KIT Royal Tropical Institute

1 Evaluation report

RCOG Making Abortion Safe Project – final evaluation

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RCOG Making Abortion Safe Project

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Abbreviations

AFEMSON	Association of Feto-Maternal Society of Nigeria
BPP	Best Practice Paper
ERG	Evaluation Reference Group
FGD	Focus group discussion
FMoH	Federal Ministry of Health
HCP	Health care provider
ICR	International Council Representatives
IRC	International Representative Committees
MAS	Make Abortion Safe (programme)
MDCN	Medical and Dental Council of Nigeria
NCMHP	National Council for Medical & Health Professions
NIMSA	Nigerian Medical Students Association
NMA	Nigeria Medical Association
NUC	National Universities Commission
KII	Key informant interview
PAC	post abortion care
RCOG	Royal College of Obstetricians & Gynaecologists
SA	safe abortion
SMC	Sudan Medical Council
SOGON	Society of Obstetricians and Gynaecologists of Nigeria
SSI	Semi-structured interview
ToC	Theory of Change
UNFPA	United Nations Population Fund
VCAT	Values Clarification and Attitude Transformation

1 Introduction

This is the report for the final evaluation of the Making Abortion Safe (MAS) programme from the Royal College of Obstetricians and Gynaecologists (RCOG). The programme has been running since 2020 and as it is coming to an end, RCOG has commissioned an external evaluation by KIT royal tropical institute, to assess and learn from the results of the programme.

The report highlights the successes of the programme and unpacks the elements that worked, the challenges and issues to learn from. After a brief overview of the program and methodology section, the report primarily describes the results along five OECD DAC evaluation criteria. Each section is structured with headings that highlight key findings. As such, reading through these headings can serve as reading an executive summary. The report ends with a discussion, including reflections on the ToC, and recommendations for the future. A separate appendix is available for more details on the methodology and harvested outcomes.

The evaluation team would like to acknowledge the contributions of the Evaluation Reference Group (ERG) who guided the evaluation approach and were invaluable in providing context, connections and feedback at different stages of the evaluation. The ERG included Ibrameem Awowole (Champion Nigeria), John Muganda (Champion Rwanda), Rumbi Zimudzi (Champion Zimbabwe), Carol Bradford (international consultant), Nia Sheppard (RCOG) and Suzanna Bright (RCOG). Furthermore we would like to express our gratitude to all Champions and other respondents who participated in interviews, focus group discussions, validation and sense-making workshops for their insightful contributions that make up the results of this evaluation.

2 Overview of the programme

2.1 Making Abortion Safe programme

The Making Abortion Safe (MAS) programme started in February 2020 with the aim to improve girls and women's access to quality and safe abortion (SA) and post abortion care (PAC) in five countries (Rwanda, Zimbabwe, Nigeria, Sudan and Sierra Leone) and globally. The programme intended to increase healthcare providers (HCP) capacity to deliver, improve and champion access to these critical services within their national legal frameworks, by implementing a set of activities along five main outcome areas:

1. **Professionalism** – Health Care Providers (HCPs) have improved knowledge on the provision of SA/PAC, which is in line with RCOG best practices
2. **Normalisation** – HCPs working to provide abortion care and PAC experience less, or are better supported to manage, abortion related stigma
3. **Leadership** – Programme Champions and other HCPs conduct research and advocacy work in the field of abortion care and PAC.
4. **RCOG Voice** - The RCOG, and it's membership has increased influence to reduce barriers to safe abortion and/or post-abortion care services at a national and international level
5. **Partnerships** – The RCOG has developed sustainable partnerships with like-minded stakeholders to support abortion advocacy work.

These pillars are represented in the programme's theory of change (ToC) and logframe which guided implementation (see annex 1 and 2).

2.2 Working through a Champions model

In the five countries of operation, alongside RCOG's global and UK activities, the MAS programme has been implemented through a Champions model. The countries of implementation were guided by the donor, with RCOG selecting donor specified countries based on criteria such as the strength of RCOG networks in country and level of need. Countries where FIGO was implementating the ASAP project were not included based on donor guidance. Following a call for applications, 73 Champions had been recruited (out of 170 applications) by the start of 2021. At the time of evaluation 59 Champions had remained engaged. The reduction in numbers has been identified as a process of natural attrition, and a result of steps to ensure that Champions were aware that there is a minimum level of engagement expected. See Table 1 for an overview of the characteristics of Champions per country.

Champions were inducted to the programme through various training initiatives and engaged in RCOG global initiatives such as the abortion provider stigma study and the contextual adaptation and adoption of best practice papers (BPPs). They also worked on their own national advocacy plans. Along the course of the programme Nigeria, Rwanda and Zimbabwe remained actively working on the objectives of their action plan (see Table 2). The plans in Sierra Leone and Sudan did not operationalize as expected; reasons and lessons learned are further explored in this evaluation. The Champions engaged with RCOG and each other through regular update mails from RCOG, monthly country meetings, quarterly all Champions meetings and Whatsapp groups. RCOG memberships were paid for Champions and those that were not a member yet have been offered an affiliate or associate RCOG membership. In the second half of the programme $100 USD monthly stipends were introduced that were intended to increase the level of engagement and reduced out of pocket expenditure for the Champions for data and hardware costs.

Table 1 ***Overview of characteristics of Champions per country.***

	Sex		Professional background*					
	M	F	MD/ Obgyn	Nurse/ midwife	NGO/ policy	Academic	Medical Student	Unknown
Nigeria (13)	8	5	8		3	2		
Rwanda (13)	12	1	6	2	1	2	2	
Zimbabwe (13)	6	7	4	2	5	1		1
Sierra Leone (13)	6	7	4		8	1		
Sudan (7)	0	7	3		3	1		
Total (59)	**32**	**27**	**25**	**4**	**20**	**7**	**2**	**1**

*Professional background indicates the current primary position of the Champion as outlined in the Champion overview from RCOG. However, most Champions hold various positions that overlap (e.g. clinical and policy).

Table 2 ***Country-specific objectives from the Champions' national advocacy plans****. Only Nigeria, Rwanda and Zimbabwe progressed with national advocacy plans, therefore the objectives for Sierra Leone and Sudan are not outlined here.*

Nigeria	Rwanda	Zimbabwe
1. To expand knowledge of reproductive health rights and choice and to increase dissemination and uptake of "National Guideline on Safe Termination of Pregnancy for Legal Indications" amongst the National Council on Health, the Society of Obstetricians and Gynaecologists of Nigeria (SOGON), the Nigeria Medical Association (NMA) and the Federal Ministry of Health (FMoH). 2. To promote networks of medical students to increase knowledge on abortion safety and access. 3. To advocate for including pre-service training in abortion and post-abortion care in Nigerian Universities, Undergraduate and Postgraduate Medical Colleges. 4. To adapt the abortion care best practice paper and promote and disseminate across healthcare professionals in Nigeria.	1. To expand knowledge and awareness among healthcare professionals about the Ministerial Order. 2. To lower abortion stigma experienced by abortion care providers from other healthcare providers, 3. To adapt the best practice paper on SA/PAC to the Rwandan context, to provide clinicians with an easy, accessible resource to use in daily practice.	1. To build capacity/improve knowledge of service providers (police, prosecutors, magistrates, social welfare officers) to support survivors in accessing timely safe abortion. 2. To work with professional bodies (Confederation of Midwives, Zimbabwe Nurses association - including their Provincial Chairs, Faculty of Health, ZSOG) and other relevant organizations to increase knowledge of Termination of pregnancy (ToP) act amongst healthcare providers. 3. To create a safer environment for women and girls to gain awareness and access information about the Termination ToP act.

3 Evaluation objectives and methodology

The general objective of this assignment was to carry out a final evaluation of the programme along the five key OECD DAC Criteria: relevance, effectiveness, efficiency, sustainability and impact. The evaluation includes an outcome evaluation as well as a process evaluation in order to document and assess the programme's results (outputs, outcomes and impact) as well as the programme's implementation (management and implemented activities and strategies, including what has worked and what has not). In other words, this evaluation assesses not only what the programme has achieved but also how and why, relating it with the programmes original plan.

3.1 Specific evaluation objectives

Starting from the proposed questions in the Terms of Reference and guided by the OECD DAC evaluation criteria, four main evaluation objectives were identified to guide the process:

1. To identify, document and assess the programme results (outputs, outcomes and (perceived) impact) and how these relate to the programme´s objectives.
2. To assess efficiency and effectiveness of the programme implementation (management, governance, hindering or enabling factors, and what strategies and activities worked or not).
3. To assess the suitability of the design and set-up of the Making Abortion Safe programme and its theory of change in relation to the objective of improving access to safe abortion and post-abortion care (relevance).
4. To assess whether the programme results and strategies are likely to be sustained (sustainability).

3.2 Evaluation scope

While the programme has been implemented in five different countries, the evaluation assessed the programme as a whole, bringing together the analysis and results from each country and RCOGs global activities. Data were collected at HQ level, as well as among Champions and key stakeholders in all five countries of operation, with specific emphasis on the countries that delivered national advocacy plans (Nigeria, Rwanda, and Zimbabwe), while also exploring the lessons learned from countries with a lower level of operation (Sierra Leone and Sudan). The period reviewed was from 2020 until early 2024. The evaluation was mostly done remotely through online means.

3.3 Evaluation framework

A comprehensive evaluation matrix was developed by RCOG, this was adopted with minor additions by the evaluation team (annex 3) and used to design the evaluation tools, in line with the OECD DAC evaluation criteria.

3.4 Outcome Harvesting approach

To collect and describe advocacy results at outcome level, an Outcome harvesting (OH) approach was employed. In this methodology, an outcome is defined as a result among those that the advocates (in this case RCOG, Champions) have been trying to influence, i.e. how 'targeted' individuals, groups, institutions, systems or the policy environment demonstrate change. Rather than measuring progress in the implementation of activities, OH collects ("harvests") information about who has changed in what, e.g. behaviour, relationships, actions and policies, positively or negatively, intended or unintended. It then, working backwards, defines whether and how a programme, concerted actions or advocacy strategies contributed to these (systemic) changes (see Figure 1). Through that we learn about the effectiveness of advocacy and how specific strategies have contributed to that (or not).

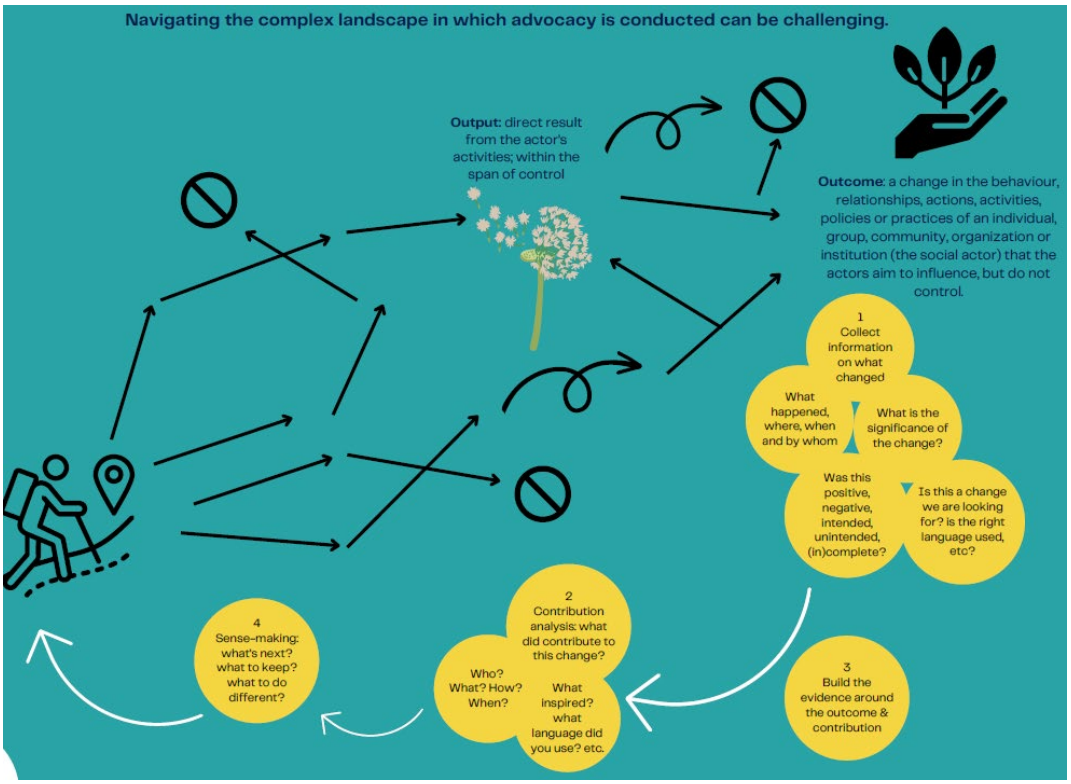

Figure 1 Schematic overview of the Outcome Harvesting approach for advocacy (by I. de Vries, KIT)

The reflection on outcomes should not primarily serve accountability purposes, but are especially important for learning: what was successful and why? Which advocacy strategies work in which contexts? and where do strategies need to be adapted?

3.5 Evaluation methods

Between December 2023 and February 2024, a desk study of programme documents was conducted, followed by focus group discussions (FGD) and semi-structured interviews (SSI) with Champions in the implementation countries and RCOG staff. These served to identify and describe effectiveness, including advocacy outcomes and contributions, and to get the Champions' and programme staff perspectives on the programme's relevance, efficiency and sustainability. Interviews with external stakeholders were also conducted to further substantiate the findings and verify, from their observations, the validity of the described outcomes and the contribution of the programme and the Champions to these outcomes (see annex for topic guides). Finally, a validation meeting was held on 27 February with 28 Champions from Nigeria, Rwanda and Zimbabwe to validate and refine results and fill data gaps where possible. In a sense-making workshop (14 March in London and hybrid) RCOG staff, leadership, partners and evaluation reference group (ERG) members (total 12 participant) contributed to the discussion and recommendations.

While a robust sampling strategy was intended (see inception report), the team faced several limitations in getting access to the right respondents (see section 3.7). Table 3 outlines the type of documents studied and number of respondents per data collection method.

The respondents varied in terms of level of engagement with the project, involvement with specific advocacy plan objective(s), professional background/job title and gender. This helped to get a wide perspective and view on the different areas engaged in. Data were thematically analysed and triangulated to provide answers to the objectives of the evaluation.

Table 3 Overview of data collection methods and number of respondents

	Desk study	FGDs	SSIs	Interviews with external stakeholders	Validation meeting
Nigeria	Advocacy plans Activity reports Guidelines, research reports, media items and organisational statements where available	1 (4 participants)	4	1	11 participants
Rwanda		1 (5 participants)	2	1	9 participants
Zimbabwe		1 (5 participants)	2	1	8 participants
Sudan		-	3	-	-
Sierra Leone		-	2	2 research grantees	-
Global	Donor reports M&E data Logframe indicators RCOG voice log RCOG membership survey	-	2 RCOG staff	2 global partners	3 RCOG
Total		3 (14 participants)	15	7	31 participants

3.6 Ethical considerations

An ethical waiver was obtained from KIT Research Ethics Committee (annex 6) as respondents were participating in their professional capacity with no exploration of personal experiences or opinions unrelated to the programme. Informed consent forms (annex 7) were used to highlight the confidential and voluntary nature of participation. The ethical principles of do no harm, autonomy, beneficence and justice guided the entire evaluation process.

3.7 Methodological limitations

The team faced several limitations in conducting the evaluation. The response to invitations for (online) interviews and FGDs was generally low, despite multiple follow-ups and the support of Champions in the Evaluation Reference Group with mobilizing contacts. Also, due to time spent chasing confirmations, no-shows, last-minute cancellations or postponement of appointments the team had to spend a substantial amount of time on participant recruitment. As a result, an overall lower number of respondents were engaged than had been planned; especially for Sierra Leone and Sudan and for external stakeholders. As a result, findings could only partly be substantiated with external observers. Another limitation was the difficulty accessing key documents and M&E data from the national teams. In country M&E capacity was not prioritized in the programme and therefore data on output indicators were not always accurate.

The evaluation was conducted while the programme was in its final phases of implementation. This means that the evaluation will not be able to capture everything that will be achieved under this programme and have less insight into its final impact.

4 Results

The results are organized along the evaluation criteria of relevance, effectiveness, efficiency, sustainability and impact. Each section is structured with headings that highlight key findings. As such, reading through these headings can serve as reading an executive summary.

4.1 Key findings in relation to Relevance

This section on relevance seeks to answer the following evaluation questions:

- *To what extent was the project design and set-up (working with Champions, focusing on advocacy and working through the 5 different pillars) the right approach to support healthcare professionals to address the barriers to safe abortion care in each given context?*
- *Did the project address the needs and priorities of Champions and what benefits were associated with engagement with the programme from their perspective?*

In most countries relevance was perceived for the projects' focus on supporting health care professionals in addressing barriers to safe abortion, especially in the need to close a knowledge gap for health care professionals on regulatory frameworks.

In Nigeria, Rwanda, Zimbabwe and Sudan, the project was seen as relevant, adding to efforts by other stakeholders in advocating for safe abortion and post-abortion care. The key knowledge gap the Champions sought to fill was the misinterpretation of existing national guidelines by healthcare providers. In three of these four countries (exception of Sudan), there were existing professional guidelines for abortion, yet the number of HCPs willing to provide the services and understanding the legal frameworks they operate in remained low. As such, the MAS project had to gain momentum from existing efforts to achieve its goals.

In Rwanda, the project commenced soon after the publishing of the Ministerial order No.002/MoH/2019 on the conditions to be satisfied by HCP's to perform an abortion which proved to be an excellent momentum for the project. From the start the Champions in Rwanda were able to join the comprehensive abortion Technical Working Group, initiated by the MoH, and amplify the existing initiatives for awareness raising of the Ministerial order. Although other countries did not have the same prevalent momentum, Champions still were able to leverage on other activities. For example, in Nigeria the launch of a task shifting policy ensured Champions extended their focus for advocacy to different cadres of health care workers beyond medical doctors. In Zimbabwe, Champions used their existing experience as starting points of engaging various stakeholders, to raise awareness of the Termination of Pregnancy Act amongst HCPs as well as to engage members of the public. In Sudan, they used the project as an opportunity to bring up issues in the ministry and health care sector on abortion and use of misoprostol and to work towards a national protocol. In Sierra Leone, however, the programme did not align with the contextual expectations of Champions, as the momentum in the country was directed more on law reform, which fell outside the scope of the objectives of the MAS project.

> *"For a number of years, over five years, Sierra Leone had been working on law reform, which a lot of people were familiar with. And so this project, it was not law reform, it was looking at building capacity. And I think... it was quite difficult for a lot of people to get their head around that because everything they had been doing was centred around law reform. And I remember a couple of times, RCOG had to remind us that, no, no, no, you can't do this, you can't do that. This is not a law reform project. What we can do is A, B, and C. So I think maybe with the programme's objectives, they didn't quite align with what people's expectations were." (Sierra Leonean Champion)*

The Champions model was generally praised by national as well as international stakeholders; Champions were well positioned, complementary to each other and strong acknowledged leaders.

Interviewed Champions and external stakeholders in all implementation countries as well as international stakeholders perceived the relevance of the Champions model positively, citing the fact that selected Champions were already working as 'Champions' in their regular capacities and often strong acknowledged leaders in their field. The profile of Champions however varied in each country, influencing their scope in different contexts. In Nigeria, the Champions were mostly clinical professionals and as such the objectives they set were primarily focused on targeting health care providers. In contrast, Zimbabwean Champions came from different fields, and they set objectives that also focused on raising awareness with the public. In Rwanda, there was a balanced mix of well-known and newer/young Champions from different backgrounds. In these three countries, success was reported in cases where Champions leveraged on each other's areas of expertise.

> *"Champions with different expertise, some being physicians, some being obgyns, others being in policymaking levels, then from the NGOs and some of the midwifery. So it was actually excellent because it was easier for them to knock every door that seems to be relevant during the implementation of the project." (Rwandan Champion)*

In Sierra Leone, however, Champions expressed that their profiles did not always entirely fit the objectives of the programme, particularly due to the differences in view of what the programme should do.

The success of the Champion model is further described under effectiveness.

The design of the project and focus on advocacy was appreciated and felt needed for creating a more enabling environment.

The Five outcome areas of the project (Professionalism. Normalisation, Leadership, RCOG voice and Partnerships), were felt to be relevant in providing a framework for objective setting and implementation of activities in each country. The results under effectiveness demonstrate the interrelated relevance of each pillar. There has been little report of elements that were missing in the design. Some expressed the wish to work more on the demand side, but it was also recognized that this may not fit within the scope and space of this specific project, hence the need to align with other initiatives in the country for an holistic approach. In Nigeria and Sierra Leone Champions also expressed there would have been relevance in working on the extension of legal frameworks, which was not possible under this specific donor grant.

In Nigeria, the focus on advocacy was seen as relevant in addressing misconceptions and stigmatisation of provision of abortion services by HCPs. This resonated in Rwanda and Zimbabwe as well, where existing abortion care guidelines are considered not widely known by most HCPs who end up not providing services in situations, even when they are in compliance with the law. As such, the awareness raising objectives in Nigeria, Rwanda and Zimbabwe, were reported as essential in increasing the acceptability of providing safe abortion and PAC within health facilities.

> *"We know the degree that abortion and everything about it is being stigmatised in Nigeria, and the HCPs need to have their confidence established and reinstated so that they can practice without difficulty and return courage, and in order to do this you need to have information. And so, this MAS project has been able to come up with a lot of information" (Nigerian Champion)*

Trainings, research and attendance of conferences facilitated Champions' opportunities and strengthening of advocacy roles

In Zimbabwe, Nigeria, Rwanda and Sudan, the Champions reported to have benefited from access to trainings, attending conferences and engaging in research. These were seen as opportunities for Champions to gain new advocacy and campaigning skills that can be translated back to their day-to-day work. In addition, Champions reported how the MAS programme provided them with a network for collaboration, empowerment to communicate about sensitive issues and understanding of advocacy strategies. Those who had been operating in the field of safe abortion before, sometimes did so without realizing what advocacy exactly entails and how to strategize most effectively. Some respondents indicated

how the programme has been helpful in providing Champions with a framework and understanding of advocacy and how to best capitalise on their role.

> *"I think for me in terms of the work that I do, especially around addressing harmful practices, cultural norms that are that have to do with, with young people's access to services, including safe abortion services, I think it was very instrumental, I was introduced to things like values, clarifications and transformation... that's something that I had had heard of, but never really gotten into proper training. So the MAS programme, made it easier for me to engage with the communities with whom I work with on a regular basis in terms of addressing their attitudes around the access to safe abortion" (Zimbabwean Champion)*

The alignment of the MAS programme and Champions' existing work enabled an integration of project activities with Champions' work.

> *"They actually recruited Champions based on the fact that we are already doing that work and we are passionate about that work. So for me, I actually saw it as complementary because I was working with a Clinic, and we were doing access to abortion services and we were also facilitating access to abortion services for survivors of rape. So for me, was really complementary" (Zimbabwean Champion)*

> *"But I think to some greater extent it supported what most Champions were doing, especially the Champions that were medical doctors" (Nigerian Champion)*

Another recurring theme across Zimbabwe, Rwanda and Nigeria was an appreciation of the support provided by RCOG to the Champions in fulfilling Champions' needs. This was seen in regard to the swift communication between the champions and RCOG. This is described in more detail under efficiency.

4.2 Key findings in relation to Effectiveness

The effectiveness section describes the extent to which the intervention achieved its objectives. It focuses especially on the harvested outcomes, i.e. systemic changes among those that the advocates have been trying to influence, in the three countries that developed and implemented their national advocacy plans. For the paragraphs on the objectives of professionalism, normalization and leadership we first describe what happened and who were involved (outcomes, while also acknowledging other efforts that have been made), followed by a description of the strategies that influenced change (contribution of the programme). As the objectives of RCOG voice and partnerships are more strategies in itself (contributing to the previous three objectives) they are described as a whole. Textboxes throughout the chapter highlight key outcomes that we harvested from Nigeria, Rwanda and Zimbabwe, the countries that progressed with their advocacy plans. For a more elaborate description of the outcomes and contributions see Annex 8.

4.2.1 Professionalism

The first objective of the programme focused on professionalism: HCPs to have improved knowledge on the provision of SA/PAC, which is in line with RCOG best practices.
This section aims to provide answers to the evaluation question:

- *To what extent has the project contributed towards healthcare professionals improving their knowledge on safe abortion or post-abortion care?*

What happened and who were involved?

In most countries contributions to professionalism were made through the development and adoption of best practice papers or similar guidelines

When the MAS programme started, the aim of the Champions in Nigeria, Rwanda, Sudan, and Zimbabwe was to ensure there is a (functional) documented reference guideline on abortion care/PAC available to HCPs to provide professional and evidence based safe abortion and post-abortion care to women in need of the services.

> *"this project afforded the opportunity for wide wide-scale dissemination of that document, and everybody is very happy about that. More importantly, also. the Nigerian BPP on PAC has come out, come out with very wide acceptability. A lot of them, the health practitioners now have it. They are doing the correct things, getting the correct information and knowing to what extent they can carry out these responsibilities" (Nigerian Champion)*

In all these countries Champions collaborated for this purpose with the Ministry of health, who have or will eventually sign the development or revision of this document. While the BPP on PAC for Nigeria is already published and being distributed across all health facilities, the CAC guidelines of Zimbabwe are signed and published and that of Rwanda is being finalized with approval from MoH. For Sudan, the BPP is developed, but yet to be published and launched. As Sierra Leone did not manage to go past the objective setting stage, no data is available on their strategic use of national guideline and/or BPP.
RCOG and Champions also made their contributions to the latest WHO guidelines, this is further described under partnerships.

Outcome Nigeria	Outcome Rwanda	Outcome Zimbabwe
The Federal Ministry of Health adopted the Nigeria Best Practice Paper on post-abortion care (PAC) developed by the Champions and highly recommended its wide dissemination and use by health workers, trainees, and policymakers.	MoH adopted input from the Champions in the national guidelines for Safe abortion, such as the counselling approach, stigma, the importance of VCAT and other key elements of the Best Practice Paper.	The Ministry of Health in Zimbabwe in 2024 has signed comprehensive abortion care guidelines that aligns with WHO's post abortion care guidelines of 2022. Multi-Stakeholders were involved in this process including the Champions.

Health care providers have improved awareness on the regulatory frameworks for abortion care, including international and national guidelines on abortion, the ministerial order and Termination of Pregnancy (TOP) Acts

The Champions from Nigeria, Rwanda, and Zimbabwe aimed to address the low awareness among HCPs on the existence and/or lack of knowledge or misunderstanding of the contents of the national guidelines for abortion. They were also concerned with the lack of awareness on law amendments on abortion, or what the law says about abortion in these countries. Therefore, Champions in these countries worked on the objective to increase this awareness among HCPs and provide them with the necessary information or documents needed to serve as reference in providing safe abortion and PAC. In these countries, outcomes were harvested that pointed towards improved health care providers awareness on regulatory frameworks. This was concluded mainly based on observations of the Champions themselves and further substantiated by external stakeholders in Rwanda and Zimbabwe. However, the level of awareness was not studied or monitored over time. Nigeria did a survey to assess the attitude of HCPs before and after receiving the guideline to support their conclusion. It revealed that among the 29 (out of 50) HCPs who had read the guideline, those who believed abortion should never be done (6.9%), and those who have never provided abortion before reading the guideline (28.6%), now believe it should be done in some circumstances, and are willing to provide abortion care (100%). In Rwanda a mixed-method study on the successes and challenges of the implementation of the 2019 ministerial order is currently under analysis.

At the global level, RCOG invested a lot in (supporting the) dissemination of Best Practice Papers and other guidelines, including the new WHO guidelines for comprehensive abortion care. Among the 837 members who filled out the endline membership survey, 33% had heard about the RCOG Best Practice Paper on Comprehensive Abortion Care, strangely slightly more (40%) respondents said they had accessed it and 23% answered they had used it. For post-abortion care this was about the same (36% heard of – 32% accessed – 20% used). Slightly more (41%) respondents had heard about the WHO 2022 guidelines on abortion care, 29% had accessed it and 16% had used it.

Outcome Nigeria

Health care providers have improved awareness and reception of the National guideline on safe termination of pregnancy for legal indications.

Outcome Rwanda

Health care workers have improved awareness on the 2019 ministerial order determining conditions to be satisfied for a medical doctor to perform an abortion.

Outcome Zimbabwe

Health workers have improved awareness of the ToP act and its mandates of lawful abortion and HCWs mandates in providing Post Abortion care service.

HCPs and medical students demonstrate increased knowledge on comprehensive abortion care

The Champions in Nigeria thought that HCPs and medical students should be trained and provided with learning materials and information, in addition to the BPP and national guidelines, on comprehensive abortion care to improve their knowledge, build their confidence and skills, and in addition, build the network of the medical students and providers for SRHR.

Therefore, the Champions partnered with relevant stakeholders such as the NMA, hospital directors, the Nursing association, and the Nigerian Medical Student Association (NIMSA) to recruit HCPs and medical students for training.

Also, the Champions are advocating for the inclusion of pre-service training in abortion and post-abortion care in the Nigerian universities, undergraduate and postgraduate medical college curricula, however, this is yet to be achieved. Even though the relevant stakeholders of the Nigeria University Commission (NUC), Medical and Dental Council of Nigeria (MDCN), and National Postgraduate colleges of Physicians and Surgeons promised to revise their curricula to include gaps identified and presented by the Champions, making use of the BPP.

Outcome Nigeria

Medical Students have improved knowledge on comprehensive safe abortion care and subsequently increased the establishment of more SCORA (Sexual and Reproductive Health and Rights including HIV and AIDS) forums in universities.

"So, what we did was to review the curriculum on the undergraduate and postgraduate curricula. That was reviewed. And we found gaps...And they've all agreed to put measures in place to revise the curriculum, include those elements. And they agree that reproductive health is very minimal in all the curricula, not only from point of view of the theory of it, but also the practical demonstration. Most of what they do is just talking about treatment of the complications of reproductive health, not about prevention, not about rights, not about justice. You know, and all those things. So, this time they've agreed that they will include all the components of reproductive health including right to access, universal access to reproductive health which was enshrined and initiated in the platform for auction at the ICPD in 1994" -(Nigerian Champion)

In order to make knowledge on comprehensive safe abortion care more widely available to the RCOG membership and global community, RCOG developed an "Abortion Care" e-learning. As of August 2023, the M&E data showed that out of one hundred and fourteen (114) learners who gave feedback, 85% reported the knowledge gained after completing the e-learning would increase their teaching or clinical practice. Three months after this, 53% of the (74) learners that filled out the extended follow-up, reported to directly apply this knowledge.

"I have been able to apply skills and/or knowledge from this tutorial - I am working as a Specialist Obstetrician and Gynaecologist at a hospital with an outpatient department census of 1300 women per month…I am the clinical lead and based on the guidelines I have been able to devise our protocol for medical termination of pregnancy with some modifications" (feedback from participant e-learning)

What strategies influenced change?

The **RCOG Best Practice Paper** was found to be an essential and credible tool for guidance by the Champions and was adapted for the development of guiding principles in partnership with policy makers and other key stakeholders in the field.

"We relied on the best practice paper that have been produced by the Royal College which highlight that was the best practice on comprehensive abortion care, and then post abortion care". (Nigerian Champion)

The Champions in Nigeria, Rwanda, Sudan, and Zimbabwe commended the **support received from and collaboration they had with the MOH** to either develop the BPP on SA/PAC, as in the case of Nigeria, Rwanda, and Sudan and/or contribute significantly to the revision of the national guidelines on CAC, as in Rwanda and Zimbabwe respectively. The co-development often entailed rigorous development processes and the use of convincing data. For instance, Nigeria and Sudan used data on the incidence of abortion through desk review to emphasize the importance of these guidelines.

"*So, when we proposed to adopt the RCOG best practice papers on Federal Level, national level, we were happy to receive the partnership from the Federal Ministry of health as our biggest ally" -(Sudan Champion)*

In Nigeria, the Champions also mentioned the crucial role of the MOH in the dissemination of their BPP on PAC to the states MOH. This was further substantiated by the external key informant although emphasised that the ministry has not been able to assess how well the document is received and used by the HCPs.

"...but what we did was that we helped them to distribute to the State Ministry of Health.... There is no programme that's set aside to follow with the state to be able to know if it is, how acceptable it is and how they are using it" - MOH Nigeria

Furthermore, the **confidence** in the Nigerian Champions by MOH led to their approval for the Champions to rebrand (that is, change the cover of) the national guidelines on safe TOP in legal cases and disseminate to HCPs. Subsequently, the RCOG sponsored the reprinting of 5000 copies of this document and the Champions distributed at every opportunity they come across HCPs such as conference or meetings.

In Rwanda, the Champions built a **trusted relationship with the MOH**, and they were given a seat in the technical working group (TWG) on abortion. This position leveraged their contribution to the national guidelines on safe abortion, spearheaded by the ministry, by ensuring sections on stigma and a counselling approach to lower stigma were included and adopted by the MOH in the next draft of the guidelines. Also, the Champions are in the final development stage of a small and digestible pocket guide, informed by the BPP and updated guidelines, to serve as a practical easy-to-use guidance next to the more elaborate national guidelines.

> *" I think we impacted because group was incorporated into the national team, or if I can say the National Comprehensive Abortion Technical Working Group- the team which ran everything. So, we, the Champions were part of the development of the national guideline"* -Rwanda Champion

Champions in Nigeria, Rwanda, and Zimbabwe, used several means to disseminate knowledge, such as **professional bodies' (annual) conferences and trainings or workshops at national, regional, and international levels, hospital departmental meetings, and publicity via newspaper and radio**. They delivered presentations, abstracts, and trainings to sensitise, most especially, HCPs and the public about the existence and contents (including clearing misconceptions) of national guidelines on abortion/PAC, as well as research they conducted.

To strengthen knowledge and skills around CAC, the Nigerian Champions conducted a 3-day training workshop on CAC and VCAT for HCPs and medical students in four different locations across the country. They did so with the expectations that step-down trainings will have a cascading effect to fellow colleagues and students. To achieve this, the Champions divided themselves into three/four groups and worked with the NMA and the Nursing association to recruit doctors from both public and private hospitals and nursing school for the training, and with the executive members of NIMSA to organise the training of the medical students across the country. Eventually, 39 (22 in the north; 17 in the south) HCPs (including nurses, obgyn, medical officers, residents and general practitioners) and 79 medical students (19 in Abuja; 18 in Kano; 20 in Enugu, and 21 in Lagos) from 30 government-owned Universities across all the geopolitical zones nationwide were trained.

> *"We came across a hundred medical students across the six geopolitical zones of Nigeria, and it is an eye-opener to know that even at that early stage of their professional life, they've been met, people have reached out to them to counsel them, to help them, to assist them to get services.... after this training, a lot of them have projects which we plan to present to the RCOG "* – Nigerian Champion

The Champions said these trainings have contributed to the boldness and confidence of HCPs and medical students to talk openly about safe abortion and PAC. Trainings were also conducted in other countries. Zimbabwe focused their trainings mainly on other groups of stakeholders, as described under normalization. And under leadership it is described how others called upon the expertise of Champions in Rwanda to provide trainings not covered under this programme.

4.2.2 Normalization

The second objective of the programme focused on normalisation: HCPs working to provide abortion care and PAC experience less, or are better supported to manage, abortion related stigma.

This section aims to provide answers to the evaluation question:

- *To what extent has the project contributed towards reducing stigma towards healthcare professionals providing abortion care? (country level/global).*

What happened and who were involved?

In most countries Champions have been working on the issue of stigma through studies and VCAT activities. There is general sense that professional spaces open-up and become more safe to discuss the issue of abortion, however it is difficult to establish evidence around that at this point in time.

Champions reported that at the commencement of the programme, there was low acceptability of providing abortion services regardless of HCP's awareness of legal limits available for them. The common perception centred around stigmatisation of providing abortion services tied to societal values around the topic. The Champions, in Rwanda,

Zimbabwe and Nigeria, set advocacy objectives that sought to address the misconceptions, negative attitudes and perception around provision of safe abortion and post-abortion care amongst HCPs.
Both Champions and external stakeholders generally reported that the issue of safe abortion is more openly and respectfully discussed in professional spaces. This is their general observation rather than a measured change in attitudes.

However, some of the harvested outcomes also point towards normalization in services. For example in Rwanda, following the improved awareness of the ministerial order, there is more clarity in health facilities on the patient pathways for people seeking termination of pregnancy, reducing delays or denials in the facility. Through concerted efforts of all stakeholders in the Rwandan context, the number of legally induced abortions in public facilities steeply increased between 2020 and 2023. The result of having stigma integrated as a concept in the national guidelines for Rwanda was already described under professionalism.

Outcome Rwanda

Hospitals and health centers clarified the patient pathways for people seeking for termination of pregnancy.

In Zimbabwe, Champions engaged with members of the public, school students and stakeholders who can be part of the chain for provision or support of abortion and post-abortion care (e.g. police, lawyers, civil society organisations, municipalities etc.) to sensitize them on abortion laws and explore their assumptions about safe abortion, with the aim of building capacity and improve knowledge to support individuals seeking abortion services. Since it is unknown how their attitudes and especially behaviour evolved after the training, this is not a full blown outcome yet, but may be one of the stepping stones.

Outcome Zimbabwe

Non-HCP stakeholders and members of the public sensitized on abortion laws and explore their assumptions about safe abortion.

> *"Particularly from my objective, which had to do with the multi sectoral approach to capacity building, so we'll bring together different players, healthcare workers, midwives, nurses, social workers, teachers, community leaders, and we would go through a session of training on what the regulations were in Zimbabwe around safe abortion. We would always start with a knowledge, attitudes and practices survey just to see and understand where people are in terms of their understanding and appreciation of the subject. And ..., maybe after two days of the training, and you go back to the same evaluation, you would find that there would be a definite shift in terms of understanding of the of the subject matter. (Zimbabwean Champion)*

In Nigeria, where the Champions conducted VCAT training for medical students in 4 states, pre- and post-test results showed an average increase of 20% in positive attitudes and a 9-21% decline of negative statements (e.g. believing abortion to be morally wrong and refusing referral) following training. Immediate post-test results do not inform about longer lasting effects on attitudes or practices, but are an important stepping stone in normalization.

At the global level RCOG produced a number of statements, blogs and conference contributions to emphasize their concern for the stigma faced by abortion providers, and its impact on the provision of services. A global study into the experiences of stigma among abortion providers resulted in the RCOG stigma guidance paper[1]. M&E data from August 2023 showed that by then the guidance was viewed 182 times on the RCOG webpage. It is unclear to what extent this has influenced normalization among the RCOG membership thus far. Among RCOG members that filled out the RCOG membership survey there was already a relative high percentage of respondents agreeing (agree + strongly agree) that "HCPs need the certainty that they can provide essential healthcare such as abortion without the fear of prosecution, harassment or stigma" at baseline (86%), which slightly increased to 89% in the endline survey conducted in September 2023 (increase from 62 to 69% for those strongly agreeing). Likewise, the percentage of respondents who reported that

[1] RCOG. Reducing and managing stigma experienced by providers of abortion care: a review of current practice. June 2023. Accessible via: https://www.rcog.org.uk/media/2cfkwwvf/rcog-stigma-guidance-paper-01.pdf

they "would not provide abortion (or provide information) but would advise them to continue the pregnancy and refer to another health worker" was low (4%) at baseline and slightly lower (1.4% said "I would not provide it, and I would advise them to continue with their pregnancy") at endline.

What strategies influenced change?

The Champions emphasized that the training they received from RCOG, was important in equipping them with skills in **value clarification and attitude transformation** which they used to engage with HCPs and other stakeholders targeted by their activities. According to M&E data 12 Champions across the countries were trained as VCAT trainers and subsequently trained over 125 (by August 2023) people on VCAT, which far exceeded the target (50) of the programme.

Respondents emphasized how the **awareness of legal guidelines and understanding of professionals that are covered by the law** is an important aspect in normalization. In Rwanda, the project commenced in the backdrop of a 2019 law amendment that set conditions for doctors to perform an abortion and removed the requirement for a court order and second doctor permission. Raising awareness of this was seen as important in ensuring that many HCPs were aware of the amendment. Champions were able to leverage on the momentum of existing awareness-raising efforts of the new amendment thereby contributing to the understanding the new legislation and reducing HCPs fear of criminalization and increasing the number of HCPs willing to provide safe abortion and PAC services.

> *"It is training and awareness. Rwanda is a very regulated country and everyone wants to respect the law...they used to say no one is eligible, so then those who were providing the services were doing it really very clandestine and hiding. Now with the change in the law, I think even providers, they think they are covered by the law." (Rwandan Champion).*

Similarly, in Nigeria the MoH was in the process of redesigning of national guidelines on safe termination of pregnancy at the inception of the MAS programme. Nigerian Champions managed to obtain permission from the MoH to distribute the guidelines amongst HCPs. A Champion in Nigeria described the importance of this strategy in improving normalization as it increased knowledge essential for practice that is within the limits of the law.

> *"Abortion and everything about it is being stigmatized in Nigeria, and the health care professionals need to have their confidence established and reinstated so that they can practice without difficulty and return courage. (...) There was information that was existing but not available to them. The guidelines on safe termination of pregnancy for legal indications is there, but a lot of the practitioners did not know about it. And then this project afforded the opportunity for wide-scale dissemination of that document" (Nigerian Champion)*

In Zimbabwe, the project was seen as contributing to normalization as the topic is considered taboo and often providers and patients seeking abortion services, even within legal limits can be stigmatized. Having a **presence at annual meetings of professional bodies and other professional conferences**, was reported as key in addressing misconceptions that have historically reduced safe abortion practices amongst HCPs.

> *"under objective 2 we had an opportunity to meet professional bodies like the ZiNA, Zimbabwe midwifery commission. So during those interactions we talked issues of safe abortion and post-abortion care and shared that video "breaking the silence." So that the Health professionals could introspect on the issues of safe abortion. Some, because of religion are not keen to support any issues to do with abortion. So, through those discussions, there were opportunities for them to think about the safety of the mother during abortion because if a woman wants to abort she can abort and us as healthcare professionals are supposed to them to get a safe abortion" (Zimbabwean Champion)*

Although the workshops, conference proceedings and trainings done by the Champions in these three countries contributed to enhanced HCP perception of safe abortion and laws regulating it, Champions note that more work needs to be done to achieve significant normalization of the topic. Challenges remain in ensuring that a majority of HCPs are willing to provide safe abortion and PAC services within the limits of the law.

> *"But for the stigma, I think it was very early to stop, because for the stigma there is still too much to do. That is my personal view, that the project ended where we are at a very early stage. It's good we managed to do the research [stigma research, described under leadership], but the dissemination of the research, the advocacy for strategizing and having the ministry to understand and the whole team to understand and strategize to fight against the stigma, I think we are not at that point." (Rwandan Champion)*

> *"When we talk of abortion its more of a taboo topic generally in our society. But then picking it up within the professional body was quite worrisome because these are the people who should be providing help. And then people knowing that I am part of the MAS programme, I had colleagues coming up to me saying 'how can you advocate for abortion' like quite angrily... some of these things are a process of learning and with time they kind of the melted, they don't agree with abortion. But at least now they agree that a woman has got a right to access safe abortion services. Which is a breakthrough because I think one of the biggest barriers was actually the health system whereby even if a woman comes, she can't access. Because we're shouting at them" (Zimbabwean Champion).*

Findings show that efforts to address attitudes and perceptions of abortion require ongoing dialogue of addressing stigma against both HCPs and patients seeking safe abortion or PAC services. This is considered a long-term effort, and the scale of activities should go beyond the healthcare system and also involve the wider community and public perceptions.

4.2.3 Leadership

The third programme objective focused on Leadership: Programme Champions and other HCPs conduct research and advocacy work in the field of abortion care and PAC.
This section aims to provide answers to the following evaluation questions:

- *What are the key achievements resulting from the advocacy work that Champions have conducted over the course of the project?*
- *What are the findings of the research which has been conducted in the field of abortion care under the project? How have the findings been used?*

What happened and who were involved?

Champions took a leadership role in advocacy; often had been leaders/advocates before, but the MAS programme further contributed to empowerment and provision of a platform to capitalise on their advocacy skills.

As described before, the Champions were a diverse group in terms of background and advocacy experience, but in general in all countries there were Champions who had been working over a longer period of time to advance safe abortion care. During the course of the programme they further developed and strengthened these skills and positions. In Nigeria, Rwanda, Sudan and Zimbabwe Champions reported that, in combination with creating normalization, they have been able to enter spaces for advocacy, both in the medical professional field, such as during conferences and other professional spaces, as well as in the policy level field, primarily with the Ministries of Health.

In Nigeria and Zimbabwe, Champions also made use of public spaces through the media, such as radio and newspapers. It was generally reported

Outcome Zimbabwe

Advocated media platforms open spaces for discussion on Safe abortion and Post Abortion Care topics with the general public.

that this induced less backlash than they had expected, an important pointer for normalization.

> *"Last week I was on radio. I was talking about unsafe abortion on radio. Before if you came to talk about unsafe abortion on radio, you'd be attacked but the person anchoring the programme said, 'yes, we need to talk about it. It is ravaging our women, and we must talk about it' And we began to talk about it and the response was tremendous. Everybody was congratulating us, the radio station for coming to talk about this topic that people don't want to talk about...." (Champion Nigeria)*

In Rwanda, Champions found themselves to be called upon by other important stakeholders - such as the MoH or universities - as credible key experts for providing trainings, lectures and to sit on technical working groups. According to a Rwandan external stakeholder the programme contributed to creating a much needed pool of health care providers that are willing and comfortable to openly speak about the topic, provide trainings, mentorship and advocate for better policies.

Outcome Rwanda

Universities/stakeholders/MoH invite Champions to speak on the topic or join TWGs.

Leveraging these leadership positions was found to be crucial in the contribution to key achievements as already described under professionalism and normalization.

Research still in progress in the active implementation countries, where preliminary results had occasionally been used to influence policy documents.

In Nigeria, Rwanda and Zimbabwe Champions conducted research as part of their advocacy plan, though due to the timeline of the project, most results were still being analysed or in write-up at the time of evaluation. All three countries conducted studies on stigma, also as contributions to the global stigma study (described under normalization). In Rwanda a larger qualitative study was conducted to understand what abortion stigma experienced by providers of abortion care looks like in Rwanda. A draft manuscript highlights the presence of stigma both in and out of the workplace. Preliminary findings were used in the TWG on the development of national guidelines and emphasizing the importance of addressing this through the national guidelines. In Rwanda the analysis of a mixed-method study on the successes and challenges of the implementation of the 2019 ministerial order is also underway. Smaller studies that were conducted, such as a desk review on incidences and mortality in Nigeria and Sudan, were used to influence BPP guidelines development and were presented during conferences. According to M&E data, by October 2023 Champions had provided a total of 68 scientific presentations (oral or poster) in national and international conferences.

Although the advocacy plans in Sierra Leone did not materialise, in 2022, RCOG partnered with Africa Research Excellence Fund to deliver grant writing skills workshops for early career researchers which resulted in research grants awarded to two Sierra Leonean researchers. Although the grants were part of the MAS strategy, the researchers were independent and not integrated with the Champions model. One mixed Method study on the effectiveness of Post-Abortion Care in Sierra Leone was completed. It highlighted the poor PAC data quality in public and absence of data in most private health facilities, HCP challenges (including stigma, lack of protection, lack of trained providers with access to commodities and poor task shifting) and user barriers (including costs, stigma, fear, absence of counselling). The findings were presented during conferences and there are ongoing advocacy efforts with the minister of health focused on public/private health facilities engagement and conducting public awareness discussions on national television. Another study focused on the impact of engaging community intermediaries in expanding post-abortion contraceptive choice (results unknown).
The research awardees felt their research was useful in bringing to light the extent to which abortion policies align with practices and what should be done to close gaps in Post abortion care provision in the country. Their studies have recently been completed but they are already engaging with Health service providers in their results dissemination and hope to become part of key decision makers when it comes to PAC.

> *"During the maternal health conference, where I made a presentation, the chief midwifery officer made a recommendation that I be one of the few that should be in the reproductive programme directorate…and she promised us she was going to take it forward." (Research Awardee Sierra Leone)*

What strategies influenced change?

Both international and national level respondents emphasized that the **Champions model** and **providing a platform** for their voices has been key for leadership.

> *"Because abortion is so stigmatized and so marginalized, particularly in some of the countries in which they were working, just having more voices who feel empowered and motivated to stick the head above the parapet, talk about abortion and try to normalize abortion, I mean that is just a massive contribution.*
> *So you know, giving the in country Champions a platform and a voice -I mean some of the Champions already had a bit of a platform because they were well established and activists in their movements. But you know, some of them didn't, and I think the work they did around that is really helpful in contributing to the normalization and just bringing abortion out into the mainstream." (Key Informant Global)*

An important element that was mentioned were the **trainings, tools and resources** for the Champions that helped them to leverage their voices, as also described under relevance. Champions were inducted to the programme through various training initiatives, including Values Clarification and Attitude Transformation (VCAT) by IPAS, capacity building workshops by experts on abortion advocacy in Africa, communications and messaging, building strong coalitions, teaching abortion and abstract writing. RCOG also developed an e-learning on advocacy that was accessible for wider audiences. By February 2024 the downloads of this e-resource had exceeded target, with a total of 846 downloads of which 174 fully completed the course.

In all countries the **authority** of some of the Champions involved and **bringing data** were also seen as important elements in leadership.

> *"First of all, credibility, because you have people like [prominent gynaecologist], we have people that have been in this field for a long time. So those people were able to use their experience in this to convince the ministry.*
> *And the other thing that we brought is data, so for example when we talked about stigma, we had conducted some different surveys with the clinicians and we bring those data in the conversation and say this is what people want. Then that was also one of the convincing ideas.*
> *So I think it's a little bit of everything that helped. We weren't like so pushy in terms of activism. I would say it was more partnerships and collaborations." (Rwandan Champion)*

> *"We are now using facts. Because we started this abortion discussion using emotions but when the Guttmacher research was done in 2016, we then had evidence, evidence that contributed to the safe engage video. So it was no more intimidating, it was information. And, as I said, the argument is that our health system is near to collapse, but we are saying we could them save a few dollars if we offer safe abortion. We can also reduce maternal mortality if we offer safe abortion because abortion is known to be the fifth contributor to maternal mortality. So we used evidence and facts over emotions to push our agenda. I think that also contributed to the acceptance of the topic at community level." (Zimbabwean Champion)*

Also at the international level RCOG had been able to bring across data to influence change. Data on the effectiveness of telemedicine that were collected during the Covid-19 pandemic were used to inform the WHO guidelines and in the UK the amendment to the Health and Care bill to continue telemedicine for abortion.

Conditional elements that were found to be important in ensuring that Champions were able to leverage their leadership are **partnerships and alignment with other initiatives in the country**. For example in Rwanda, MoH and other key partners that organize and fund trainings or other initiatives knew how to find and would call upon Champions to come in as (VCAT) trainers or key level experts.

4.2.4 RCOG voice

The fourth programme objective focused on the RCOG and its membership having increased influence to reduce barriers to safe abortion and/or post-abortion care services at a national and international level. This section aims to provide answers to the following evaluation question:

- *To what extent has the RCOG voice been leveraged and contributed to changes in creating an enabling environment for safe abortion?*

As the above sections have provided insights on how the RCOG voice and resources, especially the Best Practice Papers, have been leveraged to contribute to national advocacy by the Champions, this section will have more emphasis on the RCOG voice at global level and in the UK.

RCOG being established as a more visible and well-known partner and advocate in the field of SRHR, in the UK and in the global health field.

It is evident both from interviews with RCOG staff, global partners and the RCOG voice log that the RCOG has been present and quoted in a large amount of resources. By August 2023 (RCOG M&E data) RCOG:

- had been involved in 25 national and international advocacy platforms to raise awareness, disseminate or challenge opinions regarding abortion
- was cited in 122 high level meetings/ events, through media and/or public statements.
- shared 37 public facing communications materials from RCOG members and/or Champions about the impact of unsafe abortion; shared through RCOG, MAS programme and external communication channels.

According to RCOG staff and partners this has contributed to RCOG being established as a more visible and well-known partner and advocate in the field of SRHR, in the UK and in the global health field. Key issues that the RCOG, in collaboration with others, have been able to contribute to include the securing of access to home use of mifespristone during the Covid-pandemic in England, Wales and Schotland, allowing for services delivered completely through telemedicine up till 10 weeks. Following the Covid-pandemic evidence on the effectiveness of telemedicine had been used to advocate, ultimately leading to the House of Lords and House of Commons passing a vote on the amendment to the Health and Care bill to continue telemedicine for abortion.

4.2.5 Partnerships

The final objective of the programme was partnerships: The RCOG has developed sustainable partnerships with like-minded stakeholders to support abortion advocacy work. As partnerships were not only crucial for RCOG itself, but also for the advocacy work by Champions, the scope in this section is broader, focusing on both national and global levels.

This section aims to provide answers to the evaluation question:

- *How have new or strengthened partnerships added value to our abortion advocacy work?*

In the implementing countries key partnerships were found with ministries of health for the development and dissemination of guidelines, with professional bodies for knowledge exchange and with NGOs as advocacy allies

As a core element in effective advocacy strategies, this project demonstrates the importance of partnership and how in Nigeria, Rwanda, Sudan and Zimbabwe partnerships were crucial for the advancement of safe abortion. In these four countries the Champions closely collaborated with the Ministry of health (and for Rwanda the MoH's implementing institution Rwanda Biomedical Council – RBC), especially on the development and dissemination of guidelines. Political will of the ministry of health was mentioned to be crucial and in general the collaboration in these countries was smooth. In Rwanda and Sudan Champions were involved that hold a position in the MoH which facilitated easy

access to the policy maker level. As described before, the authority of some of the Champions involved and bringing data were also seen as important elements for the MoH being susceptible to the arguments of Champions.
In Sierra Leone, Champions felt they could not establish a viable relationship with their MoH and this led to delays in getting the project running. When Covid hit, the Champions Priorities also changed and led to a decline in participation .

Key partnerships reported on in Zimbabwe

Ministry of Health and child care (MOHCC), College of Primary Care Physicians Zimbabwe (CPCPZ), Zimbabwe Nurses Association (ZINA), Zimbabwe Society of Obstetrics and Gynaecology (ZSOG), Adult Rape Clinic,, INSTITUTE, Women's Action Group, Health Times, CapiTalk 100.4FM, Star FM.

> *"Because it was us, the participants who were leading the project and having to implement a new network… up to a certain points with the Ministry because even though some people did try to engage with them, they would say: yes, they're interested, come up with a proposal, do a budget and when they realised the budget wasn't what they wanted then they lose interest. I think that's one main issue from the Ministry's perspective. But from the participants' perspective, I think maybe because part of it was during COVID, since most of them were in the medical field they were drawn to that, they couldn't connect" Sierra Leonian Champion.*

Other important partners were found in professional associations, such as medical councils, national obstetrics and gynaecology societies, nurses and midwife associations. This served especially for knowledge exchange such as during conferences. Also here, the strategic involvement of Champions linked to different organizations and different cadres, was reported to be an important element of success. In Nigeria there was also close collaboration with the Nigerian Medical Student Association which facilitated the mobilisation and training of medical students and strengthened the SCORA (Sexual and Reproductive Health and Right including HIV&AIDS) unit of the association and with the National University Commission and medical and dental council of Nigeria for the inclusion of pre-service training for safe abortion and post-abortion care in the curriculum.
Finally there was collaboration with local NGOs who were important allies in advocacy.

Key partners reported on in Nigeria

Federal ministry of Health, Society of Obstetricians and Gynaecologists of Nigeria (SOGON), Nigeria Medical Association (NMA), Medical and Dental Council of Nigeria (MDCN), Association of Feto-Maternal Society Of Nigeria (AFEMSON), National Universities Commission (NUC), Postgraduate medical colleges, Nigerian Medical Student Association (NiMSA), IPAS

Key partners reported on in Rwanda

Ministry of Health and its implementing institution Rwanda Biomedical Center (RBC), Rwanda Society of Obstetricians and Gynaecologist, UNFPA, CHAI, Health Development Initiative (HDI) and the Rwanda health initiative for girls and women.

> *"So the new ministerial order was in place. But how do we deal with raising awareness of the ministerial order?*
> *A lot of trainings to doctors, engaging civil society, working with other SRHR focused organizations to raise awareness on the ministerial order, creating demand at community level, working with professional settings like gynaecologists and other physicians to show they are aware of what the law provides (…) And most of the Champions are physicians, that we have been working with and we see it as a very significant contribution because again you want doctors, you want gynecologist to be part of this, who are comfortable to talk about it. The more they do it, the more they encourage their peers." (Rwanda NGO representative)*

Global partners benefit from a network of well-positioned Champions in countries

For the RCOG the programme brought new in-country partnerships with organizations that they got to know through their Champions and also global partners reported to benefit from the Champions' networks. For WHO the collaboration with RCOG, being a health care workers organization with people/Champions on the ground, was mentioned to be crucial in the development and dissemination of WHO guidelines. First of all, having access to a pool of practitioners helped to fine-tune WHO guidance.

> "*Hearing their questions it just helped to inform, and understand what we need to do a little better in our messaging and improving on it. So that's why we were like, 'you know, we definitely need an*

operational guidance for the law and policy to really tease things out.' And we came out with that evidence brief[2]. So you know each of those feedback does help inform what we do (...) And I think they, they've confirmed and verified it'd be good to have tools, especially for the clinicians and so that's what prompted me to just really push, at the same time as I was getting ready to launch, I started doing the update process for the clinical practice handbook, because those are all the clinical recommendations housed in in our abortion care guideline." (Global key informant)

But the partnership was felt to be especially crucial for the dissemination of the guidelines. Having access to a network of Champions ensured WHO that their guidelines would be locally received. Champions were also mobilized by WHO and RCOG to contribute with the health care providers voice to panels during conferences and webinars around the launch.

"*And it's it's kind of like a symbiotic relationship, right?*
Like we WHO as an organization, even though it's neutral, it's a convening power. And you know, we issue very rigorous evidence based guidance, but then of course we want that to be implemented and used and so that's why we are really strengthening our ties to partners because our implementing partners are the ones who are carrying on - which I think is the most challenging - in making sure that these recommendations are being taken up and how they being taken up." (Global key informant)

Also another global key informant emphasized how having access to such a group of well positioned Champions can leverage advocacy and wished there was more exchange on which key figures are positioned where and how they could be approached for collaboration or mobilization. These global stakeholders expressed concerns about the sustainability of the Champion's network and wondered how and through what mechanisms they could continue to collaborate.

[2] Towards a supportive law and policy environment for quality abortion care: evidence brief. https://www.who.int/publications/i/item/9789240062405

4.3 Key findings in relation to Efficiency

This section on efficiency seeks to answer the following evaluation question:
To what extent was the project structure and staffing within the Centre/the RCOG and use of a Champion model appropriate for the delivery of this work? And what were the enabling and hindering factors for delivery?

The presence of a dedicated project team was important to drive change

Lead implementation has been with the MAS programme team, based in the Centre for Women's Global Health in RCOG, consisting of a senior programme manager, a programme support officer, an advocacy & communication manager and a monitoring & evaluation manager. For the first year there was also a clinical lead seconded from University College London (UCL). Both Champions and global partners emphasized the importance of having a dedicated project team being able to drive the change at central level and benefited from having a clear point of contact and quick turn-around.
In all the countries, Champions also expressed their satisfaction and appreciated the RCOG MAS team in their level of professionalism, organisation, communication with the Champions and among themselves, prompt response to messages and their needs, close monitoring of the progress of their activities, and, surprisingly, the smooth coordination and hand-over of activities among the team.

> *"Even when they were trying to, you know change the baton probably somebody is leaving, giving it up to somebody else, they don't come in as a newbie, you know, when you come in and say, "Oh, I don't know where this person left, Oh, sorry it was an omission, there was never anything like that. When the baton is being passed it is seamless, and then they take it over with it like that. So, I really, I really commend that" (Nigerian Champion)*

To strengthen the internal accountability processes, a MAS Project Board was established at the beginning of 2021. This comprised all Executive Directors in RCOG, relevant Directors as well as the RCOG CEO. The aim of this Board was to provide high-level oversight of the programme in terms of monitoring results and budget and to report back to RCOG leadership structures, including the Executive Directors, Board of Trustees and Council.
Other governance structures involved were

- A programme advisory group (PAG) had been established to leverage on existing knowledge and networks that could augment the programme and to ensure a collaborative approach with key stakeholders, such as FIGO, MSI, Ipas, IPPF and key RCOG Fellows and Members, including representatives from the Global South. The PAG met on a bi-annual basis.
- An RCOG Programme Steering Group was established to ensure that the programme was well integrated within RCOG activities and to harness cross-departmental collaboration within RCOG. The steering group comprised of internal RCOG key representatives from the sections of Digital; Media and PR; Policy; Marketing; eLearning; Patient and Public Engagement; Faculty of SRHR; and Membership and was meeting at a monthly basis.
- RCOG International Council Representatives (ICR) and International Representative Committees (IRC) were supposed to be engaged to strengthen connections in the regions, but their role has been reported to be minimal.

Self-coordination in a network of Champions generally went well and contributed to a feeling of togetherness, but also came with challenges.

The Champion model consisted of a group of individual Champions rather than Champions connected to an existing network or organization. This meant that Champions had the freedom to operate and work in an agile way, without being restricted to organizational interests or conflicts. However, it also meant there was no appointed in-country leadership or coordination. In-country finance partners had been contracted based in Nigeria (Women's Health and Action Research Centre), Zimbabwe (Adult Rape Clinic) and Rwanda (Rwanda Health Initiative for Youth and Women) to oversee the financial management of Advocacy Plan budgets, but these were not appointed with a coordinating role. The Champions generally reported that self-coordination of their tasks and activities went well, but a central point for coordination was an expressed preference by some. Also, for external partners the loosely organized networks meant they would still depend on known connections to reach out for collaboration, while they acknowledged it would be useful to get new connections for specific roles.

Champions expressed that the level of efficiency of the programme was determined by the calibre of people and complementarity that make up the Champion team, as was also described under relevance. For Zimbabwe and Rwanda, the Champions were mostly of mixed professional background or field such as physician, midwife/nurse, policy maker, activist etc, and this was seen to be an effective way of distributing tasks that match professional experience with objectives and in accomplishing these objectives. On the other hand, in Sierra Leone Champions experienced a lack of alignment about the objectives due to different backgrounds; this resulted in division of focus and contributed significantly to the inability to continue the programme. For Nigeria and Sudan, most of the Champions were specialist Obstetricians and Gynaecologists with a strong professional network or connection. This was seen to be advantageous in achieving their objectives that were mostly targeted at HCPs, however, the overrepresentation of health care professionals over others risked the sense of belonging for all (including non-HCP) Champions involved. At least for Nigeria, it was also expressed that the mix of younger and older Champions served less experienced Champions to be supported and learn from more experienced ones.

Cross-country engagement was considered crucial for learning, but intermediate learning and reflection within the advocacy cycle could be strengthened

The cross-country engagement was perceived by the Champions in Nigeria, Rwanda, and Zimbabwe to be productive. They said the experience was crucial in learning from one another. They were able to learn the strategies utilised by other countries.

> *"The cross-country engagement was, indeed, I think it was very necessary, because we now saw what strategies the various countries utilized to achieve whatever they achieved. And we had to also sell our own strategies. There were things that those countries were not able to know how to manoeuvre to get across, so we were able to give them benefit of our own strategies, and we were also able to take on what they had in some areas that we had found them difficult to be able to strategize upon, so it was…I think it was a very good thing" (Nigerian Champion)*

However, less continuous learning within the national advocacy cycles was identified. The rush of the programme (timeline challenges described below) and ambition of the teams supported strong and dedicated implementation, but with little reflection time in between to evaluate what was actually being achieved, whether results were delivered in a way that was intended, whether strategies had to be re-steered and how to ensure sustainability.

> *"And I think to me, that's what advocacy is right. So you you maybe you test something, you talk about something, but then you try to sort of like get long term systemic change in policy or guidelines or so on.*
> *And I think what I found is that often we started in sort of like the advocacy programme design and and strategies. 'this is what we want to show, so we bring together some people in a workshop to talk about this'. But then there weren't necessarily the steps after, like how can we make that that become sustainable?"* (RCOG staff)

The implementation of the programme was observed to be successful by some facilitators, but also faced with obstacles that either delayed or totally hindered implementation

While engaging the Nigerian, Rwandan, Sudanese, and Zimbabwean Champions during the qualitative data collection, they expressed several factors that enabled the programme to be achieved and these included; the training received from RCOG and the support provided by RCOG to sponsor them to conferences, provision of funds for training and printing of documents, the (high) quality and expertise of Champions chosen for the programme, the passion of Champions for the programme, close monitoring of the programme by the RCOG, and the monthly stipend received that was identified as a necessary need which facilitated engagement.

> *"I think the close monitoring kept us on our toes. So, I think that aspect for me was important, just being able to be…. So, we're very accountable in what we, you know, what we set out to do, we really had to, we really had to deliver. And when we started, I don't remember if we had like the monthly data [i.e. internet data bought with monthly stipends], I don't remember when that kicked in. But it was, for me, it was very important aspect, just receiving that support"* (Zimbabwean Champion)

The programme was also faced with some hindering factors of different forms across the countries.

Generally, short or **compressed timeline** for the programme was a common factor expressed by the Champions in Nigeria, Rwanda, and Zimbabwe. Overall, the implementation timeline was perceived as too short, also to achieve and witness systemic change or impact. At the time of the evaluation Champions were still busy implementing, rounding off research and feeling they are at their peak when they have to stop. Also, other stakeholders emphasized the need for longer continuous advocacy.

> *"I started doing HIV interventions way back in 2003 and one of the lessons I learned is that mindset change is a long-term process. You need your seven years and you keep nailing it into people over six, seven years and being consistent. If you are going to achieve a mindset change as well as a behaviour change in service providers to accept that the need is there.*
> *So, I would probably rather just give a recommendation - I don't know how long this has been going on for - but I believe at least six years of continuous noise, sustained noise in an enabling environment is what it will take." (Zimbabwean external stakeholder – NGO representative)*

Even though the programme started during the COVID-19 period, Champions did not report on the pandemic as a major obstacle. However, in Sierra Leone, Champions said that it increased the workload and priorities of medical staff with the result of limited attention given to the programme. Likewise in Zimbabwe, it affected Champions from obtaining Visa to attend a regional conference. Other impeding factors either totally prevented the implementation of developed objectives, as in the case of Sudan and Sierra Leone or delayed achievements of some objectives.

Sudan experienced a major **internal political instability and civil war** that resulted in national disruption of services which subsequently lead to relocation of Champions, thus halting the activities of the Champions. In addition, there was a ban on international money transfer, and as a result it was difficult for the Champions to get funds to continue the programme. Also, technical problems such as bad internet connection experienced by the Champions living in Sudan, and the different time zones among the Champions significantly disrupted smooth flow of their meetings. For Sierra Leone on the other hand, it was perceived that the lack stipends at the start made some Champions drop out. Also, absence of a dedicated leader to lead or champion the programme, emigration of Champions as well as technology barriers resulted in discontinuations in the programme.

The issue of brain drain was also a perceived risk for other settings:

> *"Another challenge is: you work with people and you need to have them stay in the same place to be effective. So one of the biggest challenges that we have is there's so much brain drain in Zim right now, especially for our providers. So you might find, just when you have one with a particular individual in the rolling, then because of the environment that they're working in things don't work out and then they move on with their knowledge, move on with their attitude, they move on with their safe abortion skills." (Zimbabwean external stakeholder – NGO representative)*

In Nigeria, factors such as **insecurity and national elections in 2022** interrupted their activities and led to postponement or cancellation of activities such as HCPs and medical student training, meeting with relevant stakeholders to execute the programme objectives, especially the third objective on inclusion of pre-service training in undergraduate curricula. As a result, the objective is yet to be achieved, with ongoing meetings taking place at the time of evaluation.

Similarly, in Zimbabwe, reshuffling of members of parliament and the national elections in 2023, resulted in loss of progress with sensitized legislators leading to delays as they had to reorient new ministers and solicit their support for reviewing the CAC guidelines.

> "*So you could just imagine our concern when you have, you know, policymakers that are open...when we had a director at the ministry like that, then we're also pushing for them to adopt and approve the whole guidelines. Then the minister also changed and I remember all headlines where he was actually open and saying '...women are promiscuous, they go around, get pregnant and then they want to remove these pregnancies.' Which was just concerning for us that was our work in all objectives going to continue or going to be received well, especially by the policymakers and so the government. But you know last year they approved the guidelines*." (Zimbabwean Champion)

4.4 Key findings in relation to Sustainability

This section on sustainability seeks to answer the following evaluation question:

- *What is the likelihood of the project's results being sustained?*

Established changes, especially those described under professionalism, are likely to be sustained

Champions as well external stakeholders were of the opinion that, at least in Nigeria, Rwanda and Zimbabwe various project results - especially those achieved in the regulatory framework (described under professionalism) such as the contribution to BPPs, guidelines and incorporation of safe abortion best practices in examination questions - are established and will continue to influence the practices of health care providers. There is also general hope that those health care professionals who already have improved awareness and behaviour within the regulatory framework on abortion will set example for others and this will have a ripple effect in the abortion ecosystem.

Champions will likely continue to champion, but it is unclear how they will be organized as a network

As mentioned before, some of the Champions had already been Champions for years, while others had newly stepped in the field of advocacy. Generally it is expected that many Champions will continue to champion (as some have always done), further skilled and empowered through the MAS programme. However, without the programme or funding this will be less coordinated and focused. The same applies for the RCOG and both RCOG staff as well as international partners expressed concern that the RCOG will not be able to continue the position they have established with the same strong global voice for safe abortion. A lot of the work and time investments needed were possible because of the available resources and dedicated project team. And despite efforts no new funding could be secured.

> *'But I mean, to be honest, we're all grappling with that.*
> *I mean, the reality is the biggest abortion donor has stopped funding everyone, which left a really, really big hole that we're all grappling with in our own way.*
> *You know it's hard finding donors that really want to unapologetically dedicate themselves to abortion, they kind of don't exist.'* (global partner)

RCOG staff expressed confidence that safe abortion will stay on the agenda of the Centre for Women's Global Health, it being one of the core thematic areas of the strategic plan, and that the RCOG will probably also continue to use its voice in the UK, as the main professional body there. However, they also acknowledged that without having a team or advocacy lead to drive the agenda, its influence will be less. Also international partners expressed the concern that after the project's ending they would not know who to reach out to when seeking collaboration with RCOG. It is thus unclear (at least for outsiders) how and where the theme of safe abortion will be anchored in the governance structure of RCOG.

As previously described under partnerships there would be value in a continued network of Champions that can lead on advocacy with local and international partners. Champions and other stakeholders in the countries also expressed a general interest (and a felt need) to continue with networks and partnerships that have been built. As donor funding is shifting more to the global south it may be worthwhile to explore whether Champion networks can be directly funded, but it needs to be anchored somewhere. Linked to this is the question on how to continuously build the capacity of Champions.

> *'So it's not about a one year project that is now ending. Actually we need a movement of Champions, because now the main challenge in Rwanda is how do we build the capacity of doctors and other providers to be able to provide stigma-free safe abortion services.' (Rwanda NGO representative)*

This was also emphasized by Champions; there needs to be opportunities for new and younger Champions to build their capacity. Without funds the capacity building may be less structured, but experienced Champions could play a mentorship role and existing resources (such as advocacy e-learning) could be used. Something that was identified as a missed opportunity was the adaptability of the training resources for national medical curricula. The e-learnings were not always very accessible in places with lower speed internet and getting local accreditation for it proved to be difficult. Both RCOG staff and other interviewees expressed a better strategy may have been to, together with the Champions, identify what was needed and - for example - develop a script that could be used or adapted in various forms (like the BPP).

There was also an expressed interest to keep a network across countries (e.g. through Whatsapp) for information sharing. As funding is moving away from RCOG, it is unlikely that RCOG will continue to have a strong role in there,

unless international safe abortion is also clearly anchored in the governance of RCOG. This would at least serve information sharing between RCOG and partners with in-country Champions.

4.5 Key findings in relation to Impact

Impact, as defined by the Organisation for Economic Co-operation and Development (OECD), is the extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects. The project's M&E framework has indicated this as a reduction in maternal mortality and morbidity through improved access to safe abortion and post abortion care. Such impact cannot be measured for this evaluation for various reasons: it would require yearly national and accurate abortion and mortality estimates, the absence of a counterfactual would make it unfeasible to attribute change purely to this project and it is unrealistic to expect such impact from an advocacy project over a short period of time. History has demonstrated that it may take years even decades to observe the longer lasting effects of safe abortion advocacy. However, this evaluation demonstrates through the harvested outcomes, that the project and its Champions have been able to establish a number of significant changes that can be seen as stepping stones towards a greater impact.

To end with a testimony of true appreciation:

> *"I just can't emphasize enough how fantastic this team and this programme has been for the guideline and the dissemination efforts and it's been… they're fun you know, I really thoroughly have enjoyed my interactions, my time with them and I really appreciate their energy and their initiatives. And that's why I am a big cheerleader for them and would love if there's any possible way of having this thrive and continue then it should, because I feel there's so much that has been done and there is potential for more, especially like we're just starting and building up." (WHO)*

5 Discussion and reflections on Theory of Change

This evaluation of the Making Abortion Safe programme **demonstrated key outcomes under the various pillars of the Theory of Change (ToC) and most prominently under the pillar of professionalism**. Within a relative short time, Champions in three of the five implementation countries have been able to contribute, in partnership with allies and through strong relations with the ministries of health, to the development and adoption of national guidelines and their further dissemination, leading to improved health care professionals' awareness on regulatory frameworks. The evaluation also demonstrated the importance and **interrelatedness of all strategies**. Clarification of the legal frameworks and guidelines further contribute to normalization, partnerships are crucial in effectuating change and the RCOG voice and leadership have been continuous drivers of the change in all outcome areas, globally and in-country. This means the theory of change has worked, at least in three countries of implementation. Commonalities in these countries were the right political momentum, a successful group of Champions that were well-positioned, complementary to each other and to what was required in the specific context and that included individuals with strong credibility, fostering a trusted relationship with policy makers. In two other countries the ToC had less effect. The progress in Sudan was heavily challenged by the political instability, undermining the first assumption of the Theory of Change. And in the case of Sierra Leone the overall objective of the programme, focusing on increasing HCP capacity to deliver, improve and champion access to safe abortion, did not fit the existing movement and goals of Champions in the country seeking law reform.

For reflection on the other assumptions of the ToC we have categorized them into three types (annex 1).

- The first four are **conditional assumptions** that - apart from the first one - withstand, meaning in Nigeria, Rwanda and Zimbabwe the project was in the right place at the right time. Even though, these conditional assumptions have been quite ambitious to expect. For example, though the backlash experienced in the project has been minimal, realities for safe abortion advocacy are often different. For future programmes it is advisable to design mitigation strategies for these type of assumptions and ensure a flexible approach where advocacy strategies are constantly reflected upon and adapted where needed to navigate the complex advocacy landscape (see also figure 1).
- Most assumptions of the ToC are **operational assumptions**. As was also discussed by participants in the sense-making meeting, these are mostly within the span of control and should therefore as much as possible be integrated in the design. The project team responded well when assumptions were not holding, for example by introducing the stipend which was experienced as a necessary mean for engagement, commitment and for internet security (linking to assumption 9). Even though, the challenge of the 9th assumption did affect accessibility of the e-learning resources that should be considered for future programmes.
- The ToC was built on only two **cause-effect assumptions**, both focusing on online resources. Even though these resources were appreciated by a wider membership of RCOG and will remain widely available, these were not the main drivers of change in the programme countries. For future programmes the strategies that have proven to be effective, as described under effectiveness, complemented with a growing body of literature on effective advocacy can be used as evidence to further strengthen the ToC.

An element that generated less effect so far was the conducted **research**. Discussions circulated around the fact that the project has been too short to appropriately finalize research, let alone use it for advocacy purposes, and whether projects of such short timeline should invest in research. Even though, for Champions the research aspect was deeply appreciated, felt to contribute to opportunities and empowerment and they emphasized even more investment in research should be made. The ability to present research also increased prominence of the topic at annual meetings of professional bodies and other professional conferences, contributing to professional debates and normalization.

The efficiency section highlights various other issues that should be taken in consideration both for future programmes as well as for sustainability of what was currently achieved. This relates, amongst others to RCOG and the programme's **governance** structures, how to make most use of the existing structures to remain leading on the issue of abortion globally and how to ensure Champions continue to have access to global resources and contacts. Also the organization of Champions networks is something to reflect on. The composition of the network in the successful implementation countries worked and contributed to a feeling of connectedness and safety, however the network being a loosely organized group of individuals may hamper the ability of networks to acquire future funding and notoriety for others to find and work with them.

5.1 Recommendations

Informed by the evaluation and co-created with participants of the sense-making meeting, the following recommendations have been formulated.

For RCOG:

- The evaluation demonstrated the relevance and success of working with a **Champions model** and leveraging health care providers voices. Critical elements of success were a balanced group of professionals who were well-positioned, complementary to each other – covering various health care professional cadres, connected to NGOs and with access to the policy making level, fostering partnerships -, included professionals with credibility, working on trusted relationships with the ministry of health, access to training, tools and credible resources that help to leverage their voices and strengthen advocacy skills and opportunities to conduct research and attend conferences. It is recommended for RCOG to document and reflect on these critical learnings and foster for future programmes working with the Champions model.

Critical elements of success for the Champions model

- A balanced group of professionals who are
  - well-positioned
  - complementary to each other - covering various health care professional cadres, connected to NGOs , access to the policy making level
  - including professionals with credibility,
- trusted relationships with the ministry of health
- access to training, tools and credible resources that help to leverage the Champion's voices and strengthen advocacy skills
- opportunities to conduct research and attend conferences.

- National as well as international partners emphasized the importance of having access to and partnering with a group of advocates from the health care professional field. It is worthwhile to explore how a **non-programmatic connection between RCOG and Champions** among their UK AND global mentorship could remain to exist, is visible and serves as a channel for international partners that seek collaboration (as exemplified for WHO in this report).
  Also, it is important to explore and clarify (both internally as well as to partners) where the theme of safe abortion will be anchored within the RCOG governance structures and **how RCOG will keep the strong global voice and partnerships built**.
  Examples on how to address these two points, could be through the establishment of thematic working groups (including for abortion) with seats from various settings. Such a working group could serve as a spokesperson/channel, network for information sharing to a wider group of Champions and entry point for partners who seek specific collaborations. Another option is to explore embedding this into existing structures, such as integrating abortion and networking with Champions more with the International Council Representatives, and/or embedding RCOG global health work more in the existing sections (Digital; Media and PR; Policy; Marketing; eLearning; Patient and Public Engagement; Faculty of SRHR; Membership). It was expressed that the work through these sections could become more inclusive for the global membership (which is 50% of the RCOG total membership).
- The evaluation revealed why the programme worked in some and not in other countries. For future programmes it is recommended to develop a **set of criteria that informs the selection of programme countries**, while also ensuring the fragile contexts, such as Sudan, are not left behind. A thorough stakeholder mapping in each country can help to identify which specific mix of Champions is required for the context.
- Inform future **ToCs on more evidence, especially for the cause-effect assumptions**. Evidence of what worked in the MAS programme, complemented with a growing body of literature on effective advocacy, can be used to further strengthen the ToC.
- Strengthening **in-country M&E capacity** during programmes will help to monitor and foster learning throughout the project and provide more data for in-between reflections. **Build in learning cycles** throughout the programme to understand what was actually being achieved, whether results were delivered in a way that was intended (e.g. was the right language used, are the right stakeholder involved, risk of backlash minimized?) and whether strategies have to be re-steered.

- To understand longer-term impact and sustainability a post-programme evaluation or longer-term follow-up would be required.

For Champions:

- Given the success of the Champions' model and interest of national and global stakeholders to work with advocates from the medical professional field, it is worthwhile to explore how (for now an informal) network of Champions could remain to exist. To ensure coordination, inclusiveness (i.e. opportunities for championing not being dependent on individual connections) and open up for funding there may be value in anchoring this network to an existing organization. However, the freedom and agility of the Champion's network in this programme should not be restricted by organizational interests.

For donors:

- Champion's networks have proven to be, under the right conditions, an effective mean to leverage advocacy. A threeyear timeline however was too short to generate long-lasting effects under all outcome pillars and to allow for in-between learning of advocacy cycles. Longer programmes are required.