support or proper training of staff. The MPS course *Planning for appropriate perinatal care* was created to help planners and decision-makers identify priorities, choose appropriate technologies and optimise their use in organizing and providing health care. Two regional courses¹⁰ have taken place, both organized in collaboration with UNICEF, covering ten countries in the Region. At each course, country representatives developed a draft of a national plan of action for appropriate perinatal care.

The course has been modified to take into consideration participants' evaluation, for example, allowing greater interaction among participants and presentations of lessons learned during implementation. It should be remembered that the course is an introduction to the subject, and that each topic needs further work at national level by using local data for development of a more detailed plan of action. Skills are progressively acquired on the job, through consecutive cycles of planning, implementation, monitoring and evaluation.

9.6 Preventing HIV infection in infants– Mikael Ostergren

The European region, particularly in the Eastern part, is facing one of the fastest growing HIV/AIDS epidemics in the world. The number of HIV-infected women is steadily increasing as is the transmission of the infection to newborns. However, high antenatal care coverage, availability of an extensive health care infrastructure, high literacy levels, the relatively low number of infections and effective interventions to reduce mother-to-child transmission, offer an opportunity for elimination of HIV infections in infants from the Region, providing a model for the rest of the world.

The challenge is to prepare health systems affected by economies in transition – and particularly maternal and child health services – to deal, in an integrated manner, with transmission of the HIV infection to infants. This goes beyond clinical care and needs to include a range of care and protection issues in both health institutions and in the community. The Strategic Framework for Prevention of HIV Infections in Infants in Europe was developed by the UNAIDS Co-sponsors under the leadership of WHO, based on the experiences countries in the Region. The Strategic Framework outlines strategies for implementation at country level to achieve the global goals and those for Europe and Central Asia set out in the Dublin Declaration.

9.7 Follow up tools – Dalia Jeckaite

The objectives of follow-up, monitoring and supervision after EOC and ENC/PBF training courses are to acknowledge achievements, identify gaps, provide skill reinforcement, help health workers find appropriate solutions to recurring problems, and strengthen ongoing clinical supervision. The tool is made up of 10 questionnaires for interviews with clients and caregivers, and includes standard protocols on epidemiology, essential drugs and vaccines, education and

¹⁰ MPS Regional Activities: Planning for Appropriate Technologies, Chisinau, Republic of Moldova, 31 March to 9 April 2003; Planning for Appropriate Perinatal Care, Almaty, Kazakhstan 14-18 July 2003. Reports. WHO Regional Office for Europe, Copenhagen, Denmark, 2003.

training. Follow-up visits are seen as a sharing of information, benefiting both health workers and supervisors.

The MPS/PEPC follow-up tools were piloted in the Russian Federation⁹ (November 2002); subsequent courses have been held during 2003 in Kyrgyzstan, Uzbekistan and Armenia. This has allowed the course to be refined in the most effective way, including participation of multi-disciplinary groups.

9.8 Standards of care – Gianfranco Gori

This presentation also served as an introduction to the working groups on prototype structure for guidelines¹¹, and included information on the utility of tables of evidence in developing clinical protocols. The primary objective of standards for maternal and neonatal care is to present the available evidence in a way which is reproducible, user-friendly and evidence-based. The approach should be explicit, i.e., formally described and written down, with systematic analysis of evidence, estimation of outcomes, calculation of costs, and assessment of preferences.

9.9 MPS and research – Giovanni Zanconato

Research plays a fundamental role in producing the evidence-base ideas which are pillars of the MPS intervention programmes. The purposes of research are to integrate human and financial resources while searching for new solutions to improve quality of care, without overlooking differences in cultures and traditions and in social and medical policies.

9.10 Implementing communication through telemedicine – Gian Paolo Chiaffoni

The purpose of the presentation was to show how communications can be improved through telemedicine. There is often a gap between the early implementation phase of MPS/PEPC and its dissemination and, in order to face challenges and manage selected issues, more effective communications could be made through the use of telemedicine. It could be possible to set up a network between implementing countries and the MPS/PEPC Coordination office in Copenhagen, using a central node, f.e., at the University of Verona. Such a network would become an additional tool for implementation, be used for follow-up and monitoring, strengthen links between ongoing and planned activities, and promote an interactive discussion on a variety of issues.

¹¹ See Annex 3, Working group outcomes, Section 2, Prototype structures for guidelines

10 Session 2 – Working on clinical guidelines and protocols

10.1 Introduction – Alberta Bacci

A number of countries are working, or planning to work, on the development of clinical guidelines and protocols. To provide technical support for this procedures, the MPS *Evidence-based mother and newborn care* (EBMN) course is being used by WHO and partner agencies in a number of countries. EBMN is a preliminary step for guideline makers to agree on how to define evidence and how to use evidence for making and assessing protocols.

Following the presentation on country experience about preparing and using guidelines and evidence-based model care, participants were divided into three groups and requested to develop a prototype framework on three major clinical issues: obstetric haemorrhage, newborn asphyxia and using the partograph¹². These prototypes will support national teams in developing local guidelines.

10.2 Country experience in using scientific evidence to develop guidelines – Valentina Baltag

The Republic of Moldova is the pilot country for the MPS Initiative in Europe. MPS was launched at an orientation and planning meeting in Chisinau, January 2002¹³. The recommendations from the meeting included that the MPS Initiative should provide support for the development of evidence-based guidelines on antenatal care, normal birth, management of complications and the postpartum period.

A series of activities related to evidence-based care have been carried out in Moldova¹⁴, including an EBMN training course for decision makers, following which a number of protocols were developed (antenatal, intrapartum and neonatal care), which have been officially endorsed by the Ministry of Health. Further, evidence-based didactic material was developed for pre-service training and the relevant curricula updated, including a new model for antenatal care, appropriate use of ultrasound, integration of the family in perinatal care and psychological support for women during pregnancy, delivery and postpartum.

11 Session 3 – Quality of care

11.1 Quality of care: keeping birth normal – Alberta Bacci

Although childbirth can be a positive experience for women, it does happen that pregnancy and childbirth are associated with pain, illness and even death. Very often, there may be an imbalance between primary and specialty care in the health care system, particularly as regards hospitalization. It is common to see that in the structure of the care delivery system, financial

¹² See outcome from the working groups in Annex 3

¹³ Republic of Moldova. Planning and Orientation meeting, Chisinau, 16-17 January 2002. Report. WHO Regional Office for Europe, January 2003.

¹⁴ MPS: Evidence-based Approach. Report of Activities, 2001-2. Chisinau, Republic of Moldova. WHO Region Office for Europe, June 2003.

incentives embedded in the budgeting process and the providers and patients expectations on the type of care all come together and sustain the imbalance for hospital over primary care. Hospitals continue to be given the major part of available resources for health, and in consequence, hospitalization rates and the length of hospital stays continue to be high.

Over-diagnosis, excessive interventions and unnecessary hospitalizations without any evidence of positive effects on health outcomes are common. Interventions during pregnancy, childbirth and the post-partum period should be reduced whenever it is safe to do so, and evidence-based interventions provided – when needed – in a supportive environment.

11.2 Psycho social aspects of perinatal care – Beverley Chalmers

Pregnancy, birth and parenthood are wonderful, but can also be difficult. Women and their partners need both sensitive and clinically appropriate care. This is true in a normal pregnancy, but even more so if things go wrong and, in order to cope with the woman and her partner's feelings, there is a need to train specialist perinatal psychologists.

This was discussed at a meeting on psycho-social issues in perinatal care sponsored by UNICEF in November 2003 which, amongst other issues, focused on coping with miscarriage, stillbirth, newborn abnormality and illness, HIV and pregnancy, post-partum depression and violence during pregnancy. There is a need to develop academic curricula for training of perinatal psychologists and social scientists. This matter should be considered as a further development for MPS/PEPC.

11.3 Human management of the sick child – Adik Levin

The Baby Friendly Hospital Initiative (BFHI) has been successfully implemented in a number of settings over the past ten years. BFHI has considerably assisted the physical, biological and mental development of the child, and has been instrumental in protecting the rights of mothers and children. Practice has shown that BFHI is well integrated to support healthy children in maternity units; however, this has not included sick and preterm babies, who are usually transferred to NICUs from maternal units where mothers are treated as visitors. It is recommended that a new initiative be launched which would focus on the NICUs and the rights of children and mothers, focusing on the rights of the mother to stay with her sick newborn where they would be considered as a “closed” psychosomatic system.

11.4 The challenge of keeping birth normal in the European region – Gelmius Siupsinskas and Gianpaolo Chiaffoni

Care during pregnancy, birth and post-partum should follow the values and principles set out in the 1998 meeting of the MPS/PEPC Task force³. Perinatal care should address physical, psychological emotional and social needs. Meeting holistic needs should not be separated from the improvement of technical quality of care; on the other side, health services are not user-friendly if the technical aspects of care are not optimal. Addressing holistic needs is the task of all health professionals and policy makers, is a matter of human rights and good practices, increases patients' compliance and satisfaction, and is therefore a good investment.

There is increased awareness of perinatal issues among the general population, and there is real evidence that a user-friendly environment during labour and birth has a positive effect on outcome.

11.5 Normality in childbirth: the role of midwifery – Polli Glatleider

The term *skilled health attendant* refers to persons with *midwifery skills* who can manage normal deliveries and diagnose and treat – or refer – obstetric complications. One of the WHO maternal quality indicators is *Proportion of births attended by skilled health personnel*. The basis of midwifery care is based upon the fact that pregnancy, labour and birth is a normal physiological process in a woman's life, and the midwife is the best professional figure to facilitate, guide and support this process.

11.6 Quality of hospital paediatric care – Giorgio Tamburlini

An assessment of paediatric hospital care was carried out in the Republic of Moldova as part of a broader WHO\EURO initiative to improve quality of hospital care in the NIS countries in order to identify the main problems related to the quality of paediatric hospital care and make suggestions for improving the quality of care at national level as well as contributing to the identification of strategies to improve care at a broader, region-specific, level.

The assessment was carried out in two subsequent phases: a questionnaire-based survey in paediatric hospitals to collect data on existing facilities, supplies and hospital workload, and a direct assessment was carried out in five hospitals, selected to represent all levels of care and different geographical areas. The results showed that, while the existing hospital network is quite good and staffing is generally adequate and dedicated, the quality of case management needs to be improved: deficiencies are present in diagnostic work-up, treatment and follow-up of a substantial proportion of cases, and patients are often given unnecessary and potentially harmful treatments. Over-diagnosis is common, particularly in the neurological field. Although most facilities need renovation and diagnostic equipment and supplies are sometimes lacking, the assessment showed that effective, child friendly and equitable management can be ensured with the existing structure, staff and facilities.

11.7 Quality of maternal and newborn care – Alberta Bacci

A tool is being developed for assessing the quality of hospital-based mother and newborn care, based on a similar instrument used for evaluating quality of hospital paediatric care and tested in a series of assessments¹⁵. The tool is made up of two protocols, a questionnaire to be completed by the institution (director/administrator), and a protocol to be completed by the assessors during an observation visit, after which assessors and hospital administration will agree on a plan of action for quality improvement.

The purpose is to obtain information on practices and routine in obstetric and neonatology care in hospitals and identify areas with potential for improvement; the process will include

¹⁵ Russian Federation, Republic of Moldova, Kazakhstan, May-June 2002

information from observation of case management and physical environment and information from interviews with hospital staff and women. These components will be combined to assess the quality of each defined areas of care, taking into consideration the burden of disease and available resources, as a basis for developing a specific plan of action.

12 Closure

At the close of the meeting, Dr Bacci thanked those present for giving their time and expertise to the Task Force. She stressed the importance of the work carried out in refining and improving the tools used in the Region within the framework of MPS/PEPC.

Annexes 1 - Programme

➤ Thursday, 23 October 2003

08:30 – 09:00	Registration	
09:00 - 09:30	Welcome from regional authorities	Maria Luisa Coppola, Regional Minister for International Cooperation Ermanno Angonese, General Director Verona Health Unit
09:30 - 9:45	Veneto Region: Achievements and constraints in local implementation of WHO recommendations	Luigi Bertinato
09:45 – 9:50	Welcome from WHO	M. Ostergren
09:50 – 10:00	Objectives of the meeting	A. Bacci
10:00 – 10:15	Summary of previous task force meeting recommendations	G. Chiaffoni
10:15 – 10:30	How the Family and Community Health Unit works	M. Ostergren
10:30 – 10:45	MPS/PEPC in European Region: report on activities, future plans	A. Bacci

➤ Session 1 – Update on tools and manuals

11:10 – 11.30	MCPC/ECPG, EAPPC and ENC/BF	G. Siupsinskas
11:30 – 11:50	Essential Newborn Care Course and other recent tools (HQ)	J. Zupan
11:50 – 12:00	Evidence Based Mother and Newborn Care course	T. Azatiani
12:00 – 12:15	Beyond the Numbers	A. Bacci
12:15 – 12:30	MPS Planning for Appropriate Technology course	F. Uxa
12:30 – 12:45	Preventing HIV infection in infants	M. Ostergren
12:45 – 13:00	Discussion	
14:00 - 14:15	Follow up tools	D. Jeckaite
14.15 – 14:30	Standards of Care	G. Gori

14:30 – 14:45	Making Pregnancy Safer and research	G. Zanconato
14:45 – 15:00	Implementing communication through telemedicine	G. Chiaffoni
15:15 – 17:00	Group work manuals and tools adoption, adaptation, integration, update proposals	Facilitators: F. Uxa, G. Siupsinskas
17:00 – 17:30	Presentations	

➤ **Friday, 24 October 2003**

➤ **Session 2 – Working on clinical guidelines and protocols**

09:00 - 09:20	Introduction	A. Bacci
09:20 – 09:40	Country experience	V. Baltag
09:40 – 10:00	Introduction to group work: Obstetrician	G. Gori
10:00 – 10:20	Introduction to group work: Neonatologist	G. Chiaffoni, F. Uxa
10:20 – 16:00	Two groups working on preparation of 2 level examples of prototype clinical protocols (1) obstetric haemorrhage, (2) newborn asphyxia, (3) protocol for partograph use	Facilitators G. Gori, V. Baltag, G. Chiaffoni, F. Uxa
11:15 – 12:00	Group work continued	
14:00 – 16:00	Group work continued	
16.00 – 17:30	Presentations and discussions	

➤ **Saturday, 25 October 2003**

➤ **Session 3 – Quality of care**

09:00 – 09:15	Quality of care: keeping birth normal	A. Bacci
09:15 – 09:30	Psychosocial aspects of perinatal care	B. Chalmers
09:30 – 09:45	Human management of the sick child	A. Levin
09:45 – 10.05	The challenge of ‘keeping birth normal’ in the European region	G. Siupsinskas, G. Chiaffoni
10:00 – 10:20	Normality in childbirth: the role of midwifery Group work introduction	P. Glatleider

10:20 – 11:00	Group work	
12:15 – 14:00	Reception of the Verona Mayor	
14:00 – 14:30	Group work	
14:30 – 15:15	Presentations of group work	
15:30 – 15:50	Quality of Hospital Paediatric Care	G. Tamburlini
15:50 – 16:10	Quality of Maternal and Newborn Care	A. Bacci
16:10 – 16:40	Discussion	
16:40 – 17:00	Closure	

Annex 2 – List of participants

➤ Temporary Advisers

Tengiz Asatiani,

Head, Obstetrics and Gynaecology, Medical Academy for Postgraduate Education, Tbilisi, Georgia

Stefania Avanzini

Pediatrician, Verona, Italy

Elena Baibarina

Chief Researcher, Neonatal Intensive Care Department, Research Centre of OB/GYN & Perinatology, Russian Academy of Medical Sciences, Moscow, Russian Federation

Vittorio Basevi CeVEAS

NHS Centre for the Evaluation of the Effectiveness of Health Care, Modena, Italy

Malin Bring

Copenhagen, Denmark

Ms Ana Calancea

Chief Midwife, Municipal Maternity Hospital 1, Chisinau, Republic of Moldova

Beverley Chalmers

Women's College Hospital & Sunnybrook, Health Sciences Centre, University of Toronto; Toronto, Canada

Gian Paolo Chiaffoni

Ospedale Policlinico GB Rossi, Clinica Pediatrica, Verona, Italy

Ala Curteanu

Mother and Child Health Care Research Institute, Chisinau, Republic of Moldova

Tatiana Dinekina

Maternity Home 3, Murmansk, Russian Federation

Polli Glatleider

MotherCare, Los Angeles, United States of America

Gianfranco Gori

U.O. Ostetricia Ginecologia, Forli', Italy

Stelian Hodorogea

State Medical University N.Testemitsanu, Chisinau, Republic of Moldova

Dalia Jeckaite

Panevezys Public Hospital, Panevezys, Lithuania

Zaure Kudaibergenova,
Kazak Academy of Nutrition, Almaty, Kazakhstan

Adik Levin
Tallinn Univ. of Educational Science, Tallinn, Estonia

Audrius Maciulevicius
Kaunas Medical University Hospital Kaunas, Lithuania

Gillian McIlwaine
Simpson's Centre for Reproductive Health, Edinburgh, Scotland, United Kingdom

Lucian Puscasiu
University of Targu-Mures, Targu Mures, Romania

Irina Ryumina
Healthy Russia 2020, Moscow, Russian Federation

Ms Irina A. Stepanova,
City Maternity 21, Orel, Russian Federation

Gelmius Siupsinskas
Kaunas Academic Hospital, Kaunas, Lithuania

Oleg R. Shvabskii
Perm, Russian Federation

Giorgio Tamburlini
IRCCS Burlo Garofolo, Trieste, Italy

Fabio Uxa
IRCCS Burlo Garofolo, Trieste, Italy

WHO Regional Office for Europe

Alberta Bacci
European Coordinator, Making Pregnancy Safer

Valentina Baltag
NPO, Making Pregnancy Safer, Republic of Moldova

Mikael Ostergren
A.i. Regional Adviser, Child and Adolescent Health and Development

Helle Rink
Programme Assistant, Child and Adolescent Health and Development

Annex 3 – Working Group outcomes

1 Group work on manuals and training: EOC, ENC/PBF, Follow-up after training, EBMN

Groups were asked to indicate strong and weak points of manual, tools and training courses, and give suggestion on how to improve

1.1 Group 1

➤ **Strong points:**

- Good quality manuals and materials;
- Role of trainers and facilitators well identified;
- Good coverage of topics; and
- Well-designed methodology, interactivity, appropriate language.

➤ **Weaknesses**

- Psycho-social component reinforced, more attention to:
 - Family centred care;
 - Preparation for birth/parenthood; and
 - Primary care component and counselling skills:
 - ⇒ Involvement of decision makers to be improved.

➤ **Suggestions**

- Improvement monitoring after training events;
- Develop a list of indicators, including:
 - Evaluation of “family friendly” practice of care;
 - Evaluation of evidence-based practice of care; and
 - Women’s awareness of evidence-based practices of care.
- Expand practical sessions;
- Promote pilot projects at national level;
- Promote training events in national centres of excellence;
- Strengthen antenatal care component;
- Compact training contents into a pocket guide;
- Use decision makers, opinion leaders and well-known testimonials as promoters of training events;

- Make an appropriate choice of participants;
- Add a 10th principles of effective perinatal care: to respect privacy, dignity and confidentiality of women;
- Provide two/three days' orientation meeting for decision makers before training;
- Increase the role of professional associations in training events;
- Reinforce multidisciplinary approach.

1.2 Group 2

➤ Suggestions:

- According to MPS/PEPC principles, caregivers' team should be multidisciplinary for the whole perinatal period, made up of:
 - Antenatal educator
 - Companion
 - Family members
 - GP or family doctor
 - Midwife
 - Obstetrician
 - Neonatologist
 - Nurse
 - Psychologist
 - Special support groups
 - Social worker
- Identify and answer appropriately to other needs:
 - Ensure continuity of care and caregiver;
 - Consider midwifery care as first choice for care wherever a good referral system is in place;
 - Enhance involvement of family, companion at all stages;
 - Provide that midwife is included in health care team at district level;
 - Ensure good training of all caregivers, especially midwives and family doctors; and
 - Give midwives the opportunity to teach midwives and family doctors about health care in normal pregnancy.
- Reinforce holistic care:
 - Care should be addressed not only to physical needs, but to emotional and intellectual needs
 - Promote demedicalised appropriate and EBM-oriented physical needs;
 - Give appropriate answers to emotional needs, needs of support of the family, requests for counseling regarding normal and complicated situations, respectful care; and
 - Consider client satisfaction.

1.3 Group 3

➤ **Strong points:**

- Participants provided with enough materials
- Good balance between theory and practice
- Interactive approach
- Multidisciplinary team
- Participants and facilitators coming from different settings
- Flexible
- Trainers are practicing clinicians

➤ **Weak points:**

- Too short duration (EBM, EOC plus practical week)
- Too ambitious agenda
- Not enough learning and teaching tools
- Not enough trainers, especially midwives
- Language issues (translation needs, not teaching in local language, teaching materials not all translated into Russian, especially updated versions)
- more technical than managerial approach
- not easy to maintain consistency when new sessions are included
- lack of pre-course preparation time

➤ **Suggestions:**

- More participants to be invited from the same health facility (stronger multidisciplinary teams, including decision maker and SanEpi)
- Combine the three trainings and adapt them to the audience, and consider a modular approach
- Ensure minimal literacy on EBM e.g. train people to read table of evidences
- More regional facilitators from all professional bodies
- Improve contacts between facilitators before course
- Include preparation of the courses including visit to health care facilities before courses
- Improve training at first level of care (family doctors)
- Strengthening the social approach
- Consider to include bioethical issues

2 Group work: Prototype structures for guidelines

Three groups were set up and asked to prepare *prototype structures* for guideline-making, using three examples: obstetric haemorrhage, newborn asphyxia and the use of the partograph.

Outcome from working groups

2.1 Group 1 - Obstetric haemorrhage

- **Purpose: To design a prototype guideline for obstetric haemorrhage:**

- **In the European Region:**
 - Most deliveries – in maternities
 - Most deaths because of haemorrhage – in maternities

- **Standard – for intermediate maternity.**
 - The Group reviewed ‘12 interventions’ and agreed with the following:
 1. Statements are in line with IMPAC;
 2. Standards should be developed for each level of care, protocol – for each facility;
 3. Whatever management is chosen, the woman and her companion must be informed and supported;
 4. Whenever possible, the baby should be kept with the mother;
 5. Tables of evidence are very useful tools in the process of applying of evidence into practice;
 6. May be useful to have flow-charts for action in emergencies; and
 7. IMPAC could be used for auditing in European region.

- **Major concerns (regional and non-regional):**
 - Evidence is scarce, not always consistent;
 - Too liberal use of blood or, opposite, blood is not available in many places;
 - Too many different blood volume expanders are used
 - If surgery – only option – hysterectomy, instead, for example, ligation; and
 - No psychosocial component is reflected in most standards/protocols/documentation.

- **Active management 3rd stage of labour (could be region/facility-specific) low risk**
 - Informed consent; and
 - Weight NNT vs NNH

- **For high-risk women for haemorrhage – recommendation for active management:**
 - Haemorrhage <500 ml. But could be difficult to assess. Relay on clinical condition;
 - Call for help; and
 - Instead of using routinely i/v use only for therapeutics.

Assessment of condition – BP/P every 15 min (as in ECPC).	I/V line, expander – normal saline, volume – depending on status (MCPC)
Check fundus of uterus.	Oxytocin – first choice (MCPC)
External massage of uterus	Catheterisation only if ladder is full

2.2 Group 2 –Newborn asphyxia

➤ Purpose: To design a prototype guideline for neonatal asphyxia

- General considerations::
 - Many existing guidelines;
 - Limited evidence to support (Cochrane library); evidence is not too strong for most of the proposed interventions; and
 - Instead of producing new guidelines, it is more useful to adopt/adapt existing materials.
- Three step approach when considering preparation of guidelines:
 1. Intervention:
 - ⇒ Recognition of neonatal asphyxia;
 - ⇒ Classification;
 - ⇒ Management; and
 - ⇒ Post asphyxia care.
 2. Audience (to whom the guidelines are address):
 - ⇒ Midwives, ob-gyn;
 - ⇒ Neonatologist
 - ⇒ Anaesthesiologist-neonatologist; and
 - ⇒ Every doctor attending a birth.
 3. Level of care:
 - ⇒ Guidelines according to levels to care, equipment and supplies.
- The participants agreed to use for the evaluation of existing guidelines *AGREE appraisal of guidelines for research and evaluation* and provided the following structure:

➤ **Scope and purpose: to design a prototype of protocol of care to prevent, assess and manage neonatal asphyxia in a 2nd level health care facility, using the AGREE instrument.**

- Two main issues:
 1. What is optimum for current level of care; and
 2. What are the appropriate intermediate steps for each facility (independently from level of care).
- Additional objectives:
 1. Resuscitation in emergencies;

2. Resuscitation of LBWI;
3. Resuscitation in older infant (beyond neonatal period);
4. Treatment of post-asphyctic syndrome;
5. Special conditions (i.e., meconium aspiration syndrome, malformations, etc.); and
6. Communication with parents.

➤ **Stakeholder involvement:**

- When not to start, or to stop – medico legal, bioethical, parents presence etc.;
- Check legal support (who is allowed to do and what?);
- Optimal composition of staff (at least one person able to perform resuscitation effectively has to be present at each birth or to be available immediately upon request): and
- National coverage of neonatal resuscitation training and skills (comprising geographical issues and composition of the team to include different professional groups).

➤ **Rigour of development:**

- There is a need of agreement on technical issues;
- Level of evidence should be indicated for each policy of care;
- Systematic review of literature, systematic updating of guidelines;
- Link between guidelines and the process of accreditation; and
- Extern review of guidelines.

➤ **Clarity of presentation:**

- Field testing of guidelines; and
- Tools for dissemination.

➤ **Applicability**

- Need to integrate guidelines in setting specific protocols to be consistent with general national framework;
- Consider costs – not only cost of running equipment, but for training;
- Guidelines accreditation and certification process desirable to linked; and
- Indicators (structure, process, outcome) and audit.

➤ **Editorial independence**

- Conflicts of interest have to be considered into the group

2.3 Use of the partograph

➤ **Purpose:** To design a prototype protocol for use of the partograph

➤ **Protocol title:** Use of the WHO Partograph for Labour¹⁶

- Introduction: From *the Lancet* article
- Include the level of evidence.

The WHO partograph is a tool “for managing labour only; it does not help to identify other risk factors which may have been present before labour started”¹⁷.

- Definitions:
 - The WHO partograph is the graphical representation of the progress of labour. It is a method of displaying progress in cervical dilatation as a continuous graph, while at the same time displaying as many other features of the state of the mother, the foetus and the labour as possible in graphic form¹⁸;
 - Latent phase (slow period of cervical dilatation) is from 0-2 cm with a gradual shortening of the cervix¹⁹; and
 - Active phase (faster period of cervical dilatation) is from 3cm to 10 cm)⁹.
- Inclusion criteria:
 - Woman in labour:
 - ⇒ Latent phase: *1 or more contractions* in 10 minutes each lasting 20 seconds or more; and
 - ⇒ Active phase: *2 or more contractions* in 10 minutes each lasting 20 seconds or more:
 - Eg.: presentation of foetus twins, etc., comments during presentation of articulate use with breech or multiple gestation.
 - The WHO partograph should be completed for every woman that meets inclusion criteria and should be completed prospectively in real time.
- Exclusion criteria:
 - Woman in labour with complications of the pregnancy that require immediate action;
 - Woman not in labour; and
 - Woman admitted with full dilation (to be considered).
- Starting the WHO partograph:
 - Complete the two lines “identifying information”, eg., find sentence(s) from partograph workbooks to easily and clearly articulate this;

¹⁶ Lancet, 4 June 1994, Volume 343, pp 1399 - 1404

¹⁷ WHO/FHE MSM/93/9; pg 1

¹⁸ EAPPC, p. 184

¹⁹ WHO/FHE/MSM/93.9, p.5

- **Latent Phase** (This could be placed into a table) – monitor:
 - ⇒ Cervical dilatation – every 4 hours;
 - ⇒ FHR – every 60 minutes;
 - ⇒ Contractions per 10 minutes – every 60 minute;
 - ⇒ Maternal pulse – every 4 hour;
 - ⇒ Maternal BP - every 4 hours or more frequently if indicated;
 - ⇒ Maternal temperature - every 4 hours or more frequently if indicated;
 - ⇒ Urine – check for acetone and protein in the urine; measure urine volume (encourage woman to pass urine every 2 to 4 hours);
 - ⇒ Cervical dilatations – plot the dilatation of the cervix at 0 times and perform a vaginal examination every four hours. If the woman does not reach the active phase by 8 hours, reassess the situation and consider possible options:
 - (1) False Labour - woman not in labour, abandon partograph. Provide the woman with information about her status and discharge the woman and encourage her to return if signs of labour recur;
 - (2) Prolonged latent phase - ask for physician consultation and/or see the MCPC Guidelines for Unsatisfactory Progress of Labour.
- **Active Phase** (This could be placed into a table) – monitor:
 - ⇒ Cervical dilatation – every 4 hours unless indicated;*
 - ⇒ FHR – every 30 minutes;
 - ⇒ Contractions per 10 minutes – every 30 minutes;
 - ⇒ Maternal pulse – every 4 hours;
 - ⇒ Maternal BP – every 4 hours or more frequently if indicated;
 - ⇒ Maternal temperature - every 4 hours or more frequently if indicated;
 - ⇒ Urine – check for acetone and protein in the urine; measure urine volume (encourage woman to pass urine every 2 to 4 hours);
 - ⇒ For emergency signs, use rapid assessment (RAM – B3-B7); and
 - ⇒ Cervical dilatation.*
- If the woman is admitted in the active phase, the dilatation of the cervix is plotted on the alert line and the clock time is written directly under the X in the space for time;
- If the woman is admitted in the latent phase and goes into the active phase, plotting must be transferred by a broken line to the alert line and the clock time is written directly under the X in the space for time;
- If progress is satisfactory, the plotting of cervical dilatation will remain on or to the left of the alert line;
- If plotting of cervical dilatation is between the alert and action line:
 - ⇒ Reassess woman and consider criteria for referral;
 - ⇒ Call senior person if available. Alert emergency transport services;
 - ⇒ Encourage woman to empty bladder;
 - ⇒ Ensure adequate hydration but omit solid foods; and
 - ⇒ Encourage upright position and walking if woman wishes;
- Monitor intensively. Reassess in 2 hours and refer if no progress. If referral takes a long time, refer immediately (DO NOT wait to cross action line)²⁰:
 - ⇒ If the plotting of cervical dilatation passes to the right of the action line, refer urgently to hospital unless birth is imminent²¹;

²⁰ Integrated Management of Pregnancy and Childbirth: Pregnancy, Childbirth, Postpartum and Newborn Care: A guide to essential practice; D9. World Health Organization, Geneva, 2003.

⇒ If the cervix is dilated 10cm or bulging perineum, manage as in Second Stage of Labour (See Second Stage of Labour, D10-11).

- Audit – Could use the partograph items from the MPS follow-up tool
- References:
 - Lancet; and
 - WHO documents.

3 Group work on quality of care

Three groups were set up to discuss the presentation and to draw up recommendations on how to assess and improve quality of care.

3.1 Group 1 – eight steps to improve quality of care

1. Ensure information on reproductive health and human rights;
2. Ensure appropriate assistance during pregnancy, birth and postpartum;
3. Strengthen normal and “humanize” delivery;
4. Have written guidelines to guide clinical management;
5. Provide adequate training to improvement guidelines;
6. Improve the physical environment of the delivery room (i.e., space. Cleanliness, equipment, privacy, silence, etc.);
7. Promote data collection and information system; and
8. Identify appropriate indicators to evaluate

3.2 Group 2 – MPS/PEPC principles and values

1. Care for normal pregnancy and birth should be de-medicalized:
 - Presence of following (if this equipment present, then “medicalized care” is like being practiced):
 - ⇒ Enema equipment;
 - ⇒ Shaving equipment;
 - ⇒ Ice pack equipment;
 - ⇒ Rachmonov bed; and
 - ⇒ Labour ward and separate delivery room vs individual labour/birth room.
2. Care should be based on the appropriate use of technology:
 - Presence of the following:
 - ⇒ Resuscitation kit +/-;
 - ⇒ Delivery kit;
 - ⇒ Partograph %;
 - ⇒ Clock;
 - ⇒ Hand washing liquid soap;
 - ⇒ Individual towels;

²¹ See Refer the Woman Urgently To the Hospital B17 in Pregnancy, Childbirth, Postpartum and Newborn Care: A guide to essential practice

- ⇒ Gloves; and
- ⇒ Position in 2nd stage %.

3. Care should be regionalized:

- Number of referrals for mother;
- Number of referrals for newborn;
- Bed occupancy rate;
- Number of trainings;
- Number of trained staff;
- Appropriate budget allocation;
- Presence/absence of EBM guidelines; and
- User's interviews.

4. Care should be evidence-based:

- Number of antenatal visits/investigations;
- Episiotomy rate;
- Caesarean section rate;
- Amount of expenditure for drugs/equipment;
- Duration of hospital stay for normal birth;
- Readmission rate for mother;
- Readmission rate for newborn.

5. Care should be multidisciplinary:

- We need multidisciplinary caregiver teams for all perinatal period;
 - ⇒ Midwife;
 - ⇒ Neonatologist
 - ⇒ Antenatal educator
 - ⇒ Nurses
 - ⇒ GP or family doctor
 - ⇒ Psychologist
 - ⇒ Social worker
 - ⇒ Companion
 - ⇒ Family
 - ⇒ Special peer support group (e.g., adolescents; HIV).
- Continuity of care and caregiver;
- First choice is midwifery care with good referral system and involvement of family;
- Companion at all stages;
- Enduring family doctors institution to have midwife in team;
- Ensure good training of all caregivers, especially midwives and family doctors, e.g., midwives should teach midwives and family doctors about normal pregnancy, labour, birth and postpartum.

6. Care should be holistic:

- Care should be addressed not only to physical needs but to emotional and intellectual needs:
 - ⇒ Physical needs:
 - De-medicalized;
 - Appropriate; and

- EBM.
 - ⇒ Emotional needs:
 - Support of the family;
 - Support from the staff;
 - Counselling for normal and complicated situations;
 - Clients' (users') satisfaction; and
 - Respectful care.
 - ⇒ Intellectual needs:
 - Preparation for birth and parenthood; and
 - Involvement in decision making.
7. Care should be family-centred:
- % partners present during delivery;
 - % partners attending ANC;
 - % of skin-to-skin contact;
 - % mothers BF;
 - Facility environment; and
 - Free access to family.
8. Care should be culturally appropriate:
- Survey of caregivers:
 - ⇒ Knowledge (regarding cultural aspects of care for specific groups); and
 - ⇒ Action (documented actions, e.g., reading material, signs).
 - Survey of users:
 - ⇒ Understandable written content; and
 - ⇒ Culturally acceptable practices, e.g., female versus male companion.
9. Care should involve women in decision-making:
- Skills in human attitude;
 - Family involvement;
 - Forms present (in the chart) for informed consent; and
 - Survey of women – were they asked for informed consent for interventions.
10. Care should respect a woman's dignity, autonomy and privacy (proposed addition to the 9 principles):
- Values and principles:
 - ⇒ Physical site;
 - ⇒ Individual rooms;
 - ⇒ Number of complaints to insurance company;
 - ⇒ Providers knock on door prior to entering;
 - ⇒ Position of bed in relation to door; and
 - ⇒ Presence of door in changing area.

3.3 Group 3 – recommendations for midwives caring for women in labour: meeting physical and emotional needs

1. Continuous presence with the labouring woman:
- Midwife remains with woman during active phase of labour.

2. Freedom of movement and position of comfort is encouraged and assisted as needed:
 - Based on woman's choice, midwife encourages and physically assists a labouring woman into various upright, sitting and/or kneeling positions during labour;
3. Physical comfort measures are used:
 - Hand, foot and back massage;
 - Reassuring touch (physically holding, stroking hand, wiping brow);
 - Shower and/or bath;
 - Cool cloth to brow or neck;
 - Fanning;
 - Cold pack, hot pack, warm blanket;
 - Linen change; and
 - Other.
4. Various non-pharmacological methods of pain relief are used during women's labour:
 - Freedom of movement and positions;
 - Back labour pain relief:
 - ⇒ Counter pressure;
 - ⇒ Double hip squeeze; and
 - ⇒ Knee press.
 - Hydrotherapy.

Annex 4 – Principles for MPS/PEPC in the European Region

1. Care for normal pregnancy and birth should be de-medicalized
2. Care should be based on the use of appropriate technology
3. Care should be regionalized
4. Care should be evidence-based
5. Care should be multidisciplinary
6. Care should be holistic
7. Care should be family-centred
8. Care should be culturally appropriate
9. Care should involve women in decision making
10. Care should respect the privacy, dignity and confidentiality of women (Verona principle)

Annex 5 – Pre-meeting: brainstorming on quality of mother and newborn care

A small group of experts met to prepare the input to the 3rd Task Force, and were asked to provide a list of key issues for quality of care which could be used as input to working group activities.

- Skilled caregiver
- Holistic attitude to the client
- Patients satisfaction
- Multidisciplinary involvement
- Care in accordance with best practices from medical point of view
- Needed equipment and medicines present in the facilities and used appropriately
- Oriented on psychological and human values
- Family involvement and satisfaction
- Satisfaction of medical staff

- Skilled medical care
- Natural / facilitate physiological process
- Satisfied family
- Satisfied staff
- Strengthen the psychology of pregnancy and assure safe mother and baby
- Improve sexual education of young people
- Involve women in decision making
- Demedicalization
- Education / the possibility to study
- Freedom / but on the basis of evidence based medicine
- New model of medical system
- Respect for the individual / feelings, needs and habits
- Defining strategy and tactics
- Preparation of the couple
- Family oriented delivery
- Healthy mother and baby
- Early discharge
- Satisfaction of family
- Appropriate knowledge and skills of health providers
- Friendly attitude towards women, newborns and families
- Effective links with overall health promotion
- Evidence based medicine / best practices
- Satisfied family and community
- Data
- Patients satisfaction
- Low mortality and morbidity
- Cost effectiveness
- Good skills
- Professionalism
- Friendly
- Care based on sound evidence
- Auditing patient satisfaction
- Personnel satisfaction
- Mother feels she has received the care she hopes for
- Mother seen as equal partner with caregivers
- Users needs seen and recognized
- Considering mother, baby and father as most important persons in birth, pregnancy and post partum experience
- All decisions regarding care should be determined in response to the question What is best for the mother / based on evidence, family-centred values and practices
- Accessibility of perinatal medical care
- Evidence-based medical care
- Humanization
- Evidence-based information
- No financial barriers to access to services

- Good links between primary and referral care service including coherent clinical guidelines
- Information to users about what is available and where
- Good perinatal results
- Attention to the baby's , woman's and couple's needs
- Provider satisfaction
- Evidence based practice
- Family involvement
- Satisfaction of woman, family, providers
- Skills
- Accessability, availability
- System of care
 - ⇒ data
 - ⇒ planning
 - ⇒ early discharge
- Attitude
 - ⇒ multidisciplinary
 - ⇒ holistic
 - ⇒ demedicalisation
- Education

