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WHO PROGRAMME TO MAP BEST REPPRODUCTIVE HEALTH PRACTICES

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The WHO Programme To Map Best Reproductive Health Practices was initiated by the Department of Reproductive Health and Research, W.H.O. in 1997. This Programme includes activities to generate evidence by conducting primary research, synthesizing relevant evidence through systematic reviews and disseminating evidence on best practices through the WHO Reproductive Health Library (RHL). RHL is an annually updated specialist database in reproductive health targeting health workers in developing countries and is available on a free-subscription basis in these countries. RHL includes Cochrane systemátic reviews from The Cochrane Library, commentaries specially written for RHL and other useful information.

Published in English and Spanish, RHL currently has around 10,000 subscribers worldwide. A Chinese version is being prepared and the sixth issue will be published in early 2003.

Questions important in developing countries are regularly identified and systematic reviews conducted to answer these questions. These activities are undertaken with a capacity building component where training in systematic review methodology is provided.

Altogether, the Programme conducts research in implementation of reproductive health practices, systematic reviews in reproductive health and disseminates globally, reliable and up-to-date information on best practices in developing countries.

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IMPLEMENTING EVIDENCE-BASED PRACTICES IN CHILDBIRTH: THE "BETTER BIRTHS" INITIATIVE (BBI)

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In the past two decades, considerable evidence has been produced regarding the effectiveness or otherwise of childbirth procedures. Evidence from randomized trials has been synthesized in systematic reviews published in the Cochrane Library and the WHO Reproductive Health Library (RHL). The RHL is distributed by free subscription to health workers in low-income countries.

Despite the availability of evidence, surveys in resource-poor countries show that women using state maternity services are often subjected to uncomfortable and degrading procedures for which there is no evidence of benefit. They will then avoid services where there is a community perception of poor quality obstetric care.

Procedures for which there is no evidence of effectiveness include confinement to bed, routine starvation, routine early amniotomy, birth in the supine position and routine episiotomy. Procedures with evidence of effectiveness include childbirth companionship, magnesium sulphate for eclampsia, and active management of the third stage of labour.

The Births Initiative (BBI) is a new strategy developed by health professionals in South Africa and internationally, to help provide a better quality of childbirth care for women and improve maternal outcomes in low-income countries.

The purpose of the initiative is to improve the quality of care by encouraging health care workers to abandon practices that are painful, uncomfortable, and potentially harmful and have no evidence of benefit, and to implement effective procedures. This means women will have a better experience of childbirth.

Principles of the BBI:

Humanity : women to be treated with respect

Benefit: care that is based on the best available evidence
Commitment: health professionals committed to improving care
Action: effective strategies to change current practices
BBI Materials
These include a workbook, posters, video presentation, a slide power point presentation of best evidence for procedures during labour, a reference booklet, and a self-audit mechanism. The video programme shows real experiences of implementing companionship in labour wards in South Africa.
The BBI materials are available free of charge on the WHO Reproductive Health Library, from rhl@who.int , and on the BBI website: http://www.liv.ac.uk/lstm/EHCP.html. Accessing these materials and the evidence on childbirth procedures from the RHL will be demonstrated during the presentation.

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WHO ANTENATAL CARE RANDOMISED TRIAL FOR THE EVALUATION OF A NEW MODEL OF ROUTINE ANTENATAL CARE

Guillermo Carroli, *on behalf of the Antenatal Care Trial Research Group*

Most of the antenatal care models currently in use around the world have not been subjected to rigorous scientific evaluation to determine their effectiveness. Despite a widespread desire to improve maternal care services, this lack of "hard" evidence has impeded the identification of effective interventions and thus the optimal allocation of resources. In developing countries, routinely recommended antenatal care programmes are often poorly implemented and clinical visits can be irregular, with long waiting times and poor feedback to the women.
To address this paucity of information, the UNDP/UNFPA/WHO/World Bank Special Programme for Research, Development and Research Training in Human Reproduction (HRP) implemented a multicentre randomised controlled trial that compared the standard "Western" model of antenatal care with a new WHO model that limits the number of visits to the clinic and restricts the tests, clinical procedures and follow-up actions to those that have been proven by solid research evidence to improve outcomes for women and newborns.
Clinics in Argentina, Cuba, Saudi Arabia, and Thailand were randomly allocated to provide either the new model (27 clinics) or the standard model (26 clinics). All women presenting for antenatal care at these clinics were enrolled. Women enrolled in clinics offering the new model were classified on the basis of history of obstetric and clinical conditions. Those who did not require further specific assessment or treatment received the new model, and those deemed at higher risk received the usual care for their conditions.
Women attending clinics assigned the new model (n= 12568) had a median of 5 visits compared with 8 visits within the standard model (n= 11958).
The results of this trial showed that there were no significant differences between the new and standard model in terms of severe postpartum anaemia (new model: 7.59% vs standard model: 8.67%) , pre-eclampsia/eclampsia (1.69% vs 1.38%), urinary-tract infections (5.95% vs 7.41%) or low-birth-weight infants (7.68% vs 7.14%). Adjustment by several confounding variables did not modify this pattern. Similarly, there were no significant differences in secondary outcomes for either women or infants, including the rates of maternal and neonatal death. Women and providers in both groups were satisfied with the care received, although some women assigned the new model expressed some concern about the timing of visits. There was no cost increase, and in some settings the new model decreased cost.
Provision of routine antenatal care by the new model seems not to affect maternal and perinatal outcomes. It could be implemented without major resistance from women and providers and may reduce cost.