Evaluation of the adaptation and use of WHO guidelines on Reproductive, Maternal and Newborn Health (RMNH) in the WHO South-East Asia (SEA)

Evaluation Report

World Health Organization
REGIONAL OFFICE FOR South-East Asia

Report by TDV Global Inc. June 2020

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ACKNOWLEDGEMENT

TDV Global Inc was commissioned by the Family Health Gender Life Course (FGL) department at WHO Regional Office for South-East Asia to evaluate the Adaptation and Use of WHO Reproductive, Maternal and Newborn Health guidelines. We thank Dr Pem Namgyal, Director Programme Management (DPM) and Chair of Evaluation Management Group (EMG), members of EMG, Dr Neena Raina (Director a.i. FGL), Dr C. Anoma Jayathilaka, Medical Officer for Maternal and Reproductive Health, FGL and the FGL team for their oversight and advice on the evaluation.

We also would like to thank Ministries of Health of Member States and WHO country office staff to facilitate and participate in the evaluation process including our field visits.

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ACRONYMS AND ABBREVIATIONS

Abbreviation	Meaning
ABR	Adolescent birth rate
ARR	Annual Rate of Reduction
ACOG	The American College of Obstetricians and Gynecologists
ANC	Antenatal Care
BWP	Biannual work plans
CHC	Combined hormonal contraceptives
CPR	Contraceptive prevalence rate
DMPA-SC	Subcutaneously-administered depot medroxyprogesterone acetate
EMG	Evaluation Management Group
FGL	Family Health Gender and Life Course
FIGO	International Federation of Gynaecology and Obstetrics
GRC	Guidelines Review Committee
IR	Implementation Research
LNG-IUD	Levonorgestrel-releasing intrauterine device
MCA	Maternal, Newborn, Child and Adolescent Health
mCPR	Modern contraceptive prevalence rate
MDGs	Millennium Development Goals
MEC	Medical eligibility criteria for contraceptive use
mFP	Modern family planning
MoH	Ministry of Health
MMR	Maternal mortality rate (per 100,000 live births)
NGO	Non-governmental organization
NICE	The National Institute for Health and Care Excellence
NMR	Neonatal mortality rate (per 1000 live births)
NSA	Non-State Actors
POC	Progestogen-only contraceptive
RCOG	Royal College of Obstetricians and Gynecologists
RHR	Reproductive Health and Research
RMNH	Reproductive, Maternal and Newborn Health
RO	Regional Offices
SBA	Skilled birth attendant
SDGs	Sustainable Development Goals
SEA	South East Asia
SEAR	South-East Asia Region
SEARO	South-East Asia Regional Office
SOPs	Standard Operating Procedures
TAG	Technical Advisory Group
TEC	Technical Expert Committees
UNAIDS	Joint United Nations Programme on HIV/AIDS (UNAIDS)
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WCOs	WHO country offices
WHA	World Health Assembly
WHO	World Health Organization
WHO CC	WHO Collaborating Centre

EXECUTIVE SUMMARY

Evaluation Overview

The evaluation of the adaptation and use of WHO guidelines on RMNH in the WHO South-East Asia Region considered WHO guidelines in the area of RMNH released in the last 5 years (i.e. from 2014 to 2018). The overall purpose was to evaluate the contribution of WHO guidelines to improving RMNH in the Region. The evaluation Terms of Reference can be found in **Annex A.**

Specifically, the evaluation is to:

1. Assess the existing adaptation and use of WHO RMNH guidelines at the country level in selected Member States.

2. Identify enabling factors, opportunities and challenges in adaptation and use of the WHO RMNH guidelines in selected SEAR Member States.

3. Recommend concrete strategies appropriate to respective countries to strengthen and accelerate the implementation of the WHO RMNH guidelines in SEAR Member States.

4. Review and make recommendations on WHO's role at all three levels of the Organization (i.e. headquarters, regional and country offices) to strengthen implementation and impact of RMNH guidelines at the country level.

The evaluation was executed in four phases between August and December 2019. During the first phase, an Inception Report was prepared that defined the methods and scope of the evaluation and included an evaluation matrix and data collection instruments. The second phase consisted of data collection involving country visits to India, Sri Lanka, Myanmar and Bhutan for country case studies (with Bangladesh conducted as a desk review with telephone interviews), telephone interviews with SEAR and WHO headquarters staff, document review and online surveys for WHO staff at all three levels and Ministry of Health counterparts at the SEAR country level. The third phase included analysis of the lines of evidence and presentation of preliminary findings. The fourth and final phase consisted of the development of draft and final reports.

Key Conclusions

WHO reaches the intended audience for RMNH guidelines

Regarding deepening the reach of WHO RMNH guidelines to beyond national level, the evaluation recognizes that WHO is a technical, norm-setting organization and that the target audience for WHO RMNH guidelines is principally the policy makers, decision makers and programme managers in the Member States, normally at the national level, and by association the stakeholders that Members States have identified to participate in their respective processes. WHO guidelines are used as a reference by Member States when they develop their own national guidelines. In line with that, dissemination to lower levels of the health system at country level should only be undertaken by the national authority based on their policies, procedures and processes. WHO can assist, where possible, in the dissemination of national RMNH guidelines, but the evaluation itself focussed on dissemination of WHO RMNH guidelines. Based on this understanding, the evaluation concludes that to a large extent, WHO does reach its intended audience with the dissemination of WHO RMNH guidelines. There are, however, still areas for improvement described as follows.

More formal dissemination strategy and planning

Dissemination strategies and planning could be more formalized in support of WHO RMNH guidelines at the regional and country level. While there was evidence of deploying various dissemination means (e.g. electronic, regional meetings, etc.), no formally documented dissemination strategies or plans were identified by the evaluation. Some countries may present a challenge given the number of stakeholders involved in the adaptation of RMNH guidelines, and different jurisdictions, and may require more careful planning both at the WCO and Member State MoH on guideline dissemination at the national level.

Continued use of active dissemination methods

Related to the need for dissemination planning and identified under Lessons Learned/Areas for Improvement and under Reach, WHO needs to continue to use both passive (e.g. posting on web pages, emails, etc.) and active dissemination methods (e.g. conferences, dissemination meetings, presentations, webinars, etc.) in its dissemination. Identified in the evaluation was the positive impact of national level Technical Working Groups where they were functioning. These groups serve as an effective platform for WHO to actively present and disseminate information to technical stakeholders.

Monitoring reach

The reach of WHO RMNH guidelines is not well monitored or documented in terms of distribution of emails, downloads from websites and distribution of printed copies. There is room for improvement in monitoring the reach of WHO RMNH guidelines, globally, regionally and by country.

Guidelines are addressing priority country needs and are of high quality

To a large extent, WHO RMNH guidelines are found to be useful in terms of addressing priority country needs and in terms of quality (i.e. credibility, authoritativeness, and quality). It was also noted that WHO is not the only reference for guidelines for some countries. Other institutions identified by the evaluation that influence Member State guidelines and practices include The American College of Obstetricians and Gynecologists (ACOG), The National Institute for Health and Care Excellence (NICE), International Federation of Gynecology and Obstetrics (FIGO) and the Royal College of Obstetricians and Gynecologists (RCOG).

Country development may result in more specific needs

Regarding addressing needs, there is general alignment across international initiatives and goals such as the SDGs (SDG 3 targets aim to end preventable deaths of newborns and children under 5 years of age and reduce maternal mortality), and the WHO 13th General Programme of Work and country strategies and plans. WHO planning processes at regional and country level allow the opportunity for dialogue to identify country priorities and align WHO assistance to country priorities. However, the extent that the individual country needs are reflected in the global and regional agenda does vary depending on the level of maturity of the health system, stage of obstetric transition and level of mortality. The result is that WHO RMNH guidelines being produced may not be as relevant for all countries in the region, some who may have more specific needs (e.g. countries at obstetric transition level 4, etc.). This was noted in the case of Sri Lanka (and India to a lesser extent) who have needs that are not fully addressed by WHO RMNH guidelines.

WHO RMNH guidelines are used

To a large extent, WHO RMNH guidelines are referenced and adapted at the country level into national policies, strategies, plans and clinical guidelines. That process takes time, and the selected guidelines

for this evaluation demonstrated that uptake can be partial (i.e. adaptation of recommendations may be spread over several different national documents, developed at different times), or in many cases predates the selected guidelines (i.e. the recommendations were included in previous versions and already adapted). However, case studies demonstrated that referencing of WHO RMNH guidelines, as well as WHO framework and strategies, in national documents can be extensive.

The evaluation did not assess implementation of national guidelines, however, implementation of national guidelines remains an area of need. There is very limited information about either the reach and implementation of national guidelines and even less information on how well they have been implemented (quality assurance). Nonetheless, WHO has assisted in this process when possible through financial and technical assistance on implementation research, regional meetings and development of regional strategic plans, training, translation and printing of materials.

The evaluation found that for the roll-out of national RMNH guidelines, some countries are effective in implementation planning, while others are less so. It was noted that in some countries, there is a drive to update policy frameworks and guidelines, but without the requisite planning for implementation and monitoring. This is especially important in complex implementation environments or in countries that are introducing multiple changes to their policy and practices. This will have the added benefit of providing ministries with the evidence to support requests from the national budget.

Underdetermined extent of the contribution to meeting RMNH-health related SDG ~~health~~ targets

Findings under reach and usefulness noted that the role of WHO guidelines do influence national RMNH guidelines in many cases but not in all. Many countries use other sources as references, in combination with WHO guidance. More importantly, impact on health outcomes is derived primarily from guidelines implementation, and it has been noted by the evaluation that the extent that national RMNH guidelines are implemented, and the quality of that implementation, is largely unknown. Given that there are a multitude of factors that influence guideline adaptation, guideline implementation, and subsequent health outcomes, the extent that WHO guidelines contribute to WHO SEAR Member States meeting RMNH-related SDG health targets is undetermined.

Collaborative approaches at national level

The key lessons learned are the need for collaborative approaches at the national level that include all relevant stakeholders, which can be facilitated by having formal coordination mechanisms, such as standing and regular Technical Working Groups in place that serve for identifying priorities, disseminating (sharing information), adapting guidelines and supporting implementation.

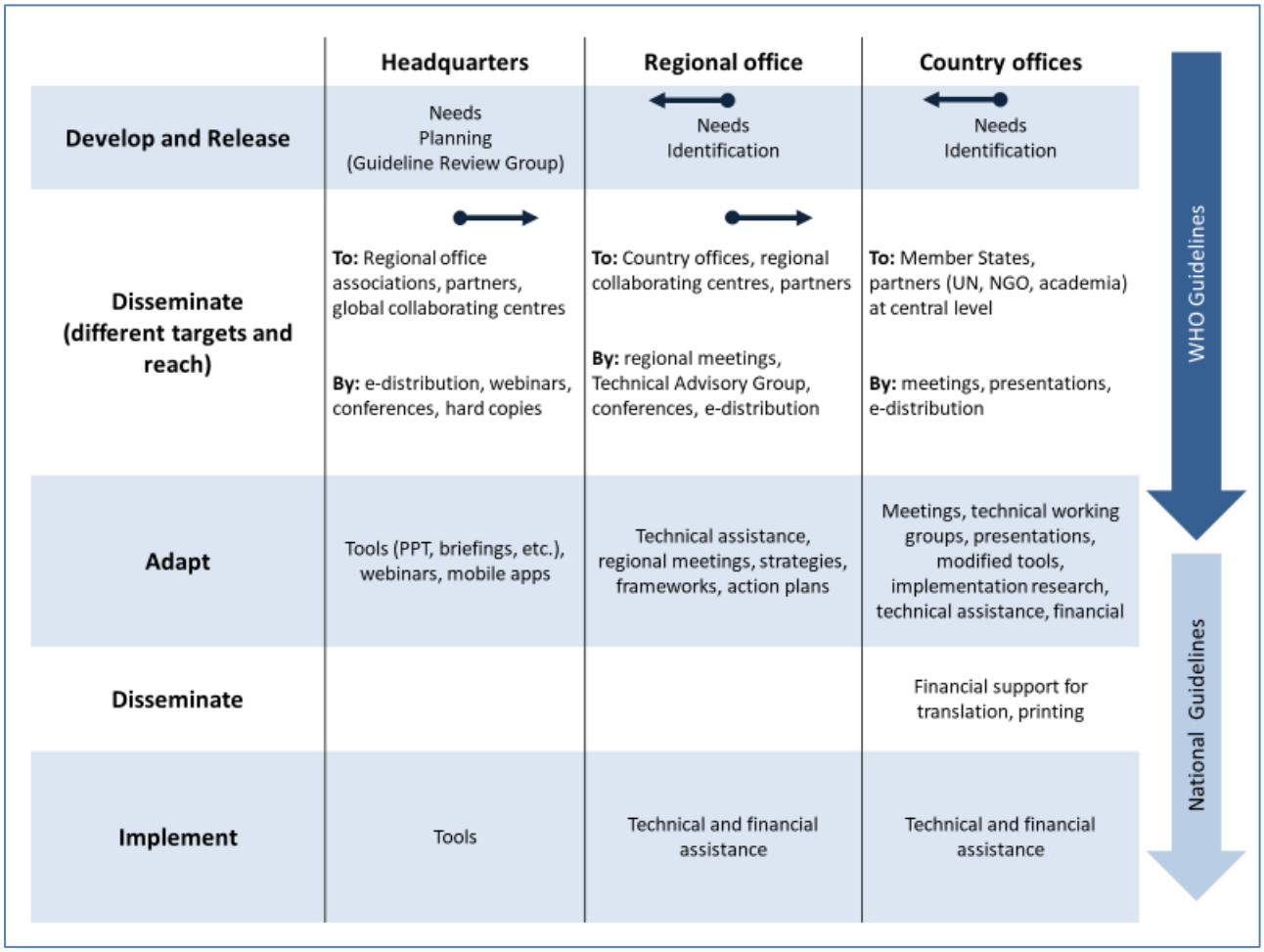
There was also a need identified to improve outreach to the private health sector where that is present. This can include outreach to professional associations and medical schools as well as directly to private sector companies.

Implementation planning and research

The key areas for improvement identified included supporting implementation planning and research, communicating guideline development schedules, improving the clarity of guidelines, and improving dissemination.

Recommendations

The following figure illustrates how each WHO level is involved in both WHO guidelines and national guidelines along a continuum of development, dissemination of WHO guidelines, adaptation, dissemination of national guidelines, and implementation. Only by having all three levels of WHO work in a coordinated manner can results be optimized.



Recommendations for WHO SEARO and SEAR WCOs:

1) SEARO and SEAR WCOs should formally document dissemination strategies and plans for WHO RMNH guidelines at regional and country level that includes both active and passive dissemination methods and that can incorporate measures for monitoring and assessing reach and use. Standard templates should be used to determine requisite stakeholder groups, including the private health sector, provide rationale for their inclusion/exclusion, identify means to disseminate to each group, and specify necessary resources. Dissemination strategies should also continue to promote, where appropriate, the use of current best practices such as regional meetings and national technical working groups/advisory committees at country level, in addition to the current approach of cascading email distribution.

2) It is recognized that WHO has considerable influence in promoting the adaptation and adoption of WHO guidelines and recommendations into national guidelines, standard operating procedures and protocols. Health impact is mostly reliant on successful implementation. In the past, WHO has supported implementation with tools, training, and mobile applications (such as the MEC Wheel). Such support is dependent on the availability of resources. It is recommended that WHO adopt as a standard practice the provision of country assistance in the development of costed implementation plans for national strategic plans and the roll-out of national RMNH guidelines and standard operating procedures. Implementation plans may include, but are not limited to, development of training materials, training delivery, information packages, tools and job aids, and monitoring. Opportunities for specific implementation support would need to be considered on a case-by-case basis and in-line with availability of resources, with a special emphasis on implementation research when warranted.

Recommendations for WHO headquarters and WHO SEARO:

3) WHO headquarters and SEARO should consider a tiered approach to needs identification for WHO RMNH guideline development in line with country health system maturity, obstetric transition and level of mortality. This may involve prioritizing different aspects of the RMNH programmes (e.g. adolescent health) or developing tiered guidelines with recommendations for countries at different levels of health system maturity and levels of mortality. Such an approach could be first piloted in SEARO to develop specific tiered guidelines or derivative products.

4) WHO headquarters and SEARO should develop and communicate a detailed forward-looking guideline development and release plan, with specific dates and timelines, that can improve country awareness and preparedness for upcoming releases of RMNH guidelines and recommendations.

5) WHO headquarters and SEARO should develop a derivative products plan in support of new/revised guidelines, including, where appropriate but not limited to, tools, job aids, mobile apps, training packages, and information packages to be developed in support of guideline uptake by Member States.

Recommendations for WHO headquarters:

6) WHO headquarters should institute a more efficient process for the life cycle management of WHO guidelines, from initial planning and development to implementation and monitoring and evaluation, which can then lead to revised guidelines. This is also related to the number of WHO guidelines and recommendations, some of what may have been superseded by more recent recommendations. Specific process recommendations include providing updates (i.e., corrigendum) instead of new guidelines and improving the usability of recommendations through innovative approaches that could include searchable recommendations on the WHO Website.

Recommendations for SEAR countries:

7) To the best of each country's ability, SEAR countries should strengthen their institutional capacity to undertake regular implementation planning for WHO guidelines, which include development of costed implementation plans for national strategies, guidelines and standard operating procedures. This will result in clearer understanding of resource needs and timelines for national budgeting purposes; documented rationale for different implementation scenarios based on available resources; an evidence base for external resource mobilization; and a foundation for ongoing monitoring and evaluation.

8) To the best of each country's ability, SEAR countries should strengthen the monitoring and evaluation of the implementation of national PMNH guidelines. This will have the advantage of providing information for decision making to improve implementation and maximizing the efficient and effective use of resources. This in turn will improve the probability of attaining positive health outcomes that are aligned to SDG targets.

1.0 Background to the Evaluation

The World Health Organization (WHO) South-East Asia Region (SEAR) contracted the services of TDV Global Inc. to conduct an external evaluation of the adaptation and use of WHO guidelines on Reproductive, Maternal and Newborn Health (RMNH) in the WHO South-East Asia Region.

The evaluation considered WHO guidelines in the area of RMNH released in the last 5 years (i.e. from 2014 to 2018). The overall purpose of the evaluation was to evaluate the contribution of WHO guidelines to improving RMNH in the Region.

1.1 Context

The WHO South-East Asia Regional Office (SEARO) covers 11 Member States, namely Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. SEARO provides technical leadership and monitoring support on health and evidence-based policy actions in these countries accounting for a population of 2 billion people (26% of the world's population) and 27% of the global annual births, translating into an addition of 180 million every year.[1]

All 11 Member States in the Region have committed to the Sustainable Development Goals (SDGs) and to the UN Secretary-General's Global Strategy for Women's, Children's and Adolescent's Health (2016-2030)[2]. Both initiatives provided new impetus for increased attention to the health needs of women, children and adolescents. In 2014, the WHO Regional Director for South-East Asia launched the Regional Flagship Priority Programmes. Among the eight Flagship Programmes, one specific Flagship program focuses on the unfinished Millennium Development Goal (MDG) agenda of ending preventable maternal, newborn and child deaths with focus on neonatal deaths. WHO SEARO aims to achieve this through various means including provision of evidence-based policy and strategic guidance to help implement WHO recommendations, capacity-building, situational analysis and scaling up of selected interventions and improving the quality of care and accountability.

The Family Health Gender and Life Course (FGL) department in the WHO SEARO is responsible for providing technical guidance and managing the work on health and development of individuals and families today and for future generations, focusing on people and addressing key stages of the life-course including the Reproductive, Maternal and Newborn Health (RMNH) programme area. FGL works to enhance health and development by supporting countries and partners to identify, develop, implement and evaluate approaches and interventions that foster health development across the life course.

A WHO guideline is defined as any document containing recommendations about health interventions, whether these are clinical, public health or policy recommendations. A recommendation provides information about what policymakers, health care providers or patients should do. It implies a choice between different interventions that have an impact on health and that have implications for the use of resources. WHO guidelines are recommendations intended to assist

[1] Evaluation Terms of Reference

[2] The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). Every Woman Every Child, a multi-stakeholder Strategy and Coordination Group facilitated by the Executive Office of the United Nations Secretary-General. https://www.who.int/life-course/partners/global-strategy/globalstrategyreport2016-2030-lowres.pdf?ua=1

providers and recipients of health care and other stakeholders to make informed decisions. The recommendations are based on a comprehensive and objective assessment of the available evidence.

WHO has adopted internationally recognized standards and methods for guideline development to ensure that guidelines are free from bias and meet public health needs. The WHO Handbook for Guideline Development[3] provides a step-by-step guidance on how to plan, develop and publish a guideline. The Guidelines Review Committee (GRC) is responsible for monitoring the development process and ensuring that the relevant regulations and standards are applied. WHO regional offices and relevant technical departments are expected to participate in the guideline development process led by WHO headquarters. All WHO guidelines must be approved by the GRC.

Once a guideline is approved by the GRC, it is disseminated to the member states by the regional offices using formal as well as informal channels such as electronic sharing with focal points in WHO country offices (WCOs) or dissemination in a regional meeting followed up with the development of individual country plans for adaptation and use. Implementation of country plans are supported with organized technical assistance and financial support based on Member States' request and requirements. WHO country offices also use different channels for dissemination to the ministries of health that include electronic sharing, distribution of hard copies for important stakeholders and presentations in advisory meetings.

1.2 Evaluation Objectives and Scope

The evaluation of the adaptation and use of WHO guidelines on RMNH in the WHO South-East Asia Region considered WHO guidelines in the area of RMNH released in the last 5 years (i.e. from 2014 to 2018). The overall purpose was to evaluate the contribution of WHO guidelines to improving RMNH in the Region. The evaluation Terms of Reference can be found in **Annex A.**

Specifically, the evaluation is to:

1. Assess the existing adaptation and use of WHO RMNH guidelines at the country level in selected Member States.

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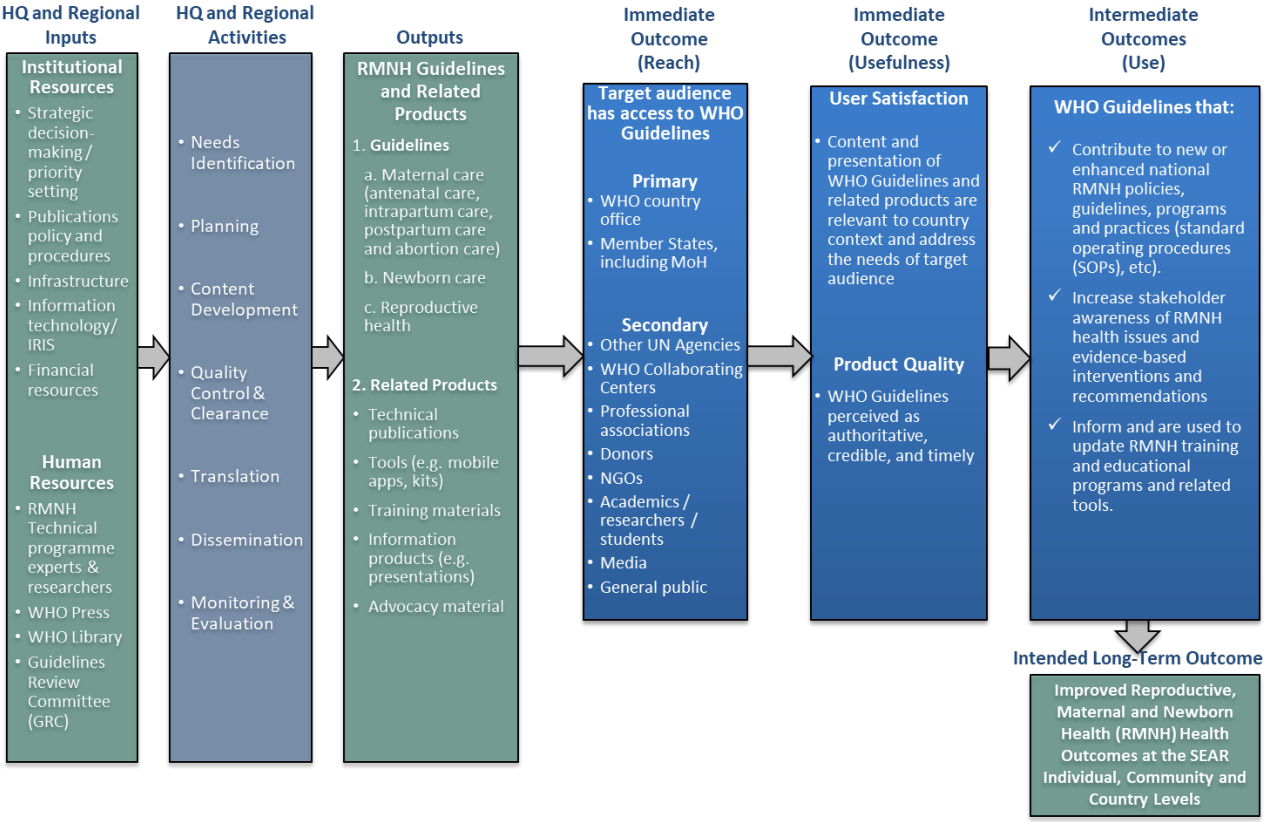
4. Review and make recommendations on WHO's role at all three levels of the Organization (i.e. headquarters, regional and country offices) to strengthen implementation and impact of RMNH guidelines at the country level.

[3] World Health Organization. (2014). WHO handbook for guideline development, 2nd ed. World Health Organization. https://apps.who.int/iris/handle/10665/145714

1.3 Results Framework and Evaluation Matrix

The results framework for the evaluation of the adaptation and use of WHO guidelines on RMNH in the WHO SEAR, which formed the basis of the evaluation, is presented in the Logic Model found below in Figure 1.

Figure 1: Logic Model for the evaluation of the adaptation and use of WHO guidelines on Reproductive, Maternal and Newborn Health (RMNH) in the WHO South-East Asia Region (SEAR)



The **inputs** into the guidelines process include both institutional resources and human resources. Institutional resources include strategic direction, policies, procedures, financial resources and technology. Human resources include technical experts and researchers, WHO Press, WHO Library and the GRC.

The **activities** relate to the various stages of the publication process and include needs identification, planning, content development, quality control and clearance, translation, dissemination and monitoring and evaluation that occur at the WHO headquarters, regional, and country office levels.

The **outputs** are actual RMNH Guidelines and related products, such as advocacy material, technical publications, mobile apps and tools, promotional material, information products and training materials.

The **results** of the publication process are defined in terms of its **reach**, **use** and **usefulness**.[4] These are measures for the impact of guidelines in SEAR.

i. **Reach**: The result for reach is *"target audiences have access to WHO Guidelines*". The evaluation assesses the policies and procedures that are in place to develop

[4] The results framework and Logic Model have been adapted from: Tara Sullivan, Molly Strachan and Barbara Timmons, 2007. *Guide to Monitoring and Evaluating Health Information Products and Services*, USAID, 2007.

dissemination strategies, distribution information (push-pull, referrals), as well as factors such as language and distribution media.

ii. **Usefulness**: There are two result statements for usefulness, one related to a) User[5] Satisfaction and the other to b) Quality.
a) User Satisfaction: In regard to **Usefulness,** the result statement is related to User Satisfaction, and is, "*the content and presentation of WHO Guidelines addresses the needs of target audiences*". User satisfaction is determined by the target audience's satisfaction with:

- **content of the guideline**: it is relevant, it is addressing a need, it is addressing a priority,
- **presentation**: it is produced in the appropriate form including language, and
- **delivery**: it is distributed in the appropriate form that makes it accessible to target audiences.

b) Quality: In regard to **Usefulness**, the second result statement is related to Quality, and is, "*WHO Guidelines are perceived as authoritative, credible, and timely*".

iii. **Use**: The result statement for **Use** is related to the application of knowledge gained from WHO Guidelines in the areas of national RMNH Guidelines, national RMNH programmes and practices, stakeholder awareness, and training.

The following table provides an overview of the definitions and results:

Table 1: Results Framework

Level of Result	Definition	Result
Reach	The extent to which WHO RMNH guidelines reach their intended target audience(s).	The target audiences have access to WHO guidelines.
Usefulness	The perceived quality, applicability and practicality of WHO Guidelines.	The content and presentation of WHO guidelines and related products are relevant to the country contexts and address the needs of the target audiences. WHO publications are perceived as authoritative, credible, and timely.
Use	The application of knowledge gained from WHO guidelines with regard to decision making in clinical, public health and policy-making contexts.	WHO guidelines that: • Contribute to new or enhanced national RMNH policies, guidelines, programs and practices (standard operating procedures (SOPs), etc). • Increase stakeholder awareness of RMNH health issues and evidence-based interventions and recommendations • Inform and are used to update RMNH training and educational programs and related tools.

[5] The term “users” includes representatives in Member States who deal with health policies, strategies and health care practices in relation to RMNH.

Based on the theory of change presented in the Logic Model in Figure 1 and the results framework in Table 1 and based on the Terms of Reference for the evaluation, an evaluation matrix was developed. Please see **Annex B** for a complete evaluation matrix.

i) Reach: What is the extent to which WHO RMNH guidelines reach their intended target audience(s)?

- How does WHO target RMNH audiences?
- To what extent is the intended reach achieved?
- How does WHO target different regional language audiences?
- Does the support (e.g. web only, print) affect reach? If so, is the right media being used?
- What gaps, if any, exist in the engagement of target RMNH audiences?

ii) Usefulness: What is the perceived usefulness of WHO RMNH guidelines?

- How does WHO respond to regional and Member State RMNH strategies and priorities (e.g. Regional Flagship Areas, etc.) through its guidelines?
- To what extent are WHO RMNH guidelines based on needs? To what extent are they addressing priority needs?
- To what extent are WHO SEAR users satisfied with the WHO RMNH guidelines?
- To what extent does the format, language and dissemination affect perceptions of usefulness?
- To what extent, if any, is there a comparative advantage of WHO RMNH guidelines over those published by other stakeholders?
- What is the quality level of WHO RMNH guidelines (credible, authoritative, trustworthy, reputable)? What shortcomings exist if any?

iii) Use: To what extent are WHO RMNH guidelines used as references and as the authoritative sources for decision making in clinical, public health and policy decision-making contexts?

- What is the perceived influence of WHO RMNH guidelines on Member State health policies, strategies and health care practices?
- How can WHO and SEAR Member States foster the better use of RMNH guidelines?

iv) Health Outcomes: To what extent are RMNH health outcomes at the SEAR Individual, Community and Member State levels improved as a result of the guidelines?

- To what extent have RMNH guidelines contributed to WHO SEAR Member States meeting RMNH-related SDG health targets?

v) Lessons Learned: What are the lessons learned from WHO RMNH guidelines dissemination and knowledge translation processes at all three levels of the Organization? (country, region, global)

- What enabling factors have influenced the adaptation and use of RMNH guidelines?
- What have been the lessons learned, both positive and negative?
- What are the areas for improvement?

1.4 Methods

The evaluation approach collected and triangulated data from multiple lines of evidence, as outlined in the Evaluation Matrix in Annex B, including:

i. **Country case studies**: Country case studies were undertaken for India, Sri Lanka, Bhutan, Myanmar and Bangladesh based on the evaluation Terms of Reference in **Annex A**. Case studies were chosen to represent countries that had different levels of burden with RMNH impact, as noted in Table 2. Case studies included interviews and document review, with all

countries being visited for face-to-face interviews except for Bangladesh where interviews were conducted remotely.

Table 2: Country Case Studies

Degree of Burden with RMNH Impact	Country
High Burden Country	Bangladesh India Myanmar
Medium Burden Country	Bhutan
Low Burden Country	Sri Lanka

ii. **Interviews**: a total of 52 interviews were conducted (22 internal with WHO and 30 external interviews). Table 3 outlines the breakdown of interviewees by interview category. WHO interviews included those at the country, regional, and headquarter levels. External interviews included Member State representatives and partners. Please see **Annex C** for the interviewee list.

Table 3: Interview Targets

Interview Category	Stakeholder	Interviews Conducted	Target
General Interview	WHO SEARO	**4**	3-5
	WHO headquarters	**5**	4-6
	Non-State Actors (Donors, Academia, WHO CC, etc.)	**3**	5-8
Case Study	Member States, ministries of health	**16**	15-20
	Member States, non-state actors (NSA) and others	**11**	5-10
	WHO country offices – RMNH Programme Leads	**13**	5-10
Total		**52**	37-59

iii. **Document Review**: relevant documents such as strategies, reports, guidelines, emails, meeting reports, presentations, surveillance data and guidelines were reviewed (over 216 documents were reviewed). See **Annex D** for list of documents reviewed.

iv. **Internal Survey**: an online survey was distributed to WHO staff working on RMNH guidelines in the three levels of the organization. The survey was launched on October 30 and weekly reminders were sent to complete the survey. Starting on November 18, daily reminders were sent to encourage the completion of the survey. The survey was closed to respondents on November 25. In total, 16 WHO staff were contacted to take part in the survey, and 11 completed responses were received, or a 68.8% response rate. See **Annex E** for internal survey results.

v. **External Survey**: an online survey was emailed to Member State representatives and other partners. The survey was launched on October 30 and weekly reminders were sent to complete the survey. Starting on November 18, daily reminders were sent to encourage the completion of the survey. The survey was closed to respondents on November 25. In all, 84 stakeholders were known to have been contacted and 35 completed responses were received, or a 41.6% response rate. See **Annex F** for external survey results.

Guideline Samples

During the planning phase and documented in the Inception Report, the evaluation identified the most realistic and effective means to assess RMNH guidelines given the timelines of the evaluation and that the number of RMNH guidelines identified by WHO produced since 2014 exceeded 17 different guidelines. A sample of three guidelines revealed over 181 specific recommendations.

The approach therefore was to assess a sample of recommendations from the guidelines sample during country case studies, in an attempt to provide more detailed insight into the findings. The WHO guidelines were selected based on representativeness, materiality and impact (e.g. mortality, etc.) across the five SEAR Member States, and were approved by the WHO SEAR Office prior to the evaluation start. That sample was as follows:

Table 4: Sample of Guidelines and Recommendations

Thematic Area	WHO Guideline	Intervention
Management of preterm babies *(Newborn Health)*	Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015)	1. Antenatal corticosteroids to improve newborn outcomes 2. Tocolytics for inhibiting preterm labour 3. Magnesium sulphate for fetal protection against neurological complications 4. Antibiotics for preterm labour 5. Optimal mode of delivery 6. Thermal care for Preterm newborns 7. Management of newborns with respiratory distress syndrome
Management of first stage of labour *(Maternal Health)*	WHO recommendations for augmentation of labour (2014)	1. Diagnosis of delay in the first stage of labour 2. Prevention of delay in the first stage of labour 3. Treatment of delay in the first stage of labour with augmentation 4. Care during labour augmentation
Medical Eligibility Criteria *(Reproductive Health)*	Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015)	1. Recommendations for combined hormonal contraceptive (CHC) (CHCs include combined oral contraceptives, combined injectable contraceptives, combined patch and combined vaginal ring) 2. Recommendations for progestogen-only contraceptive (POC) use *(POCs include progestogen-only pills, implants and injectables)* 3. Recommendations for levonorgestrel-releasing intrauterine device (LNG-IUD) 4. Recommendations for use of subcutaneously-administered depot medroxyprogesterone acetate (DMPA-SC) – new method added to the guideline

1.5 Analysis

1.5.1 Qualitative Data Analysis

For the qualitative data captured from document review, interviews, country case studies and open-ended qualitative responses in the surveys, the TDV Global team undertook a three-stage analysis process of the different lines of qualitative evidence. NVivo for Mac was also used to support some parts of the qualitative data analysis.

Table 5: Qualitative Analysis

First stage analysis	**Basic framework**: By line of evidence, evaluation question, sub-question (based on the evaluation matrix). **First level coding**: Coding interview questions by internal versus external, and by case study to nodes/evaluation questions, coding documents by evaluation question.
Second stage analysis	**Second level coding**: Themes identified that were common or recurrent (within and across stakeholder groups for interviews), patterns in data, sequences. At this stage, comparison of themes across lines of evidence and triangulation occurred, e.g. with survey results, across case studies.
Third stage analysis	**Findings:** Developed based on lines of evidence as described below.

The report does not quantify the qualitative data, but there are instances when the report provides proportional qualifiers to the data as per the following broad guidelines:

- Few: less than 20%,
- Some: more than 20%, but less than 40%, and
- Many: more than 40%, but less than 80%.

1.5.2 Quantitative Data Analysis

The online surveys were conducted and analysed using SurveyMonkey. Basic demographic analysis and frequencies are reported in the Survey Technical Reports in **Annex E and F** and are used in this report.

1.5.3 Developing Findings and Triangulation

Internal technical reports were developed for each line of evidence (i.e. internal interviews, external interviews, five country case studies, internal survey results, external survey results, document analysis). Findings from each line of evidence were consolidated in an evidence table, and conclusions and recommendations were developed based on the multiple lines of evidence. Triangulation continued at this stage, and additional data was sought, as needed, to overcome any gaps in the analysis. Preliminary findings, supported by a detailed evidence matrix, were presented to the WHO SEAR Evaluation Management Group in December 2019 for discussion and clarifications.

The findings presented in this report reflect this thorough and detailed analysis process. Findings that are inconsistent between groups are noted. Detailed case study results from specific countries are not presented, given potential sensitivities and issues of confidentiality. However, the findings below reflect the commonalities across case studies (both disease and country level), as well as the other evidence lines.

1.6 Limitations

Limitations of this evaluation, and how they have been mitigated, include:

- The scope of the evaluation was limited to guidelines that had been released between 2014 to 2018, which provided a limited number of guidelines. Given the time it takes for countries

to review and adapt guidelines, the actual use of guidelines was only expected to be observable for those guidelines released earlier in the period. This was mitigated by selecting a few guidelines (5) produced in 2014 to 2015 for more in-depth analysis.

- The period to conduct the evaluation resulted in a compressed schedule across all stages of the evaluation from planning to reporting. This was in part mitigated by deploying a larger than normal evaluation team, with four individual evaluators deployed in data collection. Nonetheless, the timeline did present a challenge for the evaluation especially given the complexity of the subject matter.
- The compressed schedule also limited the potential timings for country visits. As such, the Bhutan visit occurred when many of the Ministry of Health (MoH) officials were involved in a WASH (i.e. water, sanitation and hygiene) exercise and a suitable time was not able to be found to conduct the Bangladesh visit. The inability to visit Bangladesh to collect data was mitigated by use of videoconference and teleconference tools to conduct interviews with officials.
- For the survey, WHO staff provided lists for respondents. This may bias the survey, as it may include those who interact the most with the WHO RMNH Programme. However, the survey was sent to a wide range of stakeholders, and respondents may have shared the survey with others.
- For the document review, an initial set of Member State and SEAR RMNH documents were provided, the WHO IRIS and website were searched, and documents were collected during the interviews and field visits. This data gathering approach may result in limitations, including unpublished documents not being identified and limited documents being received from the country level. To address this, documents were collected at the field visits and in interviews, and additional documents were sought when gaps in the analysis were identified.
- The scope of the evaluation as outlined in the Terms of Reference (see **Annex A**) focused on results as defined by reach, usefulness, use and health outcomes. The evaluation therefore did not focus on activities and outputs at the various levels of WHO. Some of this information however was captured during interviews, document review and country case studies. The presentation to the EMG also provided an opportunity to identify any significant gaps regarding programme activities as it pertains to conclusions and recommendations.

1.7 How to Read this Report

The following sections present the evaluation findings, conclusions and recommendations. Evaluation findings are presented by Evaluation Question (and Evaluation Sub-question if applicable) as per the Evaluation Matrix (see **Annex B**).

- **Section 1.0** presents the background of the evaluation in terms of context, evaluation objectives and scope, and approach,
- **Section 2.0** presents the evaluation findings on reach of WHO RMNH guidelines,
- **Section 3.0** presents the evaluation findings related to the usefulness of WHO RMNH guidelines,
- **Section 4.0** presents the evaluation findings related to the use of WHO RMNH guidelines,
- **Section 5.0** presents the evaluation findings related to the contribution of WHO RMNH guidelines to health outcomes,
- **Section 6.0** presents the evaluation findings related to Lessons Learned,
- **Section 7.0** presents the evaluation's conclusions, and
- **Section 8.0** presents the evaluation's recommendations

2.0 Findings: Reach of WHO RMNH Guidelines

This section is related to the **reach** of WHO RMNH guidelines. Reach is defined as the breadth and depth of guideline dissemination and describes the extent to which guideline information is distributed, redistributed and referred to by organizations and individual users.

2.1 What is the extent to which WHO RMNH guidelines reach their intended target audience(s)?

To a large extent, WHO RMNH guidelines reach Member State officials as the principal target audience. There is a customary, but not formally documented, process of cascading dissemination from headquarters to regional office to country office to Member State officials. According to internal interviews, document review and case studies (Bhutan, Sri Lanka), there are other audiences who are targets of WHO RMNH guidelines, depending on the WHO organizational level that are disseminating the guidelines (i.e. headquarters, regional office, or country office). WHO headquarters has may have other audiences it targets, such as international associations, UN agencies, international non-governmental organizations (NGOs), global Collaborating Centres and others. Regional offices may also have additional stakeholders, such as regional Collaborating Centres or professional associations.

According to the case studies, at the country level, some stakeholders in addition to Member State officials were identified as recipients, included UN agencies, NGOs, and academics (e.g. medical schools). These stakeholders are involved in national guideline development processes that are administered by the ministries of health, sometimes participating in formal processes and mechanisms such as Technical Working Groups. Case studies indicated that such formal coordination mechanisms can act as an effective means for collaborative approaches, including information sharing, and can widen the target audience at the national level.

The interviews largely found that WHO RMNH guidelines reach their target audience through both active and passive dissemination strategies. Active dissemination refers to activities such as presentations, workshops, conferences, and webinars which allow for more interactive engagement. Passive dissemination refers to sharing emails with PDF documents and links to webpages.

Even though to a large extent WHO RMNH guidelines reach their target audience, the need to improve reach has been noted in various lines of evidence. Gaps identified include the need to improve dissemination planning (case studies, document review, internal interviews), including the development of more formalized dissemination plans, and the importance of continuing to use or increasing the use of active dissemination (internal and external surveys, case studies).

The need to disseminate WHO guidelines beyond the national level to other tiers of the health system and other stakeholders (e.g. communities, women, health care providers) was also raised throughout the evaluation, including in internal interviews and surveys. The evaluation however has taken the perspective that WHO is a technical, norm-setting organization and that the target audience for WHO RMNH guidelines is principally the policy and decision makers in the MoH in Member States, normally at the national level, and by association the stakeholders that Members States have identified to participate in their respective processes. In line with that, dissemination to lower levels of the health system should only be undertaken by the national authority, based on their policies, procedures and processes, usually in the form of adapted national guidelines of standard operating procedure (SOP). WHO can assist, where possible, in the dissemination of national RMNH guidelines, but the evaluation

itself focused on dissemination of WHO RMNH guidelines, and not the national guidelines adapted from these WHO guidelines.

Key Findings:

- To a large extent, WHO RMNH guidelines reach Member State officials as the principal target audience. In addition, country level dissemination of WHO RMNH guidelines is appropriately focused on the national level stakeholders.
- Each level of WHO has their own target audience.
- While reach is achieved to a large extent, there are still areas for improvement in terms of dissemination planning and continuing or increasing active dissemination methods.

2.1.1 How does WHO target RMNH audiences? Extent to which policies, strategies, plans, procedures for WHO guidelines support the dissemination and adaptation of RMNH guidelines.

Regarding the targeting of RMNH audiences, according to internal interviews and case studies, targeting is done by all three levels of WHO. From a headquarters perspective, dissemination is done according to communication plans for each guideline that include publishing on the WHO website, and social media announcements from WHO headquarters. Press releases are sometimes used to ensure the information is released globally. There were no formal communication plans identified by the evaluation at the regional or country level.

According to internal interviews and supported by case studies, a cascading method to disseminate WHO RMNH guidelines is used. First, WHO headquarters emails the guidelines (or the electronic link) to regional offices, as well as to other relevant stakeholders that are engaged with WHO headquarters (such as global NGOs and professional associations or global collaborating centres). Regional offices then electronically distribute the information to WHO country offices (as well as regional level partners and stakeholders), and country offices distribute the electronic link to contacts in the Member State (including MoH, academics, local NGOs and partners).

Dissemination is largely electronic (sending emails and web links). However, interviews and case studies noted that print copies are still requested by countries and provided to the extent possible.

There is some variance in responses in terms of who is the target RMNH audience. According to country case studies, the key audiences are Members States and the MoH's and national program managers in those institutions including policy makers and decision makers. Respondents however also indicated that it could be health service providers at all levels, women receiving services (and their communities and families), collaborating centres, academics, local NGOs and partners. Each level of WHO will have their respective target audience.

At country level, it is noted in the case studies on Myanmar and Sri Lanka and in document review, that WHO interacts regularly at the Member State level, and this can be facilitated by formal coordination mechanisms, such as Technical Working Groups, at the national level established by Member States and that are inclusive of partners (e.g. academia, NGOs, UN agencies, etc.). This allows for a platform for dissemination, information sharing and coordination.

Dissemination may also include active methods such as regional workshops, presentations and webinars. Case studies, internal and external surveys and internal interviews indicated that these active means are effective in disseminating WHO guidelines.

Country case studies demonstrated that each country office may operate differently. While generally WHO is achieving reach, there are exceptions, and large countries can present more of a challenge given jurisdictions and number of stakeholders, that may require more careful, formal dissemination strategies and plans. While such strategies may be place in headquarters, no such formal dissemination strategies or plans at regional or country level were identified by the evaluation.

Key Findings:

- Each level of WHO has their target audience, but the primary target audience are decision- and policy makers in Member States.
- At country level, other target audiences are identified by the Member State processes put in place to review and adapt WHO guidelines and disseminate and implement national guidelines.

2.1.2 To what extent is the intended reach achieved?

Data collection encountered no quantitative data or tracking of reach being done by WHO at any level. The assessment of reach therefore is based strictly on qualitative data, and in some instances during the conduct of country case studies, WHO country offices provided emails that demonstrated evidence of local distribution of guidelines and supporting materials. WHO regional office also provided evidence of the same.

According to internal and external interviews, surveys and case studies, in general (and assuming that the principal target audience of these guidelines are the Members States), WHO RMNH guidelines are reaching the intended audience, and there is a relatively standard means to disseminate the information through cascading down the WHO levels.

WHO undertakes a variety of dissemination methods in addition to the electronic cascading method, including more active means. As an example, document review identified the following mechanisms for dissemination and promoting adaptation:

- Holding the South-East Asia Regional Technical Advisory Group (SEAR-TAG) meetings annually, including providing relevant background documents, discussing new guidelines, and discussing issues arising.
- Regional meetings that included sharing and discussing the new guidelines and provided time for countries to develop action plans, for example:
    - *Every Newborn Action Plan and Postnatal Care for Mother and Newborn, Report of a regional meeting, Colombo, Sri Lanka,* 11–13 November 2014
    - *2015 and Beyond: the unfinished agenda of MDGs 4 and 5 in South-East Asia Report of a regional meeting* 29 April –1 May 2014, Kathmandu, Nepal
    - *Perinatal surveillance and prevention of birth defects: Progress Review (2017)*
    - *Strengthening Country Capacity on Maternal and Perinatal Death Surveillance and Response Report of a South-East Asia Regional Meeting 16–18 February 2016, Maldives*
    - *Regional Meeting on Reducing Newborn Mortality with a Focus on Birth Defects* (2018)
    - *Regional Meeting on strengthening family planning programs*: *Towards universal reproductive health coverage in the SDGs era*, 18-20 April 2017, New Delhi, India : disseminated all FP guidelines to MS

    - The Regional Office oriented Member States on the new WHO guidelines for antenatal care and intrapartum care at the regional meeting in 2018, and encouraged Member States to update their national guidelines
- Developing regional strategies and frameworks e.g. *Regional Communication Strategy for the Prevention and Control of Birth Defects (2015); Strategic Framework for Action for Newborn and Child Health and Development for the South-East Asian Region (2018-2022), Improving the Quality of Care for Reproductive, Maternal, Neonatal, Child and Adolescent Health in South-East Asia Region: A Regional Framework* (2015), and, a regional strategic framework for accelerating universal access to sexual and reproductive health and rights in Member States of WHO's South-East Asia Region, 2020-2024 is in process.

Some examples of tools that facilitate dissemination and uptake:

- Developing simplified versions of recommendations new guidelines (e.g. for ANC 2016 and IPC 2018, Pre-meeting assessment of level of implementation of ANC, IPC recommendations by SEARO).
- Developing e-learning courses, for example in 2014 and 2015, the newborn care and training on newborn-birth defects database was developed.
- Developing tools to assist uptake of guidelines, for example *Pocket Book of Hospital Care for Mothers* (2017), *Assessment Tool for Hospital Care: Improving the Quality of Care for Reproductive, Maternal, Neonatal, Child and Adolescent Health in South-East Asia Region: A Regional Framework (NO DATE)).*
- Conducting joint country missions, for example between WHO and UNICEF in 2015 to Bangladesh, Indonesia and Nepal to review progress on the implementation of national RMNCAH plans (particularly newborn action plans).
- Developing manuals (including facilitator guides) and trainings specific to SEARO, for example: *Improving the Quality of Care for Mothers and Newborns in Health Facilities (2017),* Cervical Cancer, and *Hospital-based Birth Defects Surveillance: A Guide to establish and operate (2016).*
- Developing policy briefs (e.g. *Prevent birth defects – Ensure quality of life and dignity* (No Date).
- Holding trainings in a variety of areas, for example, 2015 regional workshop on the use of the computer-based planning and costing tool, One Health.
- Releasing Regional Committee meeting documents outlining actions, for example, 2019 *Accelerating the Elimination of Cervical Cancer as a Global Public Health Problem.*
- *Regional capacity-building workshop on Training Resource Package (TRP) on Family Planning to improve Sexual Reproductive Health and Rights (SRHR) (Draft recommendations).*
- Mobile app on MEC wheel.

> *External survey respondents found that the WHO RMNH guidelines were either completely (9%), mostly (51%) or somewhat (26%) well-circulated to their audiences (n=35).*

The dissemination of WHO RMNH guidelines may be accompanied by other products that were identified across all lines of evidence. These can support adaptation and implementation including derivative tools such as kits and pocketbooks, mobile apps, presentations developed by WHO headquarters, the conduct of joint country missions to engage national stakeholders in technical discussion, training materials including e-learning modules or tutorials, and supporting implementation research (IR).

While the evaluation assessment is that to a large extent WHO RMNH guidelines reach their intended audience, there are still areas for improvement identified throughout the evaluation as noted under Section 1.1, including the continued demand for printed copies, more active dissemination such as workshops, and improved formal dissemination planning at regional and national levels.

Key Findings:

- There is no formal, quantitative monitoring of reach done by WHO at any level.
- To a large extent, WHO RMNH guidelines reach their target audience including Member States and partners, but there remain areas for improvement.
- WHO at all levels is actively engaged in dissemination, and the regional office plays an important role through the Regional meetings, regional thematic working group meetings, and adapting derivative products such as pocketbooks, training materials, and tools such as mobile apps that are disseminated at these regional meetings.

2.1.3 How does WHO target different regional language audiences?

All lines of evidence indicate that English as the language of WHO RMNH guidelines is appropriate for the region. As an example, a majority of WHO RMNH external audience survey respondents do not find that there is a language barrier at all, or only to a minor extent, in the WHO RMNH guidelines (74%, n = 35). WHO will translate WHO guidelines into the necessary UN languages if required and resources permit. As noted, in the SEARO region English is the chosen UN language of preference.[6]

Translation of national guidelines (which may be adapted from WHO guidelines) into local languages is another issue, as this needs to be done for local level comprehension following adaptation at country level and may involve multiple local languages in some cases. These are national guidelines however and not the responsibility of WHO for translation and dissemination.

According to case studies and external survey, the need to have national guidelines in local languages varies by country. For example, English is one of the official languages in India so national guidelines in English are acceptable. However national guidelines are often needed to be translated into Burmese in Myanmar or Bangla in Bangladesh. Translation is often required for the other countries in the region. Some of those countries may need the support of partners, including WHO, for translation and dissemination of these national guidelines. Case studies showed that in some cases, WHO has assisted in this process when resources permitted, for example in Myanmar and Bangladesh.

Key Findings:

- All lines of evidence indicate that English as the language of WHO RMNH guidelines is appropriate for the region.

2.1.4 How does the support (e.g. web only, print) affect reach? To what extent is the right media used?

In general, all lines of evidence indicated that electronic distribution, supported when possible by hard copies, is appropriate and the right media to use. According to internal interviews, it is WHO policy to limit the number of hard copies, and to distribute mainly by electronic means, that is by email of

[6] The UN languages are: English, French, Spanish, Russian, Arabic, and Chinese.

electronic copies and links to the WHO website or via electronic memory sticks (i.e., USB sticks). There is still demand however for printed copies, particularly at local levels where internet can be a challenge, and WHO does try to address that need, although the extent of WHO headquarters printing and distributing hard copies was not assessed.

New developments, including the use of smartphone and tablet applications to facilitate dissemination, are an increasingly important channel of dissemination according to internal interviews and case studies. These comments however were generally made in the context of distributing national guidelines, and not WHO guidelines to Member States.

Key Findings:

- In general, all lines of evidence indicated that electronic distribution (weblinks and PDF formats), supported when possible by hard copies, is appropriate and the right media to use for guideline dissemination.

2.2 What are the major gaps in reach?

While there were some dissemination challenges noted previously, no major gaps in reach regarding the dissemination of WHO RMNH guidelines were identified by the evaluation. Under Lessons Learned, there were suggestions however that outreach to the private health sector could be improved.

Interviews and case studies did identify methods that assist in dissemination, including the provision of derivative products such as providing presentations, pocketbooks, and tablet and smartphone applications, and active dissemination such as webinars, workshops and meetings (national and regional), implementation research, , distribution through other professional groups, and national level technical working group meetings.

The case studies highlighted the effectiveness of national technical working groups as a platform to coordinate and disseminate information. In these cases, there were regular, formal meetings that present an opportunity for WHO to actively disseminate to relevant RMNH stakeholders on a regular basis. These platforms also serve the purpose of general information sharing and coordination of activities across the partners and stakeholders involved.

When the lines of evidence did identify gaps, the gaps were in reference to dissemination of national guidelines to lower levels in the country's health system. In that case, issues included internet connectivity, and gaps with reaching health care providers, and women (and husbands, communities). Possible means of addressing gaps mentioned by interviewees including training and incorporating guidelines into other pre-service courses (e.g. nursing, midwifery, public health, etc.).

Key Findings:

- There were no major gaps in reach regarding dissemination of WHO RMNH guidelines identified by the evaluation. When the lines of evidence did identify gaps, the gaps were in reference to dissemination of national guidelines to lower levels in the country's health system.
- The case studies highlighted the effectiveness of regional workshops and national technical working groups as a platform to coordinate and disseminate information. These meetings are considered a best practice.

3.0 Findings: Usefulness of WHO RMNH Guidelines

This section is related to **usefulness** of WHO RMNH guidelines. Usefulness is defined as the quality of guidelines and includes such aspects as relevance (addressing priority needs), user satisfaction and quality.

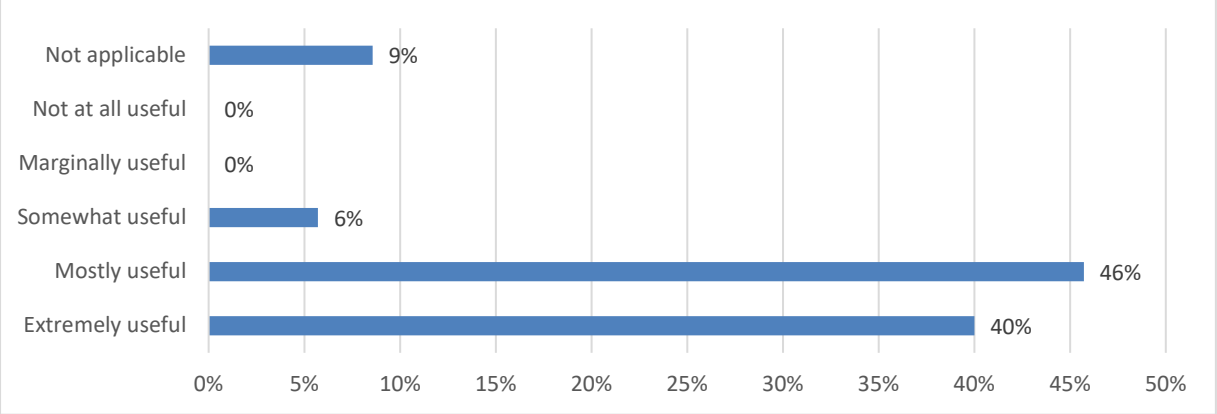
3.1 What is the perceived usefulness of WHO RMNH guidelines?

There is general agreement across all lines of evidence that WHO RMNH guidelines align with regional and country needs and priorities, and align across global initiatives such as the SDGs, WHO programmes and country plans and strategies.

The Bhutan country case study provides an example. Bhutan's national policies and strategies are aligned to international goals such as the SDGs, as are WHO programmes. The MoH and WHO country office discussed the priorities as outlined in Bhutan's national health plan (11th Five Year Plan 2013-18) and subsets thereof such as Bhutan's Reproductive Health Strategy, and the Bhutan Newborn Action Plan. Those priorities are reflected in the WHO Country Cooperation Strategy, and subsequent biannual workplans.

The external survey indicated that 86% of respondents (n=35) find WHO recommendation mostly or completely useful. Figure 2 provides a summary of the response to that question.

Figure 2: External Survey: To what extent do you find the recommendations of WHO guidelines useful? (n =35)



Internal interviews and the Sri Lanka case study indicated that not all country needs are addressed equally, and some gaps remain, including country specific guidelines and moving to guidance on implementation in different contexts. The RMNH context for each SEAR Member State is unique and requirements vary. For example, for the purposes of this evaluation, the WHO refers to the case countries as either high burden (i.e. Myanmar, Bangladesh, India), moderate burden (i.e. Bhutan) or low burden (i.e. Sri Lanka). Another framework to help frame the specific country contexts can be the health system maturity model developed by Stenberg[7] (2017). Across the selected case study countries, there are a range of health system contexts from Myanmar, which can be classified as an HS1 country (countries with poor performance across health system functions, limited resources, limited coverage of care) as well as a conflict-affected state, to Sri Lanka which is categorized as an HS3 country (mature health systems, relatively high resources, complex care with low mortality).

[7] Stenberg et al. Financing transformative health systems towards achievement of the health Sustainable Development Goals. Lancet, 2017, 5:e875-87: dx.doi.org/10.1016/S2214-109X(17)30263-2

Regardless of the framework used, there is a differentiation of needs across countries in the region that are corelated to their health system maturity and burden of disease.

Key Findings:

- In general, WHO guidelines are perceived as useful by Member States and align to global initiatives such as the SDGs.
- There are however differences in needs for countries in the region, largely based on the maturity of their health system, with the understanding that much of the WHO RMNH guidelines are targeted to countries with less mature health systems and a high burden of disease.

3.1.1 How does WHO respond to regional and Member State RMNH strategies and priorities (e.g. Regional Flagship Areas) through its guidelines?

According to all lines of evidence, WHO RMNH guidelines are well aligned to global and regional strategies, needs and priorities, and many of the SEAR country needs are reflected within that. According to case studies, for example, country development plans and sector strategies align to the SDGs. One of the eight priority flagship areas regionally (2014-2018) was the unfinished MDG agenda: ending preventable maternal, newborn and child deaths with a focus on neonatal deaths which is also reflected in the SDGs (see text box). These global and regional strategies have an influence. As an example, according to country case studies, countries have increased their focus on neonatal care (as well as preterm) within their programmes to reflect the greater focus in the SDGs, compared to the MDGs, which only focused on under-five mortality. That in turn has been supported by WHO guidelines regarding neonatal care and preterm birth care. See Table 6 for an MDG and SDG crosswalk for RMNH targets and indicators.

The Flagship Priority Area on the unfinished MDGs agenda: Ending preventable maternal, newborn and child deaths with a focus on neonatal deaths, identified in 2014 is well aligned with global priorities such as the SDGs and the 13th General Programme of Work (GPW 13) of WHO. The SDG 3 targets aim to end preventable deaths of newborns and children under 5 years of age and reduce maternal mortality. This Flagship Area will also significantly contribute to GPW 13 to achieve the goals for women, children and adolescents under the Strategic Objective of 1 billion more people benefiting from universal health coverage (UHC) and 1 billion more people enjoying better health and well-being. *WHO, SEARO A more responsive WHO in the South-East Asia Region: Our journey together, Our Journey, 2019*

Table 6: MDG and SDG Crosswalk for RMNH Targets and Indicators

MDGs	SDGs	SDG Indicators
Goal 5: Improve maternal health	**Goal 3**: Ensure healthy lives and promote well-being for all at all ages	
5a) Reduce by three quarters the maternal mortality ratio by 2015	Every country should reduce MMR by two-thirds in 2030 from 2010 value and no country should have MMR of >140, Global MMR should be <70	i. Maternal mortality ratio (MMR) ii. Proportion of births attended by skilled health personnel (SBA)

MDGs	SDGs	SDG Indicators
5b) Achieve universal access to reproductive health by 2015	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	iii. Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods (mCPR or mFP) iv. Adolescent birth rate (aged 10-14 years, aged 15-19 years) per 1,000 women in that age group (ABR)
Goal 4: Reduce child mortality 4a) reduce by two thirds under-five mortality rate	By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	v. Neonatal mortality rate (NMR) vi. Under five mortality rate

The extent that the individual country needs are reflected in the global and regional agenda does vary by level of health system maturity. By association, the extent that a country's specific needs, versus more generalized needs, can be addressed by WHO RMNH guidelines may be limited. The result is that some countries' needs may not be addressed, as those countries with more mature health systems and lower mortality and morbidity patterns in the region may have more specific needs. This was noted in the case of Sri Lanka and India, who may have needs that are a step beyond the WHO guidelines.

As an example, in Sri Lanka the national guideline for maternal care on medical diseases complicating pregnancy only refers to WHO guidelines for malaria and tuberculosis, while it is other medical conditions that attribute to the majority of maternal deaths in Sri Lanka, such as heart disease, liver disease and pneumonia in pregnancy. For such medical conditions, other guideline references that focus on improving the functioning of the health systems, such as The National Institute for Health and Care Excellence (NICE) in the United Kingdom and The American College of Obstetricians and Gynecologists (ACOG), are used. It was also noted in other case studies that WHO is not the only reference used in RMNH guidelines, with other examples identified by Myanmar including the International Federation of Gynaecology and Obstetrics (FIGO) and the Royal College of Obstetricians and Gynecologists (RCOG), at least partially based on the fact that many Myanmar doctors are trained in the United Kingdom and are therefore familiar with the RCOG.

In general, the WHO planning process at regional and country level allows for targeting of assistance to priority needs that fall within these broader global initiatives. Regional meetings are a platform for countries to identify their priority needs in dialogue with WHO and develop action plans. In addition, the WHO country cooperation strategies and resulting biannual work plans (BWP) developed at country level allow for discussion, prioritization and alignment based on national health plans and strategies.

Key Findings:

- According to all lines of evidence, WHO RMNH guidelines are well aligned to global and regional strategies, needs and priorities, and many of the SEAR country needs are reflected within that.
- The extent that the individual country needs are reflected in the global and regional agenda does vary by level of health system maturity and level of obstetric transition, and morbidity and mortality pattern.
- Some countries use other sources in addition to WHO for referencing their national guidelines.

3.1.2 To what extent are WHO RMNH guidelines based on needs? To what extent are they addressing priority needs?

While needs identification for guideline development occurs at all levels of WHO, it is led from WHO headquarters and supported by regional and country offices through various processes (e.g. surveys to Members States and networks, regional meetings, expert groups, situational or landscape analyses, and discussions in regional meetings (of challenges, success factors, suggestions, recommendations, and country plans) to set the agenda. While the developed RMNH guidelines may not match directly with all Member States' needs, there is alignment with global initiatives and priorities such as the SDGs.

Based on the recommendations of the evaluation of WHO's normative function, the WHO Secretariat will:

- prioritize normative products based on an assessment of demands and needs in order to realize WHO's commitment of driving impact in every country,
- establish guiding principles and quality assurance procedures for the design, formulation and dissemination/follow-up of all normative products (all normative products, including strategies, road maps and global action plans will be based on agreed standards and reviewed independently, as is the case for technical guidelines, and
- standardize and streamline systems and plans for monitoring and evaluation, and focus on documenting impact rather than just assessing the quality of normative products and their recommendations. (GPW13)

However, guidelines documentation was found to focus more on how the guidelines and evidence are explained to Member States, and the development of action plans at the national level, as opposed to how Member States were involved in ensuring these guidelines met their needs. The focus on priority setting for guidelines tends to be more on the evidence for the guidelines (e.g. based on data, research, where gaps are in terms of MDGs and now SDGs) and less on hearing directly from the Member States on what gaps and needs are (although surveys are identified as a major method to gather this information). Hence, it is not always clear from documentation who is setting the guideline development agenda and how much influence Member States have on this agenda. It is

Online surveys are used to gather information from key stakeholder at Member State level and regional level, to understand critical issues and find out where implementation issues might exist.

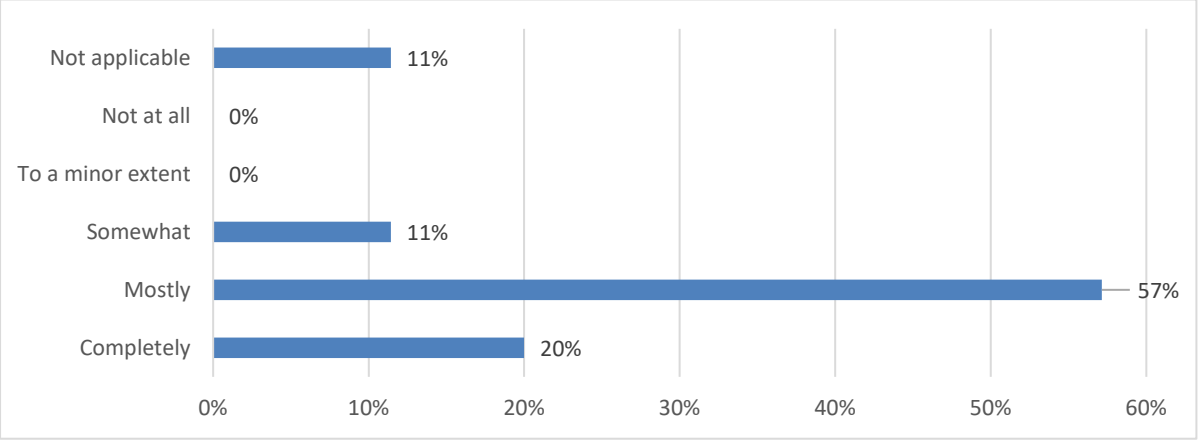
"We sent out online survey to stakeholders we could think of and specifically sent letters to each of regional Focal Point – to regional Focal Point in SEARO…and encouraged them to share link of this survey with all Country Office and Focal points….and through networks… (and ask) have you used (the guidelines), had you found it difficult to implement, what is missing, we did this survey scoping – what globally including SEARO key priorities and what was missing – and anything they had difficulty implementing, we used that information to inform the guideline development group – to scope what topics to undertake. And then a year later – we have guideline meeting – and recommendations are developed"

clear from the 13th General Programme of Work that WHO does need to prioritize and make balanced decisions so that it can reach its goals of the "triple-billion", focusing on the most benefit for the most people. In GPW 13, the HQ guideline development process is intended to be more participatory by involving WCO/RO through global public health goods.

As noted above in using the health system maturity framework (Stenberg 2017), the extent that guidelines address the individual country needs varies depending on the level of maturity of their health system and policy framework. Case studies showed that there was high usefulness of WHO guidelines for countries such as Myanmar with less mature health systems (HS1), but less usefulness for India (HS2) and even less so for Sri Lanka (HS3), both countries considered as having more mature health systems.

Amongst external survey respondents, 77% indicated that WHO RMNH guidelines completely or mostly address priority needs (See Figure 3). Comments in surveys and case studies stressed that WHO RMNH guidelines are evidence-based and can be used to influence national policy.

Figure 3: External Survey: To what extent are WHO RMNH guidelines addressing our priority health knowledge needs (n=35)



Key Findings:

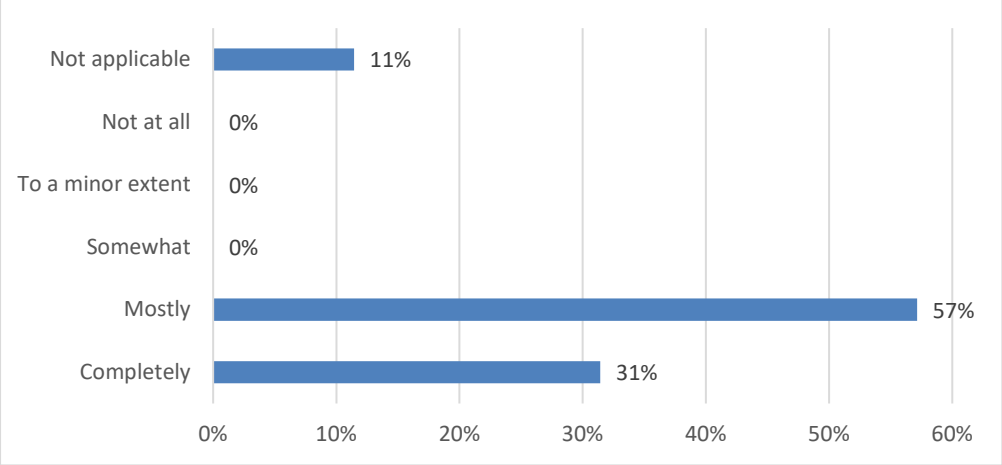
- WHO addresses Member State RMNH guideline needs using the lens of alignment to WHO's mandate and resolutions, global goals such as the SDGs, and covering the priority public health needs so that it can have the biggest impact with the resources it has available.

3.1.3 To what extent are WHO SEAR users satisfied with the WHO RMNH guidelines? To what extent does the format, language and dissemination affect/influence perceptions of usefulness? What is the quality level of WHO RMNH guidelines (credible, authoritative, and timely?)

According to all lines of evidence, in general, WHO SEAR users are satisfied, and WHO RMNH guidelines are viewed to be of quality. When asked about the WHO RMNH guidelines selected for more in-depth analysis, external stakeholders:

- were mostly or completely satisfied (88% of respondents) (See Figure 4)
- indicated that guidelines were mostly or completely useful (86% of respondents)
- had mostly or completely gained knowledge from the guidelines (86% of respondents)
- were mostly or completely satisfied with format and style (86% of respondents)
- were mostly or completely satisfied with language (86% of respondents)
- were mostly or completely satisfied with mode of dissemination (74% of respondents)
- were mostly or completely satisfied with the credibility (89% of respondents)
- were mostly or completely satisfied with the authoritativeness of WHO RMNH guidelines (85% of respondents)
- were mostly or completely satisfied with the timeliness of WHO RMNH guidelines (77% of respondents)

Figure 4: What is your level of satisfaction with WHO RMNH guidelines (n=35)?



The mode of dissemination and timeliness were the lowest ranked answers in terms of satisfaction in the external surveys. The issue of timeliness was most often raised in the case studies and the survey in the contexts of the guideline development cycle. A frequently mention example in case studies was the publication of new WHO RMNH guidelines that may not coincide with national agendas or cycles (e.g. having just updated an ANC manual and then WHO published new guidance). It was also raised in external interviews and case studies in the context of it taking time to implement recommendations, with new WHO RMNH guidelines being produced before previous guidelines could be implemented (e.g. Bangladesh). It was also noted in case studies, surveys and external interviews that Members State officials may not be aware of what guidelines WHO is developing in the next cycle, and when to expect their release.

User satisfaction regarding mode of dissemination was also ranked relatively lower than other responses. Dissemination was discussed under reach, and responses for means of dissemination tended to blur the distinction between dissemination of national guidelines versus WHO guidelines. In general, electronic dissemination of WHO guidelines was found to be appropriate and should

continue, while supported by other active dissemination methods such as regional meetings, workshops and presentations (see Section 2.1.4 in this report).

The external survey did identify areas for improvement in terms of reach, with specifically outreach to private sector health care providers being mentioned. It was noted that in some Member States, the private sector hospitals and NGOs account for 30% of health service coverage and that e-distribution may not reach everyone (reasons not mentioned) and that interactive sessions with MoH and other technical stakeholders is more effective than e-distribution.

Key Findings:

- According to all lines of evidence, in general, WHO SEAR users are satisfied and WHO RMNH guidelines are viewed to be of quality. Areas of satisfaction included with format and style, language, credibility, and authoritativeness.
- Timeliness was one of the lowest ranked answers in terms of satisfaction. The issue of timeliness was most often raised in the contexts of the guideline development cycle, and that WHO RMNH guidelines may not coincide with national agenda or policy cycles. Timeliness was also raised in regard to the time it takes to implement, and updated guidelines being produced before previous guidelines had been implemented.
- Regarding information dissemination, one area for improvement included outreach to private sector health care providers, which may require more specific dissemination strategies or activities.

4.0 Findings: Use of WHO RMNH Guidelines

This section is related to **use** of WHO RMNH guidelines. Use is defined as what is done with the knowledge gained from the guideline, and how knowledge is applied to implement change, for example, the application of recommendations.

4.1 What is the extent to which WHO RMNH guidelines are used as references and as the authoritative sources for decision-making in clinical, public health and policy decision-making contexts?

The evaluation was only able to assess use up to the point that WHO RMNH guidelines and recommendations are reflected in documents such as national plans, strategies, guidelines and protocols and procedures. No assessment of actual implementation of national guidelines at point of service delivery was undertaken as this was out of scope of the evaluation. WHO guidance may also be reflected in other areas outside the scope of the evaluation (e.g. medical school curriculum, etc.). It was also evident from case studies that many of the recommendations from selected guidelines had been implemented prior to the issuance of the selected guidelines (i.e. the recommendations were carried over from earlier guideline versions).

In general, across all lines of evidence, there is strong evidence to demonstrate that WHO RMNH guidelines are used, often being directly referenced in national strategies, plans and clinical guidelines. The case studies demonstrated that there can be extensive referencing of WHO materials in national strategies, plans and guidelines. As an example, there were 13 references to WHO materials (guidelines, reports, handbooks) in Myanmar's Family Planning Guideline for Service Providers 2018.

> "Bangladesh, India, Indonesia, Myanmar and Nepal have prepared national every newborn action plans based on the global ENAP framework, and Timor-Leste has strengthened newborn-specific activities within the National RMNCAH Plan. Each of these countries shared the main features and unique strengths of their plans for reducing newborn deaths, including progress in costing and implementation planning at the national and subnational levels." (Regional Technical Advisory Group Meeting, 2015).

The following table highlights where the 3 guidelines selected by the evaluation were referenced in national documents.

Table 7: Selected WHO RMNH Guidelines Referenced in National Policy, Strategies and Guidelines

	Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015)	WHO recommendations for augmentation of labour (2014)	Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015)
Bangladesh			
Standard Clinical Management Protocols and Flowcharts on Emergency Obstetric and Neonatal Care	✓		
Use of Antenatal Corticosteroids (ACS) in	✓		

	Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015)	WHO recommendations for augmentation of labour (2014)	Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015)
Threatened Preterm Deliveries to Reduce Neonatal Mortality and Morbidities. Bangladesh National Guideline			
Family Planning Manual			✓
Guideline on Intrapartum Care (IPC) & Postnatal Care (PNC)		✓	
Bhutan			
Bhutan Family Planning Manual 2018			✓
India			
Reference Manual for Injectable Contraceptives DMPA			✓
Supplement for MPA-SC			✓
Myanmar			
Family Planning Guideline for Service Providers 2018			✓
Essential Care for Small Babies (ECSB)	✓		
Early Essential Newborn Care / Essential Care for Every Baby	✓		
Strategy to end preventable maternal mortality 2017-21		✓	
Sri Lanka[8]			
National Guidelines for Maternal Care Volume 3 (2015)	✓		
National Guidelines for Maternal Care Volume 1 (2013)		✓	
Medical Eligibility Criteria (MEC) wheel for contraceptive use (WHO MEC wheel adapted for Sri			✓

[8] Strictly speaking, the documents listed for Sri Lanka precede the 3 WHO guidelines selected for review.

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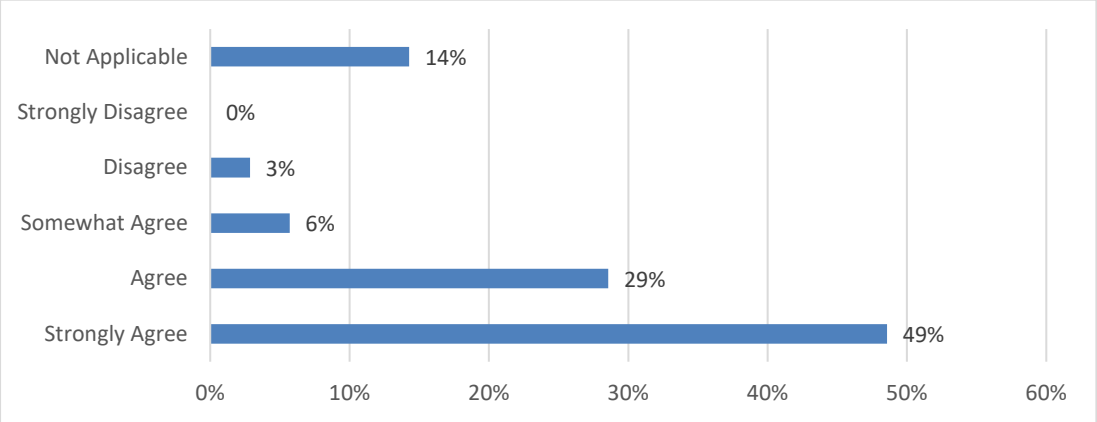
	Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015)	WHO recommendations for augmentation of labour (2014)	Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015)
Lanka) 2013 and Guidelines for service providers on the use of combined oral contraceptive (COC) pill and DMPA injectable contraceptive (2010)			

Document review demonstrated that the process of adapting WHO RMNH guidelines and recommendations into national policies, guidelines and procedures takes time and varies by country and guideline. For example, in Bhutan, of the 11 Bhutan RMNH guidelines identified and reviewed, seven referenced WHO RMNH guidelines (in some cases extensively), but only one Bhutan guideline (Family Planning Standard 2018) referenced one of the evaluation selected guidelines. Given the time period of the evaluation (2014 to 2018), and the time it takes for adaptation at the national level, there were only two realistic candidates that would reflect some of the evaluation selected guidelines, both coming out in 2018, namely the National Family Planning Standard, and Midwifery Standard (still in draft).

The external survey supports the finding that RMNH guidelines are used. According to that survey:

- 86% of respondents either strongly agree or agree that WHO RMNH guidelines are an authoritative source of health information,
- 78% of respondents either strongly agree or agree that they have used WHO RMNH guidelines for decision making,
- 83% of respondents either strongly agree or agree to have used WHO RMNH guidelines to inform advocacy, programmes, training and/or research, and
- 77% of respondents either strongly agree or agree to have adapted WHO RMNH guidelines

Figure 5: External Survey: I have used a WHO RMNH guideline to inform decision-making in clinical, public health and/or policy contexts (n=35)



Key Findings:

- There is strong evidence to demonstrate that WHO RMNH guidelines are used, often being directly referenced in national strategies, plans and guidelines.

4.1.1 What is the perceived influence of WHO RMNH guidelines on Member State health policies, strategies and healthcare practices?

In summary, WHO RMNH guidelines influence policy, programs, training and research and are adapted into national guidelines. The extent to which they improve clinical practice or performance (i.e. implementation of national guidelines) was not within the scope of the evaluation.

Regarding influence and adaptation, there are clear examples from case studies, document review and interviews of the referencing of WHO RMNH guidelines in clinical, public health and policy contexts, training, and research, although this influence may predate the period of this evaluation and/or was not included in the sample group of guidelines. See Table 7 for examples of uptake of the guidelines selected by the evaluation.

There are variations in uptake across the case study countries. As an example, uptake in Sri Lanka for selected guidelines was less evident, given that many national health policies and strategies predate WHO RMNH guidelines. In general, however the guidelines and recommendations still influence national practices by being adapted through other means, such as circulars and internal memos.

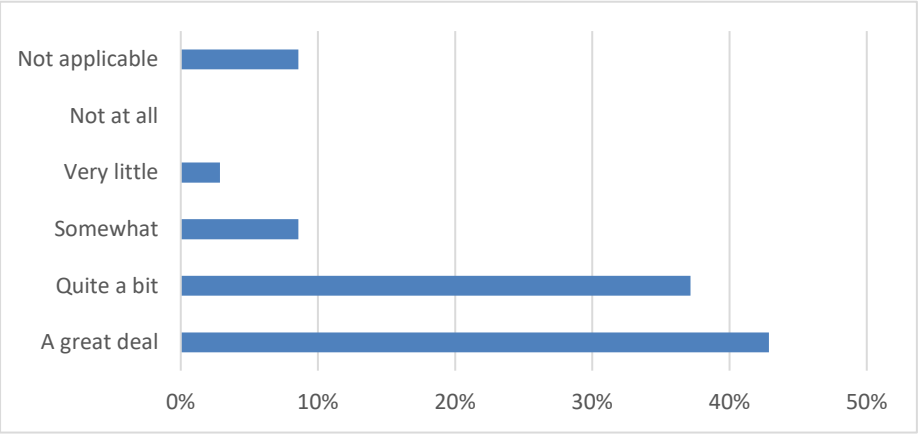
It was also found that adaptation can depend on timing. For example, Myanmar is actively updating its policy frameworks and guidelines and have produced numerous national RMNH guidelines during the evaluation period, thereby reflecting the WHO RMNH guidelines selected for this evaluation and falling within the 2014-2018 timeframe. The guideline development cycle of Bhutan however is different, with only two relevant RMNH guidelines being produced during the evaluation period (Family Planning and a draft Midwifery Standard) of which only one referenced the guidelines selected by the evaluation, specifically MEC 2015.

Uptake can be reflected in policies or guidelines. For example, in Myanmar, WHO RMNH guidelines are referenced in national strategies and frameworks, such as the 5 Year Strategic Plan for Reproductive Health and in the Strategy to End Preventable Maternal Mortality in Myanmar (2017-2021). The latter strategy referenced numerous WHO products, two of which are guidelines selected by this evaluation for review.

Regarding advocacy and research, some internal interviewees commented that guidelines can also guide research through identification of gaps that are outlined in the guidelines. The importance of supporting Implementation Research (IR) as a step in the adaptation process was also identified in internal and external interviews and the India case study. IR can help to understand contextual constraints, to support understanding of the evidence, and the “how to” that is not part of the guidelines themselves (e.g. practical implementation).

Figure 6 presents the responses of external survey respondents, from the perspective of the specific guidelines selected by the evaluation.

Figure 6: To what extent has the WHO guidelines informed Member State policies or advocacy on the subject matter?



According to the external survey:

- a vast majority of external stakeholders either agreed (31%) or strongly agreed (59%) that they have used a WHO RMNH guideline to inform advocacy and/or to enhance programmes, training, and/or research.
- a vast majority of the WHO RMNH external stakeholders found that the WHO RMNH guidelines that were selected for more in-depth analysis informed Member State policies or advocacy either a great deal (43%) or quite a bit (37%) on the subject matter. Please see Figure 6.

Regarding adaptation and use of select RMNH guidelines, the majority of external stakeholders have completely (36%) or mostly (36%) incorporated the recommendations contained in the WHO RMNH guidelines into their country's practices / procedures. This is supported by the case studies, which demonstrated that selected guidelines have been adapted and are referenced in national guidelines (see Table 7).

How the recommendations are adapted into national documents can vary across the region. To illustrate, the adaptation evidence for the WHO RMNH guideline *Summary list of WHO recommendations on interventions to improve preterm birth outcomes*, for Sri Lanka the recommendations are found in the Maternal Care Guidelines Volume 3, but in Bhutan the recommendations are incorporated in different documents, for example, the Every Newborn Action Plan 2016-2023, or the Midwifery Standard 2018 (draft).For the review of the RMNH recommendations selected for in-depth analysis for this evaluation (see Table 4), it was found that all recommendations had been applied in case study countries, but not necessarily in all countries equally. It was noted by one survey respondent that most of the recommendations were incorporated in the national program even prior to the guidelines published by WHO.

"To understand the situation of existing guidelines and countries' readiness to adopt the new recommendation, WHO SEARO conducted a survey prior to the meeting. The findings showed that even the move from 4 ANC visit to 8+ ANC contacts would need a push. Countries are at different levels of implementation and this is reflected in their mortality rates….There are 49 recommendations in total, and 31 are universal recommendations. Most of them are recommendations that have been in practice in some form or the other. Through the meeting countries that were not implementing these were encouraged to improve this" (Regional Meeting on Accelerating the Reduction of Maternal, Newborn Mortality and Stillbirths: Towards Achieving the SDGs, 2018).

Implementation monitoring is undertaken through various means including surveys and via regional meetings. See the illustration box for an example of a best practice.

Areas for improvement for adaptation were identified, although they do not necessarily fall within WHO's mandate. The issue of dissemination, implementation and monitoring of implementation of national RMNH guidelines has been noted by most lines of evidence. While there is some tracking of the implementation of national guidelines by regional office and HQ through policy surveys and TAG meetings, there is an opportunity for further monitoring of the actual implementation of national RMNH guidelines across all health system levels, or through assessments of quality of care.

All lines of evidence indicated that there is a demand for WHO financial and technical support for implementation of national guidelines, with a focus on implementation planning, implementation research and training. WHO has also supported implementation by printing and dissemination of national guidelines.

Regarding change in practice, while not verified or assessed by the evaluation, there are indications that change does occur in clinical practice as a result of the RMNH guidelines, but perhaps not at an optimum level. For example, the India case study noted that all interviewees agreed that WHO RMNH guidelines have been referred to at the time of developing training modules, which contributes to improved individual clinical practices in the public health space, but that also clinicians in the private sector will refer to their own professional Obstetrics and Gynaecology associations. The Bangladesh case study had a similar finding; that case study interviewees agreed on only partial success of use of RMNH guidelines on improving individual clinical practices and performance. This was attributed to adherence to professional textbook references among clinicians and insufficient regulations and monitoring to ensure improved clinical practise in private health services.

All lines of evidence also indicated that there is a demand for WHO financial and technical support for implementation, with a focus on implementation planning and development of costed workplans, implementation research and training. There are examples of WHO doing all these activities but there is an ongoing need from countries for assistance in this area.

Key Findings:

- In summary, WHO RMNH guidelines influence policy, programs, training and research and are adapted into national guidelines.
- Private sector health services can be a significant proportion of overall health systems, and this sector may be more aligned to their medical school training and professional associations in terms of guidance, more so or in conjunction with guidance from WHO. An area for improvement identified earlier in this report was for improving outreach to the private health sector.

4.1.2 How can WHO and SEAR Member States foster the better use of RMNH guidelines?

There was a range of suggestions identified through the lines of evidence in terms of how WHO and SEAR Member States can foster the better use of RMNH guidelines. The most frequently mentioned are elaborated upon here. Other areas for improvement have also been identified under the different questions and are summarized in the conclusions.

First, there is a need for WHO to support the implementation of national guidelines including implementation planning and training. As noted previously in this section, while WHO has provided

support for implementation, it is really the mandate of national authorities. Nonetheless, the needs for supporting countries were noted across all lines of evidence.

A core group of International Experts to clarify doubts regarding certain aspects of the guidelines through web-based communities of practice or similar mechanisms may be beneficial in better adaptation of the guidelines. (Comment in external survey).

It was also noted that the development of derivative products such as presentations, job aids and toolkits assisted in adaptation and implementation. The MEC Wheel smartphone application is a good example of a derivative product that helped in implementation of the guidelines. This application is also being translated into national languages to further facilitate implementation of adapted MEC wheels at the national level. Another issue that was frequently identified in the lines of evidence was for WHO to improve communication around the guideline development pipeline and expected release dates of new guidelines. This would assist countries in planning their own policy development cycles.

The other major challenges identified were resources for implementation at the national level and the limited WHO country capacity. In some countries visited, the WHO National Programme Office responsible for RMNH was also responsible for other health programmes, thereby impacting on capacity to respond to country specific RMNH needs.

Key Findings:

- Regarding guideline development:
  - derivative products are important to the adaptation and implementation of guidelines; and
  - communication to the Member States around the guideline development pipeline are sometimes lacking.
- Regarding guideline implementation, a need was identified for support to countries on implementation of national guidelines.

5.0 Findings: Health Outcomes

The region has experienced improvement in all RMNH indicators during the evaluation period, although overall performance is uneven, at least partially as a result of different levels of maturity of the health systems of the countries in the region. Some countries missed MDG targets and some are projected to miss the SDG targets in some areas if the annual rate of reduction (ARR) is not improved.

In theory, RMNH guidelines contribute to improved SDG health targets by helping scale up the coverage of evidence-based interventions, practices and quality of care. However, there are multiple factors that influence these outcomes, and results are determined by what happens at "field level" and health system readiness. The most notable influencing factors identified by the evaluation across different evidence lines include:

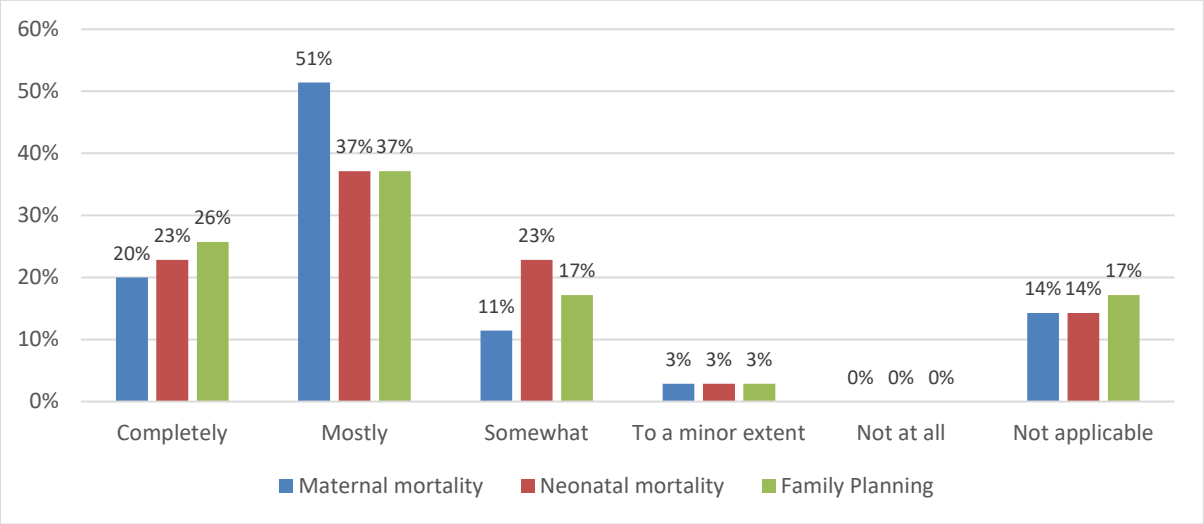
> *"To connect guidelines to SDGs – this is a challenge to attribute… But…if I am given the tools to deal with post-partum haemorrhage, antenatal care, post natal care – for me these are tools that really will help me move towards SDGs, towards reduction of newborn mortality and maternal mortality – on the ground"*
> (Internal interview)

- Health infrastructure and investment
- Level of institutional delivery,
- Procurement of commodities,
- Guideline implementation,
- Quality of care, and
- Cultural and legal context, for example as it relates to contraception and reproductive health matters.

As an example, the link between a family planning guideline and improved contraceptive prevalence rate (CPR) is a bit more direct and apparent, but only as a result of other factors such as the procurement and distribution of commodities, training of staff, job aids (e.g. MEC Wheel and application), and training of frontline workers such as midwives. All these factors also require resources. Given the above, it is difficult to assess the contribution of WHO guidelines to health outcomes, as all factors must be in place for them to be realized. The question of attribution is further complicated by the fact that countries use other references in addition to WHO (see the section on Usefulness).

Notwithstanding the above, the perspective of external survey stakeholders is that WHO guidelines do contribute to health outcomes. The external survey asked this question for maternal mortality, neonatal mortality and family planning (see Figure 7). Overall, the vast majority of respondents indicated that WHO guideline completely or mostly had an impact on those health outcomes.

Figure 7: To what extent have the adoption of RMNH guidelines in WHO SEAR Member States had an impact on (n=35):



For some countries, such as Sri Lanka, further reductions will require action in areas where WHO is not providing guidance, such as heart disease and influenza. This is more likely in countries that have more mature health systems, have undergone obstetrics transition and who have already met some of their SDG targets.

Regarding the five case study countries, the data available does not necessarily show progress since 2014, but rather progress since the last time estimates were calculated or censuses taken. There are also discrepancies in the various sources that were identified for statistics. Reported here the most recent figures, regardless of source.

- For maternal mortality rate (MMR), four of the five case study countries require acceleration to achieve the SDGs.
- For maternal mortality rate (MMR), between 2000 and 2017, WHO's SEAR has witnessed a reduction in MMR by 57.3 percent, accounting for an average annual rate of reduction of 5 percent and highest reduction in the world.[9] Despite the progress, the Region still reports the third highest Maternal Mortality Ratio (MMR). To achieve the target of a two-thirds reduction in MMR from 2010 levels,[10] it is recommended that (i) no country should have an MMR more than 140 and (ii) and maintain an Annual Rate of Reduction (ARR) of 6-7 percent. Countries are making progress, for example Bangladesh and India show an ARR of 5 percent during 2000 -2017. Bhutan achieved MDG 5.A target in 2015 (reduce by three quarters, between 1990 and 2015, the maternal mortality ratio), a significant accomplishment.
- For neonatal mortality rate (NMR), two of the five case study countries are on track to achieve the SDG target (Bangladesh, Bhutan), two will require acceleration (India, Myanmar) and Sri Lanka has already achieved SDG 2030 target.

Progress towards the other key indicators is as follows:

- For skill birth attendants (SBA), there is no target set by the SDGs. Bangladesh is the lowest at 42%, followed by Myanmar at 60%, India 81%, Bhutan 86% and Sri Lanka at 99%.

[9] Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2019.

[10] The actual SDG global target is less than 70 deaths per 100,000 births by 2030.

- For modern family planning (mFP), Bangladesh and Myanmar report 75% coverage, India 73%, Bhutan figures vary from 66-84%, and Sri Lanka reports 90% coverage.
- For adolescent birth rate (ABR) per 1,000 (ages 15-19 years old), Bangladesh reported 113, Bhutan 28, India 28, Myanmar 30 and Sri Lanka 20 as per the World Fertility Data 2015 -UB DESA. This in general is the area where the most countries need to improve performance. Adolescent health is an area identified by many as a recommended focus area for further guidelines.

Table 8: Summary of Status of SEAR Countries and Key Indicators [11]

South-East Asia Region Member States (countries arranged in decreasing order of mortality)		**MMR 2015** (per 100 000 lbs)	**SDG 2030 Target at 1990-2015 ARR**	**Adolescent Birth rate (per 1000 15-19yr)**	**Demand satisfied by modern FP (%)**	**SBA coverage (%)**
High Mortality	Nepal	*258*	*Acceleration*	88	76%	58%
	Timor-Leste	*215*	*Achieves*	70	47%	57%
	Myanmar	*178*	*Acceleration*	10	75%	60%
Intermediate Mortality	Bangladesh	*176*	*Acceleration*	113	73%	42%
	India	*174*	*On Track*	70	66%	81%
	Bhutan	*148*	*Achieves*	28	*NA*	86%
	Indonesia	*126*	*Achieves*	48	85%	83%
Low Mortality	DPR Korea	*82*	*NA*	1	90%	100%
	Maldives	*68*	*Equity/Quality*	13	43%	95%
	Sri Lanka	*30*	*Equity/Quality*	21	90%	99%
	Thailand	*20*	*Equity/Quality*	51	79%	99%
South-East Asia Region (SEAR)		*164*	*Acceleration*	68	70%	78%

[11] Summary of Maternal and Reproductive Health Situation in SEAR, Revised 2019. WHO SEAR. Figures may vary from that presented by the evaluation due to differences in timing of data collection.

6.0 Findings: Lessons Learned

This section consolidates the evidence for the three sub-questions that were aligned to Lesson Learned, namely:

6.1 What enabling factors have influenced the adaptation and use of RMNH guidelines?
6.2 What have been the lessons learned, positive and negative?
6.3 What are the areas for improvement?

Key lessons learned identified by the evaluation included:

WHO RMNH guidelines are evidenced-based and therefore credible. This finding was identified across all the lines of evidence. The credibility of guidelines was also supported by the strong, longstanding relationships that WHO has in SEAR countries, which strengthens its ability to influence policy and decision-makers. The capacity of the WHO Country Office is clearly implicated in this relationship as is access to guidelines.

> *"WHO's expertise and responsiveness to national level requests for technical support has built longstanding relationships and trust between WHO and its Member States. This strong reputation and credibility as an honest broker has clearly facilitated WHO's influence at the national and local levels."*
> (Evaluation of WHO's Contribution to Maternal Health in the South-East Asia Region, 2016)

Stakeholder engagement and collaborative approaches are important throughout the guideline process from development to implementation, at all levels of WHO. At the global level, this included engagement of the other levels of WHO and Member States and with other UN agencies, such as UNFPA and UNICEF. At the SEAR level, the role of the regional meetings and the regional technical advisory groups was emphasized for guideline dissemination and priority setting. At country level, the importance of the national technical working groups was highlighted for dissemination and adaptation, including involving the country level partners such as UN agencies, NGOs, medical schools and researchers. This also highlights the importance of WCOs having a good understanding of the stakeholder community on any given subject matter. The need to reach out to the private health sector was also raised throughout the evaluation.

The role of national level technical working groups was identified as a best practice. As an example, for selected components of the RMNH programme in Sri Lanka, such as maternal health, family planning, newborn and child health, there are separate Technical Advisory Committees (TACs) who meet every two months. Building off of WHO guidelines, evidence-based decisions taken at TACs are either incorporated in national policies, strategic plans, action plans, guidelines and training or communicated by official circulars and memorandum to the health system.

National level technical working groups were also in place in Myanmar, that provided a platform for the Ministry of Health to gain access to information and expertise from WHO, and other stakeholders, on their RMNH programs. WHO used these structures to present and disseminate newly developed guidelines, and stakeholders found these to be highly effective means of dissemination. They also served as a collaborative platform for the development and implementation of national guidelines.

The critical role of supporting adaptation of WHO guidelines into national policies, guidelines, protocols and standard operating procedures was also a key lesson learned. The adaptation process is supported by the technical support of collaborating centres, international experts. This can be greatly facilitated by political will of Member States, and engagement of professional associations in countries.

Implementation research has already been noted as an area where WHO provides support and where there are continued needs as it can play an important role in both adaptation and implementation. There is a need for continued and increased support for implementation research as a concrete means to support the national guideline processes in moving forward. Support for implementation of national guidelines can take many forms, involving all levels of a health system. Monitoring is critical in understanding what works and does not work, so adaptations can be made.

WHO support for implementation of national guidelines and the need to strengthen the role and capacity of WCOs in implementation support was an area that was frequently identified for improvement. Some examples identified by the evaluation included the need for support for implementation planning (e.g. understanding the pre-requisites for implementation, having access to funding for rolling out, undertaking a readiness assessment, having a clear costing model for implementation, etc.). Actions could include, but are not limited to, provision of resources (in-house or external expertise or financial resources) for assisting adaptation, printing and dissemination of national guidelines, and training. Implementation planning can be supported by training and tools (e.g. costing templates and approaches, etc.).

Aspects of WHO guidelines development and dissemination processes were also identified as potential areas for improvement. There were suggestions for improving the communication of the RMNH guideline development pipeline, so countries can synchronize guideline development with their national processes to the extent this is possible. There were also suggestions to streamline the number of guidelines and providing simplified updates (corrigendum) instead of new guidelines when updates are needed. Finally, it was identified that a formal dissemination strategy for each guideline (it need not be part of the actual guideline, but rather part of the publication process and be specific and detailed to that particular guideline) would be a good practice that complements electronic distribution and makes use of existing networks and state channels, including NGOs, academia, private sector, and professional associations, to reach a broader audience (please see Recommendations).

7.0 Conclusions

7.1 Relevance

WHO reaches the intended audience for RMNH guidelines

Regarding deepening the reach of WHO RMNH guidelines to beyond national level, the evaluation recognizes that WHO is a technical, norm-setting organization and that the target audience for WHO RMNH guidelines is principally the policy makers, decision makers and programme managers in the Member States, normally at the national level, and by association the stakeholders that Members States have identified to participate in their respective processes. WHO guidelines are used as a reference by Member States when they develop their own national guidelines. In line with that, dissemination to lower levels of the health system at country level should only be undertaken by the national authority based on their policies, procedures and processes. WHO can assist, where possible, in the dissemination of national RMNH guidelines, but the evaluation itself focussed on dissemination of WHO RMNH guidelines. Based on this understanding, the evaluation concludes that to a large extent, WHO does reach its intended audience with the dissemination of WHO RMNH guidelines. There are, however, still areas for improvement described as follows.

More formal dissemination strategy and planning

Dissemination strategies and planning could be more formalized in support of WHO RMNH guidelines at the regional and country level. While there was evidence of deploying various dissemination means (e.g. electronic, regional meetings, etc.), no formally documented dissemination strategies or plans were identified by the evaluation. Some countries may present a challenge given the number of stakeholders involved in the adaptation of RMNH guidelines, and different jurisdictions, and may require more careful planning both at the WCO and Member State MoH on guideline dissemination at the national level.

Continued use of active dissemination methods

Related to the need for dissemination planning and identified under Lessons Learned/Areas for Improvement and under Reach, WHO needs to continue to use both passive (e.g. posting on web pages, emails, etc.) and active dissemination methods (e.g. conferences, dissemination meetings, presentations, webinars, etc.) in its dissemination. Identified in the evaluation was the positive impact of national level Technical Working Groups where they were functioning. These groups serve as an effective platform for WHO to actively present and disseminate information to technical stakeholders.

Monitoring reach

The reach of WHO RMNH guidelines is not well monitored or documented in terms of distribution of emails, downloads from websites and distribution of printed copies. There is room for improvement in monitoring the reach of WHO RMNH guidelines, globally, regionally and by country.

7.2 Usefulness

Guidelines are addressing priority country needs and are of high quality

To a large extent, WHO RMNH guidelines are found to be useful in terms of addressing priority country needs and in terms of quality (i.e. credibility, authoritativeness, and quality). It was also noted that WHO is not the only reference for guidelines for some countries. Other institutions identified by the evaluation that influence Member State guidelines and practices include The American College of Obstetricians and Gynecologists (ACOG), The National Institute for Health and Care Excellence (NICE),

International Federation of Gynecology and Obstetrics (FIGO) and the Royal College of Obstetricians and Gynecologists (RCOG).

Country development may result in more specific needs

Regarding addressing needs, there is general alignment across international initiatives and goals such as the SDGs (SDG 3 targets aim to end preventable deaths of newborns and children under 5 years of age and reduce maternal mortality), and the WHO 13th General Programme of Work and country strategies and plans. WHO planning processes at regional and country level allow the opportunity for dialogue to identify country priorities and align WHO assistance to country priorities. However, the extent that the individual country needs are reflected in the global and regional agenda does vary depending on the level of maturity of the health system, stage of obstetric transition and level of mortality. The result is that WHO RMNH guidelines being produced may not be as relevant for all countries in the region, some who may have more specific needs (e.g. countries at obstetric transition level 4, etc.). This was noted in the case of Sri Lanka (and India to a lesser extent) who have needs that are not fully addressed by WHO RMNH guidelines.

7.3 Use

WHO RMNH guidelines are used

To a large extent, WHO RMNH guidelines are referenced and adapted at the country level into national policies, strategies, plans and clinical guidelines. That process takes time, and the selected guidelines for this evaluation demonstrated that uptake can be partial (i.e. adaptation of recommendations may be spread over several different national documents, developed at different times), or in many cases predates the selected guidelines (i.e. the recommendations were included in previous versions and already adapted). However, case studies demonstrated that referencing of WHO RMNH guidelines, as well as WHO framework and strategies, in national documents can be extensive.

The evaluation did not assess implementation of national guidelines, however, implementation of national guidelines remains an area of need. There is very limited information about either the reach and implementation of national guidelines and even less information on how well they have been implemented (quality assurance). Nonetheless, WHO has assisted in this process when possible through financial and technical assistance on implementation research, regional meetings and development of regional strategic-plans, training, translation and printing of materials.

The evaluation found that for the roll-out of national RMNH guidelines, some countries are effective in implementation planning, while others are less so. It was noted that in some countries, there is a drive to update policy frameworks and guidelines, but without the requisite planning for implementation and monitoring. This is especially important in complex implementation environments or in countries that are introducing multiple changes to their policy and practices. This will have the added benefit of providing ministries with the evidence to support requests from the national budget.

7.4 Health Outcomes

Underdetermined extent of the contribution to meeting RMNH-related SDG health targets

Findings under reach and usefulness noted that the role of WHO guidelines do influence national RMNH guidelines in many cases but not in all. Many countries use other sources as references, in combination with WHO guidance. More importantly, impact on health outcomes is derived primarily from guidelines implementation, and it has been noted by the evaluation that the extent that national

RMNH guidelines are implemented, and the quality of that implementation, is largely unknown. Given that there are a multitude of factors that influence guideline adaptation, guideline implementation, and subsequent health outcomes, the extent that WHO guidelines contribute to WHO SEAR Member States meeting RMNH-related SDG health targets is undetermined.

7.5 Lessons Learned/Best Practices

Collaborative approaches at national level

The key lessons learned are the need for collaborative approaches at the national level that include all relevant stakeholders, which can be facilitated by having formal coordination mechanisms, such as standing and regular Technical Working Groups in place that serve for identifying priorities, disseminating (sharing information), adapting guidelines and supporting implementation.

There was also a need identified to improve outreach to the private health sector where that is present. This can include outreach to professional associations and medical schools as well as directly to private sector companies.

Implementation planning and research

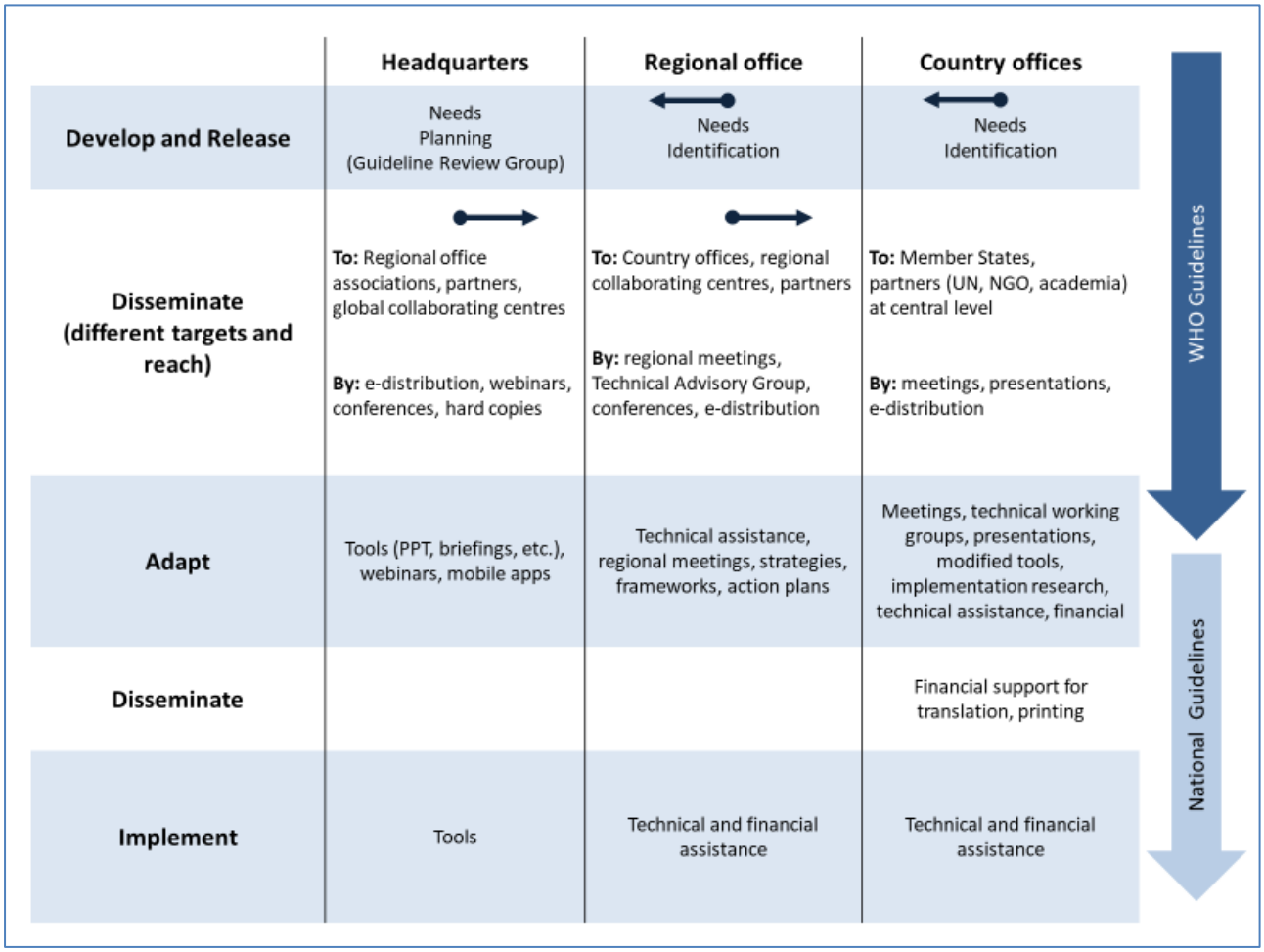
The key areas for improvement identified included supporting implementation planning and research, communicating guideline development schedules, improving the clarity of guidelines, and improving dissemination.

8.0 Recommendations

Based on the findings presented in the earlier sections and the conclusions reached in Section 7.0, this section outlines recommendations that have been targeted to the relevant level of WHO. Only by having all three levels of WHO work in a coordinated manner can results be optimized.

The following figure (Figure 8) illustrates how each WHO level is involved in both WHO guidelines and national guidelines along a continuum of development, dissemination of WHO guidelines, adaptation, dissemination of national guidelines, and implementation.

Figure 8: WHO roles in guideline development, dissemination and adaptation



8.1 Recommendations for WHO SEARO and SEAR WCOs:

1) SEARO and SEAR WCOs should formally document dissemination strategies and plans for WHO RMNH guidelines at regional and country level that includes both active and passive dissemination methods and that can incorporate measures for monitoring and assessing reach and use. Standard templates should be used to determine requisite stakeholder groups, including the private health sector, provide rationale for their inclusion/exclusion, identify means to disseminate to each group, and specify necessary resources. Dissemination strategies should also continue to promote, where appropriate, the use of current best practices such as regional meetings and national technical working groups/advisory committees at country level, in addition to the current approach of cascading email distribution.

2) It is recognized that WHO has considerable influence in promoting the adaptation and adoption of WHO guidelines and recommendations into national guidelines, standard operating procedures and protocols. Health impact is mostly reliant on successful implementation. In the past, WHO has supported implementation with tools, training, and mobile applications (such as the MEC Wheel). Such support is dependent on the availability of resources. It is recommended that WHO adopt as a standard practice the provision of country assistance in the development of costed implementation plans for national strategic plans and the roll-out of national RMNH guidelines and standard operating procedures. Implementation plans may include, but are not limited to, development of training materials, training delivery, information packages, tools and job aids, and monitoring. Opportunities for specific implementation support would need to be considered on a case-by-case basis and in-line with availability of resources, with a special emphasis on implementation research when warranted.

8.2 Recommendation for WHO headquarters and WHO SEARO:

3) WHO headquarters and SEARO should consider a tiered approach to needs identification for WHO RMNH guideline development in line with country health system maturity, obstetric transition and level of mortality. This may involve prioritizing different aspects of the RMNH programmes (e.g. adolescent health) or developing tiered guidelines with recommendations for countries at different levels of health system maturity and levels of mortality. Such an approach could be first piloted in SEARO to develop specific tiered guidelines or derivative products.

4) WHO headquarters and SEARO should develop and communicate a detailed forward-looking guideline development and release plan, with specific dates and timelines, that can improve country awareness and preparedness for upcoming releases of RMNH guidelines and recommendations.

5) WHO headquarters and SEARO should develop a derivative products plan in support of new/revised guidelines, including, where appropriate but not limited to, tools, job aids, mobile apps, training packages, and information packages to be developed in support of guideline uptake by Member States.

8.3 Recommendations for WHO headquarters:

6) WHO headquarters should institute a more efficient process for the life cycle management of WHO guidelines, from initial planning and development to implementation and monitoring and evaluation, which can then lead to revised guidelines. This is also related to the number of WHO guidelines and recommendations, some of what may have been superseded by more recent recommendations. Specific process recommendations include providing updates (i.e., corrigendum) instead of new guidelines and improving the usability of recommendations through innovative approaches that could include searchable recommendations on the WHO Website.

8.4 Recommendations for SEAR countries:

7) To the best of each country's ability, SEAR countries should strengthen their institutional capacity to undertake regular implementation planning for WHO guidelines, which include development of costed implementation plans for national strategies, guidelines and standard operating procedures. This will result in clearer understanding of resource needs

and timelines for national budgeting purposes; documented rationale for different implementation scenarios based on available resources; an evidence base for external resource mobilization; and a foundation for ongoing monitoring and evaluation.

8) To the best of each country's ability, SEAR countries should strengthen the monitoring and evaluation of the implementation of national PMNH guidelines. This will have the advantage of providing information for decision making to improve implementation and maximizing the efficient and effective use of resources. This in turn will improve the probability of attaining positive health outcomes that are aligned to SDG targets.

Annexes

Annex A: Terms of Reference

Terms of Reference:

Evaluate the contribution of WHO guidelines to improving Maternal, Newborn and Reproductive Health (RMNH) in the WHO South-East Asia (SEA) Region.

Specific objectives:

1. To assess and document the existing adaptation and use of WHO Reproductive, Maternal and Newborn Health (RMNH) guidelines at the country level in selected Member States.
2. To identify enabling factors, opportunities and challenges in adaptation and use of the WHO RMNH guidelines in selected SEAR Member States.
3. To recommend concrete strategies appropriate to respective countries, to strengthen and accelerate the implementation of the WHO Reproductive, Maternal and Newborn Health (RMNH) guidelines in SEAR Member States.
4. To review and make recommendation on WHO's role at all the three levels of the Organization to strengthen implementation and impact of RMNH guidelines at the country level.

Scope of work:

To evaluate the adaptation and use of Reproductive, Maternal and Newborn Health (RMNH) guidelines in five selected countries based on selection criteria. It is suggested to include three high burden countries with RMNH impact such as Bangladesh, India and Myanmar and two more countries with medium (Bhutan) and low burden (Sri Lanka) RMNH outcome. In WHO SEAR Member States, as each country has its unique context, set of strengths, needs and challenges, recommendations made for one country might not be applicable for others.

Evaluation addressing key questions:

a) What is the degree of adaptation process and dissemination of WHO guidelines on RMNH?
b) What is the level of use of guideline and what is the influence or added value of guidelines to change policies, practice at country level including acceptance of related specific new products (i.e. family planning methods)?
c) What are the significant success stories and best practices, enabling and impending factors and innovation at country level on use and implementation of guidelines, related interventions and products?
d) To what extent have the WHO RMNH guidelines contributed to improving health outcomes and selected results related to RMNH in the region including addressing inequities?

Approach and Expected deliverables:

1. Development and submission of inception report with detailed evaluation methodology with evaluation tools.
2. Development of requisite indicators (input, process and output) to adaptation and use of WHO guidelines on Reproductive, Maternal and Newborn Health (RMNH) in the South-East Asia Region.
3. Submission of draft and final report with recommendation

The inception report should include the list of WHO guidelines on RMNCH developed in the last five years that will be considering for this evaluation, methodology and tools you propose to apply for carrying out this project. This will be reviewed by Evaluation Management Group (EMG) for any

factual inconsistencies and feasibility study for finetuning and/or recommendations. This is to safeguard the quality and independence of the evaluation exercise.

A presentation of the findings of the evaluation will be made by the team leader to the EMG in New Delhi.

A final evaluation report will be provided as the principal output of the evaluation process. Reporting shall adhere to the guidance provided in the WHO Evaluation Practice Handbook.

For detailed description, information provided in the RFP should be referred for implementation of this project.

Timeline:

1) Signature of Agreement (19 August 2019)
2) Submission of inception report (15 September 2019)
3) Presentation of preliminary findings (24 November 2019)
4) Submission of draft evaluation report (1 December 2019)
5) Submission of final evaluation report with certificate statement of expenditure (latest by 15 December 2019)

Annex B: Evaluation Matrix

Evaluation Question	Sub-question	Indicator	Line of Evidence
Criteria 1: Reach (Immediate Outcome)			
1.1 What is the extent to which WHO RMNH guidelines reach their intended target audience(s)?	1.1.1 How does WHO target RMNH audiences?	1.1.1.i Extent to which policies, strategies, plans, procedures for WHO guidelines support the dissemination and adaptation of RMNH guidelines.	Document review Internal Interviews Case studies Internal survey
	1.1.2 To what extent is the intended reach achieved?	1.1.2.i Evidence of dissemination standards for WHO RMNH guidelines in SEAR. 1.1.2.ii Stakeholders' perceptions regarding the appropriate and sufficient dissemination of WHO RMNH guidelines.	Document review Internal and External interviews Case studies External survey
		1.1.2.iii **Primary Distribution (Push)** a. Number of copies/links distributed to existing emailing lists b. Incidence of social media presence on various platforms 1.1.2.iv **Secondary Distribution (Pull)** a. Altmetrics/cybermetrics (download rates in various social media functions) b. Number of file downloads	Document review Case studies
	1.1.3 How does WHO target different regional language audiences?	1.1.3.i (Stakeholder and WHO) Perceptions of the extent to which WHO dissemination strategies, policies and plans target different language audiences in the region.	Internal and External interviews Case studies Internal and External survey
		1.1.3.ii Reach information (i.e. push, pull), by RMNH language group.	Document review Case studies
	1.1.4 How does the support (e.g. web only, print) affect reach? To what extent is the right media being used?	1.1.5.ii Reach information by support (e.g. web only, print).	Internal and External interviews Document review Case studies

Evaluation Question	Sub-question	Indicator	Line of Evidence
1.2 What are the major gaps in reach? Why did they arise?	1.2.1 What gaps, if any, exist in the engagement of target RMNH audiences?	1.2.1.i Evidence of reasons / source / cause of gaps.	Document review Internal and External interviews Case studies Internal survey
Criteria 2: Usefulness (Immediate Outcome)			
2.1 What is the perceived usefulness of WHO RMNH guidelines?	2.1.1 How does WHO respond to regional and Member State RMNH strategies and priorities (e.g. Regional Flagship Areas, etc.) through its guidelines?	2.1.1.i Evidence of WHO publication policies, strategies and/or plans that support regional and Member State health strategies and priorities.	Document review Internal and External interviews Case studies Internal survey
	2.1.2 To what extent are WHO RMNH guidelines based on needs? To what extent are they addressing priority needs?	2.1.2.i Evidence that WHO RMNH guidelines are guided by needs assessments that are informed by WHO SEAR	Document review Internal and External interviews Case studies Internal survey
		2.1.2.ii Extent to which audience's priority information needs in the region and Member States are met.	External interviews Case studies External survey
	2.1.3 To what extent are WHO SEAR users[12] satisfied with the WHO RMNH guidelines?	2.1.3.i Degree of satisfaction with WHO RMNH guidelines in general (need, quality).	External interviews External Survey
		2.1.3.ii Degree of satisfaction with a select RMNH guideline (need, quality). 2.1.3.iii. Degree of satisfaction by users who rate the content of an RMNH guideline as useful. 2.1.3.iv Degree of satisfaction by users who report knowledge gained and action taken from an RMNH guideline. 2.1.3.v Degree of satisfaction by users who report that an RMNH guideline informed policy and	Case studies External Survey (Guideline)

[12] The term "users" includes representatives in Member States who deal with health policies, strategies and health care practices in relation to RMNH.

Evaluation Question	Sub-question	Indicator	Line of Evidence
		advocacy or enhanced programs, training/education, or research.	
	2.1.4 To what extent does the format, language and dissemination affect / influence perceptions of usefulness?	2.1.4.i Degree of satisfaction by users with regards to the format, plain language and support (e.g. web only, print, guidance tools, apps, etc.) of an RMNH guideline.	Case studies External interviews External survey
		2.1.4.ii Extent to which users view the format or presentation of an RMNH guideline as usable in terms of plain language, format, support.	Case studies External survey
	2.1.5 What is the quality level of WHO RMNH guidelines (credible, authoritative, and timely)?	2.1.5.i Stakeholders' perceptions of quality of WHO RMNH guidelines.	External interviews External survey Case studies
		2.1.5.ii Respondent opinion of credibility, authoritativeness, and timelines of WHO RMNH guidelines.	External interviews External survey Case studies
Criteria 3: Use (Intermediate Outcome)			
3.1 What is the extent to which WHO RMNH guidelines are used as references and as the authoritative sources for decision-making in clinical, public health and policy decision-making contexts?	3.1.1 What is the perceived influence of WHO RMNH guidelines on Member State health policies, strategies and healthcare practices?	3.1.1.i Evidence of users using RMNH guidelines to inform decision-making in clinical, public health and policy contexts. 3.1.1.ii Extent to which users are using RMNH guidelines to inform policy and advocacy or to enhance programs, training/education, or research. 3.1.1.iii Evidence of user adaptation of WHO RMNH guidelines. 3.1.1.iv Extent to which RMNH guidelines have been used to improve individual clinical practice or performance.	Document review Internal and external interviews External survey Case studies
	3.1.2 How can WHO and SEAR Member States foster the better use of RMNH guidelines?	3.1.2.i Identification of RMNH information needs and preferred dissemination methods and guideline tools.	Internal and external interviews Case studies

Evaluation Question	Sub-question	Indicator	Line of Evidence
Criteria 4: Health Outcomes (Intended Long-Term Outcome)			
4.1 Extent to which RMNH health outcomes at the SEAR Individual, Community and Member State Levels are improved?	4.1.1 To what extent have RMNH guidelines contributed to WHO SEAR Member States meeting RMNH-related SDG health targets ?	4.1.1.i. Progress since 2014 in SDG Targets in WHO SEAR related to RMNH: a) Maternal mortality ratio (SDG 3-1.1) b) Proportion of births attended by skilled health personnel (SDG 3-1.2) c) Neonatal mortality rate (SDG 3-2.2) d) Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods (SDG 3-7.1) e) Adolescent birth rate (aged 10–14 years, aged 15–19 years) per 1,000 women in that age group (SDG 3-7.2)	Document review
		4.1.1.ii. Extent to which the adoption of RMNH guidelines in WHO SEAR member states have had an impact on: a) Maternal mortality b) Neonatal mortality c) Family planning	Internal and external interviews Case studies Internal and external survey
Criteria 5: Lessons Learned			
5.1 What are the lessons learned from WHO RMNH guidelines development and dissemination processes at all three levels of the organization? (country, region, and global)	5.1.1 What enabling factors have influenced the adaptation and use of RMNH guidelines?	5.1.1.i Evidence of identification of enabling factors.	Internal and external interviews Case studies
	5.1.2 What have been the lessons learned, positive and negative?	5.1.2.i Evidence of identification of lessons learned.	Internal and external interviews Case studies
	5.1.3 What are the areas for improvement?	5.1.3.i. Evidence of identification of areas for improvement.	Internal and external interviews Case studies

Annex C: Interview List

Interview List			
	Name	**Position**	**Location**
General Interviews			
Internal Interviewees			
1	Dr Neena Raina	A/DFGL	WHO SEARO
2	Dr Rajesh Mehta	RA/CAH	WHO SEARO
3	Dr Anoma Jayathilaka	MO/MRH	WHO SEARO
4	Dr Meera Thapa	TO/RH	WHO SEARO
5	Dr. Özge Tunçalp	Scientist, Maternal and Perinatal Health & Safe Abortion, Department of Reproductive Health and Research	WHO HQ
6	Dr. Olufemi Taiwo Oladapo	MO, RHR department	WHO HQ
7	Dr. Mary Lyn Gaffield	Scientist , RHR department	WHO HQ
8	Ms. Cath Hamill	Communication officer RHR department	WHO HQ
9	Dr. Maurice Bucagu	Medical Officer. Maternal Health services. Policy, Planning and Programme Unit	WHO HQ
External Interviewees			
10	Dr. Aparna Sharma	AIIMS/ Prof of obstetrics (WHO CC AIIMS)	India
11	Dr. Kirti Iyengar	UNFPA (FP)	India
12	Dr. Asheber Gaym	UNICEF	India
Case Study Interviews			
Country Case Study: Bangladesh			
13	Dr. Edwin C Salvador	Deputy WHO Rep In charge of MNCAH	Bangladesh
14	Dr. Mahbuba Khan	National Professional Officer	Bangladesh
15	Dr. Md Azizul Alim	Deputy Programme Manger Maternal Health DGHS	Bangladesh
Country Case Study: Bhutan			
16	Dr. Lobzang Dorji	National Professional Officer	Bhutan
17	Mr. Wangdi Gyeltshn	Chief Programme Officer, Non-Communicable Diseases Division	Bhutan
18	Mr. Karma Jjwimia	Programme Office	Bhutan
19	Mr. Pema Lethro	Sr. Programme Officer	Bhutan
Country Case Study: India			
20	Ram Chahar	National Professional Officer (MRH)	India
21	Dr. Deepti Agrawal	National Professional Officer (NCH)	India
22	Dr. Ajay Khera	Commissioner MCH	India
23	Dr. Sumita Ghosh	Addl Commissioner MH/Jt Commissioner	India
24	Dr. Himanshu Bhushan	NHSRC (MH)	India
25	Dr. Saswati Das	Director programs and clinical training, Jhpiego	India
26	Dr. Harish Kumar	USAID supported Vriddhi project	India

Interview List			
	Name	**Position**	**Location**
Country Case Study: Myanmar			
27	Dr. Stephan Paul Jost	WHO Representative	Myanmar
28	Dr. Mohammad Shahjahan	Technical Officer (RMNCAH)	Myanmar
29	Ms. Shwe Sin Yu	National Professional Officer- RMNCAH	Myanmar
30	Dr. Hla Hla Aye	Consultant, RMNCAH and HRH	Myanmar
31	Dr. Myint Myint Than	Deputy Director General, Department of Public Health, MoHS	Myanmar
32	Dr. Myint Moh Soe	Deputy Director, Maternal and Reproductive Health, Department of Public Health	Myanmar
33	Dr. Hnin Hnin Lwin	Deputy Director, Maternal and Reproductive Health, Department of Public Health	Myanmar
34	Dr. Theingi Aung	Deputy Director, Child Health Development, Department of Public Health	Myanmar
35	Dr. Yin Yin Htun Ngwe	UNFPA	Myanmar
36	Dr. Sarabibi Thuzar Win	UNICEF	Myanmar
37	Dr. Ni Ni Lwnin	UNICEF	Myanmar
38	Prof Saw Kler Ku	Academia/Obstetric and Gynecological Society	Myanmar
39	Dr. Nay Aung Lin	Jhpiego	Myanmar
40	Dr. Moe Moe Aung	MSI	Myanmar
41	Dr. Myint Myint Win	PATH	Myanmar
Country Case Study: Sri Lanka			
42	Dr. Razia Narayan Pendse	WHO Representative	Sri Lanka
43	Dr. Manjula Dhanansuriya	National Professional Officer	Sri Lanka
44	Dr. Chitramalee de Silva	Director /MCH	Sri Lanka
45	Dr. Sanjeewa Godakanda	NPM/Family Planning	Sri Lanka
46	Dr. Irosha Nilaweera	NPM/ Antenatal care	Sri Lanka
47	Dr. Nethmini Thenuwara	NPM/Intranatal care	Sri Lanka
48	Dr. Dhammica Rowel	UNICEF, EX -NPM / Intra natal care	Sri Lanka
49	Dr. Hemantha Senanayake	Cons. VOG. Academia (retired), former College of Obstetricians and Gynaecologists	Sri Lanka
50	Dr. U.D.P Ratnasiri	Consultant VOG. Government and private practitioner	Sri Lanka
51	Dr. Nilmini Hemachandra	Former NPO WCO SRL and now TO/EMRO	RO EMRO

Annex D: Document List

General Documents		
#	**Document Name**	**Category**
1	2015 and beyond: the unfinished agenda of MDG 4 and 5 in South-East Asia - Report of a regional meeting, 29 April–1 May 2014, Kathmandu, Nepal	CAH
2	4th TAG report (Word Document)	Technical Advisory Group (TAG)
3	Accelerate Reduction of Maternal, Neonatal and Under Five Mortality	SEAR General Documents
4	Accelerating the elimination of cervical cancer as a global public health problem, Regional Committee, Seventy-Second Session, New Delhi, 2-6 September 2019 (dated July 15, 2019) SEA/RC72/11	MRH Regional Meeting Documents and Recommendations
5	Agenda: Regional Meeting on accelerating reduction of maternal, newborn mortality and stillbirths: towards achieving the Sustainable Development Goals (SDGs) 10-13 July 2018, New Delhi, India	MRH Regional Meeting Documents and Recommendations
6	Assessment Tool for Hospital Care: Improving the Quality of Care for Reproductive, Maternal, Neonatal, Child and Adolescent Health in South-East Asia Region: A Regional Framework	CAH
7	Benova L, Tunçalp Ö, Moran AC, et al. (2018). Not just a number: examining coverage and content of antenatal care in low-income and middle-income countries. BMJ Glob Health 3:e000779. doi:10.1136/ bmjgh-2018-000779	Journal article on guidelines
8	Cervical cancer screening and management of cervical pre-cancers: Counselling cards. SEARO	MRH Regional Meeting Documents and Recommendations
9	Cervical cancer screening and management of cervical pre-cancers: Flipchart. SEARO	MRH Regional Meeting Documents and Recommendations
10	Cervical cancer screening and management of cervical pre-cancers: Trainees' handbook and facilitators' guide – Programme managers' manual. SEARO	MRH Regional Meeting Documents and Recommendations
11	Cervical cancer screening and management of cervical pre-cancers: Training of community health workers. SEARO	MRH Regional Meeting Documents and Recommendations
12	Cervical cancer screening and management of cervical pre-cancers: Training of health staff in colposcopy, LEEP and CKC – Facilitators' Guide. SEARO	MRH Regional Meeting Documents and Recommendations
13	Cervical cancer screening and management of cervical pre-cancers: Training of health staff in colposcopy, LEEP and CKC – Trainees' handbook. SEARO	MRH Regional Meeting Documents and Recommendations

General Documents		
#	Document Name	Category
14	Cervical cancer screening and management of cervical pre-cancers: Training of health staff in VIA, HPV detection test and cryotherapy - Facilitators' Guide. SEARO	MRH Regional Meeting Documents and Recommendations
15	Cervical cancer screening and management of cervical pre-cancers: Training of health staff in VIA, HPV detection test and cryotherapy - Trainees' handbook. SEARO	MRH Regional Meeting Documents and Recommendations
16	Clinical practice handbook for Safe Abortion	SEAR dissemination methods
17	Email correspondence Dec 27, 2018 from Dr Anoma Jayathilaka; Subject Line: WHO New recommendations on PPH and PIH	SEAR dissemination methods
18	Email correspondence Jan 24, 2019 from Dr Anoma Jayathilaka; Subject Line: Potential work on contraception and human rights	SEAR dissemination methods
19	Email correspondence Nov 18, 2018 from Dr Anoma Jayathilaka; Subject Line: Abortion evidence and progress	SEAR dissemination methods
20	Ending preventable maternal, newborn and child mortality: Regional Technical Advisory Group Meeting Recommendations and Report December 2015	Technical Advisory Group (TAG)
21	Ending Preventable Maternal, Newborn and Child Mortality: Regional Technical Advisory Group Report and Recommendations of the Second Meeting of the South East Asia Regional Technical Advisory Group (SEAR TAG) New Delhi, India 8-9 November 2016	Technical Advisory Group (TAG)
22	Evaluation of WHO's Contribution to Maternal Health in The South-East Asia Region	SEAR General Documents
23	Every newborn action plan and postnatal care for mother and newborn: Report of a regional meeting, Colombo, Sri Lanka, 11–13 November 2014	CAH
24	Gilda Sedgh et. al. (2016). Abortion incidence between 1990 and 2014: global, regional, and sub regional levels and trends. Lancet, Vol 388 July 16, 2016	SEAR dissemination methods
25	Guttmacher Institute: Abortion in Asia	SEAR dissemination methods
26	Guttmacher Institute: Abortion Worldwide 2017 – Uneven Progress and Unequal Access	SEAR dissemination methods
27	Guttmacher Institute: induced Abortion Worldwide	SEAR dissemination methods
28	Guttmacher Policy Review: The Roadmap to Safe Abortion Worldwide: Lessons from New Global Trends on Incidence, Legality and Safety	SEAR dissemination methods
29	Hospital-based Birth Defects Surveillance Facilitator guide (NBBD with SEARO)	CAH
30	Hospital-based Birth Defects Surveillance: A Guide to establish and operate (NBBD with SEARO)	CAH
31	Improving Newborn and Child Health (A Strategic Framework 2018-2022)	CAH

General Documents		
#	Document Name	Category
32	Improving Quality of Hospital Care for Maternal and Newborn Health: Report of the Regional Workshop New Delhi, 10 to 13 May 2016	CAH
33	Improving the Quality of Care for Mothers and Newborns in Health Facilities: Facilitator's Manual (version 02)	CAH
34	Improving the Quality of Care for Mothers and Newborns in Health Facilities: Learner's Manual (version 02)	CAH
35	Improving the Quality of Care for Reproductive, Maternal, Neonatal, Child and Adolescent Health in South-East Asia Region: A Regional Framework	CAH
36	Meeting of SEAR-TAG members towards reducing preventable maternal, newborn mortality and stillbirths: Report and Recommendations of the Second Meeting of the South East Asia Regional Technical Advisory Group (SEAR TAG) 15–16 January 2019, New Delhi	Technical Advisory Group (TAG)
37	Monitoring Progress on Universal Health Coverage and The Health-Related Sustainable Development Goals in the South- East Asia Region (2019 Update)	SEAR General Documents
38	Neonatal–perinatal database and birth defects surveillance: Report of the regional review meeting, New Delhi, India, 19–21 August 2014	CAH
39	Perinatal surveillance and prevention of birth defects: Progress Review	CAH
40	PowerPoint Presentation: Overview and situation of Maternal, Newborn and Reproductive, Health 5–7 February 2019 Le Meridien Hotel, New Delhi by Dr Anoma Jayathilaka	RMNCAH – Fact Sheets
41	Prevent birth defects – Ensure quality of life and dignity (Policy briefs)	CAH
42	Prevention and surveillance of birth defects: Report of a meeting of regional programme managers, 14–16 April 2015, New Delhi, India	CAH
43	Quality of care in contraceptive information and services, based on human rights standards. A checklist for health care providers (2 pager word document)	SEAR dissemination methods
44	Quality of care in contraceptive information and services, based on human rights standards: A checklist for health care providers	SEAR dissemination methods
45	Rashid et al. (2017). Evaluating implementation of the World Health Organization's Strategic Approach to strengthening sexual and reproductive health policies and programs to address unintended pregnancy and unsafe abortion. Reproductive Health 14:153 DOI 10.1186/s12978-017-0405-3	Journal article on guidelines
46	Recommendations 1st TAG meeting report	Technical Advisory Group (TAG)
47	Recommendations 2nd TAG meeting report	Technical Advisory Group (TAG)
48	Recommendations of the SEAR-TAG Meeting held on 3-6 Oct 2017 at New Delhi	Technical Advisory Group (TAG)

General Documents		
#	Document Name	Category
49	Recommendations Uterotonics for the prevention of postpartum haemorrhage (PowerPoint presentation)	SEAR dissemination methods
50	Regional capacity-building workshop on Training Resource Package (TRP) on Family Planning to improve Sexual Reproductive Health and Rights (SRHR) (Draft recommendations)	MRH Regional Meeting Documents and Recommendations
51	Regional communication strategy for the prevention and control of birth defects: WHO Regional Office for South-East Asia	CAH
52	Regional Meeting on accelerating reduction of maternal, newborn mortality and stillbirths: towards achieving the Sustainable Development Goals (SDGs) (10-13 July 2018)	MRH Regional Meeting Documents and Recommendations
53	Regional meeting on reducing newborn mortality with a focus on birth defects (2018)	CAH
54	Regional Meeting to Strengthen Capacity in the new WHO family planning guidelines: Towards universal reproductive health coverage in SDGs era - Meeting Report 17th-19th April 2017 New Delhi, India	MRH Regional Meeting Documents and Recommendations
55	Regional situation and priorities in SRHR (presentation for TAG) by Dr Anoma Jayathilaka	SEAR dissemination methods
56	Remarkable progress, new horizons and renewed commitment: ending preventable maternal newborn and child death in South-East Asia Region	CAH
57	Ritchie et. al. (2016). Low- and middle-income countries face many common barriers to implementation of maternal health evidence products. Journal of Clinical Epidemiology 76 (2016) 229e237	Journal article on guidelines
58	Safe abortion: technical and policy guidance for health systems: Second edition	SEAR dissemination methods
59	SEAR TAG Recommendations Jan 2019	Technical Advisory Group (TAG)
60	SEARO Region: Pocket Book of Hospital Care for Mothers: Guidelines for Management of Common Maternal Conditions	MRH Regional Meeting Documents and Recommendations
61	Smith et al. (2017). Improving implementation of health promotion interventions for maternal and newborn health. BMC Pregnancy and Childbirth 17:280 DOI 10.1186/s12884-017-1450-1	Journal article on guidelines
62	Strategic framework for the Comprehensive Control of Cancer Cervix in South-East Asia Region	MRH Regional Meeting Documents and Recommendations
63	Strengthening Country Capacity on Maternal and Perinatal Death Surveillance and Response Report of a South-East Asia Regional Meeting 16–18 February 2016, Maldives	MRH Regional Meeting Documents and Recommendations
64	Summary of Maternal and Reproductive Health (MRH) Situation in South-East Asia Region (SEAR) (Word Document)	RMNCAH – Fact Sheets

General Documents		
#	**Document Name**	**Category**
65	Susan L Norris, Nathan Ford. (2017). Improving the quality of WHO guidelines over the last decade: progress and challenges. Lancet. Volume 5, September.	Journal article on guidelines
66	Vogel JP, Moore JE, Timmings C, Khan S, Khan DN, Defar A, et al. (2016). Barriers, Facilitators and Priorities for Implementation of WHO Maternal and Perinatal Health Guidelines in Four Lower-Income Countries: A GREAT Network Research Activity. PLoS ONE 11(11): e0160020. doi:10.1371/journal.pone.0160020	Journal article on guidelines
67	Wang et al. (2016). Implementation plans included in World Health Organisation guidelines. Implementation Science 11:76 DOI 10.1186/s13012-016-0440-4	Journal article on guidelines
68	WHO recommendation: Calcium supplementation during pregnancy for the prevention of pre-eclampsia and its complications	SEAR dissemination methods
69	WHO recommendations: Drug treatment for severe hypertension in pregnancy	SEAR dissemination methods
70	WHO recommendations: Policy of interventionist versus expectant management of severe pre-eclampsia before term	SEAR dissemination methods
71	WHO recommendations: Uterotonics for the prevention of postpartum haemorrhage	SEAR dissemination methods
72	WHO SEARO: Draft Global Strategy Towards the Elimination of Cervical Cancer as A Global Public Health Problem	MRH Regional Meeting Documents and Recommendations
73	WHO TS guidelines workshop charts – Kigali Workshop	SEAR dissemination methods

Case Study Documents	
#	**Document Name**
Bhutan	
1.	11th Five Year Plan, 2013-18, Gross National Happiness Commission, 2013
2.	Bhutan Every Newborn Action Plan
3.	Bhutan Population and Housing Census 2017
4.	Bhutan RMNCAH Factsheet July 2018, SEARO
5.	Cervical Cancer Screen Manual, 2014
6.	Guideline on Mother and Child Health Handbook, 2017
7.	Implementation Guideline for One Stop to Child Health Care Service Centre for Children 0 to 5, 2014
8.	Infertility Prevention and Management, 2014
9.	Maternal Mortality – Bhutan, Interagency Group
10.	Maternal, Perinatal and Neonatal Deaths Surveillance and Response Guideline 2016
11.	Midwifery Standard (Draft 2018)
12.	National Family Planning Standard, 2014
13.	National Family Planning Standards, 2018

Case Study Documents	
#	**Document Name**
14.	National Health Policy, no date, estimating 2011
15.	National Reproductive Health Strategy 2012-16
16.	National Standards of Midwifery Practice for Safe Motherhood, 2009
17.	Standard Guideline for Postpartum Hemorrhage, 2016
18.	Standard Operating Procedures on Case Management for Women and Children in Difficult Circumstances, no date (estimate 2014)
19.	WHO Country Cooperation Strategy, Bhutan, 2014-18
India	
20.	Assessor guidebook for quality Assurance in District Hospitals Vol-1
21.	Ayushman Bharat
22.	Contraceptive Updates: Facilitators Guide
23.	Daksh skill lab for RMNCH+A services (training manual for facilitators)
24.	DAKSHATA – Empowering Providers for Improved MNH Care during Institutional Deliveries – Operational guidelines
25.	EmOC training guide
26.	Facility Based Newborn Care: Neonatal Resuscitation Module
27.	Family participatory care for improving newborn health – Operational guidelines for planning and implementation
28.	FBNC operational guide
29.	FBNC Operational Guidelines
30.	FBNC operational guidelines
31.	Guidance Note on Use of Uterotonics during labour
32.	Guidebooks for quality Assurance in District Hospitals Volume 2
33.	Guidelines for administration of ECPs by health service providers
34.	Guidelines for Antenatal Care and Skilled Attendance at Birth by ANMs/LHVs/SNs
35.	Guidelines for JSSK
36.	Guidelines for pregnancy care and management of Common Obstetric Complications by MOs
37.	Guidelines for Skilled Attendance at birth
38.	IMNCI Facilitator guide -II final
39.	IMNCI Facilitators Guide for Modules – (I) final
40.	India Newborn Action Plan (INAP)
41.	IUCD reference manual for medical officers and nursing personnel
42.	KMC & optimal feeding of low birth weight infants
43.	Laqshya: labour room quality improvement initiative
44.	Management of sick and small newborns at FRUs
45.	Maternal and Newborn Health Tool Kit
46.	MHS Operational Guidelines
47.	Neonatal Resuscitation Protocol for MOs and staff Nurses under FBNC training
48.	NHRC Annual Report 2015-2016
49.	NSSK Training manual – Basic Newborn Care and Resuscitation Programme
50.	Operation Guidelines-Use of Antenatal Corticosteroids in Preterm Labour
51.	Operational framework Management of Common Cancers

Case Study Documents	
#	**Document Name**
52.	Operational Guidelines and Reference Manual for Misoprostol for PPH
53.	Operational guidelines for F-IMNCI
54.	Operational Guidelines on Quality Assurance
55.	Reference manual for doctors (contraceptives updates)
56.	Reference Manual for Injectable Contraceptives DMPA
57.	RKSK Implementation Guideline
58.	RKSK Operational Framework
59.	RKSK Strategy Handbook
60.	Safe Delivery Application
61.	SBA handbook for ANMs, LHVs and SNs
62.	Supplement for MPA-SC
63.	The National Policy for Children
64.	Use of Gentamicin by ANMs for management of sepsis in young infants under specific situations
Myanmar	
65.	5 Year Strategic Plan for Reproductive Health
66.	Auxiliary Midwife Family Planning Manual
67.	Auxiliary Midwife Family Planning Manual Training
68.	Basic Emergency Obstetric and Newborn Care: A manual for basic health staff, 2016
69.	Early Essential Newborn Care / Essential Care for Every Baby
70.	Essential Care for Small Babies (ECSB)
71.	Facility based IMNCI Facilitator Manual, 2017
72.	Facility based IMNCI Participant Manual
73.	Family Planning Guideline for Service Providers 2018
74.	FP2020 Costed Implementation Plan
75.	Guideline on Postabortion Care for Public Sector Health Facilities
76.	Guideline on Secondary Prevention of Cervical Cancer, 2018
77.	IMNCI Chart
78.	IMNCI Guideline for Providers, no date
79.	Jhpiego documents
80.	Manual for Integrated Community Malaria Volunteer
81.	MCH Handbook 2016
82.	MEC Wheel
83.	MSDR Technical Guidelines
84.	MSDR Training Manual
85.	National Guidelines for Antenatal Care for Service Providers, 2018
86.	National Health Plan 2017-21
87.	National Sexual and Reproductive Health and Rights Policy, 2018
88.	National Standards for Midwives, Core Competencies and Education
89.	National Strategy for Newborn and Child Health Development, 2015-18
90.	Postnatal Care Guideline in Hospital Setting, no date
91.	Presentations

Case Study Documents	
#	**Document Name**
92.	Revised Costed Workplan for FP 2020
93.	Strategy to End Preventable Maternal Mortality in Myanmar (2017-2021) (2018)
94.	WCO Distribution emails
95.	WHO Summary document on MCNH in Myanmar
96.	Youth Policy Cover
Sri Lanka	
97.	Annual Report of the Family Health Bureau 2017
98.	Birth & Deaths Registration Act 1954
99.	Building and other guidelines for neonatal intensive care units, special care baby units and mother baby centres
100.	Full Blood Count test as screening method for anaemia during pregnancy
101.	Guideline for health staff on providing Adolescent Sexual and Reproductive Health services
102.	Guideline on introduction of the HPV vaccine into the National Immunisation Programme
103.	Guidelines for management of pregnant women with HIV infection
104.	Guidelines for service providers on minilaporotomy for female sterilisation
105.	Guidelines for service providers on the use of combined oral contraceptive (COC) pill and DMPA injectable contraceptive
106.	Guidelines for the management of maternal syphilis & congenital syphilis
107.	Guidelines on de-worming children and pregnant women against soil transmitted helminths in community setting 2019-2022 (circular)
108.	Handbook to guide health staff on healthcare for newly wedded
109.	Implementation of the National Feto-infant Mortality Surveillance System - Hospital Perinatal Mortality Surveillance
110.	Institutional Maternity Care: Norms for services, equipment, drugs and human resources
111.	Maternal care package: A guide to field healthcare workers
112.	Medical Eligibility Criteria (MEC) wheel for contraceptive use (WHO MEC wheel adapted for Sri Lanka)
113.	National family planning programme review 2016
114.	National guidelines for maternal care Volume 1
115.	National guidelines for maternal care Volume 2
116.	National guidelines for maternal care Volume 3
117.	National guidelines for newborn care Volume 1
118.	National guidelines for newborn care Volume 2
119.	National guidelines for newborn care Volume 3
120.	National list of essential medicines Sri Lanka (4th revision)
121.	National policy and strategic framework on cancer prevention and control Sri Lanka
122.	National policy on Maternal and Child Health
123.	National strategic plan Maternal and Newborn Health (2017-2025)
124.	National strategic plan on child health in Sri Lanka 2018-25
125.	Newly married screening card
126.	Policy framework and national plan of action to address Sexual and Gender Based Violence (SGBV) in Sri Lanka 2016-20
127.	Pregnancy record 512 A

Case Study Documents	
#	**Document Name**
128.	Prevention and early detection of common gynaecological cancers
129.	Programme for ending HIV by 2015 in Sri Lanka
130.	Registration of still births (circular)
131.	Revised guidelines for implementation of Well Woman Services for women of reproductive and post reproductive age
132.	Sexually Transmitted Infections management guidelines
133.	Standards for maternal care for quality improvement of maternal care services in Sri Lanka
134.	Terms of reference (TOR) of Technical Advisory Committee on Maternal Health and Family Planning (TAC-MH/FP)
135.	Terms of reference (TOR) of Technical Advisory Committee on Newborn and Child Health (TAC-NCH)
136.	The programme for elimination of mother to child transmission of syphilis and HIV (EMTCT syphilis & HIV) in Sri Lanka (circular)
137.	Well Woman Clinic record
138.	Youth friendly health services (training of trainers manual II)
Bangladesh	
139.	Guideline on Antenatal Care (ANC)
140.	Guideline on Intrapartum Care (IPC) & Postnatal Care (PNC)
141.	National Guidelines on KMC
142.	Standard Clinical Management Protocols and Flowcharts on Emergency Obstetric and Neonatal Care
143.	Use of Antenatal Corticosteroids (ACS) in Threatened Preterm Deliveries to Reduce Neonatal Mortality and Morbidities. Bangladesh National Guideline

Annex E: Internal Survey

Questions 1: At what level of WHO do you work?

Answer Choices	Responses	
Headquarters	0%	0
Regional Office	0%	0
Country Office	100%	11

Answered: 11
Skipped: 0

Questions 2: In which Country Office do you work?

Answer Choices	Responses	
Bangladesh	18%	2
Bhutan	0%	0
Democratic People's Republic of Korea	0%	0
India	0%	0
Indonesia	0%	0
Maldives	9%	1
Myanmar	27%	3
Nepal	9%	1
Sri Lanka	18%	2
Thailand	9%	1
Timor-Leste	9%	1

Answered: 11
Skipped: 0

Questions 3: How long have you been involved in the area of Reproductive, Maternal and Newborn Health (RMNH)?

Answer Choices	Responses	
Less than one year	9%	1
Between 1 year and less than 3 years	9%	1
Between 3 years and less than 5 years	27%	3
Between 5 year and less than 7 years	18%	2
Greater than 7 years	36%	4

Answered: 11
Skipped: 0

Questions 4: **Are you aware of WHO's programme on RMNH (particularly work done in the years 2014-2018)?**

Answer Choices	Responses	
Yes	100%	11
No	0%	0

Don’t know	0%	0
What gaps, if any, exist in the engagement of target RMNH audiences?		5

Comments

- WHO guidelines reach to central level RMNH audiences to significant extent for informing to policy change, advocacy and national level adaptation. However, reaching to sub-national level after the adaptation is not optimal.
- Commitment on the part of stakeholders to reach the grass root level.
- For countries with low maternal and neonatal mortality levels, there is not much in terms of WHO guidance except improved QoC which we know is important but much more is needed
- Engagement of most key audiences are highly satisfactory, except service providers in armed conflict (self-administered) zone, which are under the government's limited control.
- None

Answered: 11
Skipped: 0

Questions 5: To what extent are WHO RMNH guidelines addressing Member State priority health knowledge needs?

Answer Choices	Responses	
Completely	0%	0
Mostly	91%	10
Somewhat	9%	1
To a minor extent	0%	0
Not at all	0%	0

Answered: 11
Skipped: 0

Questions 6: What methods do you use to disseminate WHO RMNH guidelines to Member States?

- Mostly emails and face to face trainings or orientation
  - sharing of electronic and hard copies of the guidelines to government counterparts. - during meetings of technical groups (advisory and working) of Myanmar Health Sector Coordination Committee. - Convening seminars and workshops at national levels - sharing during regional technical consultation meetings and workshops
- workshops, meetings and trainings
- Workshop, Seminar, TV talk show and IEC material
- Dissemination through sending emails to concerned stakeholders, presenting at the technical working group meetings, partners forums, sending hard copies of RMNH guidelines to concerned organizations/stakeholders, conducting dissemination workshops and disseminating at campaigns (eg. World Contraception Day).
- We receive WHO guidelines from Regional Office related to RMNH
- Technical support for review and update of existing guidance; support for evidence generation; knowledge exchange through technical discussions and seminars in key professional and academic events
- Translation of the Guideline into local language to facilitate the adaptation to the national guideline.

- Send Hard Copies, Mail to stakeholders including Government, professional bodies, partners Disseminate during meetings, workshops, trainings Sharing with national participants during WHO regional meetings
- Advisory groups, professional colleges, Dissemination and adaptation workshops, online sharing through emails, groups and websites, opportunistic dissemination (requests, personnel discussions), post graduate teaching

Answered: 10
Skipped: 1

Questions 7: To what extent do WHO RMNH guidelines respond to Member State RMNH strategies and priorities?

Answer Choices	Responses	
Completely	9%	1
Mostly	82%	9
Somewhat	9%	1
To a minor extent	0%	0
Not at all	0%	0

Answered: 11
Skipped: 0

Questions 8: To what extent does WHO dissemination strategies, policies and plans target different language audiences in the region?

Answer Choices	Responses	
Completely	9%	1
Mostly	45%	5
Somewhat	18%	2
To a minor extent	18%	2
Not at all	9%	1

Answered: 11
Skipped: 0

Questions 9: In general, please mark your level of agreement with the following statements.

	5 - Strongly agree		4 - Agree		3 - Somewhat agree		2 - Disagree		1 - Strongly disagree		0 - Not applicable		Total	Weighted Average
a. WHO RMNH guidelines are the authoritative source of health information.	82%	9	18%	2	0%	0	0%	0	0%	0	0%	0	11	**4.82**
b. WHO RMNH guidelines inform decision-making in clinical, public health and/or policy contexts.	45%	5	55%	6	0%	0	0%	0	0%	0	0%	0	11	**4.45**
c. WHO RMNH guidelines inform advocacy and/or enhance programmes, training, and/or research.	45%	5	55%	6	0%	0	0%	0	0%	0	0%	0	11	**4.45**
d. WHO RMNH guidelines are regularly adapted (e.g., modified to another medium,	45%	5	36%	4	18%	2	0%	0	0%	0	0%	0	11	**4.27**

training, translation, etc.) at Member States.														
e. WHO RMNH guidelines improve clinical practice or performance.	18%	2	73%	8	9%	1	0%	0	0%	0	0%	0	11	**4.09**

Questions 10: What are some of the barriers or enabling factors for the adaptation of WHO RMNH guidelines at country level?

- WHO guidelines are adapted at country level with support from international or local experts and in agreement with all stakeholders
- Enabling factors: - WHO's unique position as technical advisor, which is purely technical, un-biased and non-political - Long-term partners with mutual respect and trust - WHO's comprehensive supports, e.g during adaptation, translating to national strategy and programme planning, during implementation of strategy including capacity building.
- language (translated to local language), government capacity to implement new guidelines, dissemination to implementers (district health officers)
- language
- Some enabling factors are: timely dissemination from regional level to country offices; availability of ready-made power point presentations, graphics and posters; credibility of WHO technical materials and recommendations; good collaboration of partners at country level (UNICEF, UNFPA, Jhpiego, H6 partnership); availability of relevant technical platforms (technical working groups, partners forums)
- There is need for adaptation to country context. Cannot apply without consideration of country service readiness and context where wide diversity exist.
- Enablers - WHO guidelines viewed as credible, evidence based and accepted as standards
- Some barriers include local stakeholders' limited understanding of English language used in the WHO guidelines and too few local experts are capable to promote and transfer knowledge from the WHO guidances. Enabling factors for the adaptation could include but not limited to: 1) funding to support translation of the guideline into local language and training on the use of the guideline, 2) building a community of practice of RMNCH experts in the region to help promote WHO guidelines.
- Barriers: Current transition of the country into federal structure, roles of different level of government for guideline development and implementation not well defined Capacity of provincial and local level program managers to understand and implement the WHO recommendations Enabling Factors: Need identified by the Government and developed safe motherhood and newborn roadmap to accelerate reduction of MMR and NMR to reach SDG targets Planning and implementation by provincial and local level governments create more opportunity for better monitoring and implementation
- Enabling factor: Credulity and the faith of the process of development and WHO, Positive experience from the past Barriers: number of guidelines from different departments on the same subject without referring to each other, lack of clear reference to previous related guidelines, lack of guidance on implementation based on the maturity of the health system, and national indicators, Lack of integrated approach in delivering within the health system,
- There are some programmatic Barrier. Example: WHO ANC guideline recommended 8+ visit abut as Bangladesh National data shows the 4 ANC visit is still low so MoH is not interested

in adopting 8 ANC visit to the New National ANC Guideline Though many other WHO recommendations are there in the New Guideline.

Answered: 11
Skipped: 0

Questions 11: To what extent have the adoption of RMNH guidelines in WHO SEAR Member States had an impact on:

	5 - Completely		4 - Mostly		3 - Somewhat		2 - To a minor extent		1 - Not at all		0 - Not applicable		Total	Weighted Average
Maternal mortality	18%	2	55%	6	18%	2	9%	1	0%	0	0%	0	11	3.82
Neonatal mortality	9%	1	64%	7	18%	2	9%	1	0%	0	0%	0	11	3.73
Family planning	27%	3	55%	6	18%	2	0%	0	0%	0	0%	0	11	4.09

Answered: 11
Skipped: 0

Questions 12: What suggestions do you have to improve the reach, usefulness or use of WHO RMNH guidelines?

- no further suggestions
- To improve particularly use of RMNH guidelines which are clinical in nature, - to engage reputed experts from the region/international for advocating among national experts/leading clinicians (particularly when it demands a major shift of clinical practice)
- reach - using technology (webinars, virtual conferences) to reach national and sub national partners (government and non government) usefulness - continued engagement of national WHO colleagues with government and partners on WHO guidelines; continue to support national experts and Health officials in the development or revision of any WHO guidelines
- No
- To establish follow up or monitoring mechanism on consistent use of WHO RMNH guidelines
- WHO RMNH guidelines are useful and has authority among users in the country level. It is important for WHO CO to adapt to national and local level context with the Ministry of health to ensure ownership and relevance. Language is another v=b artier to over come. so, WHO Global and regional guidelines;ines have authority and useful but there is room for CO to adapt.
- Guidelines to be accompanied by short policy and program briefs to highlight the relevance, context, what's new
- For every guideline, please always include a snapshot, a summary, job aid that are more ready to use and easy to communicate with policy makers and practitioners.
- Dissemination to wider sectors including Academia, National Planning Commission, non-health sectors (specially for programs such as Adolescent health which require multisectoral collaboration) Review of adaptation of recommendations to identify gaps and strengths Support from Regional office and
- Consider and provide the implementation requirements for the guidelines. 2. Link all the new guidelines with related guidelines already published, as countries are already implementing the guidelines, they only need what has changed or what has added new for the existing guidelines. 3. Have a definite frequency for updating and strictly adhere to it. Then countries can plan for their updates. 4. Instead of having number of small guidelines publish packages of guidelines together eg. maternal care. Then countries can review and revise the whole package together. Ad hoc and infrequent release of guidelines over the years, prevent effective use and adaptation as well as exhaust human as well as financial resources. 4. Have a strong coordination among the different units of HQ who are working on similar topics. For

example there are number of publications on QOC in RMNH and they are not link with each other as well as not with the health care quality and safety. At the country level, it is difficult to connect.

- Sometimes stakeholders particularly Clinician like to have HARD copies rather then going to web.

Answered: 11
Skipped: 0

Annex F: External Survey

Overview

"Thank you for your participation in this survey. The World Health Organization (WHO) South-East Asia Region (SEAR) has contracted the services of TDV Global inc. to conduct an external evaluation of the adaptation and use of WHO guidelines on Reproductive, Maternal and Newborn Health (RMNH) in the WHO South-East Asia Region.

The evaluation is expected to cover all the WHO guidelines in the area of RMNH released in the last 5 years (i.e. from 2014 to 2018). The overall purpose is to evaluate the contribution of WHO guidelines to improving RMNH in the Region.

As part of the evaluation, this survey is aimed at the intended audience of WHO RMNH guidelines to help provide input into this process.

Please be assured that your responses will be managed with confidentiality. The information gathered from the survey will be reported at the aggregate level, and individual responses will not be attributed to you in any report.

The survey will take approximately 15-20 minutes to complete.

For your responses to be included in the study, please complete the survey by Friday, November 22, 2019. If you prefer, you can obtain an electronic copy of the survey in MS Word format by e-mail request to s.ennis@tdvglobal.com and fax the completed survey to +1-613-231-3970.

If you are experiencing technical problems accessing the survey or during the session, please contact us at s.ennis@tdvglobal.com or call +1-613-231-8555."

Intro Questions 1-5

Number of Respondents (n=35)

1. **In which Member State do you work?**

Country	Responds	Percentage
Bangladesh	5	14%
Bhutan	4	11%
DPR Korea	1	3%
India	6	17%
Indonesia	2	6%
Maldives	2	6%
Myanmar	7	20%
Nepal	3	9%
Sri Lanka	3	9%
Thailand	2	6%
Timor-Leste	0	0%

2. **What type of institution do you work for? (please check all that apply)**

Institution	Responds	Percentage
Ministry of Health (MoH)	14	40%
Governmental institution (other than MoH)	2	6%
Health or public health related agency	2	6%
Healthcare facility/institution	1	3%
Academia/Research Institution/Collaborating Centre/Other health and public health related agency	4	11%
UN agency	8	23%

Professional Association	4	11%
NGO	5	14%
Donor	0	0%
Other (please specify)	1	3%

3. **How long have you been involved in the area of reproductive, newborn and maternal health (RMNH)?**

Time	Responds	Percentage
Less than one year	1	3%
Between 1 year and less than 3 years	3	9%
Between 3 years and less than 5 years	2	6%
Between 5 year and less than 7 years	4	11%
Greater than 7 years	25	71%

4. **Are you aware of WHO's programme on RMNH (particularly work done in the years 2014-2018**

Yes/No/Don't know	Responds	Percentage
Yes	33	94%
No	1	3%
Don't know	1	3%

5. **A sample of WHO guidelines was selected for more in-depth analysis. Please select the WHO RMNH guideline that you are most familiar with: (Please select only one)**

Country	Responds	Percentage
Newborn Health - Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015)	6	17%
Maternal Health - WHO recommendations for augmentation of labour (2014)	4	11%
Maternal Health - WHO recommendations on antenatal care (ANC) for a positive pregnancy experience (2016)	15	43%
Family Planning and Reproductive Health - Medical eligibility criteria for contraceptive use (MEC), and MEC Wheel, fifth edition (2015)	8	23%
Unfamiliar with any of the selected WHO RMNH guidelines	2	6%

Usefulness Summary: Questions 6-11, 16-21, 26-31, 37-42

Number of Respondents (n=35)

Q6-16-26-37 What is your level of satisfaction with the WHO guideline entitled Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015)?

Level of Satisfaction	Q6. (NH)	Q16. (MH)	Q26. (ANC)	Q37. (MEC)	Total	Percentage
Very satisfied	3	3	7	4	17	49%
Satisfied	3	1	7	3	14	40%
Neutral	0	0	1	0	1	3%
Dissatisfied	0	0	0	0	0	0%

Very dissatisfied	0	0	0	0	0	0%
Not applicable	0	0	0	1	3	9%

Q7-17-27-38 To what extent do you find the recommendations of the WHO guidelines useful?

Level of Satisfaction	Q7. (NH)	Q17. (MH)	Q27. (ANC)	Q38. (MEC)	Total	Percentage
Extremely useful	2	3	4	5	14	40%
Mostly useful	4	1	9	2	16	46%
Somewhat useful	0	0	2	0	2	6%
Marginally useful	0	0	0	0	0	0%
Not at all useful	0	0	0	0	0	0%
Not applicable	0	0	0	1	3	9%

Q8-18-28-39 To what degree have you gained additional knowledge from the recommendations of WHO guidelines?

Level of Satisfaction	Q8. (NH)	Q18. (MH)	Q28. (ANC)	Q39. (MEC)	Total	Percentage
A great deal	3	2	6	6	17	49%
Quite a bit	2	1	9	1	13	37%
Somewhat	1	1	0	0	2	6%
Very little	0	0	0	0	0	0%
Not at all	0	0	0	0	0	0%
Not applicable	0	0	0	1	3	9%

Q9-19-29-40 To what extent has the WHO guidelines informed Member State policies or advocacy on the subject matter?

Level of Satisfaction	Q9. (NH)	Q19. (MH)	Q29. (ANC)	Q40. (MEC)	Total	Percentage
A great deal	1	2	8	4	15	43%
Quite a bit	3	2	5	3	13	37%
Somewhat	2	0	1	0	3	9%
Very little	0	0	1	0	1	3%
Not at all	0	0	0	0	0	0%
Not applicable	0	0	0	1	3	9%

Q10-20-30-41. Ranking the level of satisfaction of external stakeholders with the following features of the WHO guidelines and its recommendations.

Level of Satisfaction with the Format and Style of the WHO Guidelines and its Recommendations

Level of Adoption	Q10. (NH)	Q20. (MH)	Q30. (ANC)	Q41. (MEC)	Total	Percentage
Very Satisfied	2	3	8	4	17	49%
Satisfied	3	1	6	3	13	37%
Neutral	1	0	1	0	2	6%
Dissatisfied	0	0	0	0	0	0%
Very Dissatisfied	0	0	0	0	0	0%
I Don't Know	0	0	0	1	3	9%

Level of Satisfaction with the Language (appropriate and comprehensible) of the WHO Guidelines and its Recommendations

Level of Adoption	Q10. (NH)	Q20. (MH)	Q30. (ANC)	Q41. (MEC)	Total	Percentage
Very Satisfied	3	3	9	2	17	49%
Satisfied	2	1	5	5	13	37%

Neutral	1	0	1	0	2	6%
Dissatisfied	0	0	0	0	0	0%
Very Dissatisfied	0	0	0	0	0	0%
I Don't Know	0	0	0	1	3	9%

Level of Satisfaction with the Method of dissemination (print, electronic) of the WHO Guidelines and its Recommendations

Level of Adoption	Q10. (NH)	Q20. (MH)	Q30. (ANC)	Q41. (MEC)	Total	Percentage
Very Satisfied	2	2	6	3	13	37%
Satisfied	2	1	6	4	13	37%
Neutral	1	1	3	0	5	14%
Dissatisfied	1	0	0	0	1	3%
Very Dissatisfied	0	0	0	0	0	0%
I Don't Know	0	0	0	1	3	9%

Comments

- Electronic notifications are hardly received and Print versions have never been received.
- Format of the presentation and the style of writing should improve
- Meetings for further dissemination and involvement of private sector

I believe more interactive dissemination with not just key Ministry officials, but also their core teams may be more beneficial in generating momentum towards the adaptation of guidelines

- Indonesia has adapted the MEC 2015 into Bahasa Indonesia and develop the iOS and android web-based applications
- adapted for Persons with Disability

Q11-21-31-42. Ranking the level of satisfaction of the external stakeholders with the following features of the WHO guidelines and its recommendations.

Level of Satisfaction with the Credibility of the WHO Guidelines and its Recommendations

Level of Adoption	Q11. (NH)	Q21. (MH)	Q31. (ANC)	Q42. (MEC)	Total	Percentage
Very Satisfied	4	3	5	2	14	40%
Satisfied	2	1	9	5	17	49%
Neutral	0	0	1	0	1	3%
Dissatisfied	0	0	0	0	0	0%
Very Dissatisfied	0	0	0	0	0	0%
I Don't Know	0	0	0	1	3	9%

Level of Satisfaction with the Authoritativeness of the WHO Guidelines and its Recommendations

Level of Adoption	Q11. (NH)	Q21. (MH)	Q31. (ANC)	Q42. (MEC)	Total	Percentage
Very Satisfied	2	3	5	2	12	34%
Satisfied	4	0	9	5	18	51%
Neutral	0	1	1	0	2	6%
Dissatisfied	0	0	0	0	0	0%
Very Dissatisfied	0	0	0	0	0	0%
I Don't Know	0	0	0	1	3	9%

Level of Satisfaction with the Timeliness of the WHO Guidelines and its Recommendations

Level of Adoption	Q11. (NH)	Q21. (MH)	Q31. (ANC)	Q42. (MEC)	Total	Percentage
Very Satisfied	1	2	4	2	9	26%
Satisfied	3	2	10	3	18	51%
Neutral	1	0	1	2	4	11%
Dissatisfied	1	0	0	0	1	3%
Very Dissatisfied	0	0	0	0	0	0%
I Don't Know	0	0	0	1	3	9%

Comments

More focus on addressing malnutrition (if evidence dictates so) would be crucial in LMIC like India would be critical.

Use Summary: Questions 12-22-32-43 and 15-25-35-51

Q12-22-32-43. To what degree does the WHO guidelines and its recommendations contribute to the health outcomes listed below.

Contributed to WHO leadership and credibility on critical RMNH issues and priorities

Level of Adoption	Q12. (NH)	Q22. (MH)	Q32. (ANC)	Q43. (MEC)	Total	Percentage
Completely	1	2	5	2	10	29%
Mostly	5	2	8	5	20	57%
Somewhat	0	0	0	0	0	0%
To a minor extent	0	0	1	0	1	3%
Not at all	0	0	0	0	0	0%
Not applicable	0	0	1	1	4	11%

Contributed to setting national policy, norms and standards

Level of Adoption	Q12. (NH)	Q22. (MH)	Q32. (ANC)	Q43. (MEC)	Total	Percentage
Completely	0	3	5	3	11	31%
Mostly	4	1	7	4	16	46%
Somewhat	2	0	2	0	4	11%
To a minor extent	0	0	1	0	1	3%
Not at all	0	0	0	0	0	0%
Not applicable	0	0	0	1	3	9%

Contributed to the enhancement of national programmes and practices

Level of Adoption	Q12. (NH)	Q22. (MH)	Q32. (ANC)	Q43. (MEC)	Total	Percentage
Completely	2	2	5	3	12	34%
Mostly	3	2	6	4	15	43%
Somewhat	1	0	3	0	4	11%
To a minor extent	0	0	1	0	1	3%
Not at all	0	0	0	0	0	0%
Not applicable	0	0	0	1	3	9%

Used to inform decision-making in clinical, public health and policy contexts

Level of Adoption	Q12. (NH)	Q22. (MH)	Q32. (ANC)	Q43. (MEC)	Total	Percentage
Completely	1	2	6	4	13	37%
Mostly	5	2	6	3	16	46%
Somewhat	0	0	1	0	1	3%

To a minor extent	0	0	1	0	1	3%
Not at all	0	0	0	0	0	0%
Not applicable	0	0	1	1	4	11%

Increased stakeholder awareness of health issues

Level of Adoption	Q12. (NH)	Q22. (MH)	Q32. (ANC)	Q43. (MEC)	Total	Percentage
Completely	2	2	4	2	10	29%
Mostly	1	1	8	4	14	40%
Somewhat	2	1	2	1	6	17%
To a minor extent	1	0	1	0	2	6%
Not at all	0	0	0	0	0	0%
Not applicable	0	0	0	1	3	9%

Used to inform and update training and education programmes

Level of Adoption	Q12. (NH)	Q22. (MH)	Q32. (ANC)	Q43. (MEC)	Total	Percentage
Completely	1	2	7	4	14	40%
Mostly	3	2	5	3	13	37%
Somewhat	1	0	3	0	4	11%
To a minor extent	1	0	0	0	1	3%
Not at all	0	0	0	0	0	0%
Not applicable	0	0	0	1	3	9%

Used to guide health research agendas and methods

Level of Adoption	Q12. (NH)	Q22. (MH)	Q32. (ANC)	Q43. (MEC)	Total	Percentage
Completely	1	2	4	1	8	23%
Mostly	1	2	5	4	12	34%
Somewhat	2	0	4	2	8	23%
To a minor extent	2	0	2	0	4	11%
Not at all	0	0	0	0	0	0%
Not applicable	0	0	0	1	3	9%

Used to improve individual clinical practice or performance

Level of Adoption	Q12. (NH)	Q22. (MH)	Q32. (ANC)	Q43. (MEC)	Total	Percentage
Completely	0	2	5	4	11	31%
Mostly	3	2	4	3	12	34%
Somewhat	2	0	4	0	6	17%
To a minor extent	1	0	2	0	3	9%
Not at all	0	0	0	0	0	0%
Not applicable	0	0	0	1	3	9%

Q15&25&35&51 what is the current level of national compliance with the WHO guidelines?

Level of Adoption	Q15. (NH)	Q25. (MH)	Q35. (ANC)	Q51. (MEC)	Total	Percentage
Completely	0	1	1	0	2	6%
Mostly	0	1	3	1	5	14%
Somewhat	0	0	3	0	3	9%
To a minor extent	0	0	1	0	1	3%
Not at all	0	0	1	0	1	3%
No Reporting system for monitoring compliance to the	6	2	6	7	21	60%

national clinical guidelines						
Not applicable					2	6%

Newborn Health - Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015) (Questions 6-15)

Number of Respondents (n=6)

Q6. What is your level of satisfaction with the WHO guideline entitled Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015)?

Level of Satisfaction	Responds	Percentage
Very satisfied	3	50%
Satisfied	3	50%
Neutral	0	0%
Dissatisfied	0	0%
Very dissatisfied	0	0%
Not applicable	0	0%

Q7. To what extent do you find the recommendations of the WHO guideline entitled Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015) useful?

Usefulness	Responds	Percentage
Extremely useful	2	33%
Mostly useful	4	67%
Somewhat useful	0	0%
Marginally useful	0	0%
Not at all useful	0	0%
Not applicable	0	0%

Q8. To what degree have you gained additional knowledge from the recommendations of WHO guideline entitled Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015)?

Degree	Responds	Percentage
A great deal	3	50%
Quite a bit	2	33%
Somewhat	1	17%
Very little	0	0%
Not at all	0	0%
Not applicable	0	0%

Q9. To what extent has the WHO guideline entitled Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015) informed Member State policies or advocacy

Degree	Responds	Percentage
A great deal	1	17%

Quite a bit	3	50%
Somewhat	2	33%
Very little	0	0%
Not at all	0	0%
Not applicable	0	0%

Comments

- Addition of CPAP need detailed elaboration to get incorporated into national framework. In addition, Concentration of Oxygen need to be standardised. It differs in respect to the guidance provided in Maternal guidelines.
- Though the guidelines are very useful, most of the times these guidelines are not used for program designing. Dissemination of guidelines and advocacy for evidence-based interventions need to improve further.
- When this publication came in 2015, most recommendations were already included in national guidelines.
- In addition to WHO guidelines, NICE, SIGN and AAP guidelines too were used when these were adopted to the country

Q10. Please rank your level of satisfaction with the following features of the WHO guideline entitled Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015) and its recommendations.

Format and style		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	2	33%
Satisfied	3	50%
Neutral	1	17%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Language (appropriate and comprehensible)		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	3	50%
Satisfied	2	33%
Neutral	1	17%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Method of dissemination (print, electronic)		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	2	33%
Satisfied	2	33%
Neutral	1	17%
Dissatisfied	1	17%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Comments		
• Electronic notifications are hardly received and Print versions have never been received. • Format of the presentation and the style of writing should improve		

Q11. Please rank the quality level of the WHO guideline entitled Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015) and its recommendations in terms of:

Credibility		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	4	67%
Satisfied	2	33%
Neutral	0	0%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Authoritativeness		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	2	33%
Satisfied	4	67%
Neutral	0	0%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Timeliness		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	1	17%
Satisfied	3	50%
Neutral	1	17%
Dissatisfied	1	17%
Very Dissatisfied	0	0%
I Don't Know	0	0%

Q12. To what degree does the WHO guideline entitled Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015) and its recommendations contribute to the health outcomes listed below.

Interventions	Number of Respondents	5 - Completely		4 - Mostly		3 - Somewhat		2 - To a minor extent		1 - Not at all		0 - Not applicable		Average Rating
Contributed to WHO leadership and credibility on critical RMNH issues and priorities	**6**	1	17%	5	83%	0	0%	0	0%	0	0%	0	0%	**4.17**
Contributed to setting national policy, norms and standards	**6**	0	0%	4	67%	2	33%	0	0%	0	0%	0	0%	**3.67**
Contributed to the enhancement of national programmes and practices	**6**	2	33%	3	50%	1	17%	0	0%	0	0%	0	0%	**4.17**
Used to inform decision-making in clinical, public health and policy contexts	**6**	1	17%	5	83%	0	0%	0	0%	0	0%	0	0%	**4.17**
Increased stakeholder awareness of health issues	**6**	2	33%	1	17%	2	33%	1	17%	0	0%	0	0%	**3.67**

Used to inform and update training and education programmes	**6**	1	17%	3	50%	1	17%	1	17%	0	0%	0	0%	**3.67**
Used to guide health research agendas and methods	**6**	1	17%	1	17%	2	33%	2	33%	0	0%	0	0%	**3.17**
Used to improve individual clinical practice or performance	**6**	0	0%	3	50%	2	33%	1	17%	0	0%	0	0%	**3.33**

Q13. Regarding management of preterm babies, to what degree have the recommendations contained in the WHO guideline entitled Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015) been incorporated into your country's practices / procedures for the following interventions:

Interventions	Number of Respondents	5 - Completely		4 - Mostly		3 - Somewhat		2 - To a minor extent		1 - Not at all		0 - Not applicable		Average Rating
Antenatal corticosteroids to improve newborn outcomes	**6**	4	67%	1	17%	1	17%	0	0	0	0%	0	0%	**4.50**
Tocolytics for inhibiting preterm labour	**6**	4	67%	1	17%	0	0%	0	0	1	17%	0	0%	**4.17**
Magnesium sulfate for fetal protection against neurological complications	**6**	4	67%	0	0%	1	17%	0	0	0	0%	1	17%	**3.83**
Antibiotics for preterm labour	**6**	5	83%	1	17%	0	0%	0	0	0	0%	0	0%	**4.83**
Optimal mode of delivery	**6**	4	67%	2	33%	0	0%	0	0	0	0%	0	0%	**4.67**
Thermal care for Preterm newborns, including Kangaroo Care	**6**	6	100%	0	0%	0	0%	0	0	0	0%	0	0%	**5.00**
Management of newborns with respiratory distress syndrome	**6**	5	83%	1	17%	0	0%	0	0	0	0%	0	0%	**4.83**

Q14. Is there a reporting system for monitoring compliance to the national clinical guidelines (adapted from the WHO guideline entitled Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015)?

Yes/No/Don't know	Responds	Percentage
Yes	0	0%
No	6	100%

Q15. What is the current level of national compliance with the WHO guideline entitled Summary list of WHO recommendations on interventions to improve preterm birth outcomes (2015)?

Level of Adoption	Responds	Percentage
Completely	0	0%
Mostly	0	0%
Somewhat	0	0%
To a minor extent	0	0%

Not at all	0	0%
Not applicable	6	100%

WHO recommendations for augmentation of labour (2014) (Questions 16-25)

Number of Respondents (n=4)

Q16. What is your level of satisfaction with the WHO guideline entitled WHO recommendations for augmentation of labour (2014)?

Level of Satisfaction	Responds	Percentage
Very satisfied	3	75%
Satisfied	1	25%
Neutral	0	0%
Dissatisfied	0	0%
Very dissatisfied	0	0%
Not applicable	0	0%

Q17. To what extent do you find the recommendations of the WHO guideline entitled WHO recommendations for augmentation of labour (2014) useful?

Usefulness	Responds	Percentage
Extremely useful	3	75%
Mostly useful	1	25%
Somewhat useful	0	0%
Marginally useful	0	0%
Not at all useful	0	0%
Not applicable	0	0%

Q18. To what degree have you gained additional knowledge from the recommendations of WHO guideline entitled WHO recommendations for augmentation of labour (2014)?

Degree	Responds	Percentage
A great deal	2	50%
Quite a bit	1	25%
Somewhat	1	25%
Very little	0	0%
Not at all	0	0%
Not applicable	0	0%

Q19. To what extent has the WHO guideline entitled WHO recommendations for augmentation of labour (2014) Member State policies or advocacy on the subject matter?

Degree	Responds	Percentage
A great deal	2	50%
Quite a bit	2	50%
Somewhat	0	0%
Very little	0	0%
Not at all	0	0%
Not applicable	0	0%
Comments		
These are clear guidelines every obstetritian was inspiring for. Universal guidelines help planning individual plan of action		

Q20. Please rank your level of satisfaction with the following features of the WHO guideline entitled WHO recommendations for augmentation of labour (2014) and its recommendations.

Format and style		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	3	75%
Satisfied	1	25%
Neutral	0	0%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Language (appropriate and comprehensible)		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	3	75%
Satisfied	1	25%
Neutral	0	0%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Method of dissemination (print, electronic)		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	2	50%
Satisfied	1	25%
Neutral	1	25%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Comments		
Meetings for further dissemination and involvement of private sector		

Q21. Please rank the quality level of the WHO guideline entitled WHO recommendations for augmentation of labour (2014) and its recommendations in terms of:

Credibility		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	3	75%
Satisfied	1	25%
Neutral	0	0%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Authoritativeness		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	3	75%
Satisfied	0	0%
Neutral	1	25%
Dissatisfied	0	0%
Very Dissatisfied	0	0%

I Don't Know	0	0%
Timeliness		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	2	50%
Satisfied	2	50%
Neutral	0	0%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%

Q22. To what degree does the WHO guideline entitled WHO recommendations for augmentation of labour (2014) and its recommendations contribute to the health outcomes listed below.

Contributed to WHO leadership and credibility on critical RMNH issues and priorities		
Level of Adoption	**Responds**	**Percentage**
Completely	2	50%
Mostly	2	50%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Not applicable	0	0%
Contributed to setting national policy, norms and standards		
Level of Adoption	**Responds**	**Percentage**
Completely	3	75%
Mostly	1	25%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Not applicable	0	0%
Contributed to the enhancement of national programmes and practices		
Level of Adoption	**Responds**	**Percentage**
Completely	2	50%
Mostly	2	50%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Not applicable	0	0%
Used to inform decision-making in clinical, public health and policy contexts		
Level of Adoption	**Responds**	**Percentage**
Completely	2	50%
Mostly	2	50%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Not applicable	0	0%
Increased stakeholder awareness of health issues		
Level of Adoption	**Responds**	**Percentage**
Completely	2	50%
Mostly	1	25%

Somewhat	1	25%
To a minor extent	0	0%
Not at all	0	0%
Not applicable	0	0%
Used to inform and update training and education programmes		
Level of Adoption	**Responds**	**Percentage**
Completely	2	50%
Mostly	2	50%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Not applicable	0	0%
Used to guide health research agendas and methods		
Level of Adoption	**Responds**	**Percentage**
Completely	2	50%
Mostly	2	50%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Not applicable	0	0%
Used to improve individual clinical practice or performance		
Level of Adoption	**Responds**	**Percentage**
Completely	2	50%
Mostly	2	50%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Not applicable	0	0%

Q23. Regarding management of first stage of labour, to what degree have the recommendations contained in the WHO guideline entitled WHO recommendations for augmentation of labour (2014) been incorporated into your country's practices / procedures for the following interventions:

Diagnosis of delay in the first stage of labour		
Level of Adoption	**Responds**	**Percentage**
Completely	1	25%
Mostly	2	50%
Somewhat	1	25%
To a minor extent	0	0%
Not at all	0	0%
Do Not Know	0	0%
Prevention of delay in the first stage of labour		
Level of Adoption	**Responds**	**Percentage**
Completely	1	25%
Mostly	3	75%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Do Not Know	0	0%

Treatment of delay in the first stage of labour with augmentation		
Level of Adoption	**Responds**	**Percentage**
Completely	2	50%
Mostly	2	50%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Do Not Know	1	25%
Care during labour augmentation		
Level of Adoption	**Responds**	**Percentage**
Completely	2	50%
Mostly	2	50%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Do Not Know	0	0%

Q24. Is there a reporting system for monitoring compliance to the national clinical guidelines (adapted from the WHO guideline entitled WHO recommendations for augmentation of labour (2014))?

Yes/No/Don't know	Responds	Percentage
Yes	2	50%
No	2	50%

Q25. What is the current level of national compliance with the WHO guideline entitled WHO recommendations for augmentation of labour (2014)?

Level of Adoption	Responds	Percentage
Completely	1	25%
Mostly	1	25%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Not applicable	2	50%

WHO Recommendations on antenatal care (ANC) for a positive pregnancy experience (2016) (Questions 26-35)

Number of Respondents (n=15)

Q26. What is your level of satisfaction with the WHO guideline entitled WHO Recommendations on antenatal care (ANC) for a positive pregnancy experience (2016)?

Level of Satisfaction	Responds	Percentage
Very satisfied	7	47%
Satisfied	7	47%
Neutral	1	7%
Dissatisfied	0	0%
Very dissatisfied	0	0%
Not applicable	0	0%

Q27. To what extent do you find the recommendations of the WHO Selected Practiceguideline entitled WHO Recommendations on antenatal care (ANC) for a positive pregnancy experience (2016) useful?

Usefulness	Responds	Percentage
Extremely useful	4	27%
Mostly useful	9	60%
Somewhat useful	2	13%
Marginally useful	0	0%
Not at all useful	0	0%
Not applicable	0	0%

Q28. To what degree have you gained additional knowledge from the recommendations of the WHO guideline entitled WHO Recommendations on antenatal care (ANC) for a positive pregnancy experience (2016)?

Degree	Responds	Percentage
A great deal	6	40%
Quite a bit	9	60%
Somewhat	0	0%
Very little	0	0%
Not at all	0	0%
Not applicable	0	0%

Q29. To what extent has the WHO guideline entitled WHO Recommendations on antenatal care (ANC) for a positive pregnancy experience (2016) informed Member State policies or advocacy on the subject matter?

Degree	Responds	Percentage
A great deal	8	53%
Quite a bit	5	33%
Somewhat	1	7%
Very little	1	7%
Not at all	0	0%
Not applicable	0	0%

Comments

- We have considered this new recommendation to adapt our national guideline
- WHO recommendation of ANC 8 contacts is a good one but it is difficult to comply especially in the rural and hard to reach areas.
- With the WHO recommendations, the MoH has been prioritizing on increasing the coverage of ANC, in particular, the recommended 8 visits

Q30. Please rank your level of satisfaction with the following features of the WHO guideline entitled WHO Recommendations on antenatal care (ANC) for a positive pregnancy experience (2016).

Format and style		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	8	53%
Satisfied	6	40%
Neutral	1	7%
Dissatisfied	0	0%

Very Dissatisfied	0	0%
I Don't Know	0	0%
Language (appropriate and comprehensible)		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	9	60%
Satisfied	5	33%
Neutral	1	7%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Method of dissemination (print, electronic)		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	6	40%
Satisfied	6	40%
Neutral	3	20%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Comments		
I believe more interactive dissemination with not just key Ministry officials, but also their core teams may be more beneficial in generating momentum towards the adaptation of guidelines.		

Q31. Please rank the quality level of the WHO guideline entitled WHO Recommendations on antenatal care (ANC) for a positive pregnancy experience (2016) in terms of:

Credibility		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	5	33%
Satisfied	9	60%
Neutral	1	7%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Authoritativeness		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	5	33%
Satisfied	9	60%
Neutral	1	7%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%
Timeliness		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	4	27%
Satisfied	10	67%
Neutral	1	7%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	0	0%

Comments
More focus on addressing malnutrition (if evidence dictates so) would be crucial in LMIC like India would be critical.

Q32. To what degree does the WHO guideline entitled WHO Recommendations on antenatal care (ANC) for a positive pregnancy experience (2016) contribute to the health outcomes listed below.

Interventions	Number of Respondents	5 - Completely		4 - Mostly		3 - Somewhat		2 - To a minor extent		1 - Not at all		0 - Not applicable		Average Rating
Contributed to WHO leadership and credibility on critical RMNH issues and priorities	15	5	33%	8	53%	0	0%	1	7%	0	0%	1	7%	3.93
Contributed to setting national policy, norms and standards	15	5	33%	7	47%	2	13%	1	7%	0	0%	0	0%	4.07
Contributed to the enhancement of national programmes and practices	15	5	33%	6	40%	3	20%	1	7%	0	0%	0	0%	4.00
Used to inform decision-making in clinical, public health and policy contexts	15	6	40%	6	40%	1	7%	1	7%	0	0%	1	7%	3.93
Increased stakeholder awareness of health issues	15	4	27%	8	53%	2	13%	1	7%	0	0%	0	0%	4.00
Used to inform and update training and education programmes	15	7	47%	5	33%	3	20%	0	0%	0	0%	0	0%	4.27
Used to guide health research agendas and methods	15	4	27%	5	33%	4	27%	2	13%	0	0%	0	0%	3.73
Used to improve individual clinical practice or performance	15	5	33%	4	27%	4	27%	2	13%	0	0%	0	0%	3.80

Q33. Regarding antenatal care, to what degree have the WHO guideline entitled WHO Recommendations on antenatal care (ANC) for a positive pregnancy experience (2016) been incorporated into your country's practices / procedures for the following interventions:

Interventions	Number of Respondents	5 - Completely		4 - Mostly		3 - Somewhat		2 - To a minor extent		1 - Not at all		0 - Not applicable		Average Rating
Dietary interventions	15	4	27%	8	53%	2	13%	1	7%	0	0%	0	0%	4.00
Iron and folic acid supplements	15	8	53%	7	47%	0	0%	0	0%	0	0%	0	0%	4.53
Calcium supplements	15	7	47%	4	27%	1	7%	1	7%	2	13%	0	0%	3.87
Vitamin A supplements	15	6	40%	3	20%	4	27%	0	0%	1	7%	1	7%	3.67
Zinc supplements	15	2	13%	5	33%	4	27%	1	7%	2	13%	1	7%	3.07
Multiple micronutrient supplements	15	3	20%	6	40%	3	20%	1	7%	1	7%	1	7%	3.40

Vitamin B6 (pyridoxine) supplements	**15**	3	20%	5	33 %	2	13%	3	20%	1	7%	1	7%	**3.20**
Vitamin E and C supplements	**15**	3	20%	4	27 %	3	20%	2	13%	1	7%	2	13%	**3.00**
Vitamin D supplements	**15**	3	20%	6	40 %	2	13%	1	7%	1	7%	2	13%	**3.20**
Restricting caffeine intake	**15**	1	7%	8	53 %	3	20%	1	7%	1	7%	1	7%	**3.27**
Anaemia	**15**	7	47%	7	47 %	1	7%	0	0%	0	0%	0	0%	**4.40**
Asymptomatic bacteriuria (ASB)	**15**	3	20%	4	27 %	3	20%	0	0%	1	7%	4	27%	**2.73**
Intimate partner violence (IPV)	**15**	4	27%	4	27 %	2	13%	2	13%	1	7%	2	13%	**3.13**

Comment

IPV is considered culturally sensitive and therefore doesn't prominently figure in the discussions.

Q34. Is there a reporting system for monitoring compliance to the national clinical guidelines (adapted from the WHO guideline entitled WHO Recommendations on antenatal care (ANC) for a positive pregnancy experience (2016))?

Yes/No/Don't know	Responds	Percentage
Yes	9	60%
No	6	40%

Q35. If yes, what is the current level of national compliance with the WHO guideline entitled WHO Recommendations on antenatal care (ANC) for a positive pregnancy experience (2016)?

Level of Adoption	Responds	Percentage
Completely	1	7%
Mostly	3	20%
Somewhat	3	20%
To a minor extent	1	7%
Not at all	1	7%
Not applicable	6	40%

WHO Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015) (Questions 36-51)

Number of Respondents (n=8)

Q36. Regarding family planning and reproductive health, to what extent are the following methods of contraception available in your country?

Combined pills, COC (low dose combined oral contraceptives, with ≤ 35 µg ethinyl estradiol)

Level of Adoption	Responds	Percentage
Completely	7	88%
Mostly	1	13%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Do not Know	0	0%

Combined contraceptive patch, P		
Level of Adoption	**Responds**	**Percentage**
Completely	1	13%
Mostly	0	0%
Somewhat	1	13%
To a minor extent	1	13%
Not at all	5	63%
Do not Know	0	0%
Combined contraceptive vaginal ring, CVR		
Level of Adoption	**Responds**	**Percentage**
Completely	1	13%
Mostly	0	0%
Somewhat	1	13%
To a minor extent	0	0%
Not at all	6	75%
Do not Know	0	0%
Combined injectable contraceptives, CIC		
Level of Adoption	**Responds**	**Percentage**
Completely	2	25%
Mostly	1	13%
Somewhat	1	13%
To a minor extent	2	25%
Not at all	2	25%
Do not Know	0	0%
Progestogen-only pills, POP		
Level of Adoption	**Responds**	**Percentage**
Completely	2	25%
Mostly	3	38%
Somewhat	1	13%
To a minor extent	0	0%
Not at all	2	25%
Do not Know	0	0%
Progestogen-only injectables, DMPA (IM,SC)/NET-EN (depot medroxyprogesterone acetate intramuscular or subcutaneous or norethisterone enantate intramuscular)		
Level of Adoption	**Responds**	**Percentage**
Completely	7	88%
Mostly	1	13%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Do not Know	0	0%
Progestogen-only implants, LNG/ETG (levonorgestrel or etonogestrel)		
Level of Adoption	**Responds**	**Percentage**
Completely	4	50%
Mostly	4	50%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Do not Know	0	0%

Levonorgestrel-releasing intrauterine device, LNG-IUD		
Level of Adoption	**Responds**	**Percentage**
Completely	2	25%
Mostly	1	13%
Somewhat	0	0%
To a minor extent	3	38%
Not at all	2	25%
Do not Know	0	0%
Copper-bearing intrauterine device, Cu-IUD		
Level of Adoption	**Responds**	**Percentage**
Completely	6	75%
Mostly	2	25%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Do not Know	0	0%

Q37. What is your level of satisfaction with the WHO Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015)?

Level of Satisfaction	Responds	Percentage
Very satisfied	4	50%
Satisfied	3	38%
Neutral	0	0%
Dissatisfied	0	0%
Very dissatisfied	0	0%
Not applicable	1	13%

Q38. To what extent do you find the recommendations of the WHO Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015) useful?

Usefulness	Responds	Percentage
Extremely useful	5	63%
Mostly useful	2	25%
Somewhat useful	0	0%
Marginally useful	0	0%
Not at all useful	0	0%
Not applicable	1	13%

Q39. To what degree have you gained additional knowledge from the recommendations of WHO Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015)?

Degree	Responds	Percentage
A great deal	6	75%
Quite a bit	1	13%
Somewhat	0	0%
Very little	0	0%
Not at all	0	0%
Not applicable	1	13%

Q40. To what extent has the WHO Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015) informed Member State policies or advocacy on the subject matter?

Degree	Responds	Percentage
A great deal	4	50%
Quite a bit	3	38%
Somewhat	0	0%
Very little	0	0%
Not at all	0	0%
Not applicable	1	13%

Q41. Please rank your level of satisfaction with the following features of the WHO Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015)?

Format and style		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	4	50%
Satisfied	3	38%
Neutral	0	0%
Dissatisfied	0	0%

Very Dissatisfied	0	0%
I Don't Know	1	13%

Language (appropriate and comprehensible)		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	2	25%
Satisfied	5	63%
Neutral	0	0%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	1	13%

Method of dissemination (print, electronic)		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	3	38%
Satisfied	4	50%
Neutral	0	0%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	1	13%

Comments
Indonesia has adapted the MEC 2015 into Bahasa Indonesia and develop the iOS and android web based applications
Adapted for Persons with Disability

Q42. Please rank the quality level of the WHO Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015) in terms of:

Credibility		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	2	25%
Satisfied	5	63%
Neutral	0	0%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	1	13%

Authoritativeness		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	2	25%
Satisfied	5	63%
Neutral	0	0%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	1	13%

Timeliness		
Level of Adoption	**Responds**	**Percentage**
Very Satisfied	2	25%
Satisfied	3	38%
Neutral	2	25%
Dissatisfied	0	0%
Very Dissatisfied	0	0%
I Don't Know	1	13%

Comments

Q43. To what degree does the WHO Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015) and the MEC Wheel / Mobile app contribute to the health outcomes listed below.

Interventions	n	5 - Completely		4 - Mostly		3 - Somewhat		2 - To a minor extent		1 - Not at all		0 - Not applicable		Average Rating
Contributed to WHO leadership and credibility on critical RMNH issues and priorities	7	2	29%	5	71%	0	0%	0	0%	0	0%	0	0%	4.29
Contributed to setting national policy, norms and standards	7	3	43%	4	57%	0	0%	0	0%	0	0%	0	0%	4.43
Contributed to the enhancement of national programmes and practices	7	3	43%	4	57%	0	0%	0	0%	0	0%	0	0%	4.43
Used to inform decision-making in clinical, public health and policy contexts	7	4	57%	3	43%	0	0%	0	0%	0	0%	0	0%	4.57
Increased stakeholder awareness of health issues	7	2	29%	4	57%	1	14%	0	0%	0	0%	0	0%	4.14
Used to inform and update training and education programmes	7	4	57%	3	43%	0	0%	0	0%	0	0%	0	0%	4.57
Used to guide health research agendas and methods	7	1	14%	4	57%	2	29%	0	0%	0	0%	0	0%	3.86
Used to improve individual clinical practice or performance	7	4	57%	3	43%	0	0%	0	0%	0	0%	0	0%	4.57

Q44. Regarding family planning and reproductive health, to what degree have the WHO Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015) and the MEC Wheel / Mobile app been incorporated into your country's practices / procedures for the following interventions:

Interventions	Number of Respondents	5 - Completely		4 - Mostly		3 - Somewhat		2 - To a minor extent		1 - Not at all		0 - Not applicable		Average Rating
Combined hormonal contraceptive (CHC) (CHCs include combined oral contraceptives, combined injectable contraceptives, combined patch and combined vaginal ring)	7	2	29 %	4	57 %	0	0%	0	0%	1	14%	0	0%	3.86
Progestogen-only contraceptive (POC) use (POCs include progestogen-only pills, implants and injectables)	7	2	29 %	4	57 %	0	0%	0	0%	1	14%	0	0%	3.86
Levonorgestrel-releasing intrauterine device (LNG-IUD)	7	1	14 %	3	43 %	0	0%	1	14%	2	29%	0	0%	3.00
Subcutaneously-administered depot medroxyprogesterone acetate (DMPA-SC)	7	3	43 %	3	43 %	1	14%	0	0%	0	0%	0	0%	4.29
Comment														
Combined patch and combined vaginal ring is not available in Bhutan														

Q45. Combined hormonal contraceptive (CHC) (CHCs include combined oral contraceptives, combined injectable contraceptives, combined patch and combined vaginal ring)?

Yes/No/Don't know	Responds	Percentage
No, national programme guidelines are compatible with MEC criteria	6	75%
Yes, national programme guidelines do specify medical contraindications or other reasons for not prescribing a method of contraception that are not compatible with the MEC criteria	0	0%
I don't know	2	25%
Comments		
Its not available in Bhutan		

Q46. Progestogen-only contraceptive (POC) use (POCs include progestogen-only pills, implants and injectables)

Yes/No/Don't know	Responds	Percentage
No, national programme guidelines are compatible with MEC criteria	4	50%
Yes, national programme guidelines do specify medical contraindications or other reasons for not prescribing a method of contraception that are not compatible with the MEC criteria	2	25%
I don't know	2	25%
Comments In Myanmar, we do not use progestogen-only contraceptive (POC) as one of the contraceptive method.		

Q47. Levonorgestrel-releasing intrauterine device (LNG-IUD)

Yes/No/Don't know	Responds	Percentage
No, national programme guidelines are compatible with MEC criteria	4	50%
Yes, national programme guidelines do specify medical contraindications or other reasons for not prescribing a method of contraception that are not compatible with the MEC criteria	2	25%
I don't know	2	25%
Comments		
We do not use levonogestrel-relasing intrauterine device as one of the family planning method.		

Q48. Subcutaneously-administered depot medroxyprogesterone acetate (DMPA-SC)

Yes/No/Don't know	Responds	Percentage
No, national programme guidelines are compatible with MEC criteria	5	63%
Yes, national programme guidelines do specify medical contraindications or other reasons for not prescribing a method of contraception that are not compatible with the MEC criteria	1	13%
I don't know	2	25%

Q49. To what degree extent has the WHO Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015) and the MEC Wheel / Mobile app been used in your country.

WHO Medical eligibility criteria for contraceptive use (MEC)		
Level of Adoption	**Responds**	**Percentage**
Completely	3	38%
Mostly	4	50%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Do not Know	1	13%
Translated version of the WHO Medical eligibility criteria for contraceptive use (MEC)		
Level of Adoption	**Responds**	**Percentage**
Completely	3	38%
Mostly	3	38%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	1	13%

Do not Know	1	13%
MEC Wheel		
Level of Adoption	**Responds**	**Percentage**
Completely	3	38%
Mostly	4	50%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Do not Know	1	13%
Mobile App for WHO's Medical eligibility criteria		
Level of Adoption	**Responds**	**Percentage**
Completely	1	13%
Mostly	1	13%
Somewhat	3	38%
To a minor extent	1	13%
Not at all	0	0%
Do not Know	2	25%

Q50. Is there a reporting system for monitoring compliance to the national clinical guidelines (adapted from the WHO Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015))?

Yes/No/Don't know	Responds	Percentage
Yes	1	13%
No	7	88%

Q51. What is the current level of national compliance with the WHO Medical eligibility criteria for contraceptive use (MEC), fifth edition (2015)?

Level of Adoption	Responds	Percentage
Completely	0	0%
Mostly	1	13%
Somewhat	0	0%
To a minor extent	0	0%
Not at all	0	0%
Not applicable	7	88%