Report of the Second Regional Francophone West Africa Postabortion Care Meeting: Strengthening Postabortion Family Planning

July 2014

E2A Overview

The Evidence to Action (E2A) Project is the US Agency for International Development's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A five-year Cooperative Agreement awarded in September 2011, E2A is led by Pathfinder International in partnership with the African Population and Health Research Center, ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

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Acronyms

AYSRH	Adolescent and Youth Sexual and Reproductive Health
BCC	Behavior Change Communication
CEFOREP	Centre Régional de Formation, de Recherche et de Plaidoyer en Santé de la Reproduction
E2A	Evidence to Action Project
EmONC	Emergency Obstetric and Neonatal Care
FP	Family Planning
FIGO	International Federation of Gynaecology and Obstetrics
IBP	Implementing Best Practices Initiative
ICM	International Confederation of Midwives
LARCs	Long-Acting Reversible Contraceptives
LMS	Leadership Management and Sustainability
LA/PM	Long Acting and Permanent Methods
MAEE	Ministère des Affaires Etrangères (France)/ French Foreign Affairs Ministry
MCH	Maternal Child Health
MMR	Maternal Mortality Rate
MSH	Management Sciences for Health
MPPD	Medical Protect and Procurement Department
MVA	Manual Vacuum Aspiration
PAC	Postabortion Care
PNA	Pharmacie Nationale d'Approvisionnement (National Supply Pharmacy)
PNP	Policy/Norms and Protocols
PM	Permanent Methods
PRA	Pharmacie Régionale d'Approvisionnement (Regional Supply Pharmacy)
RH	Reproductive Health
USAID	US Agency for International Development
VFCP	Virtual Fostering Change Program
WHO	World Health Organization

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Introduction

The management of complications arising from abortion is an essential component of strategies to reduce maternal mortality. Of the approximately 210 million pregnancies that occur annually around the world, nearly 80 million are unintended. Furthermore, of the approximately 35 million induced abortions each year, 20 million are unsafe—that is, performed by people lacking the necessary skills, in an environment that does not meet minimal medical standards, often in unhygienic conditions, and using inappropriate tools or materials. Unsafe abortions result in nearly 67,000 abortion-related deaths annually. Those 67,000 deaths account for 13% of all pregnancy-related maternal deaths. It is widely acknowledged that the availability of contraceptives that are accessible and consistently and correctly used to avoid pregnancy would result in an estimated 25-35% decline in maternal mortality. The High Impact Practice brief *Postabortion Family Planning: Strengthening the family planning component of postabortion care* presents strong evidence that reorganizing services to provide counseling and contraceptives at the same time and in the same location as emergency treatment for abortion complications increases contraceptive use and reduces repeat, unintended pregnancies.

This report gives a brief status of the history of postabortion care (PAC) programs in Francophone West Africa and efforts to improve PAC services. This history serves as context for a workshop held in October 2013, where the USAID-funded Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A) Project disseminated findings from its assessment of PAC programs in Burkina Faso, Guinea, Senegal, and Togo. At the 2013 workshop, representatives from seven Francophone West African countries, plus representatives from Cameroon and Rwanda, came together with local and international implementing partners and donors to share knowledge about PAC best practices and/or to develop roadmaps for strengthening PAC programs in their countries. Summaries of presentations from that conference and other supporting information are found in the body and annexes of this report.

1. Background

1.1 PAC Initiative in Francophone West Africa

The PAC model was first introduced to West Africa through operations research in Senegal and Burkina Faso. In 1998, *Projet de Recherche Operationnelle et d'Assistance Technique en Afrique II* introduced PAC services to Senegal as an operations research pilot project in collaboration with Jhpiego, the Ministry of Health (MOH), and *Centre Régional de Formation, de Recherche et de Plaidoyer en Santé de la Reproduction* (CEFOREP). The pilot project was based on an integrated model of PAC that included:

- Management of abortion complications, including introduction of manual vacuum aspiration (MVA) for the treatment of incomplete abortion;
- Family planning (FP) services and counseling and selected reproductive health (RH)-related treatment or referral (STI, HIV)
- Community empowerment through community awareness and mobilization

Meetings organized by the PAC Initiative

- 2002 conference in Dakar on the expansion of high-quality, sustainable, and easily accessible PAC services

- 2004 meeting of PAC country focal points in Cotonou to review progress made in the introduction of PAC; presentations revealed different stages of progress among several countries

- 2006 conference in Dakar, with the objective to facilitate the acceleration of PAC service implementation

Between 2002 and 2008, a consortium of international and regional partners organized a series of conferences and workshops. The consortium established the "PAC Initiative for the Francophone Africa Committee" to address the programmatic issues of increasing access to and improving the quality of

PAC services in Francophone Africa, as well as advocating for FP services and counseling during PAC, based on research conducted in the region. The PAC Initiative organized a number of conferences and meetings (see box above).

1.2 2008 Saly Workshop: Introduction of High Impact Best Practices for Scale-Up of PAC in Francophone West Africa

In 2008, the United States Agency for International Development (USAID), the World Health Organization (WHO), the Implementing Best Practices (IBP) Consortium, the Initiative Francophone Régionale, and CEFOREP organized a workshop, entitled "Introduction of High Impact Best Practices for Scale-Up of PAC in Francophone West Africa." The meeting was held in Saly, Senegal and participants included: representatives from USAID Washington and WHO/IBP; MOH RH and maternal and child health (MCH) teams; WHO/RH officers; and PAC stakeholders from Burkina Faso, Cameroon, Guinea, Mali, Niger, Rwanda, Senegal, and Togo.

Representatives of USAID cooperating agencies supporting PAC in the countries mentioned above also attended the meeting, including: Jhpiego (Guinea), IntraHealth (Senegal and Rwanda), and Management Sciences for Health (leadership and management development program and fostering change program in multiple countries). Representatives from each country attending the 2008 workshop gave a brief report on the challenges and successes of PAC services based on questions asked by the workshop organizers. The teams also worked together to develop action plans for strengthening postabortion family planning (PAC-FP) in their countries. Findings from the assessment conducted by CEFOREP were disseminated at the meeting. Those findings revealed that in the six countries assessed, notable progress had been achieved throughout the previous decade, with the pilot countries (Senegal, Burkina Faso, and Guinea) continuing to be leaders. Nevertheless, some major challenges still remained, including those related to:

- Communities' involvement through local authorities and municipalities;
- Sustainability of achievements in strengthening PAC;
- Improvement in the provision and quality of national PAC services;
- Ensuring continuity of care, especially outside of normal facility business hours;
- General counseling and efficient FP;
- Ensuring a continuous supply of functioning MVA kits and constant availability of FP commodities at point of treatment; and
- Supervision.

During the workshop, the Leadership, Management and Sustainability (LMS) Project introduced the Fostering Change methodology and country teams developed action plans to strengthen PAC-FP in their countries based on the findings of CEFOREP's assessment. The 2009 – 2010 action plans for four countries (Burkina Faso, Guinea, Senegal, and Togo) involved service reorganization and training in PAC service provision, the supply of FP commodities and MVA kits, advocacy for funding, and community involvement.

1.3 Implementation of Action Plans through the Virtual Fostering Change Program

As a follow-up to the workshop, between January 2009 and March 2010, the LMS project and Jhpiego facilitated a Virtual Fostering Change Program (VFCP) for PAC clinical support to help countries systematically implement their action plans to strengthen PAC-FP services at select health facilities. Some country team members from Burkina Faso, Guinea, and Togo were able to complete the VFCP, while others did not finish due to difficulties with Internet access and other competing responsibilities. In Togo, teams from the Division of Family Health and selected health facilities participated in a face-to-face leadership development and management training as well as PAC trainings.

1.4 E2A Assessment of Progress in Implementation of Action Plans

In 2012, USAID/Washington provided funding to the E2A project to conduct an assessment of progress made in implementing the action plans refined under the VCFP for PAC. E2A assessed the processes required to successfully strengthen and possibly sustain (at the institutional level) FP within PAC services in four Francophone West African countries (Burkina Faso, Guinea, Senegal, and Togo). The assessment sought to understand the role that the VFCP for PAC played in assisting countries to strengthen PAC-FP services. The assessment methodology involved a three-pronged approach, which included: a desk review, qualitative key informant interviews and focus group discussions, and a review of quantitative data from health facility registers. E2A interviewed country team members who attended the 2008 Saly meeting, other country-level implementers, and technical assistance providers or facilitators (Jhpiego, Engenderhealth, Management Sciences for Health, IntraHealth International, WHO/IBP, and USAID/Washington). Focus group discussions were held with service providers from the health facilities selected by each country team for implementation of the action plan.

2. 2013 Saly Meeting Workshop

2.1 Purpose

The stated purpose of the 2013 Saly workshop was to share progress towards implementation of PAC-FP in Francophone West Africa since 2008, exchange country experiences, and provide global updates and tools/effective practices to further strengthen PAC-FP programs and map a way forward. The workshop was held at the Palm Beach Hotel in Saly**,** Portudal, 100km from Dakar and brought together 85 participants (policymakers, academicians, service providers, public health specialists, program managers,) with expertise in PAC (see Annex 1: List of Meeting Participants).

2.2 Objectives

1. Provide global updates:
    - Justify the need to strengthen PAC-FP
    - Introduce permanent and long-acting contraceptive methods as viable methods for PAC clients
    - Describe methodologies for scale-up.
    - Describe integrated/holistic programming.

2. Promote experience-sharing between countries:
    - Share results from the assessment conducted by E2A in four countries.
    - Present program updates by country teams, with examples of policy and guidelines related to provision of PAC services, training curricula, and reliable data showing what works and what does not work.

3. Develop action plans aiming to reach new targets:
    - Identify existing national roadmaps, plans, and strategies to determine documents through which postabortion FP services can be extended gradually.
    - Establish donors' and stakeholders' commitment.
    - Define preliminary actions/steps for strengthening PAC-FP services, including elements of holistic/integrated programming, how long-acting reversible contraceptives (LARCs) and permanent methods (PMs) will be included and the selected scale-up approach.

The following sections summarize presentations, concurrent sessions, and small group work that took place during the workshop, which highlight the status of PAC-FP in Francophone West African countries (plus Rwanda).

2.3 Country Experiences: Success and Challenges in PAC-FP Programming

2.3.1 Postabortion Family Planning: "Let's celebrate our successes and embrace new opportunities 2008/2013," Carolyn Curtis, USAID

Ms. Curtis emphasized the magnitude of the problem (20 million unsafe abortions in the world every year that account for 13% of maternal deaths) and the importance of PAC services to the management of abortion complications. Prevention of these conditions ultimately involves better access to contraception to prevent unwanted pregnancies that may result in abortions. Ms. Curtis noted in her presentation that among PAC clients, 20% had had a previous abortion, 60% were interested in using an FP method, and only 27% left the facility with a contraceptive method in hand. She also mentioned that women 25 years and older seek unsafe abortions at a 20% higher rate than younger women up to the age of 25. However, because of unfavorable socioeconomic conditions and delays in seeking care, the mortality rate observed in those under 25 years was proportionally higher. For this reason, more attention should be paid to this age group and to PAC services for youth.

Reflecting on the 2008 Saly workshop, Ms. Curtis noted that four countries (Burkina Faso, Guinea, Senegal, and Togo) had developed and implemented action plans tailored to the needs of 12 health facilities and received follow-up through the VFCP. Despite several achievements (training, creation of PAC units separate from other obstetric emergency services, and availability of FP commodities in MVA rooms), ensuring access to PAC-FP has remained a challenge in relation to national standards, the health system, service providers, and clients.

To facilitate the implementation of solutions at the programmatic level, Ms. Curtis reminded participants of the consensus statement on PAC-FP, which was approved by International Federation of Gynecology and Obstetrics (FIGO), the International Confederation of Midwives (ICM), The White Ribbon Alliance, DFID, and the Bill and Melinda Gates Foundation.

2.3.2 From Saly 2008 to Saly 2013: Assessment from PAC Programs in Burkina Faso, Guinea, Senegal, and Togo, Fariyal Fikree and Stembile Mugore, E2A Project

Dr. Fariyal Fikree and Ms. Stembile Mugore of E2A presented the results of the four-country PAC assessment. The main results from this assessment were, in summary: PAC-FP services were available in all countries, counseling was insufficient in Senegal, and provision of contraceptive methods was limited in Burkina Faso, Senegal, and Togo. The cost of services, as reported by clients, was considered high in all countries.

At the national level, the assessment revealed the need to promote and make available a range of FP methods to PAC clients. Training service providers also emerged as a key component to enable clients' access to FP methods at point of treatment. The need for advocacy for the provision of free FP commodities was raised as an issue in all four of the countries. The E2A assessment specifically conveyed the need for the following:

- A dedicated PAC room;
- PAC services that are available 24 hours per day, 7 days per week, with a variety of FP methods and well-maintained client registers;

- Qualified staff who provide a package of PAC services incorporating MVA, counseling and provision of FP services, which is based on national policy, norms, and protocols;
- A sustainable system for ensuring pre-service and ongoing training of staff involved in PAC-FP services;
- Improved supply chain management of MVA kits and FP commodities;
- Promotion of the provision of diversified FP methods; and
- Advocacy for resource mobilization.

Discussion:
From discussions following the presentation, a recommendation was made about the approach to be applied in the presentation of results—it was suggested that target facilities be identified rather than generalizing the results to countries. Two corrections about PAC services in Senegal were raised: PAC services are actually included in Senegal's protocols and policy documents, and contraceptive commodities are available in warehouses. A question was raised on the meaning of the concept "one-stop-shop" for PAC clients. The "one-stop-shop" was defined as a room where the whole PAC service package is provided onsite to clients. Feasibility of this "one-stop-shop" was questioned given the shortage of health workers as well as the availability of a dedicated space. In conclusion, the presenter emphasized the importance of the availability of FP products and training of service providers to improve service provision and meet demand. Participants received four briefs for review, detailing the assessment in each of the four countries. Final versions of those briefs can be downloaded here: Burkina Faso, Guinea, Senegal, and Togo.

2.3.3 Prevalence and Impact of Abortion in West Africa, Michel Brun, UNFPA

Dr. Michel Brun presented findings from a recent needs assessment of emergency obstetric and neonatal care (EmONC) conducted by UNFPA in 12 countries in West Africa (Benin, Burkina Faso, Cote d'Ivoire, Gambia, Ghana, Liberia, Niger, Sierra Leone, and Togo) and Central Africa (Cameroon, Chad, Democratic Republic of Congo). Data were collected from health facility records and interviews with health care workers. Findings among the countries represented at the workshop included:

- Abortion-related maternal mortality is as high as 28% in health facilities in Burkina Faso and 6% and 5% in Cameroon and Niger respectively.
- Availability of PAC guidelines and protocols at the facility level is limited; 45% of health facilities in Burkina Faso had guidelines and 25% of health facilities in Togo had guidelines.

Service providers lacked knowledge about PAC:

- Complicated abortion: 2% to 53% of providers were able to identify all of the complications.
- Treatment of complications: 0.3% to 44% of providers were able to mention the complete treatment.
- Counseling: 5% to 37% of providers were able to state all information to be provided to patients following treatment for abortion complications.

Records revealed that 45% of facilities in Togo and 40% of facilities in the Gambia had provided PAC-FP in the previous three months. The percentage of health facilities that had provided PAC services three months prior to the assessment was not documented for the other countries due to lack of data; incomplete data reflected the lack of attention given to PAC. In addition, when information was available, the data showed the magnitude of the problem of PAC and persistent challenges.

Recommendations from this review were as follows:

- Create conditions for the integrated provision of PAC services.

- Improve monitoring and recording of abortions in special registers.
- Promote delegation of tasks to midwives and improve the training of service providers to enable them to manage PAC, especially diagnosis and treatment (MVA) and postabortion counseling.
- Provide better follow-up and evaluation of PAC services.

Discussion:
These interventions were primarily linked to the methodology of EmONC surveys. In fact, some participants requested there be a much better definition of direct and indirect maternal death causes and a less restrictive definition of Basic EmONC, thus avoiding the exclusion of any facility not providing one of the seven Basic EmONC functions, for example. The presenter noted that these concepts (Basic EmONC, Comprehensive EmONC) had been validated long ago internationally and that it would be better to focus on making available the seven basic functions rather than excluding one of them. Other participants raised doubts about the reliability of the data presented. Regarding the possibility of bias, the presenter stated that the EmONC surveys used standard methodology, based on a representative sampling of health facilities in the country and included a review of all records, providers' interviews, and an information verification process.

Another participant mentioned the insufficient delegation of tasks to midwives in Cameroon, emphasizing the crucial role of midwives in Basic EmONC procedures. Along the same lines, the presenter deplored the underemployment of midwives in some countries and stressed the importance of transferring skill competencies in order to reach a larger number of women. The presenter urged the audience to introduce new programs and insisted on creating conditions conducive for comprehensive PAC, because the data showed that women were not receiving all PAC services.

2.3.4 Summary of the PAC Experience in Eight Countries

A questionnaire assessing national PAC programs in eight countries, including the type of complications noted and clients' profiles, was sent to participating countries prior to the workshop. Questions are included in Annex 2 of this report.

Each country made a presentation focusing on responses to questions asked of participants before their arrival. The table on the following page summarizes those presentations. Detailed presentations by country can be accessed here: http://www.respond-project.org/pages/pac/pac-meeting-saly-october-2013/pac-meeting-saly-october-2013.php

Country	Successes	Challenges
Benin	• Ownership by the Ministry of Health • 500 providers trained • Packaging and making MVA kits available in 34 health zones • Availability of PAC services 24/7	• Partnership with the community • Insufficient monitoring and evaluation of PAC services • No follow up of women post treatment of abortion complications and FP • Misuse of misoprostol • Low adoption of long-acting methods
Burkina Faso	• Integration of PAC in national guidelines and protocols • Integration of PAC in the curricula for pre-service and continuing education	• Information not provided
Guinea	• FP provision in all PAC services • Real attitude change among service providers • Counseling services and the community component • Promotion of long-acting methods	• No facility satisfies the 7 Basic EmONC procedures
Mali	• Introduction of PAC in RH policy, norms and protocols • Improvement in the replacement of MVA syringes • Improvement of PAC case notification by all stakeholders • Improvement /inclusion of PAC data in NHIS documents	• Continuing training of PAC providers • Monitoring of PAC activities
Niger	• Information not provided	• Contraception prevalence rate: 12% • Unmet need for FP: 16% • Total Fertility rate: 7.6
Rwanda	• Increased CPR coverage from 10% to 45% in 5 years • Decrease in total fertility rate from 6.1 to 4.6 in 5 years • Decrease in unmet need for FP from 38% to 19% in 5 years	• Availability of PAC in 8 districts out of 30 • High turnover of staff
Senegal	• PAC provision in all but 2 hospitals, all health centres, and health posts (MVA in all health posts with midwife) • Existence of a management information system	• No quantitative data from the lower level since 2010 because of inaccessibility of information due to a paperwork strike by certain health providers
Togo	• Existence of RH policies • PAC integrated in protocols for RH/FP/STI • Integration of PAC in the roadmap for reduction of maternal mortality • Integration of PAC in training curriculum • Existence of a pool of trainers • Administration involvement • PAC costs reduced (10,000 CFA) • Adequate # providers trained in PAC	• Low coverage:19 districts out of 40 • Expansion of PAC services to all health facilities with midwives, including private facilities, not clear • Establishment of a community component • PAC providers not receiving adequate FP training on all methods • Lack of formal training supervision • Lack of technical and financial support for PAC

Discussion:
The Rwanda team was asked to share factors contributing to the success of its FP program to support the data presented by the team. The presenter from the Rwanda team mentioned the following: Rwanda has relied on its President's leadership, health insurance companies, performance-based financing contracts, absence of stock-outs, free provision of FP methods, assistance from faith-based organizations, and community-based distribution of injectables, pills, and Cycle Beads (Standard Days Method). The Ministry of Finance has included the purchase of contraceptives as a line budget item. The Ministry of Good Governance ensures that health districts are held accountable by their communities.

According to the presenter, the community plays an important role in the process of women accessing PAC services and FP methods. Performance-based financing contracts are signed by mayors who are responsible for the performance of their health districts. In Rwanda, health care is decentralized, so the health system relies on city mayors, legislators, and religious leaders to raise awareness. Rwanda is focused on the accountability of providers and performance-based financial incentives that will motivate them. Providers' performance is assessed every six months using specific indicators. A monetary compensation, set aside in the government's budget, is made to local officials and municipalities according to performance.

2.4 Framing PAC to Respond to Global Initiatives

The following summarizes all the global updates on PAC, which sought to improve participants' knowledge on the importance of PAC-FP, long-acting reversible FP methods, holistic PAC programming, and systematic scale-up approaches.

2.4.1 How Does Postabortion Care Assist Countries in Reaching their Objectives? Carolyn Curtis, USAID

A decrease in the global maternal death rate occurred between 1990 and 2010, but reductions have varied considerably by region. In sub-Saharan Africa, for example, the maternal mortality rate fell by 41%, while in South Asia it declined by 64%, and in East Asia and Pacific, 69% combined. The large rate of decline in East Asia and the Pacific regions has influenced the worldwide rate of decline. Maternal deaths were attributed to, among other causes, hemorrhage (35%), sepsis (9%), and unsafe abortion (9%). Ms. Curtis pointed out that an increase in FP use would prevent unwanted pregnancies and unsafe abortions.

Ms. Curtis discussed the Global Health Initiative, which is made up of principles based on the promotion of gender equality, country ownership, partnership strengthening, service integration, and improved research and monitoring and evaluation practices. Ms. Curtis also discussed the FP2020 goals, which include having an additional 120 million women use FP in 69 countries by 2020. Ms. Curtis described FP as making an important contribution to the realization of the commitment to child survival: "A Promise Renewed" to end preventable child deaths, particularly within high burden countries, with respect to:

- Prevention of unwanted pregnancies
- Reduction in unmet need for FP
- Determination of family size
- Helping to plan pregnancies during a woman's safe childbearing period (between 18 and 34 years, at least 24 months after a live birth and 6 months after an abortion or miscarriage)

To conclude, she pointed out that access to voluntary FP could reduce the number of maternal deaths by between 25% and 40% (104,000 maternal deaths per year) and prevent up to 20% of child deaths worldwide.

Discussion:
Exchanges among participants reiterated the importance of delegating tasks to midwives and nurses. Participants also agreed that these two groups of health professionals can help physicians who are often overwhelmed by other patient responsibilities. Furthermore, delegation of tasks may improve women's access to health services.

2.4.2 Ouagadougou Partnership: The Urgency to Act, Suzanne Reier, WHO/IBP

The goal of the Ouagadougou Partnership is to work with nine Francophone countries in West Africa where contraceptive uptake is weak and maternal mortality high. The partnership (USAID, French Foreign Affairs Ministry, French Development Agency, Bill & Melinda Gates Foundation, Hewlett Foundation, WHO, UNFPA, GTZ, and others) offers assistance to countries in the process of developing strategies and budgeting FP plans. As of October 2013, Burkina Faso, Benin, Côte D'Ivoire, Guinea, Mauritania, and Senegal had finalized their FP plans. Partners work with countries to ensure that the plans are financed by mobilizing funds from various sources. These funding sources also include H4+[1] and Muskoka.

Discussion:
Discussion centered on the lack of financial support to countries in Central Africa. The presenter reminded the audience that Muskoka funds focus on Francophone countries in West and Central Africa, but because they are lagging behind, health care is underfinanced in Central African countries, and the language barrier puts them at a disadvantage compared to Anglophone countries in the subregion.

2.4.3 FIGO and Prevention of Unsafe Abortions: Long-Acting Reversible Contraceptives and Permanent Methods in PAC, Anibal Faundes, FIGO

The speaker first reiterated FIGO's commitment to combating maternal mortality and unsafe abortions. Dr. Faundes focused on the utility of FP in decreasing unwanted pregnancies and unsafe abortions, which account for a number of maternal deaths. The presenter emphasized that particular attention should be given to adolescents, and facilitating their access to RH services including low-cost FP. Providing FP as part of postabortion care was particularly important for several reasons, including presenting the perfect opportunity for contact with the client and preventing the risk of clients lost to follow up if FP is postponed.

Dr. Faundes also presented the difference between perfect use and typical use of a contraceptive method and mentioned that this difference was evident with oral contraceptive pills and DMPA, which make it necessary for clients to be particularly proactive and comply with follow-up; on the other hand, this is not the case with LARCs and PMs. This makes the provision of LARCs and PMs especially important to PAC clients. The importance of meeting WHO eligibility criteria was also stressed. Stocks-outs of contraceptive products, lack of knowledge about long-acting methods among women, and a shortage of qualified service providers limit access to contraception after abortion. The provision of LARCs and PMs, specifically, is hindered by the level of effort required among providers for their administration.

[1] The H4+ is a joint effort by United Nations and related agencies and programs: UNAIDS, UNFPA, UNICEF, UN Women, WHO, and the World Bank. As the lead technical partners for the United Nations Secretary-General's Global Strategy for Women's and Children's Health, H4+ works to improve the health of women and children.

2.4.4 Long-Acting Reversible Contraceptives and Permanent Methods for PAC Clients, Erin Mielke, USAID

The presentation started with an overview on LARCs and PMs, which revealed female sterilization (19%) and the IUD (14%) as the two most frequently used modern contraceptive methods worldwide. The presenter also identified the types of clients who are eligible for LARCs and PMs:

- Those who want to delay childbearing
- Those who want to space pregnancies after a birth or an abortion
- HIV-positive couples can use any LARC or PM
- Those who have reached their desired family size

The presentation also focused on the cost-saving benefits of LARCs and PMs, citing the average unit cost for long-acting methods in the FP public sector, including US$8.00 - $8.50 for implants and $0.56 for copper IUDs. Upcoming LARC innovations (such as a yearly vaginal ring and biodegradable implants) were also discussed. The presentation ended with the reiteration of the importance of satisfying global unmet need for FP, which could prevent 54 million unwanted pregnancies, 26 million abortions, and approximately 80,000 maternal deaths.

Discussion:
Questions revolved around the cost of methods and how to meet communities' expectations in terms of qualified and trained personnel who will deliver services once demand has been created. As communities become aware of these methods, the demand for them will rise. The obstacle related to service providers' significant workload could be remedied through delegation of tasks. Ms. Mielke mentioned that the uptake rate depends on the information given to clients about the methods. To optimize access to LARCs, costs need to be reduced, high-quality information needs to be offered to clients, and generics need to be made available. At the end of the presentation, participants expressed appreciation for the increasing attention given to LARCs and PMs, and emphasized the need to replicate programs that have successfully included LARCs and PMs in West Africa countries.

2.4.5 Holistic Programming and Health Systems Strengthening with the SEED Model, Linda Ippolito, EngenderHealth

The main objective of the SEED model is to provide holistic programming in order to improve access to high-quality FP. This program integrates three components: supply side, creating an enabling environment, and demand.

- Supply or service provision: Requires that staff members are supported to provide high-quality services that are accessible and acceptable, and that providers are accountable to the clients and community they serve. Quality is reflected by, for example, adequate infrastructure, equipment, and existing materials.
- Enabling environment: Multiple sociocultural, economic, and political factors influence both the functionality and maintenance of health services. A favorable environment to health necessitates equitable policies and adequate resources.
- Demand: Many obstacles could keep individuals from achieving their sexual and reproductive well-being.

Each of these components influences and reinforces the other. Creating synergies between components was also discussed, including quality interaction between clients and providers, a well-equipped and well-managed service delivery site, and investment in the supply side for the training of personnel in counseling. Ms. Ippolito emphasized that experience has taught us that all of these components are

necessary for a successful program. Participants were encouraged to apply the SEED model in the development of their roadmaps to strengthen PAC-FP within their countries.

2.4.6 Holistic Programming and Contraceptive Security in Rwanda, Solange Hakiba, USAID

This presentation described the supply chain of contraceptive commodities in Rwanda. The Medical Protection and Procurement Department (MPPD) assists the MOH with the procurement of contraceptive products. The MPPD supplies district pharmacies, which are responsible for distribution at the peripheral level. The public sector provides 92% of FP services (77% at health centers). All points of entry by clients into the health system are used for FP promotion. Factors that contribute to the successful distribution of contraceptive commodities included:

- High levels of political commitment
- Involvement of various ministries to ensure accountability
- Decentralization strategy to ensure local ownership
- Annual forecasting and quantification exercises
- Regular follow-up meetings
- Trained national warehousing and distribution entity committed to monthly storage and distribution of RH commodities

Nevertheless, this system faces shortages due to:

- Quick turn-over of personnel, which complicates professional development
- Lack of basic training, supervision, and data reporting system

Discussion:
A participant highlighted the importance of incentives within the Rwandan system. The presenter added that the incentives were monetary in nature, based on improvement of indicators and on providers' competency. Another participant inquired about cervical cancer screening in the context of PAC. According to Ms. Hakiba, cervical cancer screening is not currently included in routine PAC in Rwanda. In conclusion, the presenter stated that Rwanda expected to bypass foreign assistance and was looking forward to finally becoming self-sufficient.

2.5 State of the Art Approaches

2.5.1 Family Planning: An Important Component of Postabortion Care, Anibal Faundes, FIGO

This presentation emphasized needed interventions, including service reorganization, provision of a wide range of contraceptive methods, counseling related to contraception, sustainable FP service provision, and leadership among health professionals, which would help increase access to PAC-FP. The presenter emphasized risks associated with abortion, which are blamed for 800 deaths per 100,000 unsafe abortions in Africa. To mitigate this outcome, FIGO has established a four-phase abortion-prevention policy (for its 44 member countries):

- Primary prevention: avoid unwanted pregnancies.
- Secondary prevention: avoid postabortion infections (this is directly tied to the quality of PAC).
- Tertiary prevention: establish a protocol for quick treatment of unsafe abortion-related complications (there is a 24 hour-window between complications and death).
- Quaternary prevention: postabortion counseling and prevention of repeated pregnancy termination.

2.5.2 Role of the International Confederation of Midwives, Laurence Monteiro, ICM

This presentation highlighted ICM's leadership role in the development and definition of the midwife's responsibilities. Ms. Monteiro talked about ICM's role with the seven essential skills for the basic practice of midwifery, which include pre-pregnancy care, FP, and other health care related to abortion. The "essential skills" are a living document in the sense that they are regularly reviewed and amended as soon as new evidence or information emerges. Ms. Monteiro reminded the audience of the three pillars of ICM: education, rules and regulations, and the development of member associations. These three pillars are built on the foundation of the essential skills and are regularly updated. The three pillars are interdependent and provide a complete information package for midwives, policymakers, and governments.

2.5.3 Training and Supervision for High-Quality PAC Services, Tsigué Pleah, Jhpiego

Ms. Pleah highlighted the scope of the problem concerning lack of high-quality PAC services due to clinical training and supervision approaches that do not support adequate skills development. She went on to outline the following elements, which are needed for provision of high-quality PAC services:

- Training based on identified needs and skill competency
- Development/adaptation of the training in accordance with national policies, standards, and procedures
- Identification of providers who can offer these services
- Availability of materials and equipment for the provision of services
- Orientation for all staff
- Skills transfer
- Supportive supervision using performance standards skill acquisition (assistance needed)
- Skill mastery (can perform the required action or activity)
- Perfect skill mastery (can perform efficiently)

Training innovations reside in the combined approach of instructional methods (distance self-learning, onsite training, and individual coaching) and the principle of "small doses and high frequency." There are critical elements to skill development (knowledge transfer, acquisition of skills and practice, coaching by an experienced provider and trainer, performance evaluation during service provision). Knowledge transfer involves different players, including supervisors, trainers, learners, and colleagues. Training institutionalization and scale-up of services were also discussed.

Discussion:
A participant pointed out the high cost of basic training associated with professional development and wondered if this type of training was feasible. Despite these challenges, it was emphasized that skills development is very important for achieving high-quality services.

2.5.4 Fostering Change for Scale-up, Suzanne Reier, WHO; ExpandNet for Scale-up, Stembile Mugore, E2A

Ms. Reier gave an overview of IBP, which is made up of 41 partners working together to ensure high quality of and access to RH services. Ms. Mugore provided an overview of the ExpandNet scale-up tools and then Ms. Reier gave an overview of the Fostering Change methodology for efficiently scaling up health care delivery practices, the three areas impacting diffusion of innovations, the principles of change, and the four principles guiding scale-up:

- Country ownership and leadership
- Systematic approach that takes into account a complex network of interactions
- Emphasis on sustainability
- Knowledge of factors determining success of a scale up, and use of this knowledge to guide the scale-up strategy, respect for human rights, participation, gender equity, equitable access to high-quality care, and country ownership

The presentation emphasized the difference between "vertical" and "horizontal" scaling up and the need for both; horizontal scale-up focuses on geographic expansion, while vertical scale-up includes institutionalization of an innovation.

Discussion:
Participants appreciated and took note of the different approaches to ensure successful scale-up. One participant pointed out the importance of a rewards system to encourage change and commitment, and the pivotal role of advocacy in providing the reasons for change. Another participant highlighted the fact that vertical scale-up (politics, institutions, and laws) should accompany horizontal scale-up (expansion/replication) in order to prevent institutional barriers and create a favorable environment. The last intervening participant reiterated the importance of country ownership to the process of scale-up and resource mobilization. The presenters reminded the audience that guidelines were available, that scale-up should be kept in mind from the onset of a project, and that ongoing follow-up was necessary to make the desired changes and ensure sustainability.

2.5.5 Senegal's Community Youth Experience, Maïmouna Sow, Childfund

This presentation focused on Strategy "5910," a community-based approach to educate and promote adolescent sexual and reproductive health. The main program elements include the Community Action Cycle model, the development of action plans for adolescents' and parents' groups, the implementation of the action plans through three components ("Let's dare to talk about it," corners for information and care of adolescents, and community-based distribution of condoms). A 10-minute film entitled "The Community Action Cycle-PAC: Ownership, a Reality," which depicts testimonials from health personnel and community leaders, was shown to illustrate the intervention.

According to the film, an assessment of program activities reported that 211 informational and behavior change communication sessions took place at three sites in two regions of Senegal (Joal and Ziguinichor): 433 teachers and 389 adolescents were trained in adolescent and youth sexual and reproductive health; 657 awareness campaigns were conducted for adolescents; 58 school outreach events involving question and answer games on RH were carried out; and 13 cervical cancer screening days were held.

Discussion:
At the end of the film and presentation, the audience made a number of suggestions. They wanted to hear more about what new knowledge adolescents had acquired as a result of participating in the program, as well as the inclusion of personal stories from the young people participating in Strategy 5910, especially those who were sexually active in the movie, to make it more relevant. Participants also asked a number of questions including: What is the proportion of young people in Senegal? What other activities have been carried out? Were there other ministries involved other than the MOH? Were peer educators involved?

In response to questions raised by participants the presenter stated that:
- Baseline data were not collected before the intervention.

- Other activities consisted of information exchange, advanced strategic and screening sessions.
- The Ministries of Youth, Education, and Family were actively involved in the project.

2.6 Concurrent Sessions

Participants were invited to engage in concurrent technical sessions organized around the themes of supply, demand, and enabling environment, with sub-topics on examples of tools, practices, etc., to reinforce the themes. The supply-side theme included two stations; one demonstration station on long-acting methods and another on training and supportive supervision. The demand-side theme entailed one session on youth-friendly PAC services. The enabling environment theme was composed of four separate sessions: integrated service delivery, Fostering Change, monitoring PAC services, and the global PAC resource package.

2.7 Preparing for Quality Improvement and Expansion: Development of Country Roadmaps

2.7.1 USAID support to PAC & FP in West African Countries, Didier Mbayi Kangudie, USAID West Africa

Prior to participants breaking out to work on their roadmaps, Dr. Mbayi Kangudie presented an overview of USAID West Africa's support for FP in the region to inform participants of additional resources that are available. Dr. Kangudie indicated that the USAID regional office for West Africa, based in Ghana, has placed PAC and FP among its priorities. It offers support to reduce unmet need for FP through the following projects:

- AGIR-PF - service provision
- Futures Group - political dialogue and advocacy
- DELIVER - security of RH commodities and service provision

The five countries receiving technical and financial support that have FP repositioning plans are: Burkina Faso, Côte D'Ivoire, Mauritania, Niger, and Togo. Burkina Faso, Niger, and Togo have been selected to receive specific PAC assistance related to the Ouagadougou Partnership. The presenter noted that the plans resulting from the Ouagadougou Partnership were generally good, but were taking a long time to implement. He recommended private-sector involvement and requested that FIGO and ICM be invited to country meetings.

2.7.2 Small Group Work in Country Teams

Participants were given guidelines to develop six-month roadmaps for implementation that will strengthen PAC in their countries. The country teams were each assigned a facilitator who guided the development of the roadmaps. Participants worked together, describing the desired performance of their PAC programs, assessing the current status of their PAC programs, and identifying gaps and developing roadmaps for addressing performance gaps within a six-month timeframe (see Annex 3 to view the draft country roadmaps).

2.7.3 Country presentations of the roadmaps

Countries presented these roadmaps during a final plenary session and were invited to engage in the peer-review process with each other to discuss issues and further strengthen them. Common practices that emerged from the roadmaps were:

- Establishment of dedicated PAC rooms

- Training service providers
- Improvement of PAC and FP coverage within countries
- Community involvement
- Improvement in flow of FP products and MVA syringes
- Preparation of PAC training guides

3. Next Steps

On behalf of USAID, Ms. Carolyn Curtis promised to share all the information collected during the 2013 PAC conference and coordinate with other partners to provide technical assistance to the countries strengthening PAC in Francophone West Africa. USAID also offered to follow up with PAC country teams and announced that there would be a session on PAC at the 2013 International Conference on Family Planning in Addis Ababa.

Representatives from UNFPA (Nuriye Ortayli) and WHO (Suzanne Reier), which work with Muskoka's plan and H4+ reported on a planning meeting with health ministers, to be held in November 2013 in Senegal. Different countries were invited to participate and advocate for PAC support. The audience was reminded that Muskoka funds usually finance two or three activities. Country representatives were asked to prioritize their objectives.

WHO/IBP was interested in the scale-up of PAC activities. The IBP representative encouraged the participants to include scale-up in priority activities and to send a request to WHO country offices notifying them of any activity being considered for scale-up in order to obtain support for the process. Ms. Curtis ended the meeting by giving out certificates of recognition to the country team members to celebrate their progress.

4. Meeting Evaluation

At the end of each day of the meeting, an evaluation questionnaire was given to meeting participants so that conference organizers could receive feedback on participant's satisfaction with the meeting. The majority of meeting participants expressed that they were more interested in the state-of-the-art and best practice approach sessions than those focusing on scaling-up methodologies, but more than half of all participants who responded appreciated all eight sessions and the overall conference organization.

Regarding meeting logistics, participants expressed discontent with the power cuts and poor lighting in the conference room. Participants also found the per diem amounts to be low, the agenda rather busy, and complained that uploading presentations sometimes caused delays. Participants also said they would have enjoyed a scheduled excursion in the city (Dakar). Overall, participants liked the setting in Saly, the selected hotel, catering, and the availability of facilitators, and friendliness among the working groups.

5. Conclusion

The purpose of this workshop was intended to shed light on the status of PAC programs in Francophone West Africa (and Rwanda) since the implementation of the 2008 action plans and create road maps for ongoing action. Presentations given by country teams, stakeholders, and donors raised awareness about the toll of unsafe abortion on women's health and underlined the importance of immediate postabortion contraception at point of treatment, and improving access to all methods, including LARCs and PMs. Countries were able to share their unique experiences with PAC

programming and exchange information with other countries and stakeholders about both the successes and challenges faced during implementation. Objectives set for this meeting were met, as indicated by the results of the country team group work. Short-term action plans clearly identified certain challenges and priority activities emerged. The next step will be to implement the road maps and assess their implementation after a certain time period to continually improve PAC. For this purpose, it would be useful for stakeholders to share experiences by establishing communities of practice that would lead to a better follow-up and generate input from other sectors.

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Annex 2: Country Team Questionnaire

Question		Response (indicate reporting period/year)	
		Total number	Percentage
1. In your country, what is the number of women with obstetric complications treated in health facilities in the last year?			
2. What proportion of women with obstetric complications are treated/admitted in EmOC facilities? (subset of 1)	Total number		
	a. Women <=20 years old		
	b. Women with gestational age <=20 weeks		
	c. Women who died		
3. What proportion of women up to 20 weeks of gestation were: (subset of 2b)	a. <=20 year old		
	b. Admitted due to hemorrhage		
	c. Admitted due to sepsis		
4. Please provide the following for your country: a. Total number of health facilities _____ b. Number of health facilities providing Basic EmOC _____ c. Number of health facilities providing Comprehensive EmOC _____ d. Number of facilities providing PAC services _____			
5. Please provide the following for your country: a. Total number of health facilities _____ b. Number of health facilities providing Basic EmOC _____ c. Number of health facilities providing Comprehensive EmOC _____ d. Number of facilities providing PAC services _____			
6. In your country, within health facilities offering PAC, where are the PAC services provided? (Tick all applicable answers): a. In a dedicated room _____ b. In a general procedure room_____ c. In an operating theatre _____ d. Other (please specify)			
7. Where does PAC fit into your national policies/roadmaps/national guidelines? If PAC does not currently fit into any of your national documents, do you have any of the following national documents for PAC?			

a. National policies for reproductive health? Yes _____ No _____ b. National policies for maternal health? Yes _____ No _____ c. National guidelines for PAC? Yes _____ No _____ d. National curricula for in-service training? Yes _____ No _____	
	8. Describe how your country's health facilities have organized services to allow for PAC treatment and family planning counseling and services to be provided to clients before they are discharged.
9. Is PAC included in the pre-service education curricula for physicians, midwives and nurses in your country? Please indicate where PAC is included in the curricula (medical school, midwifery schools, nursing school)	
10. In your country, describe how MVA kits and FP commodities and essential equipment are procured and the process for getting these items to the PAC treatment room in health facilities nationwide.	

Annex 3: Draft Country Roadmaps

Benin

Country Team:
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Mme. Laurence Monteiro, Président, Association of Midwives of Benin/Intl. Confederation of Midwives, Dr. Albertine Traore Ribiere

PAC Roadmap, November 2013 – May 2015

Objectives	Gaps	Proposition to overcome gaps	Needs	Available Resources	Stakeholders	Stakeholder-supported resources	Responsible
50% of providers from 2 CHU (HOMEL, CNHU) of CHD 5, 10 HZ, and 10 private health facilities offer PAC	Lack of trained staff Lack of demonstration models for FP, MVA Inadequate medical and technical equipment	Train 230 midwives, SFE, Gynecologists, IDE maternity (30 – CNHU-CUGO; 30 HOMEL; 50 private; 120 HZ) Acquire demonstration models Acquire equipment	Financial & material resources (models, MVA syringes, flip charts, etc.)	Trainers Training guide Contraceptives	- MOH - Technical & Financial Partners - UNFPA, USAID - Social Marketing Associations (ABMS/PSI) - AFD - Suisse Cooperation - Embassy of Netherlands - Belgian Technical Cooperation - UNICEF		MOH
Ensure the complete treatment according to the protocols of 80% of women with incomplete	Absence of PAC room	Organize planning workshop for scaling up PAC room in HOMEL and CUGO					

Objectives	Gaps	Proposition to overcome gaps	Needs	Available Resources	Stakeholders	Stakeholder-supported resources	Responsible
abortion (MVA or misoprostol, FP, HIV screening, cervical cancer screening) within 2 CHU (HOMEL, CNHU), 5 CHD, 10 HZ, and 10 private health facilities trained in PAC							
Succeed in providing PAC/FP counseling to at least 80% of women seeking PAC, with 70% actually leaving with a contraceptive method in two CHU (HOMEL, CHNU, 5 CHD, 10 HZ, and 10 private health facilities trained in PAC	FP services not integrated with PAC Counseling not systematically performed for all women receiving PAC Systematically offer combination hormonal contraceptives in PAC Lack of implementation and stock-out of contraceptives in PAC rooms	Establish mechanism to manage and control contraceptives in PAC rooms Organize a workshop for making flipcharts and monitoring tools for PAC Organize quarterly supervision of trained providers in targeted health facilities					

Objectives	Gaps	Proposition to overcome gaps	Needs	Available Resources	Stakeholders	Stakeholder-supported resources	Responsible
Establish tools for the collection of data on PAC including contraceptive methods, misoprostol, HIV testing, and cervical cancer of the uterus	Diversity and incomplete data collection tools for PAC	Harmonize data collection tools at all levels Systematically record all PAC cases in PAC registers					
Organize monitoring of activities and annual evaluation of results	PAC not included in routine monitoring activities	Organize a workshop for the review of tools and mechanisms for monitoring and evaluation of the Direction de la Santé de la Mère et de l'Enfant, taking into account PAC Edit and disseminate tools for monitoring and evaluation					

Burkina Faso

Country Team:
Pr Ali Auedraogo, Teacher practitioner, CHU YO, Université de Ouagafougou/SOGOB
Dr. Belemvire, National Program Officer/RH, UNFPA
CHU: 2; CHR: 9; CMA/CM: 76; CSPS: 26 (2 by region) (113 structures for 2014)

Performance Goal	Gaps	Suggestions for closing the gaps	*Resources Needed by Type	**Available Resources by Type	Stakeholders in country	Resources/ Support from stakeholders	Responsible
Objective 1: Ensure that women admitted for PAC emerge with a contraceptive method: Baseline: 50%; Target: 75%							
Strengthen the capacity of providers of PAC / FP	- Only 66,5% of health facilities ensure the removal of products of conception - Only 0.3% of providers had complete knowledge about the actions in case of complications of unsafe abortion or incomplete - The majority of interviewed providers are unaware of what to tell a patient treated for incomplete abortion or risk - Only 50% of patients seen for PAC receive a contraceptive method	Training Providers on PAC / FP - Capacity building for newly released school students based on PAC / FP - Increased on-site supervision	Financial Resources (RF) - Estimation and valuation of the Plan, - Share with partners to mobilize: Finances for training; contraceptives; MVA kits, misoprostol, etc.;	- H4+/CIDA - GPRHCS - MHTF - AGIR/PF - E2A ?	Directorate of Reproductive Health - DS-NGO/Associations	Technical Support	DSF (Division Sante Familiale) Family Health Division

Ensure the availability of medicines supplies and equipment for PAC	Only 6.3% of maternity units have guidelines for the management of abortions - Only 6.3% of health facilities/FS have MVA kits - -Only 50% of patients seen in PAC receive a contraceptive method - -Absence of the full range of contraceptives in some service delivery points	- Provision of boxes and MVA kits to health facilities - Provision of misoprostol - Making available guidelines for facilities on PAC / FP - Training providers on LMIS/HMIS	RF/ Financial Resources		DRS-DS-NGO/Associations /CAMEG/PTF/Technical l and Finance Partners	Technical Support / Update inventory/stocks	DSF
Ensure advocacy to partners and authorities from the Ministry of Health for the integration of contraceptives in the kit for the management of abortion complications	- High cost of contraceptive methods	- Development of advocacy tools - - Organisation of meetings at the central level of RH group to discuss the integration	RF/AT (Technical Assistance) - Continuous improvement of quality; - Maintenance of achievements and quality assurance for new sites		NGO/Associations /PTF	Technical and financial support	DSF
Objective 2: Provide supervision, monitoring and evaluation of PAC / FP interventions							

Performance Goal	Gaps	Suggestions for closing the gaps	*Resources Needed by Type	**Available Resources by Type	Stakeholders in country	Resources/ Support from stakeholders	Responsible
Strengthen the data collection, monitoring and evaluation	Lack of data disaggregated by age, gestational age and type of complications	- Making available data collection tools to the health structures - Biannual meetings (starting year 1) and quarterly (from year 2) to discuss performance - Program Review in 2016 - Documentation of lessons learned and best practices	RF		DRS-DS-NGO/Associations /PTF	Technical and financial support	DSF
Ensure advocacy to the authorities from the Ministry of Health for the integration of PAC indicators in the system to gather routine health information	PAC indicators not included in the Annual Statistical Report from the Ministry of Health	- Meetings with DSF-Partners to discuss the issue	RF/AT		NGO/Associations /PTF	Technical and financial support	DSF

Guinea

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Goal/ Expected Results:	Gaps	Suggestions to overcome challenges	Resources according to need	Available resources by type	In-country Stakeholders	Resources / support from stakeholders	Responsible
I. By the end of April 2015, 100% of district hospitals and 5% of Health Centers providing quality PAC services	**HP : 6(31-25) CS : 16 (20-4 ; 5% de 410=20 CS)**	**1. Advocacy with government and donors to mobilize resources**					
		a. Organize a round table with MOH and donors working in SM/maternal health and FP to facilitate the implementation of the roadmap on PAC	Roadmap-Mission Report Financial Resources Logistics	Roadmap Mission Report	MoH, Ministry of Economyand Finance , MDB, donors Private sector	Leadership Funding Funding technical support	Dr Féridah

Goal/ Expected Results:	Gaps	Suggestions to overcome challenges	Resources according to need	Available resources by type	In-country Stakeholders	Resources / support from stakeholders	Responsible
		b. Attend meetings to mobilize resources for repositioning plan FP and the reorganization of BEmONC	Roadmap Assessment Results	Roadmap Assessment Results	MoH, MEF, MDB, donors Private sector	Advocacy for obtaining funding	Dr. Diakhaby
		2. PAC Implementation					
		a. Integrate PAC productsin the 2014 MoH orders	Lists of RH products for purchase from the MoH	Lists of RH products	MoH (DNPL, DNSFN), UNFPA, USAID/ JHPIEGO	Coordinating technical support	Dr. Houleymatou
		b. Identify sites, needs and partners for the implementation of PAC	List of non-integrated sites, documents for the identification of needs, supervisors / trainers in PAC, financial and logistical resources	List of non-integrated sites documents for the identification of needs, supervisors / trainers PAC	MoH (DNSFN,DPS), UNFPA, USAID /JHPIEGO, WHO, World Bank	Coordination, leadership and logistics funding and technical support	Dr. Houleymatou
		c. Provide training to providers in IP, TC and PAC at targeted sites;	Lists of providers, trainers, training materials, logistics and financing	trainers, training materials	MoH (DNSFN, DPS), UNFPA, USAID /JHPIEGO, WHO, World Bank, UNICEF	Coordination, leadership and logistics funding and technical support	Dr Diakhaby

Goal/ Expected Results:	Gaps	Suggestions to overcome challenges	Resources according to need	Available resources by type	In-country Stakeholders	Resources / support from stakeholders	Responsible
		d. Support the setup of PAC sites including the provision of MVA kits, contraceptives and IP equipment at health facilities	Trainers, MVA kits, contraceptives and IP material, financial and logistical resources	Trainers	MoH (DNSFN, DPS),	Coordination, leadership and logistics	Dr Diakhaby
					UNFPA, USAID /JHPIEGO, WHO, World Bank, UNICEF	funding and technical support	
		e. Organize information and referral service meetings, for policy makers and communities on PAC	PAC support information, supervisors, trainers, financial and logistical resources	Supervisors, Trainers	MoH (DNSFN, DPS),	Coordination, leadership and logistics	Dr Diakhaby
					UNFPA, USAID /JHPIEGO, WHO, World Bank, UNICEF	funding and technical support	
		f. Ensure supervision post training	Trainers, monitoring tools, financial and logistical resources	Supervisors, Trainers	MoH (DNSFN, DPS),	Coordination, leadership and logistics	Dr Diakhaby
					UNFPA, USAID /JHPIEGO, WHO, World Bank, UNICEF	funding and technical support	
		g. Implement the process of improving	Performance standards, trainers,	Performanc e standards, Trainers	MoH (DNSFN, DPS),	Coordination, leadership and logistics	Dr Diakhaby

Goal/ Expected Results:	Gaps	Suggestions to overcome challenges	Resources according to need	Available resources by type	In-country Stakeholders	Resources / support from stakeholders	Responsible
		performance and quality	financial and logistical resources		UNFPA, USAID /JHPIEGO, WHO, World Bank, UNICEF	funding and technical support	
		3. Ensure PAC Monitoring and Evaluation					
		a. Ensure monitoring and supervision of PAC implementation	Trainers / Supervisors collection tools, NHIS report and PAC, financial and logistical resources	Trainers / Supervisors collection tools, SNIS (National Health Information system) report and	Trainers / Supervisors collection tools, SNIS report and	Trainers / Supervisors collection tools, SNIS report and	Dr Feridah
		b. Support data collection and analysis of data at all levels (CS, DPS, and DRS DNSFN and SSEI)					
		c. Implement corrective actions based on the data analysis and supervision results					
II. By the end of April 2015, community involvement and adolescents and youth access are strengthened	**Weakness in the strategy and PAC communication tools**	1. Develop strategy and communication plan for PAC	Resource Package PAC (USAID), human and financial resources Resource Package PAC (USAID),	PAC Resource Package	MOH Communications Officer and donors	Technical and financial assistance	Dr Houley

Goal/ Expected Results:	Gaps	Suggestions to overcome challenges	Resources according to need	Available resources by type	In-country Stakeholders	Resources / support from stakeholders	Responsible
in two districts			human and financial resources				
		2. Production of IEC materials (posters, pictures ...)	Resource Package PAC (USAID), human and financial resources	PAC Resource Package	MOH Communications Officer and donors	Technical and financial assistance	Dr Houley
		3. Develop education and awareness on the prevention of unwanted pregnancies and the PAC for the benefit of men and teens / young people:	List of municipalities and prefectures collection tools for situational analysis, list of peer educators, strategies and communication tools, tools for monitoring and	No resources	MoH (Teen/Youth Division), MJ, AGBEF, MATAP (DMR), Santé scolaire UNFPA, USAID /JHPIEGO, WHO, World Bank, UNICEF	Coordination, leadership and logistics technical support funding and technical support	Dr. Feridah
		a. Perform a quick situational analysis in two towns (urban and rural)					

Goal/ Expected Results:	Gaps	Suggestions to overcome challenges	Resources according to need	Available resources by type	In-country Stakeholders	Resources / support from stakeholders	Responsible
		b. Train peer educators (including youth and men);	evaluation, human and financial resources				
		c. Organize education sessions and outreach targets					
		d. Do monitoring and evaluation					

Mali

Dr. Tessougue Fatoumata Cisse, NPO/MPS, OMS
Dr. Bore Saran Diakite, Chef DSR/DNS
Dr. Diakaridia Koné, Gynecologist CSRéf, Commune IV
Sirantou Wagué, Medical Assistant DNS/DSR, Department of Health, PAC Focal point
Dr. Mala Sylla, OB/GYN
Dr. Chaka Kokaina, OB/GYN
Dr. Mounkoro Niani, OB/GYN, CHU Gabriel, Touré
Dr. Famakan Kane, OB/GYN
Dr. Jeanne Tessougué, PSI Mali
Dr. Kalifa Keita, Public Health Doctor

Goals for 2015	Gaps	Intervention Strategies	Challenges	Resources Needed	Resources Available	Stakeholders	Stakeholder Resources	Responsible
Increase PAC coverage from five to nine health regions	4 regions not covered	Situation analysis, training, equipment, drugs and supplies, monitoring PAC activities	Security, Financial Resources, refusal by some communities	Human resources, financial resources, products, equipment and modules for training	Trainers Modules Finance: government, PSI, USAID	MS, OMS, PSI, USAID, UNFPA, MSI	HR MS and technical and financial support from partners	DSR
Cover 50% of private and semi-public facilities	95% of private and parastatal facilties aren't covered	Situation analysis, training, equipment, drugs and consumables, provision of PAC supports (registers, admission sheets, monthly and quarterly records) Advocacy with reluctant facilties	Refusal of adherence Refusal of data collection	Human resources, financial resources	Trainers Modules Finance: government, PSI, USAID, MSI	MS, OMS, PSI, USAID, UNFPA, MSI	HR MS and technical and financial support from partners	DRS/DESR

Goals for 2015	Gaps	Intervention Strategies	Challenges	Resources Needed	Resources Available	Stakeholders	Stakeholder Resources	Responsible
Improve community involvement in PAC / FP	Only community health workers and ATR are involved in PAC	Developing an advocacy tool on PAC / FP Development of a communication program on PAC / PF for the community Implementation of the program developedfor the communities Using tools developed for communication among community (advocacy tool and other tools IEC / BCC)	refusal by some communities	Human resources, financial resources	Human Resources Finance: government, PSI, USAID, UNPFA WHO	MS, MDES, MPFEF, MIC, OMS, PSI, USAID, UNFPA, MSI	HR MS and technical and financial support from partners	DSR/DRS
Integrate MVA equipment in SDAME	Lack of MVA equipment in SDAME	Advocacy for the integration of MVA in SDAME	Lack of MVA equipment in the SDAME	Human resources, financial resources	Human Resources Finance: government, USAID, UNPFA	MS, UNFPA, USAID	HR MS and technical and financial support from partners	DPM
Have a PAC / FP unit in 08 regional hospitals and 03 hospitals in Bamako	No room dedicated to PAC / FP	Advocacy to responsible facilities to have a room dedicated to PAC/FP	Inability to create a dedicated room	Human resources, financial resources	Human Resources Finance: State hospitals	MS, hôpitaux	HR MS and own resources of hospitals	Directeurs

Goals for 2015	Gaps	Intervention Strategies	Challenges	Resources Needed	Resources Available	Stakeholders	Stakeholder Resources	Responsible
Integrating PAC / FP data in the NHIS	Absence of PAC / FP data in the NHIS	Advocacy for revision of NHIS Establishing support for PAC / FP (register report)	Refusal of adherence Refusal of data collection	Human resources, financial resources	Human Resources Finance: State UNPFA, MUSKOKA	MS, Muskoka (OMS, UNFPA) PSI, USAID, MSI	HR MS and technical and financial support from partners	DSR
Expand training in MLD (long-acting methods) in three northern regions and continue in other regions	Lack of trained providers in MLD (long-acting methods) in uncovered areas	Situation analysis, training, equipment, monitoring	Security, Financial Resources	Human resources, financial resources	Trainers Modules Finance: government, USAID, UNFPA, PSI, WHO	MS, Muskoka (OMS, UNFPA), USAID, PSI,	HR MS and technical and financial support from partners	DSR

Niger

Country Team:
Dr. Habila Tsahirou, Head of the Maternity Division (DSME)
Nana Idi Fassouma, PAC Focal Point, DSME
Dr. Garbba Mahamoudou, OB-GYN, Centre Hospitalier Régional Poudrière (CHR) de Niamey
Mme Gaoh Zaharatou, Adjunct Director, Maternité Issaka Gazoby (MIG) de Niamey
Mme Soumana Aminata, Midwife Trainer, National Public Health School, Niamey
Dr. Labo Ibrahim, Head of Supply Service, National Office of Pharmaceutical and Chemical Products
Dr. Miriama Pascal, RH Program Officer, UNFPA Niger

N°	Performance Goal	Gaps	Suggestions for closing the gaps	*Resources Needed	**Available Resources	Stakeholders in country	Resources/ Support from stakeholders	Responsible
1	Have a national PAC training guide by January 2014	Lack of a specific national guide for PAC	Capitalize on all aspects of PAC contained in EmOC and strengthen a complete package for PAC services	Support, Documentation, Reprographics, Workshops development and validation	Existence of EmOC, Draft module guide national PAC; availabilty trainers	STATE, UNFPA, WHO, USAID, UNICEF VSI COMMUNITY	Material and financial resources	Division of Mother and Child Health (DSME)
2	Have competent managers for the provision of PAC	Lack of health workers trained in EmOC and PAC and those who have received some training need to be refreshed	Identify and train workers in PAC	Support, Documentation, Reprographics, Workshop	PAC module and trainers	STATE, UNFPA, WHO, USAID, UNICEF VSI COMMUNITY	Material and financial resources	Division of Mother and Child Health (DSME)

N°	Performance Goal	Gaps	Suggestions for closing the gaps	*Resources Needed	**Available Resources	Stakeholders in country	Resources/ Support from stakeholders	Responsible
3	Create PAC rooms at nine maternity referral facilities (regional and national)	7 regional maternity hospitals do not have specific rooms for PAC	Identify the rooms in the seven maternity referral facilities	Rehabilitation, Equipment, Materials, drugs and consumables and other materials	2 rooms available PAC and functional	STATE, UNFPA, WHO, USAID, UNICEF VSI COMMUNITY	Material and financial resources	Division of Mother and Child Health (DSME)
4	Establish a mechanism for monitoring PAC data	The current system takes into account only the number of cases and deaths related to abortion	Implement specific tools that take into account all age ranges from 10 to 49 years, advocate for the integration of data in the NHIS (National HMIS system)	Reproduction of tools for data collection, definition, the transmission data	Existing media at the website www.postabortioncare.org	STATE, UNFPA, WHO, USAID, UNICEF VSI COMMUNITY	Material and financial resources	Division of Mother and Child Health (DSME)
5	Establish a system of training and improving the quality of services	Nonsystematic and specific supervision of PAC	Establish formative supervisions at least two times a year at the health facilities particularly	Documentation, logistics,	Existence of an integrated supervisory system at all levels	STATE, UNFPA, WHO, USAID, UNICEF VSI COMMUNITY	Material and financial resources	Division of Mother and Child Health (DSME)

N°	Performance Goal	Gaps	Suggestions for closing the gaps	*Resources Needed	**Available Resources	Stakeholders in country	Resources/ Support from stakeholders	Responsible
			in PAC units					

Rwanda

Country Team:
Dr. Solange Hakiba, USAID
Dr. Laurien Nyabienda, ARBEF
Francine Mukamanzi, RFHP
Dr. James Ssenfuka, UNFPA
Daphrose Nyirasafali, UNFPA

Performance Goal	Gaps	Suggestions to fill the gaps	Responsible	Timeline
1. Raise awareness to MoH regarding PAC recommendations	MoH not able to participate in PAC workshop in Senegal	Conduct a debrief meeting to MoH	Country Team in PAC meeting	Before the end of October 2013
2. Policy/Norms/Protocols	Road Map, Standards, protocols and training manuals still in draft form	The MCH Technical Working Group to advocate for signature/endorsement by the Minister of health	The Director of MCH in MoH & the Country Team in PAC meeting	From October-December 2013
3. Pre-service Training	PAC is not included in the midwives curricula; medical doctors curriculum	Advocacy to integrate PAC in midwives and medical doctors curricula and to train students using anatomic model	Country Team in PAC meeting & the Director of MCH in MoH & Ministry of Education	From October-December 2013
4. Supply of Quality PAC Comprehensive Services	-PAC is only in 8/30 districts -Counseling is weak: only 54% of PAC women leave with FP methods -High turnover of trained staff	-Develop a plan to scale up PAC gradually in all districts -Train at least 2 health providers by HF -Procurement of MVA kits and Misoprostol -Supportive supervision Reinforce the counseling, integration of PAC and FP -On the job training approach -Advocate for motivation of Health Providers (Include PAC in PBF indicators)	MoH, UNFPA, USAID, RFHP, VSI	2013-2015
5. Demand/community	Not all people are aware of	-Organize meetings with	MoH, UNFPA, USAID, VSI,	Continuous

Performance Goal	Gaps	Suggestions to fill the gaps	Responsible	Timeline
mobilization	PAC services	various groups including young people -Disseminate BCC materials using various channels (radio &TV/talk show, spots, news paper, community work/umuganda, brochures, leaflet) -Orient CHWs on PAC and involve them in sensitization and referral -Male involvement, key population	RFHP, RALGA, RPRPD, ORINFOR, PMC	
6. Reproductive Health Commodity Security	N/A	-Maintain the momentum to prevent stock-out -Refresher training for pharmacy managers -Increase the Government pledge	MoH, UNFPA, USAID, VSI, JSI/DELIVER, Global Fund, DFID	Continuous
7. Researches and good practices sharing, south-south cooperation	-Limited operational and qualitative researches on unmet needs -Limited documentation and sharing of good practices	-Perform researches -Document and share best practices -Organize study tours	MoH, UNFPA, USAID, VSI, JSI/DELIVER, Global Fund, DFID	Continuous

Senegal

Country Team:
Dr. Bocar Mamadou Daff, Directeur de la SRSE, MSAS
Ramatoulaye Dioum, RH/FP Advisor, USAID
Dr. Fatou NDiaye, USAID
Mamadou Diagne, Chief of Party, ChildFund
Seyni Konté Diop, RH Coordinator, DSRE/DSMN
Sébastiana Diatta, RH/FP Advisor, Child Fund
Dr. Marième Dia NDiaye, CTPRS/DSRSE, IntraHealth
Maïmouna Sow Camara, Thiès Regional Focal Point, ChildFund
Alphonsine NDione, ChildFund
Ndeye Maguette Diop LY, Assistant RH/FP, Childfund
Dr. Fanding Badji, Head of FP Service Provision ISSU/Intra, IntraHealth

DSRSE = Direction de la santé, de la reproduction et de la survie de l'enfant (Department of Reproductive Health and Child Survival)
EPS –Etablissment publique sanitaire (Public health facilities)

Expected Performance	Gaps	Steps to overcome gaps	Resources by need and by type	Resources available by type	Technical Partners	Resources/Partner Support	Responsable
FP products are available in the wards of health centers and public health facilities	Point of Sale of FP products is separate from the PAC delivery point	Create a working group to propose a mechanism to ensure the availability of FP products at the PAC unit	Group of Experts	RH are available	PTF	NO	DSRSE Direction de la santé, de la reproduction et de la survie de l'enfant (Department of Reproductive Health and child survival)
		Develop a Ministerial Directive on the basis of the recommendations of the Working Group	DSRSE	DSRSE	NO	NO	DSRSE Direction de la santé, de la reproduction et de la survie de l'enfant

Expected Performance	Gaps	Steps to overcome gaps	Resources by need and by type	Resources available by type	Technical Partners	Resources/Partner Support	Responsable
							(Department of Reproductive Health and child survival)
		Monitoring and coordination of these measures at all levels	DSRSE	DSRSE	PTF	financial logistics	DSRSE Direction de la santé, de la reproduction et de la survie de l'enfant (Department of Reproductive Health and child survival)
MVA syringe is integrated into the national pharmacy supply (PNA) circuit and made available in the health centers and EPS	MVA syringe not included in the list of essential medicines and products of the PNA	Advocate for the integration of MVA Syringes in the list of essential drugs and supplies	DSRSE DPL PNA CEFOREP	DSRSE DPL PNA CEFOREP	PTF	PTF	DSRSE Direction de la santé, de la reproduction et de la survie de l'enfant (Department of Reproductive Health and child survival)
Coverage the Community Action Cycle (CAC) applied to the FP is strengthened to cover 602 health huts	500 health huts aren't covered	Implement CAC for FP in 500 health huts	250 000 000 CFA Human Resources (project staff, service providers, community	125 000 000 CFA	PTF	MI and others PTF	Child FUND DSRSE Direction de la santé, de la reproduction et de la survie de l'enfant

Expected Performance	Gaps	Steps to overcome gaps	Resources by need and by type	Resources available by type	Technical Partners	Resources/Partner Support	Responsable
			stakeholders)				(Department of Reproductive Health and child survival)
		Systematically offer long acting methods as part of advanced strategies at the community level	RH (midwives, nurses, drivers, community stakeholders) financial resources Long-acting methods	To be srengthened	PTF	PTF	Child Fund DSRSE Direction de la santé, de la reproduction et de la survie de l'enfant (Department of Reproductive Health and child survival)
		Strengthen the capacity of midwives and nurses in MLDA (les méthodes de longue durée d'action) Long-acting methods	XX Trainers YYY Participants ZZZ Training sites	XXX Millions of CFA in the PNPF	PTF	PTF	DSRSE/DPF
The cost of providing PAC is reduced and harmonized across Health Centers and public health facilities	Service provision costs vary from 5000 to more than 25,000 CFA between PPS	Conduct a study of the impact of cost and benefit of PAC to recommend a reduced price and harmonized	DSRSE Consultants	XX Millions	PTF	PTF	DSRSE/DSMN
		Develop a note of Ministerial services for implementation	DSRSE	DSRSE	NO	NO	DSRSE/DSMN

Expected Performance	Gaps	Steps to overcome gaps	Resources by need and by type	Resources available by type	Technical Partners	Resources/Partner Support	Responsable
		and monitoring of the Directive					

Activities in next three months

Expected Performance	Gaps	Steps to overcome gaps	Resources by need and by type	Resources available by type	Technical Partners	Resources/Partner Support	Responsable
FP products are available in the wards of health centers and public health facilities	Point of Sale of FP products is separate from the PAC delivery point	Create a working group to propose a mechanism to ensure the availability of FP products at the PAC unit	Group of Experts	RH are available	PTF	NO	DSRSE Direction de la santé, de la reproduction et de la survie de l'enfant (Department of Reproductive Health and child survival)
		Develop a Ministerial Directive on the basis of the recommendations of the Working Group	DSRSE	DSRSE	NO	NO	DSRSE Direction de la santé, de la reproduction et de la survie de l'enfant (Department of Reproductive Health and child survival)
		Monitoring and coordination of these measures at all levels	DSRSE	DSRSE	PTF	financial logistics	DSRSE Direction de la santé, de la reproduction et de la survie de l'enfant

Expected Performance	Gaps	Steps to overcome gaps	Resources by need and by type	Resources available by type	Technical Partners	Resources/Partner Support	Responsable
							(Department of Reproductive Health and child survival)

Togo

I – Achievements to be sustained
Existing health policies
Existing RH policies
Existing Health Code
Existence of RH laws
Existence of Policies, Norms, and protocols
Existence of a trainer pool
Start of integration of FP/PAC/HIV/AIDS services
Existence de curricula de formation dans les facultés des sciences de la santé Existence of a training curricula in the faculty of health sciences

II. Goals/Desired Performance
Service Provision
Between January 2014 and June 2015, XXX PAC sites are functional 24H/day, and 7 days/week and offering quality services
Demand
Between January 2014 and June 2015, the individuals, the families, and the communities from XXX PAC sites have retained the necessary knowledge and capacity for SRH and the research of PAC
Environment
From January 2014 to June 2015, the involvement of policymakers, partners and community leaders is strengthened for the offer of PAC services based on evidence from XXX selected sites.
Coordination
From January 2014 to June 2015, coordination, monitoring, supervision and the evaluation are strengthened at all levels for PAC/FP

PERFORMANCE GOAL	INTERVENTIONS	GAPS	SUGGESTIONS FOR CLOSING THE GAPS	RESOURCES NEEDED	AVAILABLE RESOURCES BY TYPE	STAKEHOLDERS IN COUNTRY	RESOURCES/ SUPPORT FROM STAKEHOLDERS	RESPONSIBLE
SERVICE PROVISION								
From January 2014 to June 2015, XXX PAC sites are functional 24 H/24, and 7/7 and offer quality services	Create PAC rooms at XXX PAC sites	XXX rooms created					Government Beneficiary communities PTF AGIR / FP IPAS UNFPA WHO	

PERFORMANCE GOAL	INTERVENTIONS	GAPS	SUGGESTIONS FOR CLOSING THE GAPS	RESOURCES NEEDED	AVAILABLE RESOURCES BY TYPE	STAKEHOLDERS IN COUNTRY	RESOURCES/ SUPPORT FROM STAKEHOLDERS	RESPONSIBLE
							UNICEF ATBEF/ IPPF Plan Togo PSI AFD USAID / DELIVER (John Snow, Inc) Jhpiego IBP	
	Competency strengthening of XXX PAC/FP providers	XXX providers trained						
	Supply xxx PAC sites Kits MVA and FP products (Jadelle IUD, injectables and pills) and consumables (bleach, gloves, towels, antiseptic ..)	Xxx MVA Kits Xxx range of contraceptives used Xxx amount of consumables						
	Equip xxx PAC/FP sites with PAC / FP technical equipment (gynecological table, speculum, forceps, urinary catheter)	Xxx gynecological tables Xxx boxes of instruments Xxx infection prevention materials						
DEMAND								

PERFORMANCE GOAL	INTERVENTIONS	GAPS	SUGGESTIONS FOR CLOSING THE GAPS	RESOURCES NEEDED	AVAILABLE RESOURCES BY TYPE	STAKEHOLDERS IN COUNTRY	RESOURCES/ SUPPORT FROM STAKEHOLDERS	RESPONSIBLE
From January 2014 to June 2015, individuals, families and communities at xxx PAC sites retained the knowledge and skills necessary for RH and seeking PAC	Design messages on PAC / FP	Different messages available?? Xxx posters, flyers, posters						
	Multimedia information and awareness campaign targeted toward women of childbearing age, adolescents and youth, men and community leaders	Xxx television broadcasts Xxx radio broadcasts xxx Targets hit Xxx communities sensitized Xxx community leaders sensitized						
	Promoting the constructive involvement of men	Xxx men reached						
	Strengthening the capacity of religious leaders in RH / FP	Xxx types of religious leaders to reached						
ENABLING ENVIRONMENT								
From January 2014 to June 2015, the commitment of	State and community involvement financing of	Funds allocated?						

PERFORMANCE GOAL	INTERVENTIONS	GAPS	SUGGESTIONS FOR CLOSING THE GAPS	RESOURCES NEEDED	AVAILABLE RESOURCES BY TYPE	STAKEHOLDERS IN COUNTRY	RESOURCES/ SUPPORT FROM STAKEHOLDERS	RESPONSIBLE
policy makers, partners and community leaders is strengthened to offer PAC services based on evidence at xxx sites selected.	services							
	Stabilization and diversification of funding of PAC / FP services	Funds allocated and types of partners						
	Continued advocacy for the signing of the Ministerial Decree on regulations implementing the RH law	0 ???						
	Continued advocacy for the signing of the Ministerial Decree on regulations implementing the RH law	Xxx number						
COORDINATION								
From January 2014 to June 2015, the coordination, monitoring, supervision and evaluation are strengthened at all levels for PAC / FP	Coordinating, monitoring, supervision and evaluation at all levels for PAC	Number of coordination activities carried out? Number of supervisions performed?						

Endnotes

[i] WHO, *Report on Unsafe Abortion* (Geneva, 2007).
[ii] WHO (2008)
[iii] EngenderHealth & Futures Institute (Project RESPOND), *Secondary analysis of EDS data* (New York, 2012).