

FIVE YEARS OF IMPROVING COMPREHENSIVE ABORTION CARE:

LESSONS LEARNED

FROM THE MAX PROGRAM IN KENYA AND SOUTH AFRICA

"WCG has not only empowered patients or clients, they've empowered the health care workers. Health care workers honestly do need a system that they know they can depend on, and WCG has provided that."

- Health care provider, South Africa

WCG
EMPOWER EDUCATE ENABLE

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DISCLAIMER: Any opinions, conclusions and recommendations expressed in the report are those of the authors only.

Front Cover: MAX reps, Gauteng province.

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Providers and managers, Gauteng province.



MAX provider, Limpopo province.

ACRONYMS

CAC	Comprehensive Abortion Care
CPM	Clinical Program Manager
DoH	Department of Health
D&E	Dilation and Evacuation
GA	Gestational age
IUD	Intrauterine (Contraceptive) Device
KZN	KwaZulu-Natal
LARC	Long-Acting Reversible Contraception
LNG IUS	Levonorgestrel Intrauterine System
MA	Medical Abortion
MAX	Maximizing Health Care Provider Performance
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MVA	Manual Vacuum Aspiration
PAC	Post Abortion Care
POC	Products of Conception
RHN	Reproductive Health Network
SA	Surgical Abortion
SCT	Social Cognitive Theory
TOP	Termination of Pregnancy (term used in South Africa)
TOT	Training of Trainers
UCSD	University of California, San Diego
VCAT	Values Clarification and Attitude Transformation
WC	Western Cape

EXECUTIVE SUMMARY

An estimated 25 million unsafe abortions occur worldwide each year, and in sub-Saharan Africa, an estimated 520 deaths occur for every 100,000 unsafe abortions.¹ Even when death does not occur, complications from unsafe abortion are common and debilitating. Abortion prevalence is highest in areas where the unmet need for family planning is high, contraceptive prevalence is low, and traditional methods of family planning are most common. In developing country contexts, 81% of women with pregnancies that were unintended report an unmet need for modern family planning methods. The unmet need for family planning, coupled with a lack of access to safe abortion, jeopardizes the life and health of women around the world, even where the legal grounds for abortion exist.

In both Kenya and South Africa, abortion is legal under relatively broad circumstances, yet this does not guarantee access to safe abortion. Providers and clients alike face restrictive barriers in the provision of and access to safe, quality abortion care. In Kenya, for example, private-sector abortion providers are subject to violence and harassment from authorities in direct contradiction of the law that is in place to protect them. In South Africa, abortion providers working in the public health care system face supply-chain equipment and commodity stock-outs, lack of access to training opportunities, and difficulty advocating with management for support. In both countries, the direct result of experiencing such barriers is the compromised provision of safe abortion care.

To help address this, WCG initiated the Maximizing Health Care Provider Performance (MAX) program as a holistic approach to change health care provider behavior and influence patient outcomes in comprehensive abortion care (CAC). The MAX program offered support at the provider level to identify barriers to effective abortion service provision and to implement customized solutions to increase access. The success of this approach is demonstrated by significant provider improvements in the quantity and quality of abortion and post-abortion contraception delivery in both Kenya and South Africa, especially among providers with greater MAX program participation. Through the MAX program, over 230,000 women received safe abortion services and 92% of those women received a method of contraception. This amounted to an estimated 150,000 unsafe abortions averted and 700 maternal deaths prevented.

The MAX program's approach was unique in three main ways: through its focus on **relationship building** with providers in the context of stigmatized environments; its consistent **data feedback loop** which allowed providers, managers, and field reps to monitor progress and to address ongoing issues as evidenced in the data; and in its rigorous collection and **analysis of data related to the effectiveness of interventions** provided by field reps to health care providers.

Five Years of Improving Comprehensive Abortion Care: Lessons Learned from the MAX Program in Kenya and South Africa aims to describe WCG's experience during the MAX program, from implementation and results to lessons learned and recommendations. We hope this report on the MAX program's experience will be of value to other safe abortion partners including national and provincial departments of health, implementing partners, donors, and policy makers who are operating in similar contexts seeking to reduce morbidity and mortality due to unsafe abortion.

Provider and manager, Gauteng province.

INTRODUCTION



Chief Director Mpumalanga Provincial Department of Health and MAX rep, Mpumalanga province.

BACKGROUND

Although abortion is a safe medical procedure when done in accordance with recommended guidelines, morbidity and mortality related to unsafe procedures poses a substantial risk to women's health and lives globally.² The WHO defines unsafe abortion as one that is "carried out either by persons lacking the necessary skills or in an environment that does not conform to minimum medical standards, or both".³ Deaths due to unsafe abortion may account for 8-18% of all maternal deaths, with an estimated 25 million unsafe abortions occurring worldwide each year, the majority of which take place in developing countries.^{3,4,5,6} Even when death does not result, complications related to unsafe abortion are common, often remain untreated, and place a substantial burden on women and public health care systems in developing countries.²

As of 2017, an estimated 214 million women in developing countries had an unmet need for modern contraceptives.⁷ In Kenya, unmet need for contraception was 17.5% in 2014.⁸ In South Africa, unmet need for family planning among currently married and sexually active unmarried women was 18.2% in 2016.⁹ Given that 81% of women in developing country contexts with pregnancies that were unintended report an unmet need for modern contraception, the provision of effective methods, as well as information and counseling on modern contraceptives, is essential to reducing abortions and improving the health of women and girls globally.² Notably, providing women with the most effective long-acting reversible contraception (LARC) immediately after an abortion reduces the risk of a future abortion.^{10,11}

The concentration of unsafe abortions is highest in Africa.⁵ Although the overall abortion rate in Africa was 34 per 1,000 women in 2010–2014, rates ranged from 31 in Western Africa to 38 in Northern Africa.⁵ In Kenya, unsafe abortion has long been recognized as a leading cause of preventable death and injury to women. Kenya has a relatively high case fatality rate of 266 deaths per 100,000 unsafe abortion procedures.¹² Recent findings from a national study in Kenya demonstrate that there were 465,000 induced abortions in 2012, with 120,000 women receiving care for complications; more than three quarters of those complications were moderate or severe.¹² Similarly, in South Africa, estimates by the Department of Health (DoH) suggest that between 2008 and 2010, 23% of maternal deaths resulting from septic miscarriages in public health facilities were a direct result of unsafe abortion.¹³ However, these data

must be interpreted in the context of the scarcity in availability of abortion data and the underreporting of unsafe abortion in the health care system.

In addition to barriers faced by *women* who need contraception and abortion services, *health care providers* in these contexts also face barriers to the provision of safe abortion and the most effective contraceptive methods. In many countries, laws restricting abortion may prevent providers from offering abortion services or may limit their ability to provide abortions.^{14,15} For instance, in Kenya, constitutional changes have expanded the legal grounds for abortion, but the law is poorly understood and includes heavy penalties for 'unlawful' abortion.¹⁶ Conversely, South Africa has one of the most progressive abortion laws in the world, yet an estimated 50% of abortions still occur outside of designated health facilities due in part to lack of awareness of the law or limited access to such facilities.¹⁵ More broadly, and independent of the legal environment, abortion providers may face stigma and harassment,¹⁶ have limited training in safe abortion¹⁷ and LARC,¹⁸ utilize substandard infection control procedures,¹⁹ face challenges related to accessing and maintaining stock of abortion and LARC materials,²⁰ and often work in clinics with very limited resources, space, and equipment.²¹ To reduce the prevalence of unsafe abortion and unmet need for modern contraception in resource-constrained environments, it is important to ensure that providers in the private, public, and NGO sectors have the resources and skills to deliver a range of abortion services and contraceptive methods.

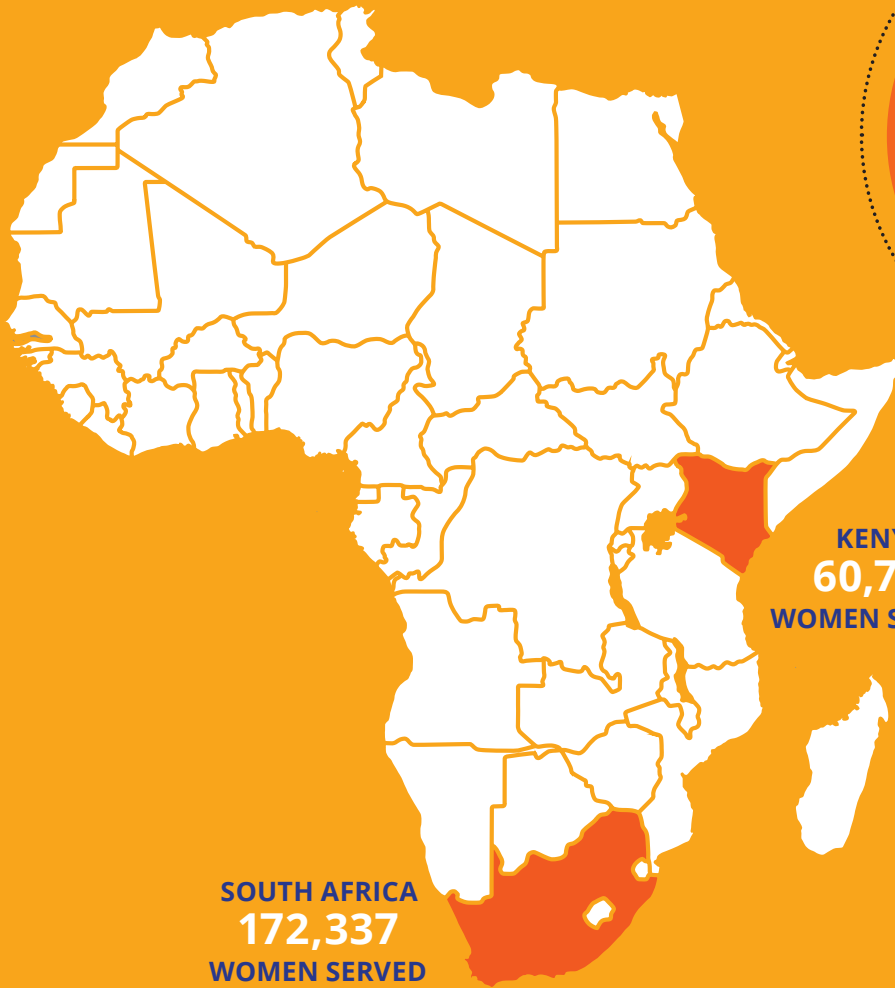


MAX providers, MAX rep (front center), Chief of Obstetrics and Gynecology Mpumalanga province (back center).

MAX PROGRAM AT A GLANCE

BY THE NUMBERS: JUNE 2012 – DEC 2017

OVER
230,000
WOMEN RECEIVED
SAFE ABORTION
SERVICES IN KENYA
AND SOUTH AFRICA
THROUGH THE MAX
PROGRAM.



PROGRAM COUNTRIES

KENYA
SOUTH AFRICA



PROGRAM PARTNERS

NATIONAL DEPARTMENT OF HEALTH,
SOUTH AFRICA

PROVINCIAL DEPARTMENTS OF HEALTH
IN GAUTENG, MPUMALANGA,
LIMPOPO, WESTERN CAPE,
KWAZULU NATAL PROVINCES

REPRODUCTIVE HEALTH NETWORK
(KENYA)

UNIVERSITY OF CAPE TOWN
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PROGRAM SUMMARY RESULTS

- Total safe abortions performed: 233,082
- Number of health care providers enrolled: 662
- Number of facilities that participated: 449
- Proportion of women who received contraception: 92%
- Proportion of women who received a LARC method: 21%

MAX:
A UNIQUE PROGRAM FOR SUCCESS

In June 2012, WCG initiated the Maximizing Health Care Provider Performance (MAX) program by hiring and training field representatives (reps) to support health care practitioners in the provision of high-quality abortion services and post-abortion contraception, especially LARC. MAX field representatives were responsible for identifying, following, and supporting health care providers who perform abortion in the private sector in Kenya and in the public sector in five South African provinces. These two countries were chosen because of their relatively liberal abortion laws. In Kenya, abortion is permitted if, in the opinion of a trained health professional, the mother's life or health is in danger. In South Africa, a woman may terminate her pregnancy for any reason until the 12th week and between 12-20 weeks, termination is permitted if the pregnancy was the result of rape or incest, if her health or the fetus health are at risk, or due to socio-economic status. The MAX team sought to understand how the barriers experienced by providers might be different in the public vs private sectors, and how this would impact the types of interventions needed or the effectiveness of the interventions provided. Ideally, the program would have been implemented in both sectors in both countries, but logistical and resource limitations did not allow for this.

The MAX program centered on the hypothesis that intensive and frequent contact between MAX field representatives and providers would lead to improved provider practices and sustained behavior change. As an initial step, and each month thereafter, MAX reps assessed the needs of each individual provider to identify any barriers to delivering CAC. In response, they delivered a series of personalized and tailored interventions to address these barriers. The goal of this tailored approach was to help identify the types of support most needed by providers in these settings as well as to help determine which interventions were most highly associated with improvements in providers' performance in the provision of CAC services.

MAX was initially informed by Social Cognitive Theory (SCT), a model of behavior change.²² SCT posits that human behavior is shaped by the interplay between personal and environmental influences, focusing on observational learning and self-efficacy as key elements of interventions aimed at changing behavior.²² The MAX program applied similar concepts to health care providers with the aim of improving provider self-

MILESTONES: TIMELINE OF THE MAX PROJECT

- 2012**
 - Pilot project launched, June 2012
 - MAX logbook developed and tested in collaboration with key opinion leaders
 - Health care provider recruitment began
 - Mifepristone introduced in Kenya, Nov 2012
- 2013**
 - Data collection began in Kenya, Jan 2013, and in South Africa, Apr 2013
- 2014**
 - Monthly intervention data collection began, Oct 2014
- 2015**
 - Benchmarking tool developed and piloted in Kenya, Nov 2015
- 2016**
 - Wrap-up of Kenya MAX project, Sept 2016
 - Benchmarking tool revised and implemented in South Africa, Nov 2016
- 2017**
 - Medical abortion policy passed in Mpumalanga Province, South Africa, Mar 2017
 - Wrap-up of field support to providers in South Africa, Sept 2017
 - Medical abortion roll-out in Gauteng and Limpopo Provinces, South Africa, Oct-Nov 2017



MAX provider and program consultant, Gauteng province.

efficacy to deliver quality CAC services. Our experiences in the field, however, also highlighted the need for directly addressing more structural issues in the social and policy environment that limited provider self-efficacy and possibilities for behavior change. Thus, over time, the program's focus expanded to include environmental and structural factors as well as core activities to influence individual provider behaviors.

The highly individualized and personal nature of MAX interventions proved to be a powerful methodology to support providers to adopt best practices and change behavior, a process which can be very challenging. As Dr. Atul Gawande wrote in describing his efforts to spread safe childbirth practices in India: "To create new norms, you have to understand people's existing norms and barriers to change. You have to understand what's getting in their way. So, what about just working with health care workers, one by one, to do just that?" The MAX reps worked one by one with providers, serving as 'mentors' to them. They came to know about the personal lives of providers, their concerns, and their challenges. They became the providers' supporters, champions, and friends, and these relationships formed the core

of the MAX program. The high level of trust between the health care providers and the MAX team allowed reps to more effectively identify and address barriers. This comprehensive and personalized approach is arguably more important for improving the delivery of CAC services than for any other health sector given the complex psychosocial and legal environment that surrounds abortion in most contexts.

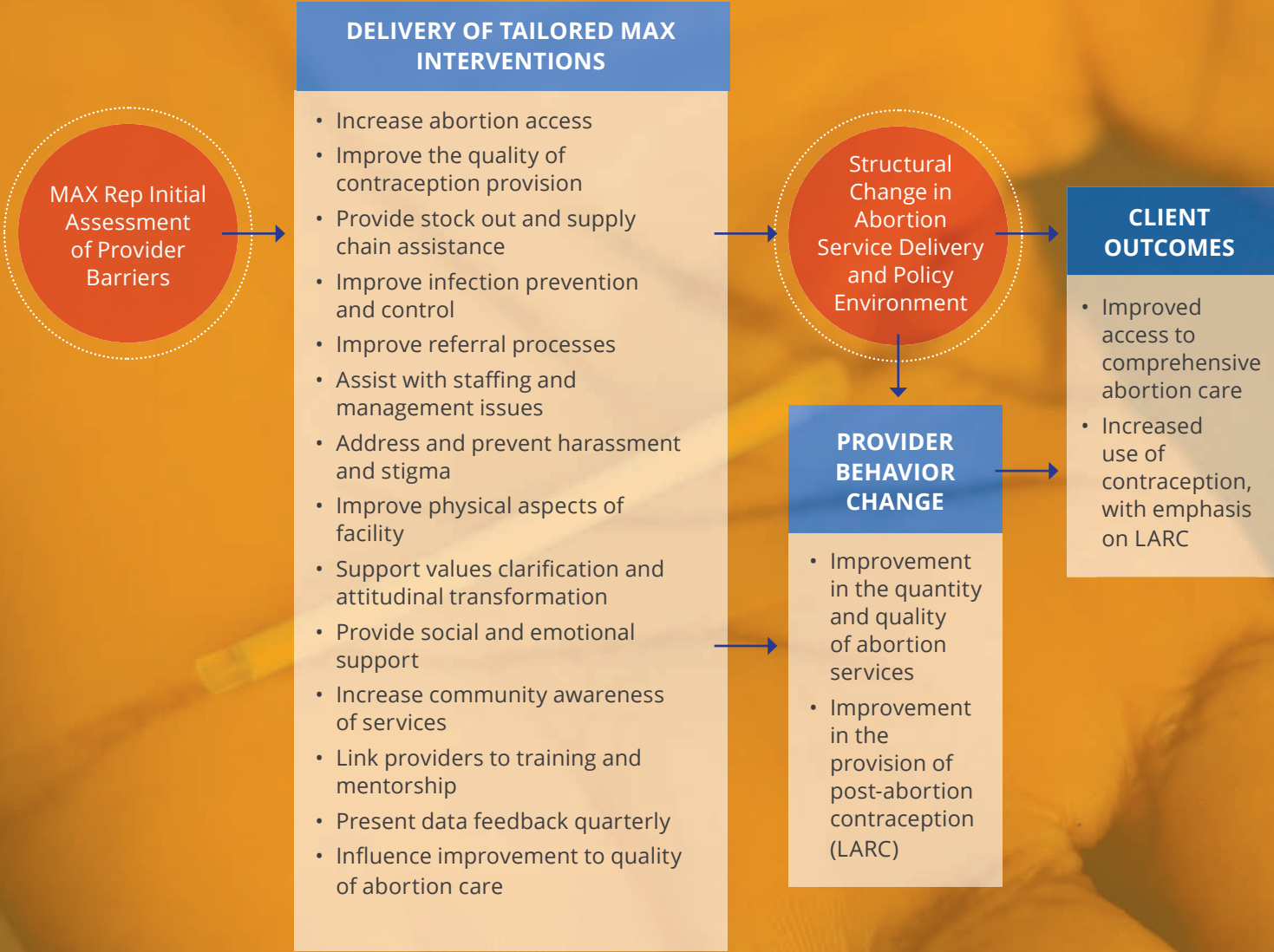
Looking back on the program a year after it ended, a provider in Kenya spoke of the relationship she formed with her MAX rep:

"It made a difference when somebody would come and ask you, 'What is your vision? What are you working to attain? How many girls have you saved? What difficulties have you come across? How do you feel that we can come in and help you?' You know, you have a shoulder to lean on."
—MAX provider, Kenya

Three aspects of the MAX program were particularly innovative. First, the focus on **relationship building** with providers in the context of stigmatized environments, which we will argue was central to effectively engaging, recruiting, and motivating providers to continue to provide CAC services despite challenges faced. Second, as part of the program's emphasis on data analysis, a consistent **data feedback loop** was established. The field representatives collected both quantitative and qualitative data each month from the health care providers they supported, which was analyzed and given back to the providers on a regular basis in the form of consolidated reports. These reports allowed both the providers and field reps to monitor and track progress, and to address ongoing issues as evidenced in the data. This feedback loop became an important source of motivation for improvement and behavior change, as well as a platform for advocacy and mobilization for structural change in the public sector. Lastly, the MAX program contributes to the field through its rigorous collection and **analysis of data related to the effectiveness of interventions** provided by field reps to health care providers. Our analyses examined the association between intervention delivery by field reps and subsequent change over time in key program indicators to determine the interventions that most often resulted in improved provider outcomes. We hope that findings from this work will contribute to our field's understanding of the types of support that are most effective at improving providers' ability to deliver quality CAC services to meet women's needs in resource-constrained areas.

MAX PROGRAM CONCEPTUAL FRAMEWORK

Problem Statement: Lack of knowledge, skills, infrastructure, and an enabling environment limits the quality of comprehensive abortion services provided



Long-Term Impact: Reduce unplanned pregnancy
Reduce incidence of unsafe abortion
Reduce maternal morbidity and mortality due to unsafe abortion

IMPLEMENTATION



MAX providers, Mpumalanga province.

INTRODUCTION

MAX was created as an innovative provider behavior change pilot project with a learning agenda. The primary objectives of MAX were: 1) to improve the quantity of abortion services provided by the network of providers to meet client demand; 2) to improve the quality of abortion services; 3) to improve provision of post-abortion contraception with a focus on LARC; and 4) to assess the possible program-related causes of changes in quantity and quality of comprehensive abortion services. The fourth, and most unique aspect of the program, was added a year into implementation, and was intended to better understand which interventions, out of all the types of support offered, resulted in the greatest behavior change. The pilot began with more questions than answers: What kinds of barriers are providers experiencing? What do they most need? Which interventions are most effective at improving women's access to CAC services? The field team learned as they engaged with providers, developed relationships with them, and began to collect and analyze service delivery data. The pilot followed an iterative process from the beginning, and data and experience were used continuously to adjust the program. This allowed for constant innovation and improvement, yet also caused disruption when changes were implemented. For example, as data collection tools changed in response to learning, it took time to re-train field reps and providers on the new tools, and it made analysis across these two time points (before the tools were changed, and after) more challenging. Yet the ability to be flexible and to adapt the program in response to learning was a critical factor in the pilot's success.

The MAX program was designed to influence individual provider behavior change and was particularly well suited to the Kenyan private sector. Many of the MAX providers in Kenya were also entrepreneurs who owned their own businesses and exercised a great deal of autonomy in the operation of their clinics. For these providers, individualized attention from a MAX field representative was often sufficient to motivate change, and many providers improved in program outcomes based on this level of support. In the South African public sector, however, individual providers do not exercise the same level of autonomy and control over their environments as private sector providers, and it became clear that one-on-one attention could only influence change to a certain degree. The program adapted to this context by working simultaneously with

facility managers, district managers, and provincial officials to resolve administrative barriers in order to improve the system within which the providers worked. The MAX program did not have the resources to provide major financial incentives to providers, such as subsidizing products, making facility upgrades, or purchasing equipment. The true value of the MAX program was in the personalized guidance given to providers, the quality of the relationships that developed between the field reps and the providers, and in the data that the program offered back to the providers on a regular basis so that they could see how they were improving in program outcomes over time.

Building on a traditional medical detailing model whereby field representatives visited participating health care providers on a monthly basis, the MAX reps' goal was to work with the provider to identify barriers and then help address the barrier by linking the provider with resources or by solving the problem jointly. During each visit, field reps collected quantitative and qualitative data, tracking service delivery indicators as well as documenting any assistance they provided. Data were reviewed, cleaned, and analyzed by the San Diego-based Monitoring and Evaluation (M&E) team, and regularly given back to providers in the form of reports to enable them to keep track of their own progress and identify remaining challenges.

Below details lessons learned and best practices from the following implementation areas: staffing, engaging stakeholders, provider recruitment, provider support, and monitoring and evaluation.

STAFFING

The MAX program was staffed with two teams, one based at headquarters (HQ) in San Diego and one in the field. The US HQ team consisted of a project director, an M&E manager, two data coordinators, and two doctoral-level researchers who were employees of University of California—San Diego (UCSD), WCG's research partner. In addition, WCG's medical director provided clinical support throughout the program to both countries. The HQ team's function was to provide strategic and program management oversight, as well as M&E support. In each country, a team of representatives was hired (four reps in Kenya, five in South Africa) and assigned to specific geographic areas. In Kenya, the four reps covered designated regions within seven provinces: Central, Coast, Nairobi, Eastern, Rift Valley, Western, and Nyanza. The reps in South Africa were



MAX provider and manager, Gauteng province.

assigned one to each of the five program provinces: Gauteng, Mpumalanga, KwaZulu Natal (KZN), Western Cape (WC), and Limpopo. Additionally, MAX reps were supported by a local clinical program manager (CPM) with a nursing background who was based in South Africa. She was responsible for supporting providers and reps in clinical issues and in conducting higher-level advocacy, including facilitating regular data sharing meetings with the providers and their managers. This role was especially important in South Africa because of the need to engage with officials at all levels of the health system in order to support provider performance. The CPM was also responsible for providing in-service training and technical updates to MAX reps to improve their ability to support providers.

Because MAX was based on a medical detailing model, many of the reps had backgrounds in sales, and in fact some of them were originally part of WCG's sales team distributing the Manual Vacuum Aspiration (MVA) device and reporting to the sales directors in each country. However, there was a conflict both with the potential perception that they could be encouraging providers to increase services to meet sales objectives, and also that they could be favoring one method (surgical abortion) over another (medical abortion) for the same reason, so they were separated from the sales team. This was an important lesson learned, as the perception by providers that the reps were neutral 'honest brokers' was important to establishing and maintaining their credibility. The field reps in both countries were hired for their high degree of emotional intelligence and ability to connect with others, and this served them well in developing solid relationships with providers.

MAX field reps exercised a lot of autonomy and were trusted to use sound judgment based on knowledge of their providers and the specific geographical context in which they worked. This allowed for innovation and flexibility. However, the reps—especially in Kenya—could have benefited from more support themselves, especially clinical support. They were supported remotely by the WCG medical director, as well as the first project director, who was a clinician and provided initial on site clinical support and subsequent remote clinical and technical support. When the initial project director left WCG approximately two years into program implementation, it was recognized that direct clinical support in the field would likely be more effective. The CPM was hired to join the program in South Africa with the plan for her to provide local clinical support to the MAX reps in both Kenya and

South Africa. Unfortunately, it was difficult for the CPM to provide the level of clinical oversight necessary to the Kenyan team and their providers. In part this was due to distance and travel constraints, but it was also because the providers did not always welcome oversight from a non-Kenyan clinician, so her influence in some instances was limited.

At the headquarters level, the high volume of data that came in from the field required careful review and often significant dialogue with reps before it could be validated and passed to the UCSD team for analysis. The data was sometimes extremely difficult to interpret and required many questions back to the field team to clarify. Invariably, the team was short-staffed, and found it difficult to manage incoming data and keep up with the creation of data reports for providers in a timely fashion. A program manager was added to the team 12 months before the end of the project, and this helped to alleviate some of the pressure. Future data-driven programs such as MAX should consider having a minimum of two dedicated staff members to clean and validate data in addition to a program manager. Overall, the team was very lean for the amount of activity and data that it managed.

LESSONS LEARNED:

- **Needed at least one CPM per country to provide clinical oversight and support.**
- **A greater diversity in field rep backgrounds, including clinical backgrounds, would have bolstered versatility of the team as a whole.**
- **The team was very lean and efficiency improved with an additional programmatic staff member.**

BEST PRACTICE:

- **Recruit field representatives with high emotional intelligence and ability to build solid relationships with people, which is very important in a field where providers feel a high degree of stigma, marginalization and harassment.**
- **Allowing field reps to exercise autonomy based on their knowledge of the terrain encourages innovation and responsiveness to issues as they arise.**

ENGAGING STAKEHOLDERS (NETWORKING/ADVOCACY)

The approach that the MAX team took to engage stakeholders was different in each country. In Kenya, the process was largely informal: the MAX team engaged very early with the Reproductive Health Network (RHN), an organized group of reproductive health care providers, for advice, technical assistance, and help with provider recruitment. Through RHN, the MAX reps gained valuable connections and were informed of higher-level policy issues, which were important but outside the scope of MAX's work in Kenya. RHN members helped to introduce the MAX team to abortion providers initially, and gave additional credibility to the project. Importantly, with RHN, WCG was able to link providers to a network of lawyers for support in legal situations related to harassment and stigma. A member of RHN and MAX provider said:

“Together, we formed a body of lawyers who are able to represent us. MAX was able to help us pinpoint the lawyers who are fearless in this country who are able to say, ‘Yes, we are here for the women.’”—MAX provider

Other important stakeholders in Kenya included nonprofit organizations working in reproductive health, which were identified largely by field reps in their respective geographical areas. These partners were important, in part because they could be resources for provider training and other needs. Some NGOs had their own networks of providers that were easily incorporated into the MAX network. This worked well as the providers were already used to partnering with an NGO, though not for abortion care. Because of the MAX program's focus on identifying the key drivers of provider behavior change, the team took care to document any relevant support that was provided by the partner NGO. Relationships with NGOs were informal, and there were no clear guidelines or formalized agreements on partnership expectations, which was burdensome for the MAX reps. Future programs should formalize such partnerships.

In South Africa, engagement with stakeholders within the public sector was a formal process that included requesting and obtaining approvals at all levels—national, provincial, district, and facility. This demanded significantly more time and energy, but was essential for working successfully within the public sector and ultimately ensured ownership and facilitated sustainability of the program. Stakeholder

engagement was aided by the CPM's reputation, as she was well known and respected for her previous work in reproductive health and safe abortion services. The CPM facilitated regular data-sharing meetings where stakeholders at all levels were invited, and interceded with managers and authorities when problems arose. This helped to maintain the MAX program's relationships with national, provincial and district-level officials. Ultimately, it proved to be very important to have a senior leader with a clinical background building relationships within the public sector and engaging with managers for advocacy purposes. Much of the MAX program's success with advocacy and sustainability in South Africa can be attributed to the CPM's focused effort.

LESSON LEARNED:

- Needed formalized partnerships and clear guidelines on working relationships between WCG and other organizations (Kenya).

BEST PRACTICE:

- A well-respected, senior leader able to focus on relationship-building and advocacy with stakeholders is an asset, especially when working within the public sector where buy-in is critical to success.

PROVIDER RECRUITMENT

The MAX team used different strategies to recruit providers in the private vs the public sector. In Kenya, providers offering abortion services were frequently isolated and worked outside of a system. Thus, local opinion leaders and groups such as RHN helped to promote MAX program acceptability and assist in the recruitment of providers and clinic sites. MAX reps also recruited providers through their own networking and referrals by enrolled MAX providers. This process was highly unstructured and reps did not have formal identification or letters introducing the project, which made the task of approaching providers and explaining the expectations and advantages of joining the MAX network more difficult. However, this informal approach was helpful in certain regions, where providers were reluctant to admit that they provide abortion services at all, and would have been wary of being approached 'officially' by a program like MAX. There was no specific guideline about how many providers to recruit or how

many providers were needed to cover a geographical area adequately. Generally, the criteria for recruitment included providers who were trained in CAC and who were willing to offer services, receive visits from MAX reps, and provide monthly data.^a The issue of willingness to offer services proved to be difficult in Kenya. In Kenya, attitudes toward abortion providers were frequently negative, with providers experiencing harassment from police, other providers, and their communities. MAX reps sometimes went to great lengths to convince trained providers to offer CAC services and recruit them into the network. To do so, they developed friendships with providers and invested time in building trust with them. For more information about building trust with providers, see case study on page 15.

In South Africa, the recruitment of providers was more systematic. In each of the provinces where MAX was implemented, the team met with provincial authorities to explain the project and to obtain approval and support. Facility managers within each province were asked to participate in the MAX program by the provincial directors of Maternal and Child Health (MCH), and if the facility manager approved, introductions to the program were made formally. The intention was that all clinical sites providing abortion in each province would participate, however, if facility managers did not want to participate they could opt out. This formal process ensured that all stakeholders were aware of the program and set up an official relationship between the MAX rep and the providers, all of which were currently-practicing abortion care providers. Despite this different context, the moral support provided by MAX reps was still crucial to provider retention and improvement.

In both countries, recruitment was conducted on a rolling basis. This allowed the MAX team to support new providers and to fill spots that were vacated by providers who transferred elsewhere, stopped providing services, or who left the MAX program. In Kenya, providers were added to a rep's portfolio upon request. Mid-way through the program, unaffiliated providers began to approach MAX reps asking to be included so that they could receive regular data reports. Data reports thereby proved to be an accidental, but highly effective recruitment tool. In South Africa, when new facilities began to offer abortion services, they were included in the program at the request of the

PROBLEM

Abortion in Kenya is a highly stigmatized service, and abortion care providers regularly experience harassment from police, other providers, family members, and their communities. Providers risk losing equipment in a police raid or paying bribes, public embarrassment, jailing, and loss of reputation or business. Some even experience threats against their lives. In this environment, it was a challenge to recruit providers to offer abortion services; to convince providers to admit that they offered services; to get them to record data accurately or at all; and to persuade them to continue providing services over the long term. The process of approving clear, official standards and guidelines at the policy level was stalled for political reasons throughout the duration of the MAX project, and this contributed to the environment of stigma and criminalization.

SOLUTION

The MAX reps sometimes went to great lengths to convince trained providers to offer abortion services and recruit them into the network. They developed friendships with the providers, visited them in their homes, celebrated family occasions with them, and took them out for lunch. In several cases, MAX reps went far beyond standard professional boundaries to ensure that services would be available to women within their geographic area. In one case, a MAX rep visited a trained provider at his family farm who was unwilling to offer services, spending afternoons over a 9-month period helping him milk cows. She approached the topic of abortion gradually, once they had become friends, and ultimately obtained his agreement to offer services. In another case, the MAX field rep was asked to leave a provider's office initially for bringing up the topic of abortion, which went against the provider's beliefs, although she was trained. Once again, the MAX rep proceeded to build a friendship with the provider over time, only returning to the subject of abortion once a strong rapport had been established. This particular provider not only committed to offering abortion care services, she became an advocate and a mentor to other providers in the community, and began working with the police to orient new police officers on the legality and public health imperative of safe abortion services.

MAX reps proactively supported providers by giving them copies of the constitution that proved the legality of their actions, and connected them with legal support in case of need. They also educated providers on appropriate abortion practices related to safe and/or legal boundaries (i.e. appropriate gestational age (GA) limits, keeping client records, informed consent, etc.). Reps made themselves available by phone any time of the day or night if the provider ran into trouble, and invariably they were the first person the provider called when an issue arose. If the provider was taken to jail, the MAX rep arrived as quickly as possible with reinforcements. The providers counted on the MAX reps to support them, and the reps took this trust in them very seriously. The strength of these relationships was often enough to convince providers to continue to provide abortion services even when the political environment was especially challenging.

MAX reps also created and reinforced relationships between the providers themselves, who were sometimes isolated and operating alone in a large geographic catchment area. Reps connected providers in mentoring relationships to build skills and confidence, and to provide support to each other in the case of harassment. Additionally, reps established provider support networks through WhatsApp groups as part of a sustainability strategy to ensure strong connections among providers after program end.

IMPACT

The time investment that was required at the outset to overcome the environmental disincentives to the provision of safe abortion services was significant, and this approach was highly individual and likely not scalable. However, the lesson learned was clear: health care providers make cost benefit analyses like all the rest of us. In MAX's experience, the key to convincing health care providers that the benefits to offering abortion services outweigh the risks in such a precarious environment was to develop solid relationships of trust and accountability. A MAX provider in Kenya said:

"The MAX project touched on a very sensitive area where no other NGO has been able to venture. It was very unique, and it was very courageous. I had a court case. I had police entrapment. We [MAX rep and provider] worked together with the Reproductive Health Network and they gave me lawyers. And always when I went to court, there was a MAX member with me for moral support. You know, that moral support really counts. I really appreciated it and it made a difference."

One year after the program closed in Kenya, the MAX team contacted select providers to ask whether they were still providing abortion services and for their thoughts on the sustainability of MAX initiatives. All 10 providers interviewed said they were still providing services and were actively part of the provider networks that were developed during the MAX program.

LESSONS LEARNED

- In highly stigmatized environments, abortion care providers need extra support to compensate for the risks they incur in offering services and recruitment into programs often takes time.
- Data collection and accuracy in a highly stigmatized environment can be enhanced by establishing trust and rapport with providers over time.
- Technology (e.g., WhatsApp) can be a good way of connecting groups of providers for support, especially when they are isolated geographically.
- It is recommended that other programs implemented in similar high-risk environments consider staffing configurations that include staff members to develop relationships with and offer additional emotional, moral, and social support to providers.

^a During the term of the project, the team periodically removed providers from the network if they were not available to spend time with the rep on a monthly basis or were unable to provide data regularly, as their progress could not be tracked.



MCH Director and if the area rep was able to support additional providers. Because the program tried to fully accommodate provider needs, reps in large geographic areas where providers were spread far apart faced challenges. Additionally, for some reps, large caseloads of providers proved too much to ensure the quality of support given to existing providers. At a certain point, enrollment was cut off to ensure reps had sufficient time to support and evaluate each provider's progress. In retrospect, it would have been helpful to have defined an enrollment period (such as the initial 12 months) and to more carefully map each reps' geographical area, employing new reps as needed to accommodate overflowing demand of providers wanting to join the program.

LESSONS LEARNED:

- Lack of program rollout and recruitment structure made for an ad-hoc approach that created additional burdens on the field team (e.g. no introductory letters in Kenya; lack of criteria for provider recruitment and ongoing enrollment).
- Needed to be more measured about adding to reps' portfolio of providers and employing additional reps to help support overflow as demand to participate in the program increased.

BEST PRACTICE:

- Field reps should go outside of 'typical' work settings to build relationships with providers if recruiting in a stigmatized environment like Kenya.
- Providing regular data reports was motivational and an effective recruitment method.

PROVIDER SUPPORT

The type of support that MAX reps offered to providers was highly individual and depended upon identified barriers. This allowed reps to be responsive to the

needs of each provider and helped the program to learn more about the kinds of barriers providers faced and types of support that were most effective. On a monthly basis, MAX reps visited each provider to gather service delivery data and discuss the previous month. MAX reps filled out a monthly report with the provider detailing any barriers the provider faced. Once the barrier was identified, the reps and providers worked to address the problem together. The section below describes the main categories of support offered to providers, and examples of the specific type of support that reps provided in response to barriers in each of these categories.

AVAILABILITY OF SUPPLIES is defined as ensuring sufficient and consistent availability of abortion, contraception and infection control supplies. This includes the medication needed for MA (e.g. mifepristone and misoprostol); and the equipment needed for surgical abortions (e.g. MVA kits) and proper infection control (e.g. disinfectant, buckets, autoclaves); as well as IUDs, implants, injectables, oral contraceptive pills, and condoms.

MAX reps worked with providers to deliver a range of interventions aimed at improving supply availability issues for abortion, contraception and infection control commodities. To prevent stock out of abortion supplies, MAX reps inspected providers' equipment and stock to assess when orders should be placed, taught providers about inventory and supply chain management, and assisted providers with ordering stock, either linking providers to distributors or connecting providers to each other to borrow supplies in an emergency. MAX reps also worked with facility management or pharmacies to check on the status of supplies and helped to arrange donated stock to the facility when it was available.

Looking back on the MAX program, a MAX rep in South Africa said,

“The challenge was getting to facilities and finding that there were no consumables and there wasn’t much willingness from managers in terms of procuring the consumables for the TOP unit. Some of the managers felt that they had more important priorities such as TB and HIV, than TOP services. Through the interaction with the district offices and the managers from the provincial offices, we have come a long way in a short amount of time. The providers get the necessary support that they need. For us it was a great achievement to influence that change in behavior.”—MAX rep

One of the highest volume providers in Kenya at first provided no contraception to his abortion clients. There were two primary barriers identified: the busy provider did not acknowledge the priority of providing post-abortion contraception; and was not connected with a source of stock. The MAX rep helped the provider understand the importance of post-abortion contraception using evidence-based literature, and then assisted the provider to obtain oral contraceptives and injectables from the District Hospital. Shortly thereafter, the provider hired a nurse to provide LARC immediately post-abortion. The rep organized a training for the nurse to insert IUCDs and implants, and all clients of this high-volume clinic then had their choice of immediate post-abortion contraception. Overall during the MAX program, 92% of the 8,187 clients who received CAC at this facility received a contraceptive method.

FACILITY AND INFRASTRUCTURE refers to the improvement of physical and infrastructure-related aspects of facilities and staffing issues to enhance service delivery. Barriers related to facilities and infrastructure are common and can interfere with a provider's ability to deliver safe and confidential services.

The MAX team delivered a range of interventions to assist providers in remedying barriers related to facility infrastructure and staffing challenges. For example, MAX reps worked with providers and clinics to increase the number of days or hours the facility offered abortion services, which is a key component of meeting client demand. To improve physical aspects of facilities, reps helped providers with simple and low-cost clinic renovations (e.g. partitioning for privacy, adding privacy curtains) and expansions (e.g. adding additional rooms for services, connecting providers to suppliers of equipment or carpenters for renovations). As part of clinic improvements, reps also worked with providers to ensure facilities had a sufficient light source, linens, and a functioning toilet. When needed, MAX reps worked with providers or clinic administration to identify larger or more conducive spaces for the provision of services.

Barriers related to staffing and management were addressed by helping providers to improve their time management and scheduling skills and by encouraging providers and managers to add staff to cover demand. Part of this process involved working with providers or management to ensure that there were enough staff to cover for providers who were out of the facility on leave

or in training, and also networking with other facilities to relocate staff to under-staffed areas. Addressing conflicts among staff was also critical and involved facilitating meetings between management and staff to resolve issues.

Finally, MAX reps helped providers to improve referral processes and worked to ensure providers had access to an operating theater, available emergency resuscitation equipment/medicine, and access to transport, if a complicated case arose. In South Africa, this involved improving the “booking system.” The booking system offered a limited number of spaces for women to see providers by appointment, and sometimes resulted in clients being denied abortion services on request. Instead, they were referred away due to the facilities being “fully booked.” This was a particular problem in Gauteng province. In response to this high referral rate, the MAX team advocated with management at all MAX facilities in Gauteng to increase TOP staff, facility hours, and availability of TOP equipment and supplies (including MA), as well as to provide transportation to nearby hospitals. At the provider level, the MAX team encouraged the accommodation of walk-in TOP clients and the removal of daily caseload limits, as well as facilitated provider networking to share caseload. This resulted in the removal of the booking system at six facilities in Gauteng, same-day access to services for clients who arrive in their 11th or 12th week of gestation, and transportation to nearby hospitals if a clinic is experiencing high patient volumes.

The South Africa MAX reps helped providers achieve better working conditions and allocation of space, which preserved the dignity of clients and reduced stigma and marginalization. In KwaZulu Natal Province, a midwife was providing abortions in a workspace that allowed no privacy. The procedure table, sink, infection control station, a recovery chair and counseling space were all in one room. In addition, there was nowhere to wait, so women waited outside even in rainy weather. The provider felt that these poor working conditions were indicative of the facility administrator’s lack of support, highlighting the stigma and marginalization of abortion services. The MAX rep discussed the issue with the Maternal and Child Health (MCH) director in the province. Together, they arranged a pre-fabricated modular unit to be attached to the space that included a waiting room, an area for counseling and recovery, and a porch to accommodate patient overflow.

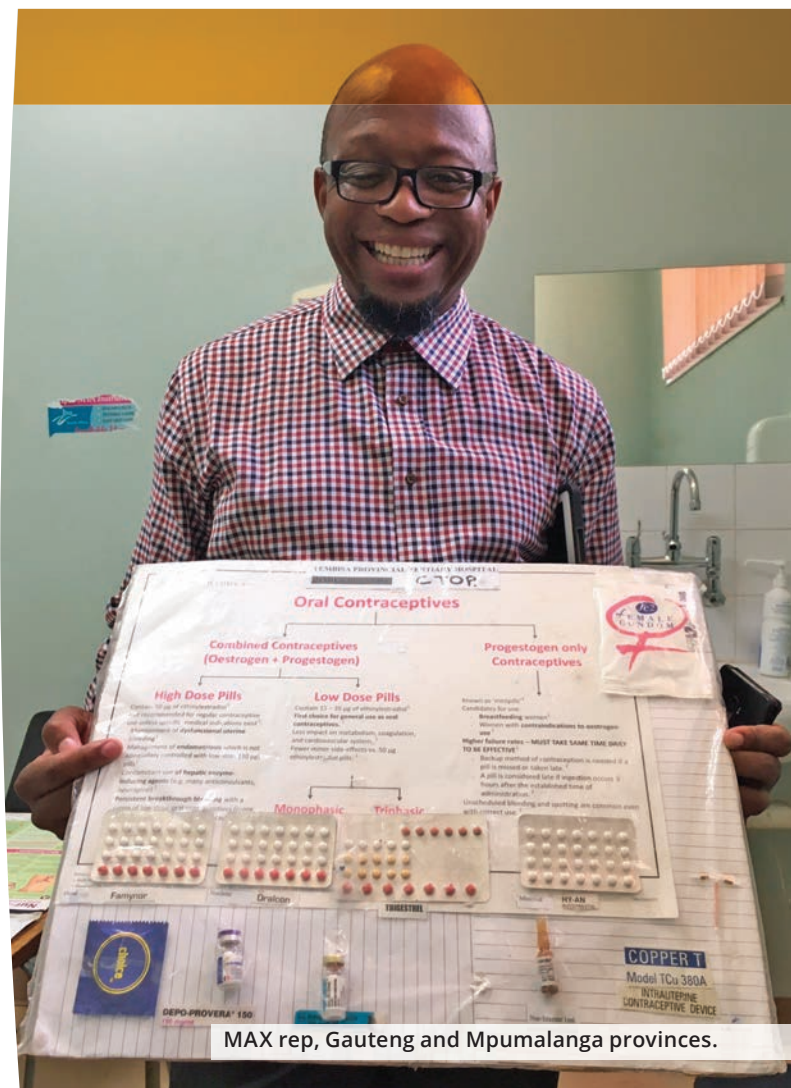
PROVIDER SKILLS is defined as improving provider knowledge and skills to promote and deliver safe abortions and post-abortion contraception, covering a range of activities from improving the quality of abortion care, advancing infection control procedures, expanding contraception services, improving provider-client communications and linking providers to training. Importantly, the need for training was cited by providers as a key barrier to the delivery of services, especially in South Africa. It was not under the purview of the MAX program to provide initial training, so instead the program focused on linking providers to trainings and mentorship on MA and SA procedures, infection control, and the delivery of LARC.

During a Limpopo dissemination meeting, providers expressed frustration at not having access to mentoring or clinical practice after their initial LARC training, resulting in hesitancy to use newly-acquired IUD insertion skills. The MAX team asked for volunteers willing to mentor newly-trained providers on LARC skills and the providers exchanged contact information on the spot. Managers at the meeting also agreed with the importance of excusing providers from normal duties for training and clinical mentorship opportunities to improve skill-building.

MAX reps, in collaboration with the CPM, worked with providers to improve the quality of care given to clients, including proper infection control. In Kenya, some of the MAX providers were part of other NGO networks but were not receiving clinical support; many others were truly isolated prior to MAX and had no support, so technical updates and skills-building was especially important. Support was provided to advance skills such as taking medical history, vital signs, and ruling out contraindications; confirming client pregnancy and estimating gestational age; providing accurate information on abortion methods; adhering to WHO standards for proper dosing of MA drugs and adhering to appropriate gestational age limits; encouraging use of the more effective MA combination, Mife-Miso; reducing abortion methods like sharp curettage and MA with methotrexate; and by ensuring that providers followed facility policies/guidelines. Proper infection control procedures were supported by teaching providers the correct reprocessing of MVA device; inspecting provider's equipment or procedure rooms; guaranteeing providers had a high-level disinfection chart to refer to; and ensuring handwashing, cleaning

room/equipment between clients, and correct disposal of products of conception (POCs), for example. For more information on the impact of infection control interventions in Kenya, see case study on page 19.

The MAX program also worked with providers to expand the contraceptive services available to women in the community. Providers in the program received a range of possible interventions, including encouraging providers to use contraceptive counseling tools and to expand contraceptive choices offered, especially LARC. This involved sharing literature with providers on improving contraception provision, role-playing with providers to practice contraceptive counseling, and encouraging providers and/or management to provide contraception at the first visit and to readdress at follow-up. Field reps shared research that stated in simple language the efficacy of LARC compared to other methods and their appropriateness for young, nulliparous, and unmarried women as well as women



MAX rep, Gauteng and Mpumalanga provinces.

PROBLEM

Proper infection prevention and control techniques are crucial to ensuring quality of abortion care; however, prior to the MAX program in Kenya, many providers did not have the knowledge, skills, or resources to ensure that necessary precautions were followed.

SOLUTION

MAX representatives (reps) influenced quality infection prevention and control through a variety of techniques including: inspecting provider's infection control equipment and procedure rooms, ensuring providers had high-level disinfection charts to refer to, connecting providers to sources of infection prevention equipment (e.g. buckets, sterilizing solution, autoclaves), educating providers on Ipas recommendations for proper MVA use and disposal, and ensuring infection control protocols (e.g. handwashing, deep cleaning procedure rooms) were followed.

Early on in the MAX program in Kenya, the infection control interventions were frequent and hands-on. The reps observed providers as they reprocessed abortion equipment. During these initial visits, MAX reps realized that many providers weren't using any infection control beyond soap and water. In response, reps would physically demonstrate proper reprocessing techniques with the provider and/or help the provider set up infection control stations with buckets and equipment. Reps would often roll their sleeves up and work shoulder-to-shoulder alongside providers during this exercise. The interactive nature of infection control interventions helped facilitate the development of cooperation, rapport, and trust very early in the MAX program.

IMPACT

Data analysis by WCG's academic research partners at the Center on Gender Equity and Health at UCSD revealed early on the importance of infection control interventions in Kenya. Analysis consistently showed that MAX providers in Kenya who received input on proper infection

prevention and control by MAX reps were more likely to improve in abortion and contraception outcomes than providers who didn't receive these inputs. This could be because providers who did not receive an infection control intervention may not have had as much room for improvement. Due to the nature of the MAX program, providers who didn't receive an intervention likely didn't need it as the project was set up to deliver interventions in response to barriers as they arose.

However, our hypothesis is that the hands-on nature of the intervention itself established a relationship of collegial support and a foundation of trust that is crucial in a highly stigmatized environment. This rapport and trust made the providers more receptive to dialogue, scientific information, and other support offered by the MAX reps. This practical, process-oriented intervention with the providers was a powerful means to establish trust and create receptivity to other interventions.

LESSONS LEARNED

- Organizations working with health care providers on improving abortion care in a stigmatized environment should incorporate activities that are process-oriented and hands-on in nature.
- Interventions such as improving infection control and preventing harassment and stigma can be just as impactful as common support activities such as ensuring supply availability and providing training.
- Hands-on, practical teaching that does not require a clinical person and is not formal "training" can be an effective means to improve infection control.



living with HIV. In Kenya, some providers initially didn't realize the importance of post-abortion family planning:

“One of the main improvements was the ability to provide post-abortion family planning. Before, people never used to take it seriously but with the MAX project and the training, we were able to provide post-abortion family planning successfully. This was one of the areas which was very beneficial.”—MAX provider

“The MAX project was an eye-opener to us. Post-abortion family planning—that was an area that was a vacuum and we had not touched it. That came with the MAX project. We embraced it, and it is gold.”—MAX provider

MAX reps also focused on improving provider communication skills to improve provider-client dynamics. Interventions with providers were designed to advance provider skills in the provision of counseling and the acquisition of informed consent. It involved utilizing a client-centered style of communication that was age-appropriate and that used non-clinical language, and greeting clients in a friendly and respectful manner as well as giving clients an opportunity to talk and ask questions.

Defining quality of care can be challenging but is important to measure well. As described more fully in the M&E discussion below, the MAX program's initial quality indicators were insufficient. In response, the benchmarking tool was developed to better define and measure specific indicators related to quality of comprehensive abortion care, and to support providers to improve skills. After completing the benchmarking assessment, providers were able to discuss challenges and were provided information and linkages to training and resources to improve skills. Please see case study on pg. 22 for more information on the impact of benchmarking in South Africa.

CLIENT DEMAND involves generating client and community awareness of abortion services and demand for LARC. Although the primary goal of the MAX program was to support providers in the delivery of abortion and post-abortion contraception, improvement in patient outcomes is also dependent on clients knowing about and seeking out services. There are a number of reasons why women may not seek care, which was not under the purview of this program; however, MAX reps did work to some extent with providers to facilitate client demand for services. Lack of community awareness of services offered in



MAX rep, Kenya.

clinics was a primary barrier reported by providers as was client opposition to LARC.

The MAX program addressed client demand in a limited fashion by working with providers to advertise and promote services, including encouraging providers to add signage to their facility or to distribute/post flyers to advertise contraception and/or abortion services offered. The MAX program also promoted collaboration between providers and community health workers to generate demand and encouraged providers to hold community outreaches to educate the community on services offered or contraceptive methods.

ENABLING ENVIRONMENT refers to securing a social, policy and regulatory environment that is supportive of abortion and post-abortion contraceptive delivery. Importantly, securing an enabling environment was recognized during the course of the MAX program as a key component that was necessary to support both provider behavior and a comprehensive solution to improving the delivery of CAC services. The cultivation of an environment more conducive to service delivery involved working at multiple levels to address interpersonal (e.g. feelings of isolation, lack of social support, conflicts between personal beliefs and the delivery of abortion or contraception services), community (e.g. harassment and stigma), and structural barriers (e.g. policy and regulatory environment).

Interventions geared toward resolving interpersonal barriers included those aimed at providing social support to providers in order to address feelings of isolation and limited support, but also to address potential conflicts between provider beliefs and the delivery of services by building self-efficacy. Social support by MAX reps was essential to building rapport and involved interactions outside of the normal work activities, like having lunch or tea with providers, checking in on sick providers and their family members at the hospital, visiting providers' homes and helping on their farms, attending providers' family events or calling to congratulate providers on successes. Such interactions built trust between providers and MAX reps while also alleviating feelings of loneliness, isolation or lack of support among providers. Lack of support was not the only barrier related to self-efficacy, however, as some providers experienced tensions between their own beliefs and the delivery of abortion and/or contraception services. To address provider values, biases or beliefs, interventions included sharing scientific information with providers to remove misconceptions, facilitating discussions on values and encouraging providers to continue offering services or to offer new services, and arranging values clarification trainings or mentorships for providers. Collectively, these interactions were intended to increase provider self-efficacy and self-esteem.

In addition, the MAX reps provided support by creating or reinforcing provider networks. They introduced providers to one another on an individual basis, facilitating mentoring relationships between more experienced providers and newer or less experienced ones. The senior providers offered not only help with clinical skills and practice but also could help to offset feelings of isolation or discrimination. MAX reps also connected providers with existing groups, and set up new WhatsApp groups so that providers could remain in contact even when they were geographically distant. These WhatsApp groups became an important source of support, as providers could easily ask questions, get updates, and request help of their colleagues. The MAX rep in the Mombasa region of Kenya helped to establish new "cluster groups," which were organized meetings to gather providers together to discuss challenges, learn new scientific findings, and support each other. Said one provider,

“The cluster meetings have helped because during them we share problems we are having in the field, and we see how we can go about it during the clusters. In case there's anything you can't

manage, we call one another and we go together and assist. That's how we help one another. We comfort one another during those clusters.”—MAX provider

At the community level, reps in both countries provided significant support to prevent and address harassment and stigma experienced by providers. For more information related to building trust with providers in Kenya, please see case study on pg. 15.

In South Africa, the MAX reps assisted providers who were being stigmatized within their work environment, called names and harassed by managers and colleagues, and limited by pharmacists who wouldn't process orders for equipment or contraceptives. The reps brought these issues to the attention of the facility administrators or district Maternal Child Health directors, who subsequently communicated a zero-tolerance policy of harassment to a clinician providing health care to which women have a legal right.

On a larger structural scale, the MAX team in South Africa actively worked to change province-level policy. When the MAX program began, only two provinces—KwaZulu Natal and Western Cape—had MA protocols already in place. In the remaining three provinces—Limpopo, Gauteng, and Mpumalanga—the CPM in consultation with WCG's medical director helped officials to draft comprehensive abortion care policies and roll out MA services. For more information on the impact of rolling out MA policies in South Africa, see case study on page 25.

LESSONS LEARNED

- The success of this type of approach is dependent upon the MAX reps' emotional intelligence, creativity, adaptability and problem-solving skills, as well as the intensity and frequency of their interaction and personalized support. Further evaluation is necessary to determine ways to ensure such a rigorous and tailored intervention can be scalable.

BEST PRACTICE:

- Tailored interventions allowed for responsiveness to issues as they arose, and resulted in both creative problem solving and capacity building with providers.

PROBLEM

Prior to MAX in South Africa, there wasn't an evaluation tool to measure quality of TOP services. Other units within the public health system such as Maternity and HIV had established, regular audits of services that were tied to employee performance reviews and incentives; however, similar audits and incentives did not exist for providers working within the TOP unit. Therefore, TOP providers did not have the same opportunities for advancement and incentives as other health care providers due to lack of performance measurements. Many managers were not actively involved in the TOP unit and were unaware of the challenges faced by TOP providers.

SOLUTION

The MAX team developed a benchmarking tool in consultation with local stakeholders at the provincial departments of health to provide a method to evaluate abortion providers according to clinical quality of care standards. The benchmarking tool consisted of two main sections: assessment of *provider* clinical skills, client interaction, and services provided and a review of *facility* infrastructure, conditions, and services available. Each section had a score card and overall grade. Both providers and managers from facility, district, and provincial levels in all five provinces were oriented on the tool prior to its implementation. This helped to set expectations, align goals, and generate buy-in with the tool. In practice, the benchmarking assessment visit was conducted by the MAX clinical program manager (CPM).

On assessment day, the air was filled with nervous anticipation. For most providers, this was the first time they were formally evaluated and they were unfamiliar with attention focused on them and the work they do. Providers were proud to show off their knowledge, attitude and skills and were hopeful that they would perform well. Many had even practiced with the tool in advance of the assessment to be sure they were ready. Some facility and district managers in all provinces joined for provider assessments; listening intently, taking fastidious notes, and asking questions about how to sustain and improve their providers and facilities. For some providers, this was the first time that their manager had shown interest and investment in their work. Upon completion of the assessment, the MAX clinical program manager reviewed the results with the team and highlighted successes and areas for improvement and thereafter the team came up with resolutions and ways forward. In some cases, the visit concluded with managers inviting the entire group for tea to celebrate.

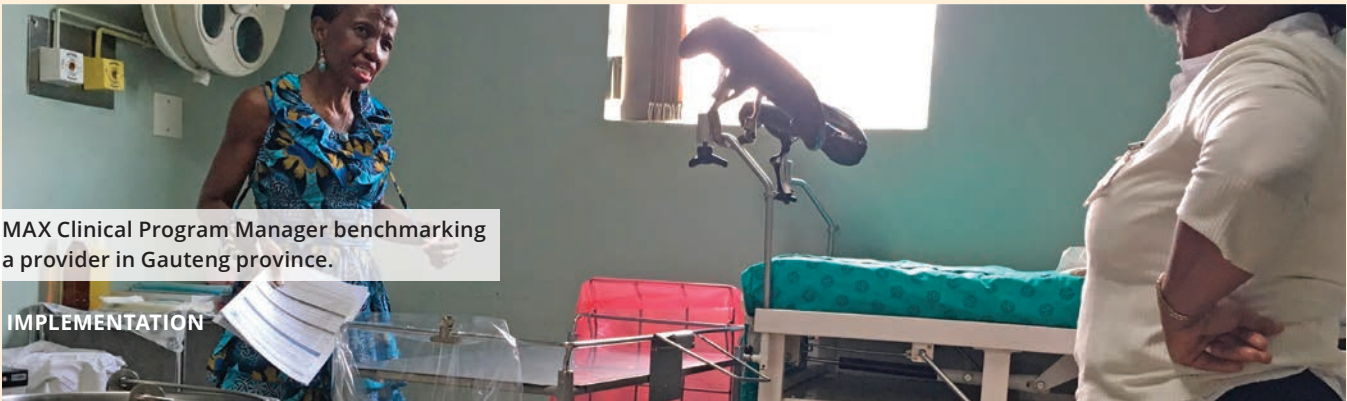
At an aggregate level, the CPM would share provincial benchmarking data with providers, managers, and district and provincial authorities at a dissemination meeting. Trends, gaps, and areas for improvement were discussed. Overall, the benchmarking assessment process garnered overwhelming support from providers, managers, and district stakeholders. Multiple provinces added their logos to the tool as a sign of ownership and have even been using it more broadly to evaluate new facilities for preparedness to provide abortion services.

IMPACT

The benchmarking process increased manager buy-in and support for abortion providers in South Africa. Managers were able to see firsthand what the daily work of the provider entailed, and how operations at a facility, district, and even provincial level directly affected the ability of the provider to succeed in their work. TOP-related barriers faced by the providers, if previously unknown, became apparent to facility managers. The tool helped bring TOP out of the shadows by introducing a formal process to recognize TOP providers. The tool offered managers a means by which they could assess their providers on their performance for hiring, firing, or promotion and providers now have a way to self-evaluate themselves regularly to ensure quality of care standards are being adhered to. In addition, sharing benchmarking results on both the provider/facility and the provincial level offered multiple avenues for providers, managers, and district or provincial stakeholders to target improvement in TOP services.

LESSONS LEARNED

- Benchmarking assessments are time consuming (at least 3 hours) and clinically-trained staff are needed to conduct assessments.
- Engaging stakeholders in the development of a tool and providing feedback after assessment increases buy-in and likelihood of sustainability.
- Facility, district and provincial managers need to be trained on how to conduct a benchmarking exercise and be encouraged to use sections of the tool every time they conduct a provider support visit.
- Providers should use the tool on daily basis to reinforce competency and confidence in rendering quality comprehensive abortion care.



MAX Clinical Program Manager benchmarking a provider in Gauteng province.

MONITORING AND EVALUATION

This section discusses implementation and lessons learned related to measure development, data collection, and analysis.

Selecting and defining indicators

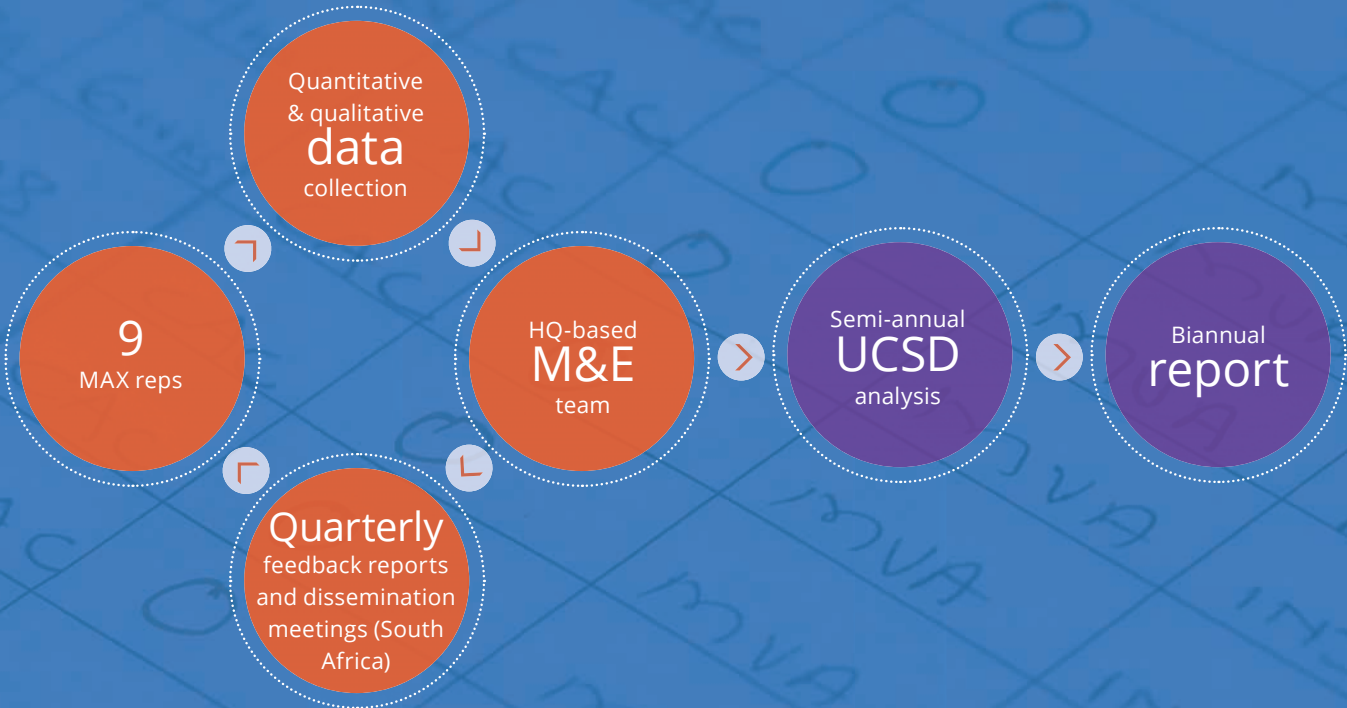
WCG selected primary objectives for the MAX program in collaboration with the donor. In addition to improving the quantity of abortion services provided by the network of providers, outcomes included improving the quality of abortion services, increasing post-abortion contraception with a focus on LARC, and assessing the possible program-related causes of changes in quantity and quality of abortion services. Indicators to measure improvements to the quantity of abortion services and post-abortion contraception were well-established from program outset; however, indicators to measure improvements to *quality* of abortion services were initially not well defined or collected. One crucial programmatic change that was made midway through the program was the recognition that the indicators related to improving the quality of CAC services were insufficient. The quality indicators, which were set when the program was initiated in Kenya, were (1) a reduction in the use of abortion regimens not recommended by WHO (e.g. sharp curettage and methotrexate for medical abortion); (2) an increase in the use of the more effective mifepristone-misoprostol regimen rather than misoprostol-only for medical abortion; and (3) an improvement to infection control measures. It was initially believed that the program would focus on non-clinical barriers such as solving supply chain issues, recruiting and retaining providers where there were no services available, and referring providers who were in need of training to a partner organization. However, as many of the providers recruited to the program in Kenya were isolated and had previously received little or no clinical support beyond initial training, it became apparent that more clinical support was needed to improve quality of care. As such, in consultation with local stakeholders, the MAX program developed a quality of care benchmarking tool to be used to (1) evaluate providers on clinical standards related to CAC; and (2) give reps more specific guidance about which areas of clinical support were needed, based on benchmarking scores. The tool was piloted with a group of providers in Kenya in November of 2015, and revised based on that field test. It was then shared with provincial, district and facility-level managers in South Africa, revised again based on their feedback, and implemented in two rounds of assessments in



MAX Clinical Program Manager.

MAX PROGRAM

DATA FRAMEWORK



2016 and 2017. Due to the late development of this assessment tool after program start and the rigorous process of gaining buy-in from various stakeholders in South Africa, there was insufficient time for the tool to function as a quality of care indicator to be measured and analyzed during the MAX program.

Data collection tool: MAX Logbooks

At the outset of the pilot project in 2012, WCG worked with key opinion leaders and groups such as Doctor John Nyamu, the Kenya OB/GYN Society (KOGS), RHN, Planned Parenthood Global, the Population Council and Kisumu Medical and Education Trust. Over five months, this group of experts developed and tested a paper-based logbook to collect client information using aspects from the Kenya MoH data collection tools. Data collected on the logbooks included client demographic information (age, education level, marital status, parity) as well as outcome data (weeks of gestation, PAC/CAC, type of abortion, date of abortion, contraception given, timing of contraception, date of follow-up, and complications or emergency care given). Provider initials were also collected for each abortion procedure they performed. Providers were de-identified using a unique MAX ID number assigned during recruitment. Similar logbooks were developed for Kenya and South

Africa, with the additional collection of HIV status in South Africa as encouraged by the National Department of Health. Intensive staff training on all data collection indicators was essential to ensuring consistency in the definition and use of measures across participating stakeholders (field representatives, health care providers, M&E program staff).

Copies of logbooks were distributed to providers as they joined MAX. Separate medical and surgical abortion logbooks were created and distributed to providers according to the types of abortion procedures they offered (medical, surgical, or both). Data collection began in January 2013 in Kenya, in April 2013 in three South African provinces (Gauteng, Mpumalanga, and KZN) and in September 2013 in two South African provinces (Limpopo and Western Cape). The medical logbooks were revised mid-2016 to collect more detailed information on timing of contraception and follow-up depending on whether clients were admitted for the procedure. This enhanced validation capabilities for the M&E team and strengthened data accuracy.

Hard copies of completed logbooks were collected once a month by MAX reps for each provider they supported. Logbooks were sent via email to the M&E

CASE STUDY

FACILITATING POLICY CHANGE AND ROLLING OUT MA SERVICES IN SOUTH AFRICA

PROBLEM

At the beginning of the MAX program, only two of the five provinces where MAX was implemented had both surgical and medical abortion (MA) policies and were implementing MA. In the remaining 3 provinces, this limited both method choice and access to women, because there were a limited number of highly trained providers available to provide surgical abortion services. In many facilities in Gauteng province in particular, providers had such limited time that most clients did not receive the service within one week of requesting it. When the slots in the booking system were filled, women had to be booked for a later date, sometimes pushing them over a gestational age limit and thereby limiting their options, as 2nd trimester services are not readily available.

SOLUTION

Medical abortion (mifepristone followed by misoprostol, or misoprostol only in case mifepristone is not available) is a safe, non-invasive alternative to surgical abortion which does not require a highly skilled provider to administer. It is highly effective with low complication rates up to, and after, 63 days gestation. Many studies have established the safety and efficacy of lower cadres of health care providers offering MA, and the World Health Organization (WHO) recommends that associate clinicians, midwives, nurses, auxiliary nurses and auxiliary nurse midwives can provide MA when properly trained.²³ Currently in South Africa, MA can be provided by physicians, registered midwives and nurses. The use of MA can greatly expand access to abortion for eligible women, and ensure that health care providers' time is available for more complicated cases.

The MAX Clinical Program Manager (CPM) worked with officials in two provinces, Western Cape and KZN, to update their policies; and in Limpopo, Gauteng and Mpumalanga provinces to draft comprehensive policies, and to help roll out the newly-approved MA services. The CPM leveraged the MAX program's data dissemination meetings as an advocacy platform, using the opportunity to point to the number of women that were barred from accessing safe abortion because of the booking system. The recommendation that came out of these discussions was to draft comprehensive abortion care policies that included both MA and surgical methods, and to roll out MA services by orienting providers, ensuring a supply of mifepristone, and supporting providers clinically. The CPM partnered with designated officials in each province to create an initial draft of a policy if one did not exist, or reviewed and provided comments to already-existing drafts. The process of drafting, reviewing, and approving policies in the public sector can be time-consuming, and only Mpumalanga province finalized its policy (March 2017) and rolled out MA services prior to the end of the MAX program. However, in all three provinces (Mpumalanga, Limpopo, and Gauteng), providers were trained and allowed to begin offering services before the policies were officially adopted. The provinces used the WHO Clinical Practice Handbook for Safe Abortion 2014 as a reference for MA procedures, and the providers were supported clinically by the CPM during the roll out of MA services. Notably, this expanded choice and access to abortion for women in three South African provinces.

IMPACT

The immediate impact of implementing MA policies and rolling out services is difficult to estimate, as there was only a short period of time

left in the MAX program to collect data after implementation. However, experience in other countries shows that the introduction of MA can significantly improve women's ability to access services, whether in a facility or at home. We expect that with time, caseload in South Africa will rise significantly, the proportion of women being turned away due to the facility being "fully booked" will be reduced, and morbidity and mortality due to unsafe abortion will decrease.

MAX program data shows that in Mpumalanga province, MA provision has been increasing since the end of the third quarter of 2016 when 63 providers attended an MA training organized by WCG and co-hosted by the province. The proportion of total caseload among MAX providers that was MA more than doubled from 16% in Q4 2016 to 33% in Q2 2017. When asked what the biggest impact of the MAX project was, the MAX rep in Mpumalanga said:

"We've rolled out medical abortion in Mpumalanga—that's one of the biggest impacts for the women in the area. We don't only serve the women of Mpumalanga, we also serve women coming from the neighboring countries such as Swaziland and Mozambique. The borders are close to Mpumalanga so it's very easy for women to come through to access the services because services are not easy to access in those two countries."

LESSONS LEARNED

- Implementing MA policies and rolling out MA services has great potential for increasing women's access to safe abortion services.
- Bringing providers, managers and officials together regularly to discuss progress and solve problems is a best practice that can result in gaining buy-in and momentum for high-level change.
- It is helpful to have a senior leader who can keep issues such as policy change on the priority list of busy health department officials, and who can take the lead on drafting and reviewing documents.
- Orienting providers and their managers on the signed protocols, policies and facility guidelines prior to dissemination is key to ensure all stakeholders are involved.
- It may be an option to be able to start offering MA with existing guidelines (i.e. WHO) while waiting for guidelines/policies to be adopted.



MAX reps, Western Cape province.

team in San Diego. Once received by the M&E team, logbook data were printed, reviewed rigorously, and validated for data accuracy. After clearing validation, logbook data was entered into individual Excel files and then combined into a master MAX Excel database. The whole data cycle from collection through processing took a minimum of 4-6 weeks. This timeframe is important to consider when establishing reporting timelines for a data-intensive project of this nature.

Initially, the MAX reps not only collected quantitative logbook data, but they were also responsible for *entering* the data into the database as there was not a dedicated M&E staff member at project onset. Having field staff enter data resulted in poor quality due to the heavy workload supporting providers, and also required a significant amount of time that could be better invested in providing additional quality support to providers. Inaccuracy in field data input was recognized and data entry responsibilities were redirected to staff in the HQ office. In October 2014, an official M&E team was established to monitor, clean, and validate incoming data, which resulted in improved data monitoring.

Tracking Intervention Delivery and Barriers

Data collection evolved significantly over the life of the MAX project. Because the project was designed to explore the association between rep interventions

and improved provider outcomes, exploratory data collection was needed at project onset to inform and enhance future data collection. Through February 2014, qualitative data on the types of support provided by representatives to providers was collected and coded by WCG staff for common themes, using a standard approach for analyzing qualitative data.

After the initial program report in June of 2014, UCSD and WCG worked together to develop a new system for collecting monthly quantitative and qualitative data on the types of interventions provided by MAX reps. The new system included quantitative assessment of the interventions delivered using pre-defined categories, as well as qualitative data detailing specifics of the interaction between the MAX rep and provider. The pre-defined intervention categories were informed by early qualitative data collection and included: infection control, harassment or stigma prevention or management, prevention of stock-outs, improving the quality of contraception provision, addressing physical and structural facility issues, addressing staffing and management issues, linking providers to trainings or mentorships (e.g. abortion, LARC, or other) structural referral issues, values clarification, and social interactions between the representatives and the providers.

Intervention categories were refined twice more during the MAX project: once to collect more specific information on categories that were originally very broad (Oct 2015), and another time to add categories to capture interventions relating to improving quality of care (second half of 2016). As intervention categories changed iteratively over time, data analysis became more difficult.

Information on barriers providers faced in the provision of quality abortion care was also collected by reps using a “monthly update” form, which included information such as whether a provider attended a training, participated in dissemination meetings, or offered any new abortion or contraception services in the past month. In the second half of 2015, the monthly update form was revised to collect detailed information on provider barriers including: stock-outs of supplies, problems with facility infrastructure (space, privacy, hours), lack of community awareness, experiencing harassment or stigma, having conflicting beliefs to providing services, or insufficient training. Since data collection on barriers did not begin until 2015, we were unable to systematically examine barriers faced by providers earlier in the project. Collecting this information from project start would allow for an analysis of how barriers changed over time after exposure to the MAX program.

All intervention and monthly update data were collected by field reps on an iPad using a custom-built software platform, *iformbuilder*, created by a MAX programming consultant. Data were uploaded to a secure website through *iformbuilder*, and each submission was reviewed by the M&E team to ensure data accuracy.

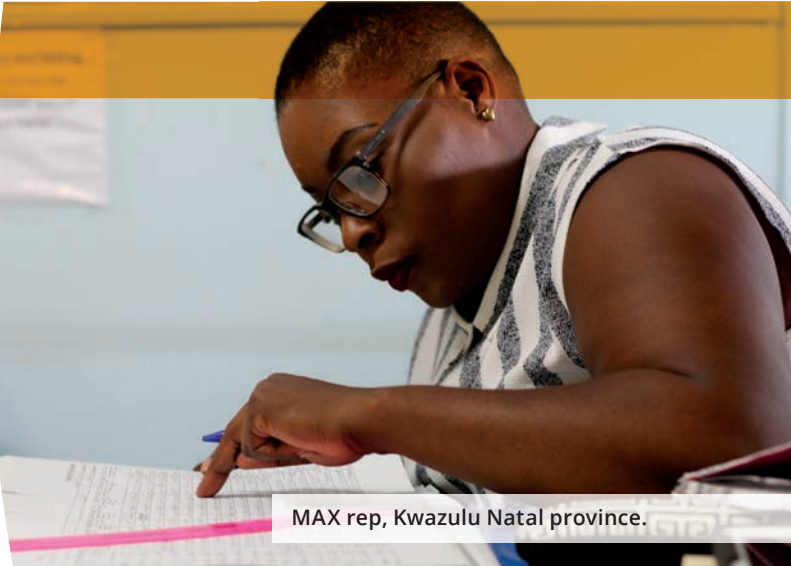
Training staff on data collection

MAX reps underwent an initial training at project start including a basic overview of the data collection tools; however, more comprehensive training on M&E practices and good data management proved useful as the program developed over time. For instance, MAX reps received intensive data training in May 2016 after logbook data collection forms were revised. Training included in-depth discussion of indicators collected as well as role-playing scenarios and interactive games. Feedback on this training highlighted the importance of regular visits and trainings from the M&E team. After this intensive training, the quality of data collection improved greatly, emphasizing the need for advanced M&E training at project start as well as ongoing support.

Data Dissemination to Providers

The M&E team regularly created reports for the field as part of a data feedback loop. In Kenya, due to the individualized nature of private facilities, MAX reps gave providers personalized data reports on a quarterly basis. Conversely, in South Africa, where buy-in and support from management was critical to program success, biannual data “dissemination meetings” were held in each of the five provinces. Attendance at the dissemination meetings included MAX providers and their managers, as well as stakeholders from the district, provincial and national levels. In both Kenya and South Africa, data feedback was used to interpret trends, identify gaps and areas of improvement, generate and facilitate discussions on achieving target goals, and drive evidence-based decisions from the grassroots level. This data feedback loop became an essential piece of the MAX project in both countries. See case study on pg. 28 for greater detail on the impact of data feedback.

Originally, individual data reports were created by hand from the M&E team; however, to accommodate the high volume of providers, a customized software was built and used to automate reporting. This enhanced the ability to generate high-quality reports on a consistent timeline with such a large number of participating providers. Automated reports included visual charts to display abortion caseload trends over time, contraception provision by method in the most recent quarter, and trends in LARC, short-term methods and no method provision over the previous year (or other specified time period). In South Africa, data were also aggregated to show similar trends at a district, provincial, and country level.



MAX rep, Kwazulu Natal province.

PROBLEM

Health care providers in developing countries often do not receive feedback on their performance in a visually-intuitive way.

SOLUTION

In both Kenya and South Africa, consistent data feedback loops were established, whereby all participating providers received individual reports consisting of easy-to-interpret visual graphs and charts showing progress on abortion and contraception service delivery. Reports were given at least twice a year to all participating providers. Delivery of data feedback was adapted for specific country context and needs.

For example, in the Kenya private sector where facilities are often run by the provider her/himself and the where the providers are the main business and decision-makers, individual data reports were hand delivered by MAX representatives. The MAX reps used the reports to generate discussion on provider performance, identify gaps and areas of improvement, and brainstorm custom-solutions to improve practices.

In South Africa, working in the public health sector, data feedback was altered to meet the more structured and bureaucratic system. At least twice a year, dissemination meetings were held in each of the five participating provinces. Attendance at the dissemination meetings included MAX providers and their managers, as well as stakeholders from the district, provincial and national levels. In both Kenya and South Africa, data feedback was used to interpret trends, identify gaps and areas of improvement, generate and facilitate discussions on achieving target goals, and drive evidence-based decisions from the grassroots level.

IMPACT

MAX's establishment of a consistent feedback loop resulted in a number of substantial and unexpected benefits. For example:

In Kenya, providers valued the data reports they were given, and many framed or pinned them proudly on their facility walls. In addition to serving as motivation for improvement and continued participation, the data reports also generated curiosity and excitement about the MAX project among the network of private providers. Providers who were not already part of the project gained interest, and the data re-

ports were used by MAX reps as a recruiting tool to get new providers to join the MAX program.

In South Africa, sharing of data at dissemination meetings became an important venue for increasing management support and buy-in of TOP services. Through identifying areas of improvements and sharing best practices (both among providers and between provinces), managers became aware and appreciative of their role as a support system to providers. They became an integral part of the solution towards improving and sustaining quality TOP services. Dissemination meetings had impact on a larger level as well. Discussions helped to advocate for adding a line in the district budgets specifically for TOP resources (e.g. supplies, staffing, equipment). Regular data feedback also helped to put TOP services back on the national health care agenda as a priority.

In South Africa, the dissemination meetings evolved into an event to bring TOP services out of the shadows. They became a platform to talk openly about a service that is often neglected. They gave providers a scheduled opportunity to discuss their thoughts freely, debrief with one another, identify commonalities in issues faced, and network amongst each other, which facilitated a sense of belonging.

Gauteng Province was the first of the five provinces to join MAX and quickly gained support from Gauteng's Director of Maternal Child Health (MCH), Nutrition and ISHP, Mr. Sikhonjiwe Masilela. He was a strong MAX supporter because the reports gave him the tools to make data-driven decisions to strengthen abortion services. At a meeting with all provincial MCH directors, Mr. Masilela shared the MAX reports and told them, "If you're not participating in this program, you are standing still, you are not improving."

LESSONS LEARNED

- Providing regular, evidence-based feedback is a useful tool to recruit, engage, motivate and empower health care providers and their managers.

Dr. Jane Harries, one of MAX's partners at the University of Cape Town, praised the data feedback loop as unique and essential for the way in which it engaged providers and policymakers:

"The MAX program is unique in its comprehensive approach to strengthening abortion care services in South Africa with a particular focus on health care providers. Having worked in the area of abortion research in South Africa for over twelve years, this is the first time I have seen such sustained and continued interest and support from providers and policy-makers in Western Cape, evidenced by their continued attendance at feedback meetings and keen engagement with all the issues. Providing regular feedback in an accessible and engaged manner was another success and different in that all stakeholders were actively engaged in the process and all feedback was evidence based."—Dr. Jane Harries

LESSONS LEARNED:

- Use trained M&E staff instead of field staff to clean and enter quantitative data. This improves accuracy of data and allows field staff to prioritize other tasks.
- Because this was a pilot project, M&E tools and indicators were developed through an iterative process and serve as a good reference point for other projects to build from to avoid similar challenges.
- Train all staff, irrespective of role, on project monitoring and evaluation. This will help increase buy-in, knowledge and understanding from field staff regarding the data cycle and its importance to a data-driven project. Provide ongoing training and support on M&E to all staff.
- Ensure adequate staffing on M&E team to allow for robust data processing.

BEST PRACTICES:

- Involve field staff in data tool creation, updates, and trainings.
- Conduct regular field visits and check-in calls by M&E team for ongoing support to field staff.
- Establish consistent data feedback loop to share data trends, gaps, and improvements with providers and managers.



MAX providers and managers at dissemination meeting, Gauteng province.



MAX rep and provider, Limpopo province.

PROGRESS AND RESULTS



Deputy Director of Women’s Health Services, Limpopo province.

During the MAX program, abortion care providers in both Kenya and South Africa showed substantial progress in both abortion and contraception outcomes. Performance indicators were based on the quantity and quality of services delivered over time and intended to inform global and country-level discussions about evaluating progress in abortion care. Our results suggest that a comprehensive program focused on supporting providers through relationship-

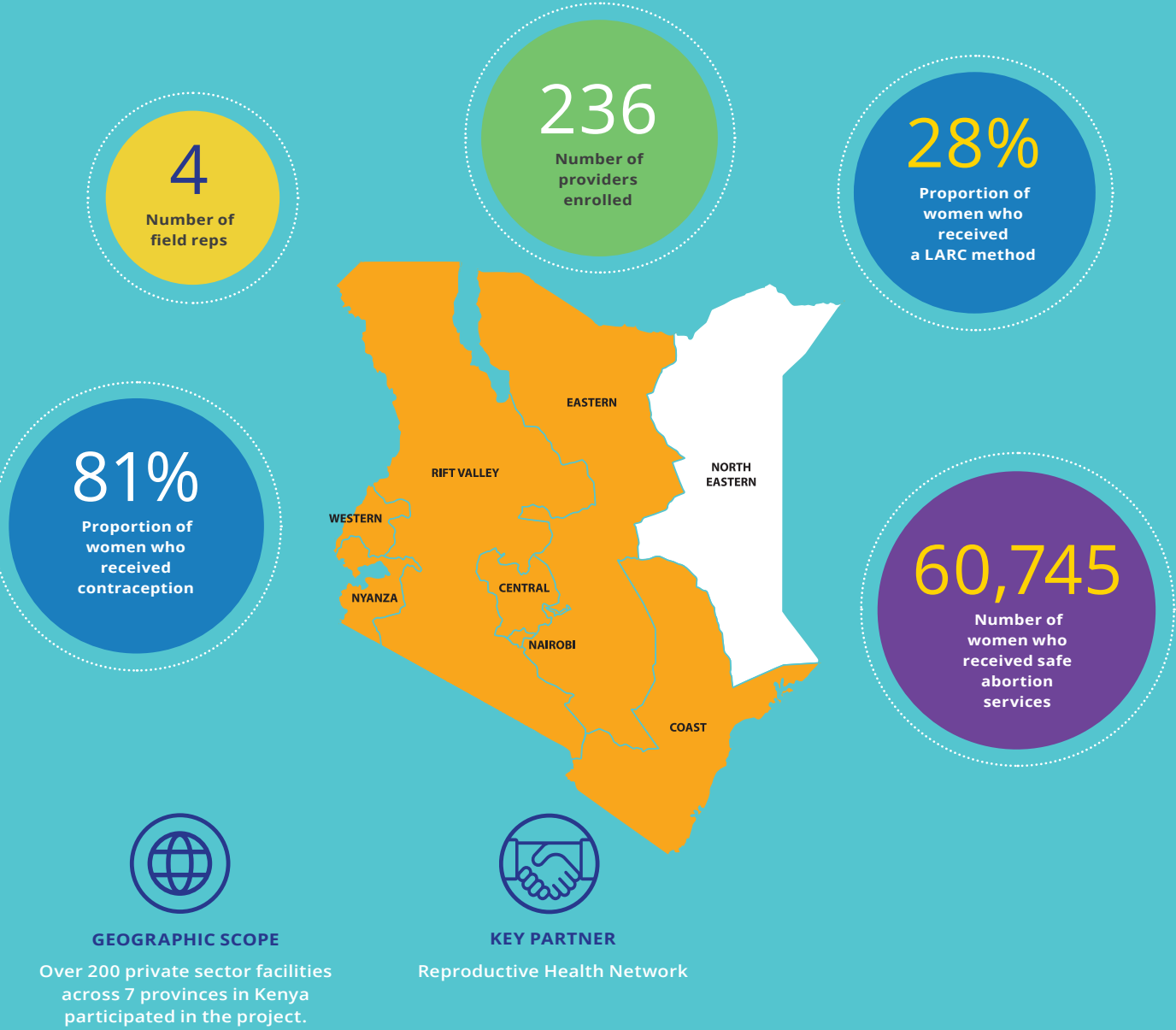
building, the tailored delivery of interventions, and data dissemination can have real effects on the quantity of abortions delivered, on the quality of abortion services, and on the delivery of post-abortion contraception with a focus on LARC. Some of the most important impacts of the MAX program are illustrated in the graphics below. The evaluation process was conducted in partnership with UCSD’s Center on Gender, Equity and Health.



Managers, Gauteng province.

EXPANDING ABORTION AND CONTRACEPTION ACCESS IN:
KENYA

BY THE NUMBERS: JAN 2013 – JUNE 2016*



ACHIEVEMENTS:

- 84% of providers improved significantly in key program outcomes
- 45% increase in average provider monthly caseload despite a highly stigmatized environment
- 51% reduction in the provision of no contraception post-abortion
- 31% increase in provision of LARC after MA
- More than 60,000 unsafe abortions prevented
- An estimated 342 maternal deaths averted

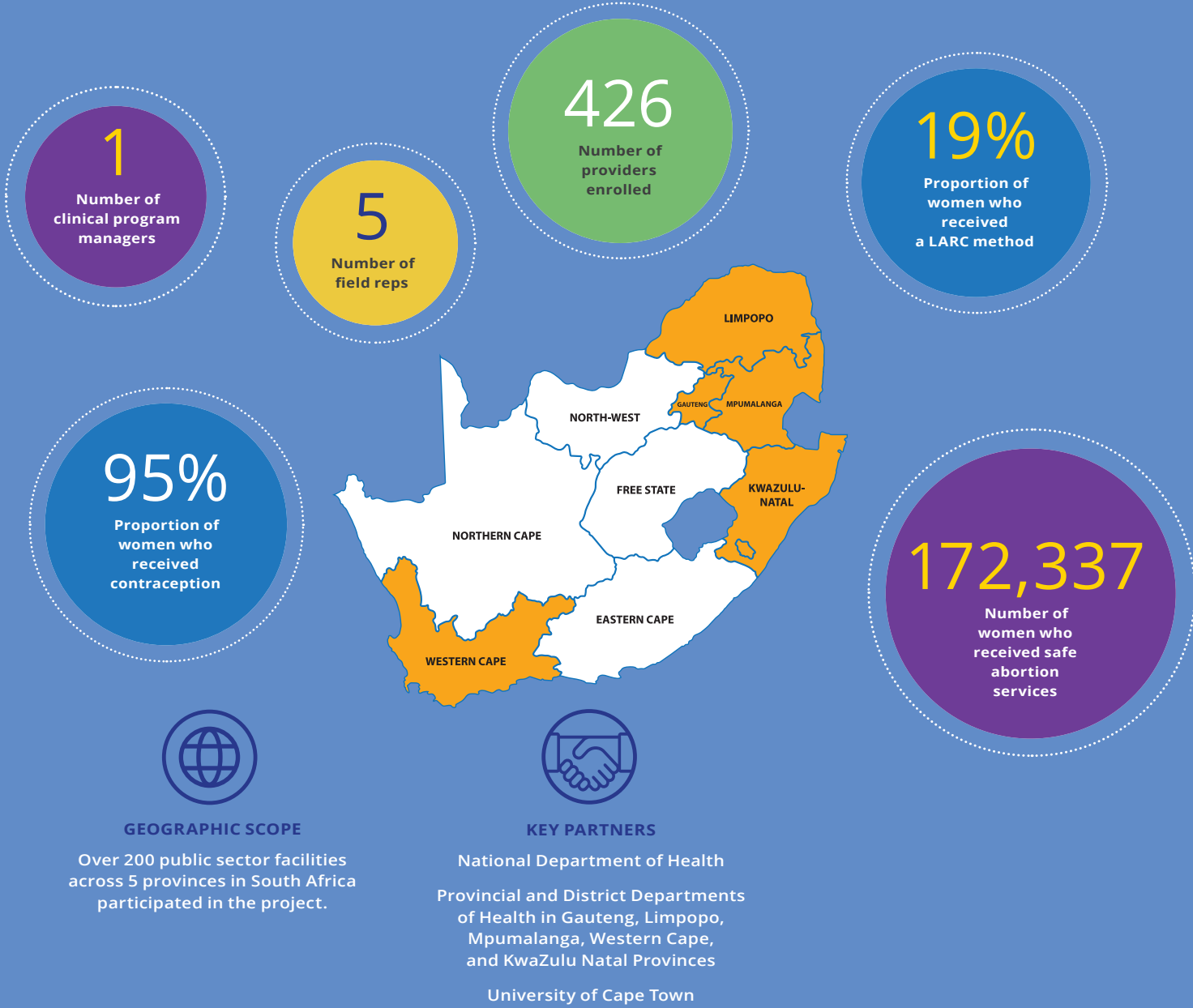
COUNTRY FINDINGS

- Most popular contraceptive method: injectables (27%)
- Surgical procedures as a proportion of total abortions: 53%

*Dates when data collection began,

EXPANDING ABORTION AND CONTRACEPTION ACCESS IN:
SOUTH AFRICA

BY THE NUMBERS: APRIL 2013 – JUNE 2017*



ACHIEVEMENTS:

- 77% of providers improved significantly in program outcomes
- 95% increase in average provider monthly abortion caseload
- 100% reduction in the provision of no contraception post-abortion
- 100% increase in IUD provision between Q2 2015 – Q2 2017
- Nearly 100,000 unsafe abortions prevented
- An estimated 375 maternal deaths averted

COUNTRY FINDINGS

- Most popular contraceptive method: injectables (71%)
- Surgical procedures as a proportion of total abortions: 87%

*Dates when data collection began,

INTERVENTIONS

District manager, Gauteng province.

This section reports on the MAX team's experience using evidence to understand the levers that drive provider behavior change. The data that the MAX reps collected on interventions given to providers was reviewed and analyzed by the program's research partners at UCSD. The research team performed rigorous analyses to assess associations between receiving each intervention and their relation to MAX outcomes as a means to identify which interventions were associated with a statistically significant improvement in MAX outcomes over time.^b The identification of the specific interventions that resulted in provider behavior change and improved patient outcomes may be of value to similar programs seeking to make evidence-based decisions about which interventions to prioritize in the context of limited resources.

To assess the potential impact of interventions, we examined the association between receiving intervention activities and improvements in MAX performance indicators over time. We present statistically significant findings for interventions associated with at least a 50% increase in outcomes (e.g., 50% or greater increase in total abortion caseload; 50% or greater increase in LARC provision, etc.) between a baseline period (before monthly intervention data collection began in October 2014) and a period *after* the intervention was conducted. Therefore, improvements in outcomes are in *addition* to any improvement providers may have already made prior to October 2014.

In Kenya, at the end of the MAX program, the highest priority interventions that were significantly associated with at least a 50% increase in provider improvements in program outcomes related to the provision of either

abortion care and/or post-abortion contraception included:

- *Preventing or addressing harassment/stigma*
- *Addressing or preventing stock-out of abortion supplies*
- *Expanding or improving contraceptive services offered^c*
- *Abortion training*
- *Increasing gestational age limits^d*
- *Improving provider-client communication^e*
- *Increasing community awareness of services*

***Additionally, interventions related to improving infection control and social support^f were also statistically significant, but at a more limited level (i.e. they were associated with statistically significant improvement of 20% or greater in one or more program outcomes).*

Although monthly intervention data was not collected until October 2014, we hypothesize that in Kenya certain interventions may have been important early on, to build a strong foundation upon which further support could be provided and would be more impactful. These early interventions included **social interactions** whereby reps interacted with providers outside of normal work activities to build relationships with providers, **improving infection control**, and **addressing or preventing harassment/stigma**. These are foundational and trust-building activities which we believe are important working with providers in a stigmatized environment. For example, the MAX

^b There are a number of potential limitations to our analyses. For each provider, analyses examine interventions received *prior* to the outcome of interest, thus giving us greater ability to say that the intervention, as opposed to other factors, was responsible for the increase. However, we cannot account for exposure to interventions prior to the time point in which we began measuring intervention exposure on a monthly basis (October 2014), so for many providers, the analyses assessing 50%+ increases over time only examines improvements since October 2014. Therefore, this measure does *not* reflect all the improvements providers made prior to this point in time. Additionally, in these analyses, we only look at whether a provider *ever* received the intervention and why at the end of the program, certain interventions were ubiquitous, making the comparison groups of providers who did not receive the intervention quite small. This limited our power to detect differences. This may also be one reason why some interventions were found to be significant in earlier analyses, but not in the final analyses; however, we also hypothesize that certain interventions, like infection control and social support, were more important to provider success earlier in the program and thus their effects were captured in early analyses only. Despite these limitations, we have made every effort to conduct rigorous analyses and believe that the observed associations hold merit and highlight interventions that have the potential to be important to supporting and improving the provision of CAC services.

^c Possible interactions in this category include: encouraging providers to use contraceptive counseling tools or expand contraceptive choices offered; encouraging providers to attend LARC training or arranging a mentorship; sharing literature with providers on improving contraception provision; role-playing with providers to illustrate the importance of contraceptive counseling; facilitating discussions with providers on the importance of providing LARC methods; encouraging providers and/or management to provide contraception at the first visit, and to readdress LARC at follow-up; working with providers and management to move contraception services into the same space as abortion services.

^d Working with providers in Kenya to expand the gestational age limit they offer services to (i.e. from 1st to 2nd trimester).

^e This includes greeting clients in a friendly and respectful manner; employing a client-centered style of communication; giving clients opportunity to talk and ask questions; using age appropriate, non-clinical language.

^f Social support includes any interaction between MAX rep and provider that is outside of the normal work activities. For example, sharing a meal (only if this is not part of normal routine); checking in on sick providers and their family members at the hospital; visiting providers' homes or helping with chores; attending providers' family events.

reps often worked alongside providers to demonstrate correct infection control procedures (e.g. sterilizing MVA equipment) and this hands-on intervention may have been part of building rapport early on. It is notable that activities related to improving infection control were uniquely and often associated with improvements to abortion services, and this may also be because it is a skill that has broad implications within a clinic environment. After the reps established rapport and trust with the providers, support activities such as training, improving the contraception services offered, and stock-out support may have helped to further enhance and expand the services that were offered, leading to improved outcomes. It is possible that these activities would have had less impact without the foundational interventions described above because providers may have been less receptive to additional inputs from field reps.

In South Africa, the highest impact interventions (50%+ improvement in program outcomes) included:

- Supporting the clarification of values
- Abortion training and other interventions that improved the quality of clinical abortion care^g
- Increasing the hours or days a clinic was open
- Improving physical aspects of facilities
- Improving referral processes^h
- Addressing staffing or management issues
- Increasing community awareness of services
- Advocacy with management
- LARC training
- Improving provider-client communication
- Expanding contraceptive services offered

****Social support was also significant at a more limited level (i.e. it was associated with statistically significant improvement of 20% or greater in one or more program outcomes).**

Importantly, many of these high priority interventions were associated with improvements in many key outcomesⁱ and with high levels of significance ($p \leq 0.05$, typically), which shows both the wide-reaching impact of these interventions and their importance. For instance, improving the quality of clinical abortion care by enhancing provider skills in taking medical histories, providing quality counseling pre- and post-TOP, and following WHO guidelines for abortion delivery, may allow providers to increase the delivery of both abortion services and post-abortion contraception. Further, a number of interventions were especially salient for increasing MA caseload specifically. These included advocating with management on behalf of the provider's needs, values clarification, and abortion training. These particular interventions were likely highly effective because MA was a new service and therefore support by management and the acquisition of new skills were requirements for success. As providers were working in the public sector, many barriers to the provision of abortion care were outside of the individual provider's control and were more likely to be addressed through management buy-in; for example, issues related to infrastructure (space, opening hours and staffing) and trainings. Thus, activities that helped to ensure that managers were supportive of their providers (values clarification and advocacy with management) were critical to making improvements that ultimately increased access to services.

Overall, several interventions were found to be highly impactful across both countries. These included enhancing abortion skills through formal *abortion training* or improving contraception provision by *expanding contraceptive services* offered. Likewise, improving *provider-client communication* was a highly impactful activity in both countries, and this is consistent with commonly accepted best practices. In both Kenya and South Africa, *increasing community awareness of services* was also associated with at least a 50% increase in program outcomes. This activity was largely outside the scope of the MAX program, so it was not a frequent intervention. However, it is important to note that it resulted in significantly improved outcomes

^g Defined more narrowly as informal or targeted interventions to enhance specific aspects of quality of care, such as correctly taking medical history, vital signs and ruling out contraindications; confirming client pregnancy and estimating gestational age; counseling and acquiring informed consent; providing accurate information on abortion methods including risks and benefits, pain management expectations and side effects; providing abortion to WHO standards including proper dosing of MA drugs and adhering to appropriate GA limits; quality post-abortion care including: clear oral and written discharge instructions; and ensuring policies/guidelines are present in facilities and providers are adhering to them.

^h This includes working with the provider, staff, or managers to improve the referral process at the facility; improving the "booking system" so that clients are seen on demand; and ensuring providers have access to an operating theater, available emergency resuscitation equipment/medicine, access to transport, etc.

ⁱ For example, both abortion and LARC training were associated with four different MAX outcomes, spanning both abortion and contraception outcomes. Abortion training was associated with improvements in total caseload, MA caseload, LARC after SA, and decrease in no method of contraception. Similarly, LARC training was associated with improvements in: total caseload, SA caseload, MA caseload, and a reduction in no method of contraception.

INTERVENTIONS WITH IMPACT

SOUTH AFRICA

- Improving quality of clinical abortion care
- Supporting the clarification of values
- LARC training
- Addressing staffing or management issues
- Advocacy with management
- Improving referral processes
- Improving physical aspects of facilities
- Increasing the hours or days a clinic was open

SOUTH AFRICA + KENYA

- Abortion training
- Expanding contraceptive services
- Improving provider-client communication
- Increasing community awareness
- Social support

KENYA

- Preventing or addressing harassment and/or stigma
- Preventing or addressing stock-out of abortion supplies
- Improving infection prevention and control
- Increasing gestational age limits

when it was provided. Additionally, *social support* was an activity in both countries that was associated with improved provider outcomes, although at a reduced significance (20% vs. 50% improvement in outcomes). Social support interventions may not emerge as equally prominent as others due to the nature of the intervention itself being difficult for reps to quantify. We also hypothesize that social support was given more prominently and frequently at the beginning of the program to establish trust and rapport with providers, and many of these initial interventions were not collected as data collection tools weren't yet established. Despite this, we include social support as a key intervention because while it is not typically

part of similar programs to improve access to safe abortion services, we found both in our analysis and through the experience of our field teams that it is important for relationship-building, which we believe is a critical aspect of supporting providers to offer services in stigmatized environments. Collectively, the interventions described in this section were associated with statistically significant improvements in key outcomes and are likely essential components of a comprehensive approach to improving abortion and post-abortion contraception services.

IMPACT AND CONCLUSIONS



Providers and managers, Gauteng province.

The primary objectives of the MAX program were to: 1) increase the quantity of abortion services provided to meet demand; 2) improve the quality of abortion services provided; 3) improve the provision of contraception after abortion with a focus on LARC; and 4) assess the possible program-related contributing factors to changes in quantity and quality of comprehensive abortion services. The impact of the MAX program is made evident by changes in provider behaviors with demonstrated increases in abortion caseloads and in the proportion of women receiving post-abortion contraception. Provider behavior change was the primary and original objective of this program and the MAX model shows promise for improving provider service delivery. However, as the program developed, the need to address barriers outside of the control of providers became clear. Providers may be motivated and willing to improve their skills and expand services, but that is not always possible due to social, administrative and structural constraints. Although training (in technical skills, and sometimes in supply chain management) is essential, it is not enough to ensure that providers go on to actually offer services, due to the stigma associated with abortion.

In the experience of the MAX program in Kenya and South Africa, when providers are operating in such a challenging environment, more needs to be done to balance things in their favor. In the private sector in Kenya, this took the form of combatting the isolation and stigma that providers felt through developing solid relationships with field reps capable of backing providers up in case of harassment. At times this was literally bailing them out of jail, connecting them with legal support, or sensitizing local police officers about the legality of and public health imperative of safe abortion services. Without this type of support, the sense of isolation and fear of losing one's license, business, reputation, or even life was simply too great a barrier for an individual to overcome. The tactical and emotional support that field reps offered in this context was critical. Providers knew that they could call on the reps at any time for advice, encouragement, and moral support, and sometimes this alone was enough to tip the scales.

The MAX reps in Kenya also created or strengthened provider support networks, so that abortion providers could rely more closely on one another. While the potential sustainability of the program in Kenya was less than in South Africa simply because it was limited to individual provider support (rather than broader systemic changes), these networks were still ongoing

sources of support over a year after the program's close. We selected providers to ask questions about the sustainability of the MAX initiatives, and all of them said they were still actively using the WhatsApp group and participating in the provider networks. Said one provider,

"When MAX came, we were just starting and weren't very well organized. MAX helped us organize a network. At first it was a district level thing, but now it's a national network. We also formed a Whatsapp group. In case anybody has issues, challenges, discoveries, we can communicate and talk to each other."
—MAX provider, Kenya

In South Africa, where the MAX providers worked within a public health system, the support of managers and the existence of clear guidelines and policies was essential. Otherwise, providers could be blocked by managers that actively opposed abortion or simply neglected the providers because they didn't want to be involved, or be constrained by policies and procedures that limited the number of women they could see. Creating an enabling environment in this context thus took the form of working toward improving management support through formal values clarification exercises and by inviting managers and other officials to attend regular data dissemination meetings where problems were discussed and data was presented as evidence to encourage change and improvements. This process engaged managers and created advocates. Said one manager,

"Before I joined the project, I didn't understand the importance of supporting TOP providers. I didn't care and I didn't have any interest, but after [I attended the first MAX dissemination meeting], I had an interest. I wanted to know what was happening in the TOP services, what those providers were going through. No one cared about them. Resources were not available, like beds. They had to use old things. After the MAX [dissemination] meeting I [wanted] to motivate and support them to have better resources. I had interest to just go there and discuss with them: 'How are you doing and what are your challenges? What is it that you want? How many women are you seeing? How many women are you referring? Why are you referring them?' [MAX] made me realize my responsibilities and accountability."
—Facility manager, South Africa

On a broader scale, the MAX program helped to secure an enabling environment for safe abortion services

by encouraging the adoption of medical abortion policies and practices where none previously existed, and by implementing the benchmarking tool. The impact of the roll-out of medical abortion is significant, as it ensures not only method choice, but facilitates greater access to services because MA does not require a highly skilled provider. The adoption of the benchmarking tool by provincial authorities is another important achievement because of its potential to 'legitimize' providers. Before the benchmarking tool was introduced, the TOP providers had no way to be measured and no way to gain access to promotions or incentives. Since its adoption, the tool has been used not only to evaluate and incentivize providers, but also to assess and designate 'ideal clinics'. While the process of gathering and integrating feedback into the tool, and orienting officials and managers took a lot of time, the provinces now feel ownership of it. A MAX manager in Gauteng Province stated:

"The quality of care assessment tool made me realize the most critical areas that we need to concentrate on when we are supervising providers. At first, I didn't care. I didn't even know [the TOP providers] were working there, but after going through that assessment I had to go [to the TOP unit]. I had to check how are they providing that service? Do they have the equipment to provide the service? Are they discarding the way they're supposed to, the infection control? All the items of critical importance that we were just ignoring throughout. So I really appreciate this project. I'm so grateful."—Facility manager, South Africa

None of this work was initially envisioned as part of the scope of the MAX program, as we expected that individual-level support would be enough to increase the quantity and quality of abortion services. However, it was evident that within this context, individual providers—no matter how skilled or motivated—could not function optimally without a supportive environment.

The MAX program demonstrates that a comprehensive approach to improving the delivery of abortion and contraception services must integrate efforts to change provider behavior with broader efforts to change the systems and socio-political environments that stand in the way of provider success. Some of the most important, and perhaps the most sustainable impacts of the MAX program stem from our role in facilitating a more enabling environment for abortion care providers. Our efforts on this front were integral to changing the

context in which providers operate, thereby breaking down barriers and creating new opportunities that will ultimately contribute to preventing unwanted pregnancies and reducing abortion-related morbidity and mortality.

RECOMMENDATIONS AND REMAINING CHALLENGES

The MAX program was a learning pilot that may have implications for other programs seeking to improve access to safe abortion services within contexts similar to South Africa and Kenya. The following recommendations distill the key learning points of the MAX program:

- In environments where abortion services are highly stigmatized, **strong relationships/support systems are essential for motivating, recruiting and retaining abortion care providers.** In the case of the MAX program, strong relationships were built between MAX field reps and their providers; in Kenya, they were facilitated between providers by creating mentoring relationships and reinforcing provider support groups; and in South Africa, relationships were strengthened between providers and their managers by increasing the engagement and buy-in of managers.
- The **provider-level interventions** that were described in this document were most closely associated with improvements in abortion care and/or post-abortion contraception and are recommended as part of a comprehensive provider follow up program. Understanding which interventions may result in the most significant provider behavior change can assist program implementers to make evidence-based decisions in an environment of limited resources.
- One of the most important activities that the MAX program undertook was to **collect, analyze and share data with providers and managers** about how they were performing in program indicators over time. In Kenya, this ongoing feedback was a strong motivator for providers, who often displayed the reports on their walls and told their colleagues, who in turn asked to be part of the network; and in South Africa, these reports were also an important evidence-based advocacy tool when shared with facility, district and provincial managers along with providers themselves.

There are a number of challenges that arose during

MAX PROGRAM IMPACT

More than
230,000
women received
safe abortion
services

Medical abortion services implemented in Gauteng and Limpopo provinces to **increase women's access** to services

An estimated
700 maternal
deaths
were
prevented

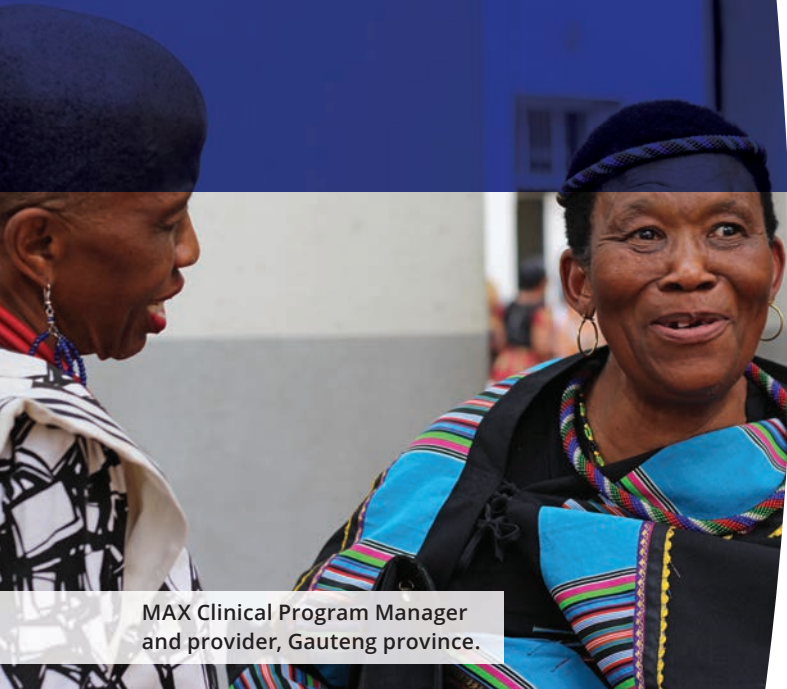
Benchmarking
quality of care evaluation tool developed and integrated into the public health system in 5 South African provinces

An estimated
150,000
unsafe abortions
were averted

Medical abortion policy developed and
MA services implemented
in Mpumalanga Province,
South Africa

More than
212,000
women received
a method of
contraception
post-abortion

Chief Director Mpumalanga Provincial Department of Health and MAX Clinical Program Manager, Mpumalanga province.



MAX Clinical Program Manager
and provider, Gauteng province.

MAX program implementation that were outside the scope of the program, and which also impact efforts to increase CAC services. These problems should continue to be addressed by ministries of health, donors and partner organizations to ensure delivery of and access to high-quality CAC services. The existence of clear and supportive policies, standards and guidelines is an obvious requirement. In Kenya, revisions to the standards and guidelines on CAC were stopped and restarted multiple times during the four years that MAX was in operation, and their lack ensured that CAC was not widely available in the public sector and compounded the stigma that private sector providers felt in providing abortion services. Funds and opportunities for training were inadequate to ensure that an appropriate number of providers were trained in CAC including post-abortion contraception and specifically LARC. In South Africa, at times managers and providers were willing and even passionately supportive, but did not have resources for training. Unfortunately, a lack of trained providers puts undue burden on the providers who are trained, often resulting in burnout and even less access to services. Increasing post-abortion contraception, specifically LARC, is a significant and complex challenge. Importantly, it must be approached in a context that respects the choice of the client, where a provider offers a range of methods. Patient-centered contraceptive counseling should not suffer at the expense of encouraging LARC. In South Africa, a lingering difficulty to increasing the uptake of LARC was the after-effect of an earlier campaign within the public sector to provide implants that was undertaken without adequate training of staff on implant removal and on contraceptive counseling about expected side effects and an emphasis on client choice. The result was a decrease in women's trust of implants specifically

and LARC methods overall. It took at least two years before the data in the MAX program showed that LARC demand had begun to normalize back to what it had been before. Increasing LARC methods requires a thoughtful, multi-pronged approach by a range of actors to address both client-side and supply-side issues. Finally, programs to support providers must be rolled out at scale, because providers are constantly being transferred, retiring, or coming into the service new.

On the client side, an ongoing challenge is promoting services to women in need, so that they can choose safe and legal abortion rather than resort to unsafe alternatives. However, the stigma surrounding abortion makes it difficult in some cases to openly promote services. In Kenya, providers were sometimes reluctant to admit that they offered services unless women came expressly requesting them. While some of the MAX providers collaborated with community health workers to inform women where they could receive services and found that it helped to bring clients in, others said that women in their communities would be unlikely to come to them for services because they would be afraid that others in their community would learn about it. In any case, informing women of where they can access safe and legal abortion—preferably in clinics that offer other maternal, child and reproductive health services—is clearly an important component to access.

Improving access to CAC is a significant challenge, and requires the skill and resources of multiple actors including ministries of health, donors, implementing organizations, and courageous and committed health care providers. The barriers are both broad and highly individual, and require creativity and dedication to solve. We have argued that in addition to the many important ways that a number of actors are approaching this problem, ongoing social and emotional support to abortion care providers and the use of data as an advocacy and motivation tool can significantly enhance outcomes. In addition, we have identified a number of specific interventions that resulted in statistically significant improvements at the provider level, and which may help future programs operating in a similar context to make more cost-effective and evidence-based decisions about which interventions to prioritize. We hope that these findings are of value as we work together to improve access to life-saving services for women and girls around the world. [WCG](#)

RECOMMENDATIONS FOR IMPROVING ABORTION CARE IN: PUBLIC VS. PRIVATE SECTOR

Private Sector

KENYA

- Establish trust with providers so they are willing to share their data and participate in the program
- Provide moral and legal support in an environment where providers feel harassed and threatened
- Assist providers with practical, creative ideas to improve their business practices

+

BOTH PUBLIC + PRIVATE SECTOR
Provide moral, social, and emotional support

+

Public Sector

SOUTH AFRICA

- Enlist buy-in not only from individual providers, but also from management
- Work on change not only at an individual level, but also an environmental, political, and structural level
- Ensure commitment from directors of health in order to achieve systematic and sustainable changes
- Hold regular meetings amongst all stakeholders to discuss challenges, data trends, and ways forward

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MAX providers and managers, Mpumalanga province.



"My years with WCG have been glorious. I've grown a lot as an individual, but I'm not the only one that has benefited. The relationships that have been formed are not going to end at the end of the program. These relationships have been developed for a reason and the lessons that have been learned will go on with me and those I interacted with to eternity. We will carry on with the baton. It's not the end of the road. The work has just started, in fact."

- MAX rep, South Africa

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