

Quality of Care Newsletter

IPPF working for clients' rights

The International Planned Parenthood Federation is the world's largest voluntary organization in sexual and reproductive health and rights

Number 9 Special issue 2008

Introduction

After the completion of the five-year Quality of Care (QOC) project in 2006, the six International Planned Parenthood Federation (IPPF) Regions faced the major task of continuing to build the project's momentum throughout 2007. To sustain the drive for improvement, those implementing the project worked to integrate Quality of Care principles into their organizational culture rather than trying to maintain a project approach.

In this issue of the QOC Newsletter, the Regions share their experiences of activities undertaken during 2007, and the ways that Member Associations have made efforts to sustain, and build upon, the improvements to the delivery of sexual and reproductive health services that flowed from the five-year project.

As part of their determination to extend QOC to their mobile health services, Member Associations around the world conducted a survey. They used a newly-developed self-assessment tool for situation analysis of their current mobile health facilities. This was a major undertaking and resulted in the collection of valuable information. In this Newsletter, we present an outline of the survey results along with an update on technical resources produced in 2007 and 2008.

Dr Nono Simelela

2007 Follow-up activities to the QOC Project

The QOC Regional advisors had a consultation meeting 21-23 March 2007 in London, to review QOC integration efforts at Regional and country levels, and to plan the expansion of the project to mobile health clinics. It was agreed that the Regions would work for quality improvement by integrating and also expanding the use of QOC tools in their Regions. They further agreed that the momentum and benefits of the five-year project should be maintained as follows:

- At the Member Association level, by integrating self-assessment exercises into annual work plans, and maintaining supportive supervision, client exit interviews, and other QOC practices.
- At the Regional Office level, by expanding the quality improvement process to new Member Associations, retaining the position of QOC focal person in each Region, and applying the Quality of Care approach, based on standards and self-assessment, to new projects.
- At the Central Office level, by integrating quality of care as a component of the Access strategy, revising the quality improvement process manual and tools to include the five 'A's, developing a quality improvement system for mobile health clinics and clinical outreach teams in consultation with Regional Offices, and publishing an annual Quality of Care Newsletter.

Regional QOC consultation meetings were held after the March 2007 meeting, to discuss how to carry forward QOC activities in their respective settings.



Sudan: Mobile clinic

Africa Region (AR)

In 2007 the Africa Region disseminated all quality of care improvement materials available (guidelines, checklists and training materials) to all the Member Associations in the Region.

The African Regional Council meeting for volunteers took place in June, in Nairobi, Kenya. The meeting included a three-day workshop on comprehensive abortion care (CAC), with emphasis on values clarification for the executive directors. CD-ROMs containing QOC materials and the 'Medical and Service Delivery Guidelines' were disseminated, to be shared with each director's team.

A two-week training session was conducted in May, in Lomé, Togo, for service providers from the Central African Republic (CAR), Côte d'Ivoire, Democratic Republic of Congo (DRC), Niger and Togo Member Associations. The DRC Member Association then carried out a self-assessment of their service provision and submitted its QOC implementation plan. It was anticipated that the DRC would include the implementation plan activities in the 2008 annual programme budget. QOC action plans were also received from Togo, and three Member Associations were reviewed for accreditation.

Nine Africa Region Member Associations received the Quality of Care training. Six Member Associations (Burkina Faso, the Gambia, Ghana, Lesotho, Rwanda and Uganda) were accredited and received their certificates, while three (Burundi, Cameroon and Congo Brazzaville) were recommended for accreditation. All Member Associations benefited from the QOC training.

In 2008, the Annual Programme Budget for Member Associations includes QOC training for another nine Member Associations. This includes Lusophone Member Associations from Angola, Cape Verde, Equatorial Guinea, Guinea Bissau, Mozambique, and Sao Tomé and Príncipe, and Francophone Member Associations from Comoros, Mali, Mauritius and Senegal. The Associations which have already received QOC training will continue to receive technical assistance while they implement their planned activities.

Arab World Region (AWR)

Six Arab World Region (AWR) Member Associations which participated in the QOC programme have all have been involved in the continuation of QOC activities. They attended training and capacity building workshops and benefited from technical assistance, provided within the QOC Framework after the completion of the QOC programme. The self-assessment procedure led to the development of action plans within the Member Associations, achieved in collaboration with IPPF AWR and the full involvement of staff and volunteers.

Since the end of the QOC project in 2006 all Member Associations and Arab World Regional Office remain committed to quality of care. It is now no longer a project, but integrated within the daily tasks and service providers' responsibilities and duties. The project was intended to be integrated, institutionalized and sustained within the existing service delivery system. The achievements of the Associations indicate that the project has been instrumental in addressing clients' rights and providers' needs based on IPPF standards. Service uptake and client satisfaction have increased, the physical conditions in the service delivery points have improved, with upgraded equipment and expanded services, and four Member Associations now have mobile health clinics.

Quality improvement activities at the Member Association level include the following:

- All Associations use the facilitative supervision tools on a regular basis to evaluate QOC improvement
- Client exit interview is one of the tools used to measure client satisfaction and ameliorate the situation if needed
- Medical and Service Guidelines were disseminated and service providers started to use them
- Some Member Associations are working to expand the QOC process to other service delivery points through the resource mobilization process at the national level, to upgrade medical equipment or add services
- Integration of the QOC concept as a process in SRH is a major achievement; it involves planning, assessing training needs and maintaining standards in the provision of services and involvement of the staff and the volunteers in the action plans
- Capacity building is the key to quality improvement, therefore all Member Associations are working to upgrade service providers' knowledge and widen their performance skills
- Self-assessment implemented within the Member Associations highlighted the QOC needs and gaps, which Member Associations are currently working to improve.

Improvements at the regional level include:

- Many workshops, involving all Member Associations within the Region, for sharing success stories, capacity building and the improvement of service providers' performance
- Technical assistance to all Member Associations to implement QOC Activities and achieve the project objectives and aims

- Field visits for evaluation, supervision and to ensure that all Member Associations use the Medical and Service Delivery Guidelines, especially for infection prevention and related issues
- Dissemination of best practices and lessons learned through regional meetings involving all Member Associations, to share QOC experiences.

The QOC Advisor at AWR will be working with all Member Associations to provide them with adequate technical assistance and appropriate, updated information in order to continue working on this crucial aspect of providing sexual and reproductive health services.

AWR will encourage all Member Associations to find local resources for funds to expand the project, and to carry out the self assessment process as an entry point for continuous progress in the field of QOC based on IPPF standards.

East and South East Asia and Oceania (ESEAOR)

The East and South East Asia and Oceania Region (ESEAOR) is committed to including QOC activities in the Annual Regional Budget for 2008 and to introducing self-assessment for quality improvement to another six Member Associations.

In 2007, activities included QOC training, the integration of QOC into mobile clinics, and increased service provision to meet the needs of new and existing clients.

Western Hemisphere Region (WHR)

In line with the QOC action plans, the QOC Advisor organized and participated in the following activities in 2007:

- 'Skills in Sexual and Reproductive Health' training course with a group of selected facilitators, to prepare them to implement an advanced training course for nurses, in collaboration with West Indies University and the Pan American Health Organization (12 participants).



Haiti: Pregnant woman at mobile clinic

- ‘Client/Provider Interaction’ training to strengthen the interpersonal communication knowledge and skills of service providers, to improve the quality of care at service delivery level. (Eight participants)
- ‘Supportive Supervision and Integrated Sexual and Reproductive Health’ training with service providers from PROFAMILIA/Puerto Rico (33 participants) and APLAFA/Panama (20 participants)

In some locations, QOC activities expanded in 2007:

- In collaboration with Federación Mexicana para la Planeación Familiar (MEXFAM), a self-assessment module for voluntary counselling and testing (VCT) was developed and pre-tested at a MEXFAM clinic in Guadalajara. The clinic director and key service providers participated in the exercise, which resulted in the development of a QOC action to improve the quality of VCT services.
- The QOC assessment tools are in use in clinics throughout WHR and they were adapted for use in mobile health clinics (MHC). The initiative is being implemented in Bolivia, Colombia, the Dominican Republic and Guatemala, and the latter two have developed QOC action plans. The implementation of the plan is being monitored by the mobile health clinic team.

IPPF WHR participated in two international meetings. The ‘Stop Cervical Cancer: Accelerating Global access to HPV Vaccines’ meeting was held in June as a follow-up to the December 2006 international meeting (London). The meeting presented the opportunity for our Member Associations, with regional and national leaders in public and private health in Latin America and the Caribbean, to explore areas of collaboration to improve: access to the cervical cancer vaccine, measures for secondary prevention, and joint efforts to decrease cervical cancer in the region.

In September, IPPF WHR was represented in the ‘Fight against Cervical Cancer’ meeting, which was both informative and inspirational. The meeting was organized by UNIFEM and the European Commission.

Situation analysis of mobile health services

At the last Quality of Care consultation meeting with regional QOC advisers in March 2007, it was decided to conduct a survey to analyse current mobile health clinic (MHC) services provided by IPPF Member Associations, in order to identify the gaps in service provision. Delegates produced a framework for a survey questionnaire, which was developed into a comprehensive tool. The Regions selected participants from among their Member Associations that provide mobile health services. Eight Member Associations completed and responded to the questionnaire. The results were analysed and are presented here.

Overview of clinics and outreach activities

The major objective of the MHC service provided by ESEAOR Member Associations is to make sexual and reproductive health services more easily accessible to under-served populations: this includes people in outreach areas, rural communities, other marginalized groups and internally displaced persons (IDPs) whose circumstances are caused by natural disasters or war. The other objectives are to raise awareness of sexual and reproductive health and distribute commodities including: contraceptives, medications, certain sexual and reproductive health services, and promotion of advocacy campaigns (by one Member Association).

The mobile clinics have been in service for periods ranging from two to 43 years. All of them except Sudan provide services in a physical space for a limited period, and three also use vehicles as clinics.



Mexico - MEXFAM mobile clinic

The clinical personnel profile includes medical and non-medical staff. They supply a range of contraceptives that can include hormonal pills, injectables, implants, intrauterine devices (IUDs) and condoms. They also provide vaccines and antibiotics, and nutritional supplements such as oral rehydration packs, folic acid, iron supplements and calcium tablets.

More than half the Member Associations are supported by government and UN donors. All except one have support from other sources and most have core funds.

Services

Services provided cover a wide range that includes: family planning; prenatal and postnatal care; counselling and information on contraception, services related to sexually transmitted infections (STIs), reproductive tract infections (RTIs), HIV and AIDS, and other sexual and reproductive health issues, mother and child health, immunization, pregnancy testing, breast screening and the provision of nutrition supplements.

The most under-served populations are those marginalized by a combination of unfavourable geographical location and low income status. All the respondents report that they provide static clinics with appropriate services for managing the clients who have been referred by their mobile clinics.

Service providers and volunteers

The MHC providers and volunteers possess a range of skills that include: training and counselling in contraception, communication skills, prevention and treatment of RTIs and STIs (syndromic management), HIV and AIDS detection and care, unwanted pregnancy assistance, diagnosis of pregnancy, ultrasound, comprehensive abortion care, mother and child health through prenatal and postnatal care, and gynaecological care. All providers and volunteers have very supportive attitudes. Some are reported to be demotivated by a lack of sustained financial support.

In the community

Target communities include: internally displaced persons (IDPs), who are mostly women of reproductive age, young people, and under-served groups (such as sex workers and truck drivers). They are reached through community visits, campaigns, social activities such as theatre, role play and video, and through peer education and awareness-raising sessions.

The frequency of visits ranges from once a week to every three months, and they visit urban, peri-urban and rural locations.

Needs assessment methods include focus group discussions, baseline survey, visits and counselling. Awareness-raising sessions and peer education are conducted.

Table 1. Gaps in service delivery and suggestions to overcome them

Gaps identified	Suggestions to overcome gaps	Support by Regional Office/Central Office
1. QOC standard tools inadequately utilized in mobile health clinics	Adaptation of QOC standard tools for mobile health setting	Working with Member Associations in adaptation and training. To collate regional responses and devise a tool for federation-wide use
2. Inadequately trained service providers for mobile health services	Regular training of service providers and incentives for service providers to increase motivation	Organize training for mobile health service providers Provide technical support to Regional Offices and Member Associations
3. Difficulties in following up with clients referred to a health facility other than an IPPF static clinic	Use of client referral cards, including a traceable contact number and address	Learn from other Regions and adapt the method of client follow-up
4. Needs of the targeted groups are not fully addressed. General medical complaints other than sexual and reproductive health, such as fever, cough, diarrhoea etc, cannot be ignored	Community needs assessment is performed to plan for integrated mobile health services. Work in partnership with other organizations to address medical needs other than sexual and reproductive health	Devise tools for community needs assessment and prioritize activities accordingly
5. Difficulties of working in conflict situations and increasing accessibility of services for the poor	Minimum initial service package of mobile health services for conflict/post conflict areas. More investment on infrastructure and suitable vehicles for clinic use	Provide tools to integrate minimum initial services package in mobile health clinics
6. Supply of medicines and commodities not sustained	Logistics and supply management tools for mobile clinics	Assist in development of tools
7. Lack of IEC/BCC materials to promote sexual and reproductive health services and rights	Appropriate IEC/BCC materials provided	Provide culturally appropriate IEC/BCC materials for respective Regions
8. Poor financial sustainability	Work in partnership with other organisations; include mobile health activities in annual programme budget	Collaborate with other organizations working in the communities. Regional Offices to support these activities
9. Increased staff turnover	Address provider's need to motivate service providers	Federation-wide commitment to retain trained staff by motivation, and addressing their training and promotion needs
10. Difficulty of assessing cost of service provided by mobile health clinics	Develop/adapt cost analysis tools	Support the development of cost analysis tools

MHC services are promoted to the communities through midwives, counsellors, peer educators, static clinic staff, community and religious leaders, and field workers. Campaigns are organized to promote information, education and communication (IEC) materials. Regular community visits and meetings are set up and services offered at discounted prices. Most Member Associations have no community assessment tools, but state that they would find such tools useful.

Many outreach workers are volunteers from the community, trained by the Member Associations. They help to identify target groups, co-ordinate with community groups, run the programmes, maintain a record of clients visiting a mobile clinic for the first time and follow up clients referred to a static clinic or another health facility.

Community feedback mechanisms include: informal evaluation, monitoring visits, questionnaires and suggestion boxes. People in the community have proved to be very supportive; they are interested in learning more about sexual and reproductive health and can be very productive if trained appropriately. The role of volunteers is critical as they are reliable and motivated, despite the low resources.

Networking and partnerships are important. Local government can provide good support, and community leaders are resourceful and help promote respect for the programmes. Recruiting service providers from within the community is helpful, because they are well aware of local challenges and opportunities.

Financial sustainability is difficult to achieve. Challenges include a high turnover of adolescent peer educators, addressing unmet needs, capacity building, monitoring, reaching all the target communities, integrating new services, training, infrastructure, lack of commodities, personnel and adequate vehicles, and the extensive time required to plan and execute trips. In addition, there are cultural barriers to the use of certain contraceptive methods and abortion. Finally, the costs of

transportation and of maintaining vehicles are extremely high.

Partnerships

Most of the clinics work in partnerships, which can include local clinics or hospitals, local government, NGOs, private or official governmental institutions, community-based organizations, the Ministry of Health and UN humanitarian agencies. Most of these partnerships work well. A majority of the clinics have some form of monitoring mechanism to meet their partners' standards, and most Member Associations have mechanisms to develop or strengthen partnerships.

Overall, partnerships are considered very important, especially within the community, and they need to be maintained and carefully developed. Challenges include the loss of ownership, and the need to maintain a partner's interest.

Quality of Care

Most mobile health clinic systems follow IPPF's 'Medical and Service Delivery Guidelines', particularly for guidance on the disposal of waste material and the methods for preventing infection. Depending on resources, they sterilize with chlorine, or by boiling or autoclaving, and use disposable needles and syringes. The mobile health clinics also follow national safe disposal guidelines, where they exist.

In all cases, clients are treated individually and discreetly, and efforts are made to maintain client privacy through the use of curtains, screens or separate rooms. Most Member Associations report that confidentiality is maintained by keeping client records in a separate cabinet, with access limited to service providers.

They try to provide clients with as much comfort as possible, with a clean space, water, seats and shade. However, clients travel great distances to attend the MHC and often have to wait in long queues. Sexual and reproductive health commodities used include vehicles,

equipment, drinking water (for staff and clients) and IEC materials. Some communities help to organize water and other available commodities before the mobile health clinic arrives for a session.

Referrals are managed through an established system between the Member Associations and other organizations, using cards and letters. Referrals are made to the Member Associations' static clinics, other available centres, government and semi-government hospitals, and approved/registered organizations. Follow-up is achieved through the records, files, cards, home visits, the next community visit, outreach, volunteer help and communication with hospitals and other clinics. To maintain a continuum of care, referral systems still need strengthening.

Challenges include the need to extend the use of the QOC process, the lack of Quality of Care tools for a mobile health setting, increasing the number of adequate services, lost referral cards, weak referral systems (especially for follow-up), insufficient infrastructure and a general lack of resources.

Cost of services

Most Member Associations have no specific tools to determine the costs related to their mobile health clinic system. They do not perform cost/benefit analyses, and tend to rely on medical records. In addition, not all clients pay, or they may pay discounted rates. It is therefore very difficult for Member Associations to estimate the full costs of commodities, services, equipment, salaries and maintenance.

Maintenance costs are very high and all the Member Associations need support and sustainability plans. The greatest need of services is among those clients least able to pay, who do not have access to alternative, affordable services. Member Associations face particular difficulties in reaching people in conflict and post-conflict areas.

Monitoring and evaluation

Monitoring and evaluation methods include community visits, check lists, monitoring plans, client exit interviews, and careful monitoring of commodities. The supervisory process involves supervisor field visits, regional co-ordinator visits, project co-ordinator meetings, reports by the medical team, client exit interviews and suggestion boxes. The supervisory process in one Member Association may include a visit from a Regional Office monitoring and evaluation officer, while in another Association it may involve supervision by public health officials.

Reporting processes include client feedback records, field reports by the medical team, reports by peer educators or counsellors, registers, diaries, regular reports on client-related statistics, services provided and activities performed at daily, monthly, quarterly, half-yearly and annual intervals.

General comments

The most important results of the mobile health clinic services are increased community involvement, increased awareness of issues related to family planning, RTIs, STIs, and HIV and AIDS, and measures to promote family planning and to prevent RTIs, STIs, HIV and AIDS. Results also include improved contacts with, and services to, vulnerable and marginalized people or those reluctant to use government services; meeting sexual and reproductive health needs and improving client satisfaction.

The challenges are manifold. They include costs and cost/benefit analyses, fund restrictions, training, improving the QOC of the services, sustainability, conflicts, logistics, organization, evaluation, the lack, and rapid deterioration of, equipment (especially vehicles), the length of time required to plan and execute trips, and cultural barriers to sexual and reproductive health. These are continuing problems for almost everyone. Strategies to address them include motivating the staff and planning trips carefully and well in advance, preferably with community assistance in setting up locally for visits, especially in the more remote locations.

Huge gaps remain between community needs and the services provided. Access to communities can be very difficult, due to poor infrastructure. The most effective strategies for the MHCs include ensuring strong leadership, careful and timely planning of trips, collaborating with government programmes, and addressing specific gaps in the government sector instead of attempting to supply a full range of services.

The table opposite summarizes where the Member Associations have identified MHC services that could be improved, and how that could be achieved.

Technical information resources, old and new

The training manuals developed under the QOC programme were finalized in the first quarter of 2007. The completed manuals are as follows:

- 'Training skills for health professionals' (Reference Manual)
- 'Self-assessment and facilitation skills for quality improvement' (Facilitator's guide)
- 'Supportive supervision for quality improvement' (Reference manual)
- 'Supportive supervision for quality improvement' (Facilitator's guide)
- 'Dissemination and implementation of the IPPF Medical and Service Delivery Guidelines' (Facilitator's Guide)
- 'Counselling and interpersonal communication skills in SRH' (Facilitator's Guide)

All Facilitator Guides contain a sample participant's guide, which can be adapted to suit local needs. A CD-ROM has also been produced, which contains the training manuals and the Microsoft PowerPoint presentations used during each of the training sessions.

'IPPF Directory of Hormonal Contraceptives' (English, Spanish and French)

The Directory was first launched in 2002 and is the first free, online searchable database of hormonal contraceptives. It provides information about hormonal contraceptives by brand, composition, country, manufacturer and type. In 2005, the Directory was updated, based on the latest information from Member Associations and pharmaceutical companies. The Directory can be accessed free by logging on to <http://contraceptives.ippf.org>

An extensive update of the Directory is scheduled for 2009, with the feedback received from Member Associations and pharmaceutical companies.

Statements of the International Medical Advisory Panel (IMAP)

2007

- Statement on sexual and reproductive health, reproductive tract infections and sexually transmitted infections
- Statement on male circumcision and HIV
- Statement on cervical cancer prevention and the potential role of HPV vaccine
- Statement on the elimination of female genital mutilation

2008

- Statement on comprehensive sexuality education
- Further Statements will address: postpartum contraception and breastfeeding; family planning in crisis situations.

'IPPF Medical Bulletin'

2007

IPPF has been producing the Medical Bulletin for over 40 years. It is published on a quarterly basis and distributed free of charge in English, French and Spanish to over 10,000 recipients all over the world. The



IPPF Medical Bulletin included IMAP Statements and reported on the following during 2007:

- Access to emergency contraception in 2006. Soledad Díaz, MD and Veronica Schiappacasse, RN
- Novel HIV prevention technologies. Gita Ramjee
- Obstetric fistula and the challenge to maternal health care systems. Joseph K. Ruminjo

2008

The Medical Bulletin is reporting on issues related to maternal and child health throughout 2008. In addition to the IMAP Statements, the following articles are included:

- Termination of pregnancy in the first trimester with misoprostol alone. Oi Shan Tang, Marcel Vekemans, Helena von Hertzen, Pak Chung Ho
- Maternal mortality and unsafe abortion: preventable yet persistent. Lale Say, Iqbal Shah
- Contraception issues in obstetric fistula management. Nathalie Maulet, Jean Macq, Pierre Buekens
- Update on condoms and diaphragm as both contraceptives and protection against STIs. Nancy Padian and Sara Newmann
- Postpartum haemorrhage. Sue Ellen Miller

Glossary

An up-to-date glossary of terms related to sexual and reproductive health will be available on the IPPF website in mid 2008. Log on to: <http://www.ippf.org/en/Resources/Glossary.htm>

'Myths and realities'

This is an initiative between IPPF and an INFO project to explore common myths about contraceptive methods, and to address them through evidence-based counselling messages to develop an online database. The information is based on responses received from service providers around the world, collected via an electronic discussion forum. Health care professionals can use this resource to correct misinformation and support informed decisions, by helping clients understand the facts on how contraceptive methods work, on who can use them, their possible side effects, and much more.

All methods of contraception, natural and modern, are included. The database was completed in November 2007 and is available online at: <http://www.jhuccp.org/myths/>. To log on you will be asked for a user name and password – enter 'myths' for both fields. If you have any suggestions for additions to the methods or messages, please email medtech@ippf.org

The database will be available on the IPPF website very soon.

'Medical and Service Delivery Guidelines' – translated into Portuguese

Associação Para o Planeamento da Família (APF), IPPF's Member Association in Portugal, focuses on information, education, training and advocacy for sexual and reproductive health and rights. APF has translated the 'Medical and Service Delivery Guidelines' into Portuguese for distribution to the service providers in the country.

'Family Planning – A global handbook for providers'

This handbook, launched in 2007, reflects the consensus of experts from the world's leading health organizations, and converts scientific evidence into practical guidance on all major contraceptive methods. It is available in English and translations are underway – French, Spanish and Portuguese versions will be available in 2008. IPPF Central Office has distributed the handbook in the all the IPPF Regions in their preferred language. For more information log on to <http://www.infoforhealth.org/globalhandbook/>

Taking forward the principles of Quality of Care

Over the fourteen years since the International Conference on Population and Development (ICPD), the trend in abortion law reform worldwide has been towards liberalization. Yet access to safe abortion services remains extremely limited and complications from unsafe abortion are one of the leading causes of maternal morbidity and mortality, leading to between 65,000 and 70,000 deaths¹ globally every year.

Most of IPPF's Member Associations work in difficult legal and socio-cultural conditions in relation to abortion. Moreover, lack of funds and technical skills restricts abortion-related activities. To meet these needs, the IPPF Global Comprehensive Abortion Care Project was launched on 1st May 2007.

The project will cover approximately 17 countries in five regions for a period of five years and focuses on increasing access to safe legal comprehensive abortion services. While the learning from the Quality of Care Project will undoubtedly contribute to the strengthening of the Global Comprehensive Abortion Care Project, the expansion of existing quality improvement systems and tools to include abortion will form a core component of the new project.

Attention will also be placed on improving the data collection and clinical management systems and, over time, these systems will be made available to all Member Associations. As with the Quality of Care project, it is intended that the learning acquired from the Global Comprehensive Abortion Care project will allow abortion programmes and services to be scaled up throughout the Federation, thereby strengthening our role as a global provider and advocate of safe abortion services.

1 WHO (2008) Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003. 5th edition.