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.

L30 & L31

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.

L36

MEDICAL MANAGEMENT OF ECTOPIC PREGNANCIES

Jaideep Malhotra, Narendra Malhotra, *Malhotra Test Tube Baby Centre, Agra*

Ectopic pregnancy is still the number one cause of maternal even in the developed countries like USA. The incidence is around 20% of all pregnancies the incidence of ectopic pregnancy is on the rise (6 fold increase) due to the increase in sexually transmitted diseases, PID and ART procedures.
If we can diagnose ectopic pregnancy early by the routine use of TVS & color doppler we might be able to offer a medical option to these patients and save them from surgery.
The medical option of treatment of ectopic could be local injections of anti trophoblastic drugs or systemic injections. It has to be kept in mind that to offer medical option a strict preselection criteria must be observed specially a sac size of < 3.5 cm and a _ HCG of less than 10,000 units with systemic methotrexate use as single injection or variable region the success role. In one study (n = 75 cases) was 90% as compared to Speroff 94 (95%) & Slaughter 95 (92%). A non-responsive rate and tubal rupture was seen in 3-4%. Only 3-10% pts. have shown side effects.Medical treatment is safe and very effective in property selected cases
Today a Risk approach to all antenatal and intrapartum cases in strangly advisable.

L37

CERVICAL PATHOLOGIES IN PREGNANCY

Fuat Demirkıran, *Istanbul University, Cerrahpaşa Medical Faculty Department of OB&GYN Division of Gynecologic Oncology, İstanbul, Turkey*

Cervical cancer and its preinvasive lesions are the first and second gynecologic malignancy in developing countries. Also in these countries, the pregnancy rate is high. So, cervical pathology is the most common gynecologic malignancy in pregnant women in developing country. When we look at the statistics of developed country, we also see that cervical pathology the first and second gynecologic malignancy in obstetrics practice. Cervical preinvasive and invasive lesions are seen one per 700-2000 pregnancies. Essentially, diagnostic and therapeutic approaches of this disease are similar to non-pregnant women. The key issue is to think possibility of cervical pathology at the management of a pregnant woman and to be aware of necessity of cervical evaluation in pregnancy.
In pregnant women, preinvasive pathologies are mostly asymptomatic and cervical screening programs using vaginal cytology and colposcopy perform their diagnoses. Punch biopsy and leep excision from cervix can be made easily with insignificant complication in pregnant women, especially in first trimester. However, indication of conization is highly limited, because of the possibility of ominous hemorrhage. Treatment of these lesions may be postponed after the delivery, but at this approach, micro invasive cancer should be eliminated.
With respect to invasive cervical cancer, the firstly there seems to be no prognostic difference between patients treated in pregnancy and non-pregnant patients with the same stage of disease. That is, pregnancy is not effect prognosis of disease. During the first two trimesters the treatment is carried out along the same principles in non-pregnant patients. The patient is treated without respect to the pregnancy. In advanced pregnancy with viable a fetus, Cesarean section is carried out. Afterwards the patient is treated in the same way as a non-pregnant pregnant woman.