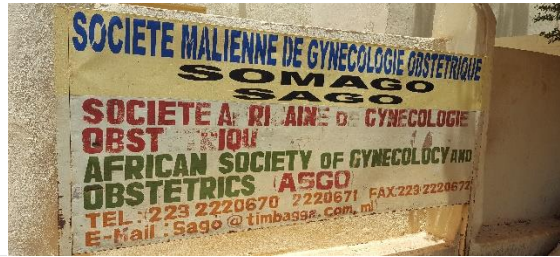




**KIT** Royal  
Tropical  
Institute



# Mali Country Report

## NEEDS ASSESSMENT ON SAFE ABORTION ADVOCACY

*FOR THE NATIONAL SOCIETY OF GYNAECOLOGY AND OBSTETRICS IN MALI (SOMAGO)*

COMMISSIONED BY THE INTERNATIONAL FEDERATION OF GYNAECOLOGY AND OBSTETRICS (FIGO)  
CONDUCTED BY: KIT ROYAL TROPICAL INSTITUTE – HEALTH UNIT

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## Abbreviations

AMPPF	<i>Association malienne pour la protection et la promotion de la femme</i> (Malian association for family protection and promotion)
CSCRPF	<i>Cadre stratégique pour la croissance et la réduction de la pauvreté</i> (Strategic Framework for Growth and Poverty Reduction)
CSCOM	<i>Centre de santé communautaire</i> (Community health centre)
CSREF	<i>Centre de santé de référence</i> (Referral health centre)
DNS	<i>Direction Nationale de la santé</i> (National directorate for health)
EVA	Electrical Vacuum Aspiration
FIGO	International Federation of Gynaecology and Obstetrics
GDP	Gross Domestic Product
IPPF	International Planned Parenthood Federation
KIT	Royal Tropical Institute
MSI	Marie Stopes International
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organisation
PSI	Population Services International
SOMAGO	<i>Société malienne de gynécologie obstétrique</i> (National Society of gynaecology and obstetrics in Mali)

## Executive Summary

This evaluation aims to provide a better understanding of the capacities and needs of the Malian Society of Obstetric Gynaecology (SOMAGO). In particular, it aims to identify the main advocacy needs for safe abortion that a future multi-country project of the International Federation of Gynaecology and Obstetrics (FIGO) could fund. In addition, it has tried to shed more light on how FIGO can more effectively build the capacity of national societies, including SOMAGO. To reach those objectives, the evaluation was based on a literature review, an online survey addressed to members of the society, interviews with various stakeholders and a workshop of members and partners of SOMAGO.

The literature search showed that limited information is available on abortions in Mali. However, the other components of the research have confirmed that unsafe abortion and its complications are a serious problem in Mali, putting the lives of many adolescent girls and women at risk. The practice of unsafe abortion is a fairly widespread phenomenon and confirms that the need for safe abortion to reduce this problem is urgent.

Mali's legal framework is restrictive and safe abortion, whether legal or illegal, is therefore provided clandestinely. In addition, advocacy for safe abortion is fraught with difficulties in a context where social norms and religious beliefs are rooted against safe abortion. For SOMAGO members, personal values versus professional norms often cause a dilemma or a real confusion in the provision of abortion care.

To strengthen advocacy for safe abortion, SOMAGO in partnership with the various stakeholders must engage in a frank dialogue to convince the ins and outs of its social norms and religious beliefs. SOMAGO's strong presence as a leader in abortion technical knowledge and experience is an opportunity to influence and enable networking with like-minded organizations for defending and providing safe abortion services to women who express the need.

As an advocate for safe abortion, the company, to set up its network will have to address the potential challenges identified during stakeholder interviews, and the two day workshop. This could include:

- Strengthen the management and organization of SOMAGO as a formidable advocate for safe abortion;
- Establish a coordinated and dynamic network of associations that support safe abortion
- Transform social and gender norms at all levels regarding safe abortion but in the context of the Malian law.
- Ensure that the legal framework is consistent while raising awareness of the legal framework to stakeholders at all levels for a harmonious interpretation.
- Ensure a process of creating and using data for monitoring and planning services

These different challenges, identified in collaboration with SOMAGO, have been taken up and translated into a preliminary action plan with concrete activities and results. The action plan will be developed in collaboration with SOMAGO and FIGO and will serve as a source of inspiration for the development of a future program for the promotion of safe abortion in Mali.

## 1. Introduction

This country report is the result of a need assessment conducted by KIT Royal Tropical Institute with the National Society of Gynaecologists Obstetricians in Mali (SOMAGO) regarding Safe Abortion Advocacy. Mali is one of the ten countries participating in a broader Needs Assessment for an upcoming multi-country Federation of Gynaecologists and Obstetricians (FIGO)-led project that aims to increase the capacity of national obstetrics and gynaecology societies to become national leaders in safe abortion advocacy work.

### Needs Assessment Purpose

This Needs Assessment is the first phase of an upcoming safe abortion project and should provide a better and more in depth understanding of the capacities and needs of SOMAGO, to then identify the main needs in relation to safe abortion advocacy that the following multi country project could address. Also, it should provide more clarity on how FIGO can strengthen more effectively the capacities of national societies, in this case SOMAGO. This includes the provision of recommendations on the content of the capacity building program by developing country action plans with budget, as well as a comprehensive program proposal for the whole ten countries.

### Needs Assessment Objectives

The specific objectives are that by the end of the needs assessment in ten countries, FIGO should have:

1. Insights on the situation of abortion in each country
2. Understanding of the capacity and needs of each National Obstetrics and Gynaecology Society on abortion advocacy
3. Plans of Action for each National Obstetrics and Gynaecology Society developed through a collaborative process
4. Recommendations on FIGOs role to strengthen the capacity of the ten National Societies as abortion advocates, translated into a comprehensive proposal

## 2. Methodology

This Needs Assessment was formative and the approach used was highly participatory. This means constant mechanisms of communication and feedback with SOMAGO took place in order to create mutual understanding and joint objectives.

In order to meet the objectives of the assessment, the following methods were used:

### 1. Literature review

The study was organized using the tool provided for this purpose between February and April 2018. The review focussed on the available and context-specific literature of Mali, the results of the graduation theses of the Faculty of Medicine, the standards and policies documents for reproductive health (RH) and post-abortion care. Given the difficulty of having information on a larger scale, professionals and post-abortion program managers in non-governmental organizations (NGOs) have been involved.

### 2. Online survey

An online survey, using the Survey Monkey software, was sent to 53 members of SOMAGO's asking them about their membership in SOMAGO, the society's position on safe abortion, and their own professional and personal position towards safe abortion. KIT sent the web link to the members of the company on April 26, 2018. After several reminders to get more answers, 18 responses returned, of which 14 were complete (completion rate of 78%). The survey remained open for 2 weeks and was closed on May 09, 2018. The analysis was conducted using the Survey Monkey software.

### 3. Key informant interview

A total of 10 key informants were interviewed on April 17, 23, 24 and May 2 and 9, 2018. In common agreement with the Post-abortion care focal point of the National Society of Obstetrics and Gynaecology, key informants were identified in the society, among national NGOs leaders (Association Malienne pour la Protection et la Promotion de la femme: AMPPF) and international NGOs (Marie Stopes International: MSI) working in the field of RH, national technical managers (National Directorate of Health, Order of Midwives), political decision-makers (National Assembly), officials of the Ministry of Security and the Human Rights Council. The interviews were conducted with the interview guide provided and compliance to the instructions related to informed consent, respect for confidentiality and anonymity in the participants' offices. Those who gave their permission were recorded; the interviewer took notes only for the others. These notes were extended using the tape recordings. The notes were reinforced and organized along thematic areas as outlined in the findings section. The findings were analysed taking into account the various perceptions regarding safe abortion.

### 4. Stakeholder workshop

A two (2) day stakeholder workshop (April 25-26, 2018) was held at Azalai Grand Hotel in Bamako. The purpose of the workshop was to identify SOMAGO's needs for advocacy on abortion and develop an action plan for the next safe abortion advocacy proposal that will be developed for the National Societies of Obstetrics and Gynaecology in ten countries involved in the needs assessment.

The objectives were that at the end of the workshop participants had:

1. Discussed and identified the opportunities and barriers for providing safe abortion in the country based on the desk review presentation and own experience.
2. Explored their personal and professional values related to abortion and identified activities for improving access to safe abortion and post-abortion care based on professional ethics.
3. Explored the implications of the national abortion law and policies for access to safe abortion.
4. The ability to explain the concept and levels of advocacy and identify challenges and barriers of abortion advocacy.

5. Identified the strengths and weaknesses of the national society in abortion advocacy.
6. Formulate action points for an abortion advocacy program.

Participants were invited from all regions across the country where gynaecologists and obstetricians work. Thirty-three participants were invited. They all participated in the two day workshop but we acknowledge that given their involvement in other activities happening concomitantly, some had to be absent during part of the workshop.

### Challenges

The limitations of the literature review were mainly related to the lack of data on abortion in general and induced abortion in particular. This meant that all the information we were looking for was not available and that we relied only on few reports, articles and theses. Also the quality of some articles/theses was low. We indicated where information was missing, which could help in the future to fill the knowledge gaps. In addition, the difficulties encountered during the interviews were largely related to the time limit to cover all relevant key informants. Some interviews were cancelled because the interviewee was not available on scheduled days or was late. If there had been more participants, there would have been more insight into the answers. However, the interviewers felt that they reached a certain level of saturation.

Respondents of the interviews were mainly from Bamako (the capital of Mali). This gave us a good overview of what is happening in this region but less information is available on rural areas that might show another reality. During the workshop participants from other regions were present: Segou, Mopti, Koulikoro and Kayes. For security/conflict reasons, participants from Gao, Kidal or Timbuktu did not come. However, the situation could be different in these regions, mainly because of the ongoing conflicts.

Concerning the survey, the response rate was 44%. We tried to take into account the voice of most members. However, due to the lack of e-mail addresses in the list of members, it was not possible to reach everyone. Therefore, the survey was sent only to 53 members from the estimated 230 that compose the society. For this reason, the results of the survey can't be extrapolated to the whole society.



### 3. Findings

#### 3.1 Literature review

##### Demographic and socio-economic Information

From March 22, 2012 to present, in social terms, Mali has found itself in a cycle of political, social and security instability, the effects of which have affected all the country's development sectors. On the political front, the events related to this precarious situation led to the gradual and widespread occupation, by armed groups, of the three northern regions: Gao, Timbuktu and Kidal. Armed groups make it difficult for people and goods to move and also cause migratory movements inside and outside the country. With a population growth rate of 3.6%, the population of Mali was 14,528,662 inhabitants in 2009 with 7,204,990 men (or 49.59%) and 7,323,672 women or 50.41%(INSTAT, 2011). The urban population accounted for 22.54% compared to 77.46% of the rural population. According to forecasts, if the trend continues, this population will double by 2030 with an age pyramid wide at the bottom; more than 55% of the population will be under 19 years of age. Life expectancy at birth was 67 years 2015 (CPS / SSDSPF, 2015). The level of education remains low in Mali for the secondary and higher level with respectively 12.4% and 4.8%. The primary level represents 82.9% of the educated. Table 1 shows an overview of socio-demographic and economic data.

The diagnostic analysis carried out in the country's Common Balance Sheet highlights the cumulative decline in gross domestic product (GDP) since the beginning of the crisis in 2012. The security, political, social, humanitarian, institutional and economic crisis negatively affected achieving the objectives set out in the Growth and Poverty Reduction Strategy Paper (CSCR). The achievement level of GDP growth has always been lower than the forecasts of the CSCR. Indeed, the growth rates achieved were 4.3% in 2007, 5% in 2008, 4.5% in 2009 and 5.8% in 2010 against an annual forecast of 7%<sup>2</sup>. Health expenditure in GDP was 6.86% in 2014 ((Index Mundi, 2018).The proportion of the national budget allocated to maternal and newborn health and family planning is difficult to assess. Provided by the Finance and Materiel Directorate (DFM), this proportion decreased from 2.1% in 2010 to 1.9% in 2012 ((DNS, 2015)(Plan SR, 2013). Mali is one of the least developed countries and benefits from the initiative of poor countries heavily indebted. The incidence of poverty is decreasing, from 55.5% in 2001 to 47.4% in 2006 and 43.6% in 2010 (INSTAT, 2010)

*Table 1 : Socio-demographic and economic data.*

	<b>Indicators</b>	<b>Values</b>	<b>Sources</b>
<i>Socio-demographic and economic data</i>	Total population	<b>17, 818, 996 inhabitants (2015)</b>	(SLIS, 2015)
	Proportion Male/Female in total population	<b>51% Female 49% Male</b>	(EDSM V, 2014)
	Life expectancy at birth	<b>67 years (2015)</b>	(SNISS, 2015)
	Proportion of Urban/Rural population	<b>22.5% Urban 77.5% Rural</b>	(EDSM V, 2014)
	Total fertility rate	<b>6.1</b>	(EDSM V, 2014)
	GDP per capita (economic situation)	<b>780.51 USD/per capita (2016) 14.05 Billiards (2016)</b>	(Gapminder, 2016)

### Indicators on Sexual and Reproductive Health Rights

In Mali, the maternal mortality rate is high at 368 per 100,000 live births. Neonatal mortality is 35 per 1000 and infant and child mortality are respectively 58 per 1000 and 98 per 1000 (Direction nationale de la santé, 2014). Early fertility is also high in Mali: 172 births per 1000 women aged between 15 and 19 years old, which increases to 252 births per 1000 women aged between 20 and 24 year old, reaching its maximum of 272 births per 100 women aged between 25 and 29 years, and then decreases to 44 % at the ages of 45-49 (Cellule de Planification et de Statistique, 2014). The contribution of adolescent girls to fertility is 12% in urban areas and 15% in rural areas. The total fertility rate remained almost static in the period between the two consecutive Mali Demographic and Health Surveys (EDSM), 6.6 children per woman in 2006 (EDSM IV) compared to 6.1 in 2012 (EDSM V)(United Nations, 2015). Table 2 shows an overview of fertility rates and maternal deaths by age (EDSM V, 2014)

*Table 2 : Fertility rate and % of maternal deaths per age.*

Indicators	15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-49 years
Fertility rate (births per 1000 women)	172	252	272	231	166	84	44
% maternal deaths	29.3	2.1	28	65	32	20	6

For family planning, the prevalence is 10% and women use essentially three modern methods: injections (3.8%), pill (2.6%) and implants (2.4%). Contraceptive prevalence among women in a relationship is not practically different from that of all women. Indeed, 10% of them use a method (essentially modern). On the other hand, among unmarried and sexually active women, the contraceptive prevalence is much higher, with 34% using a method (essentially modern (EDSM V, 2014). The rate of new sexually transmitted infections including for HIV is also high (Cellule de Planification et de Statistique, 2014). Table 3 shows an overview of the indicators for health, sexual and reproductive rights.

*Table 3: overview of the indicators for health, sexual and reproductive rights.*

	Indicators	Values	Sources
<i>Indicators for health, sexual and reproductive rights</i>	Maternal mortality rate	<b>368 per 100 000</b>	(EDSM V, 2014)
	Unsatisfied needs of family planning	<b>23,3% for the whole women</b>	(EDSM V, 2014)
	Percentage of births produced earlier than desired percentage of undesired pregnancies	<b>11%</b> <b>3%</b>	(EDSM V, 2014) (EDSM V, 2014)
	Fertility of teenage girls who have already started their reproductive life at: - 15 years - 16 years - 17 years - 18 years - 19 years	<b>11.4%</b> <b>19.7%</b> <b>37.8%</b> <b>58%</b> <b>66.2%</b>	(EDSM V, 2014) (EDSM V, 2014)

## Indicators and evidence on abortion

Limited information is available on abortion in Mali. The figures available are often based on estimates. The few available studies are characterized on one hand by the fact that they have not been national and on the other hand there is a diversity of methodology which does not allow to make a reliable estimate of the extent of abortion (in general and induced abortion in particular). Almost all studies have been conducted in health facilities either on abortions' complications or on abortions received in consultations.

In the document «Norms and protocols for abortion care in Mali», the Ministry of Health reports that abortion is the fifth leading cause of maternal death (Ministere de la Santé, 2009). Also, abortions are responsible for 9% of the direct complications of pregnancy and 5% of maternal deaths can be attributed to the complications of abortion (Ministère de la santé, 2003). In view of the magnitude of the problem, the National Reproductive Health Policy, Standards and Procedures documents were revised in 2006 to address post-abortion care for emergency obstetric and neonatal care (Direction nationale de la santé, 2013).

From 2010 to 2015, across the country, we identified different results through these dissertations. In obstetrics and gynaecology unit in Gao hospital, 24.83% (38/153) of abortions were induced abortions (Touré S. I., 2010). In Bamako, 19.47% (132/678) of abortions were complicated induced abortions at the Referral Health Centre (CSREF) in Commune V (Traoré C. T., 2010)

## Legal and political contexts

### *National laws and policies on abortion*

Until 2002, the legislation related to abortion was limited to the law of July 31, 1920 repressing induced abortion and contraceptive propaganda. With the promulgation of the RH law, in 2002, the previous provisions to the contrary were repealed; however, without legalizing abortion in accordance with the guidelines and recommendations of the Maputo Action Plan, to which the Government of Mali adhered unreservedly. The same applies to the Protocol of the African charter on human and peoples' rights on the rights of women in Africa and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). Despite the signature of these documents by the Malian Government, abortion remains subject to very restrictive legislation.

Article 13 of the 2002 reproductive health law states: «Voluntary termination of pregnancy cannot be considered a contraceptive method.

Any abortion that involves the use of means or substances for the purpose of causing the premature expulsion of the foetus is prohibited, regardless of the time of the pregnancy when the expulsion is practiced for any reason other than:

- Safeguarding the life of the pregnant woman;
- When the pregnancy is the consequence of a rape or an incestuous relationship, at the express request of the pregnant woman ».

Article 17 of the 2002 law states that any person who, except in the cases expressly provided for in Article 13, proceeds to incite an abortion or to provide advice or any means of abortion is punishable by the penalties provided for in the Penal Code art. 170-172. However, the last version of the penal code in Mali was made in 2001, before the development of the 2002 law. This means that the provisions of the 2002 RH law are not included in the penal code. The penal code of Mali criminalizes abortion for any reason other than the safeguarding of the woman's life and prison sentences (six months to 3 years), the fines of (20,000 to 200,000 francs), residence bans and suspension of the practice of the profession are provided.

However, as part of the provision and offer of RH services, policy documents and standards for (post) abortion care have been published. These are the reproductive health policies, standards and procedures (prenatal and perinatal care volumes)(Direction nationale de la santé, 2013)and Standards and Protocols for Abortion Care (Direction nationale de la santé, 2009). For local NGOs working in the field of RH, the training manual “post-abortion care: practical guide for improving quality of care” exists.

These various documents, in particular the abortion care standards and protocols, describe the procedure to be followed per level and type of service (abortion by drugs, aspiration and dilation/evacuation) and per type of staff. Generally, therapeutic abortions are practiced in hospitals. However, abortion indicators are not specifically reported in the hospitals’ statistical yearbook among gynaecological consultations (CPS/SSDSPF, 2017). Providing health services and meeting the needs of women of childbearing age in sexual and reproductive health are also problematic in our contexts (IPPF, 2014).

Currently in Mali, the implementation of legal abortion is a procedure that involves both health professionals and actors of the sectors of justice and social protection in cases authorized by the 2002 RH law. We should note however, in addition to the difficulties of the implementation of legalized or authorized abortion in cases of rape and incest, other constraints exist in the Malian context: such as the socio-cultural and stigmatization constraints associated with these cases. In those situations, victims prefer to remain silent than to claim their rights and often when they claim it, they are confronted with the absence of respondents or subject of some sort of moral blackmail « When a woman is raped, the family wants to prevent it from being known ».(Observateurs France 24, 2018).

#### Characteristics of women seeking abortion

From findings of medical students’ thesis, we capitalize that the targets have the most varied socio-demographic profiles: all ages of the reproductive life, married or single, all levels of education or uneducated, autonomous or not, urban or rural, professionally active or unoccupied, all gestures and all parities (Belek-Ngwanza, 2008)(Kelepily, 2008)(Touré C. , 2008). Traoré’s thesis (2010) revealed that among 132 women who performed abortions at the CSREF commune V, 68% were single; 32% married and 32.57% uneducated. In Touré’s thesis (2010), the main reason for abortion was celibacy (35.6%) against (22.7%)for school constraints. The single patients of Traoré’s study (2010) were motivated by fear and pressure of parents (31.6%), fear of criticism of neighbours (18.4%), unwanted pregnancy (15.8%) and marital infidelity (7.9%); while the married women were motivated by close pregnancies (5.3%) and lack of control of their contraception utilization.

From Diarra’s study in commune I in Bamako, girls aged 12-19 were the most represented (57.5%)(Diarra, 2012). Studies cited in the press evoke alarming proportions as well: 19% of girls with secondary education level and 25% of university students aged 13 to 22 in Bamako, reported having aborted at least once; and their male counterparts reported to have been involved in the abortion of a girlfriend (12.7%) from secondary education level and (21.6%) for those from universities (Dia, 2014).

#### Obstacles to safe abortion

There are no publications, reports or theses available on the obstacles to safe abortion. However, during the interviews and the workshop, these obstacles were discussed. We explain this by the penalization of abortion and stigmatization; its restrictive provisions do not encourage research for fear of not having any representative sample.

### Stigmatisation of abortion

There are no publications, reports or theses available on stigma attached to safe abortion. However, it was discussed during interviews and workshops.

### Services delivery environment

In order to improve the health of the population, the government of Mali has, over the years, extended the coverage of the territory with health structures. Thus, in 2015, there were 13 public hospitals, 63 reference health centres, 1241 community health centres and 18 intercompany medical centres or centres for maternal and child health (CPS/SSDSPF, 2015). All these structures offer a minimum package of activities in reproductive health including post-abortion care according to their position within the health system pyramid of the country. In the 2013 policies, standards and procedures, the minimum package of activities for community health centres includes the use of misoprostol and manual intrauterine aspiration (MVA) for simple cases of incomplete abortion if trained staff is available (Direction nationale de la santé, 2013). Table 4 shows an overview of the indicators of the service delivery environment.

*Table 4: Overview of indicators of the service delivery environment.*

Indicators	Values (2015)
% of the population covered by health services at less than 5 km, 15 km and other 15 km	Respectively 58%, 87% and 9%
Proportion of national budget allocated to reproductive health 1.4% (2012)	1,4% (2012)
Ratio of nursing staff	4.3 (WHO standard = 23 per 10,000 inhabitants)
Rate of births assisted by qualified health personnel	58,6% (EDSM V, 2014)
Coverage rate in postnatal consultation (compared to expected deliveries)	33,3% (SLIS)

### Availability and accessibility of safe abortion

In the 2009 standards and protocols for abortion care (Direction nationale de la santé, 2009), the service providers allowed to perform abortions in the different structures of the health system pyramid are described. At the CSREF level, MVA/electrical vacuum aspiration (EVA), medical abortions and dilation evacuation can be performed by the following providers, if they are previously trained to do so: general practitioners with surgical skills, specialists in surgery, gynaecologists, obstetricians and midwives. In second-referral level public hospitals, the same services can be provided. The same applies also for services and providers at third level public reference hospitals. Table 5 shows an overview of the types of structures, services to be provides and authorized providers.

*Table 5: overview of the types of structures, services to be provides and authorized providers.*

Levels of the pyramid	Type of structure	Services to be provided	Providers
Level 2	Referral Health Centre (CSREF)	- AMIU or EVA - Medical abortion - Dilatation / evacuation	Trained and skilled: - general practitioners with surgical skills - specialists in surgery - gynaecologists obstetricians and midwives.

Level 3	Public hospitals 2 <sup>nd</sup> referral	- AMIU or EVA - Medical abortion - Dilatation / evacuation	Trained and skilled: - general practitioners with surgical skills - specialists in surgery - gynaecologists obstetricians
Level 4	Public hospitals 3 <sup>rd</sup> referral	- AMIU or EVA - Medical abortion - Dilatation / evacuation	Trained and skilled : - general practitioners with surgical skills - specialists in surgery - gynaecologists obstetricians

When it comes to the real situation in the field, there is no information available on availability and accessibility of abortion care.

For post-abortion care, the SAA services offered in health facilities include both curative and preventive care (Direction nationale de la santé, 2013). The key components of SAA are:

- Emergency care for incomplete abortion and life-threatening complications;
- Post-abortion FP counselling and services;
- The link between emergency services and the health system for reproductive health care

The methods used are mainly the administration of misoprostol and MVA. They are practiced at all levels of the health pyramid, from the community health centres (CSCOM) to structures of 3rd reference, according to the minimum package of activity which is assigned to them. In principle, post-abortion care is free and provided as any other service in the state health structures. However, provider attitudes and mercantile practices can reduce this accessibility.

#### Unsafe abortion: actors and methods

Little information is available on unsafe abortions. Only these provide some information. They reveal that abortions are frequently done at the practitioner's home. For illustration, the study of Diallo et al. (2000) shows that 72% of abortions were done at the provider's home ; Touré's one (2010) describes that the practitioner's home was the most frequent place of induced abortion (63.2%) and Traore's thesis (2010) describes that 46.21% of induced abortions are performed at home. The thesis of Traore (2010) also shows that the majority of induced abortions were done by paramedics such as midwives and matrons, often in poor conditions that can lead to serious complications or death. The methods used vary between studies and depend on the skills of the service provider. In Traore's (2010) thesis, implemented in Bamako, modern drugs are the most frequently used methods for induced abortion (38.8%); followed by uterine probing (25%) and curettage (21.87%). This study also shows that the average price for a clandestine induced abortion varies from 20,000 CFA to 95,000 CFA.

An online journal (Mali Actu) describes several risky methods used by Malians, such as drinking «bloua» (a toxic product used to make clothes sparkle) or drinking a mixture of traditional medicines (plants) and modern medicines (nivaquine) or foods (honey or coca-cola) (Traoré A., 2015).

#### Perception of women and experience of abortion

Little information is also available on women and their experience of abortion. Only thesis dissertations provide small scale information. The study performed by Dia (2014) shows that both women and men were in favour of decriminalizing abortion for unwanted pregnancies at the rate of 57% of high school students and 74% of university students. In Traore's study (2010), 85% of women had a feeling of regret after the abortion, 15% had a feeling of relief. No explanations have been given for these feelings. In Touré's thesis (2010), 27.5% of women felt relieved after the abortion because the pregnancy was undesired.

### Advocacy activities and actors

SOMAGO, as such, does not currently advocate for safe abortion. In contrast, international NGOs such as Ipas have initiated some advocacy activities in favour of post-abortion care in Mali. For instance, they organized a workshop on the clarification of values and the development of standards on post-abortion care (ANTIM, 2009).

### Professional attitudes towards abortion

Attitudes of health professionals in favour of safe abortion legalization to reduce maternal deaths are mixed. There are as many «champions» as opponents. The main reasons given by this last group are religious, perception of doing something wrong, stigma by peers and / or clients / patients in the community, and especially the fear of a violent reaction against them and / or their relatives. The group in the middle is mainly those who are waiting for legalization to practice. These attitudes, however, are not specific to Malian providers, the same things have been observed in Ghana (Morhe, Morhe, & Danso, 2007). From Dunevoices we retain from the testimony of a physician that « I have been doing abortions for years. But, I never wrote the name of a patient. I cannot tell you how much I did. And I'm pretty sure no practitioner will give you statistics ».(Dunevoices, 2016). The online survey further explores the professional attitudes of SOMAGO members.



### 3.2 Online survey

This survey was sent to the members of SOMAGO. A total of 18 people answered the various online questions addressed in the survey. Despite the multiple encouragements from the President and KIT, the feedback rate has been low. For this reason, the results of the survey cannot be extrapolated to the whole society. The percentages given are then based on only 18 respondents and not all the members of the society. The purpose of this online survey was to better understand the level of involvement and engagement of members in SOMAGO's activities, the way they communicate with each other and the society's abortion related actions in Mali. An overview of the survey results is attached to this document.

#### Characteristics of society members

The gynaecologists-obstetricians who responded had a professional experience of 5 to 15 years in the majority (55.56%); 66.67% were registered at the Malian society of obstetrics and gynaecology for the same duration (5-15 years) but 72.22% of them were also members of another professional body.

#### Commitment and level of involvement of members of the society

In general, the majority (83.3%) of the members of the society interviewed stated that they were moderately involved up to very involved in society. Most of them participate in trainings (72.2%), conferences (77.8%), special thematic meetings (61.1%) and regular meetings (55.6%). On the other hand, participation in activities is less than half (38.89%) of the members who declared to always participate in activities.

#### Communication within the society

According to the respondents, the largest communication channels used within SOMAGO are WhatsApp (64.7%), the website (70.6%) and email updates (70.6%). The frequency of communication between the Society and its members is not well known as 29.41% of respondents do not know it while 23.53% think it is weekly. The majority of respondents (58.8%) agreed that communication between members and SOMAGO needs to be strengthened.

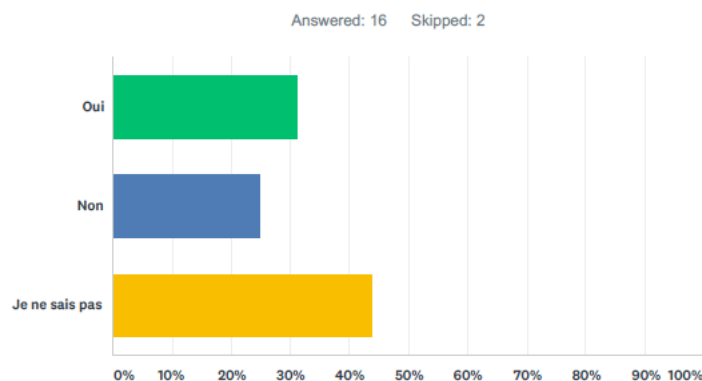
ANSWER CHOICES	RESPONSES	
La communication est déjà bonne	35.29%	6
La communication est acceptable mais peut être renforcée	58.82%	10
La communication est mauvaise et doit être améliorée	5.88%	1
Je ne lis pas les communications de la Société Malienne de gynécologie obstétrique	0.00%	0
<b>TOTAL</b>		<b>17</b>

#### Society position on abortion

43.8% of respondents said they did not know if SOMAGO has a clear position on safe abortion. The position of SOMAGO is clear for 31.25% against 25% who feel that the position is unclear. For the 05 respondents who know the company's position on abortion, 82.33% said they strongly agreed with this position and 16.67% agreed. On the other hand, to the question of whether SOMAGO informs its members of its position towards safe abortion or not, the points of view are divided, 50% think it does, 16.6% think it doesn't and 33.33 % do not know if she does it or not. Trainings were the only opportunities considered by respondents (100%) as the channel used by SOMAGO to inform its members about its position on safe abortion.



## Q12 Est-ce que la SOMAGO a une position claire envers l'avortement sécurisé ?



A majority of 56.25% (9 out of 16 respondents) states that SOMAGO informs members about new evidence of abortion, laws, policies, and practices related to abortion. And this information is mainly done by sharing materials by email (50%), during training courses (62.50%) and meetings (43.75%). All the members surveyed (100%) wish to receive more knowledge on topics related to safe abortion. The members shared that they especially want to receive more information about the laws, policies and protocols of safe abortion.

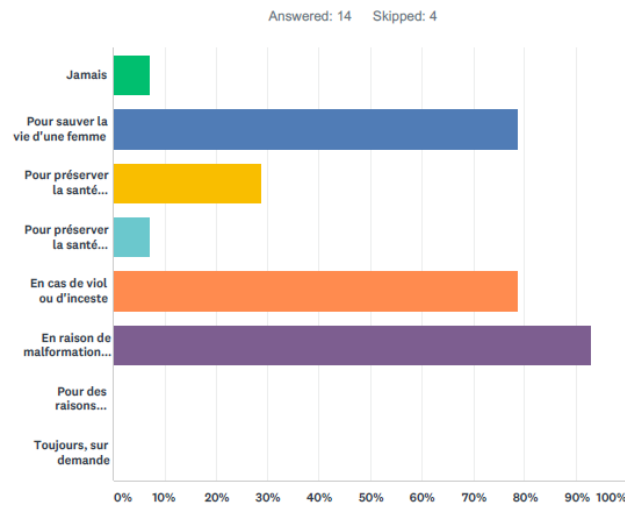
### Position of society members on abortion

In general, respondents think they are poorly informed about laws, international guidelines and national policy on safe abortion (score of 1 to 3 on a scale of 5). With regard to guidelines, policies and information on post-abortion care, respondents feel well informed (score 3 to 4 on a scale of 5).

	PAS INFORMÉ	UN PEU INFORMÉ	MODÉRÉMENT INFORMÉ	INFORMÉ	TRÈS INFORMÉ	TOTAL	WEIGHTED AVERAGE
Lois nationales sur l'avortement	14.29% 2	21.43% 3	14.29% 2	28.57% 4	21.43% 3	14	3.21
Directives internationales sur l'avortement sécurisé	57.14% 8	28.57% 4	7.14% 1	7.14% 1	0.00% 0	14	1.64
Politiques nationales sur l'avortement sécurisé	42.86% 6	28.57% 4	14.29% 2	14.29% 2	0.00% 0	14	2.00
Informations pratiques relatives à la pratique de l'avortement médicalisé (lignes directrices, recommandations)	42.86% 6	14.29% 2	21.43% 3	21.43% 3	0.00% 0	14	2.21
Directives internationales sur les soins post-avortement	21.43% 3	7.14% 1	14.29% 2	35.71% 5	21.43% 3	14	3.29
Politiques nationales sur les soins post-avortement	0.00% 0	14.29% 2	7.14% 1	50.00% 7	28.57% 4	14	3.93
Informations pratiques relatives aux soins post-avortement (lignes directrices, recommandations)	0.00% 0	7.14% 1	7.14% 1	57.14% 8	28.57% 4	14	4.07

The majority of members surveyed believe that safe abortion should be allowed or legalized when it comes to saving life (78.57%) or in case of rape or incest (78.6%) and foetal malformation (92.9%). A minority believe that abortion must be allowed to preserve a woman's physical health (28.6%) or to preserve a woman's mental health (7.1%). None of the respondents think abortion should be legal for economic or social reasons (0%) or always on demand (0%). One respondent thinks that abortion should never be allowed.

## Q22 Dans quelles circonstances pensez-vous que l'avortement sécurisé devrait être autorisé / légalisé?



The majority of the members of SOMAGO surveyed agree:

- That health workers should have the right to decide whether or not to perform safe abortions based on their personal values and position towards abortion (42.9% strongly agree, 14.3% agree).
- Health workers have a role to play as advocates for safe abortion (28.6% strongly agree, 35.7% agree).
- Post-abortion care is part of health care and should not be separated from the rest of medicine (57.1% strongly agree, 35.7% agree).
- That health workers should be required to provide post-abortion care to all women, regardless of whether the abortion was legal or not (85.7% strongly agree, 14.29% agree).  
Health workers should report to the respective authorities, cases showing signs of illegal abortions (28.6% strongly agree, 50% agree).

But rather don't agree:

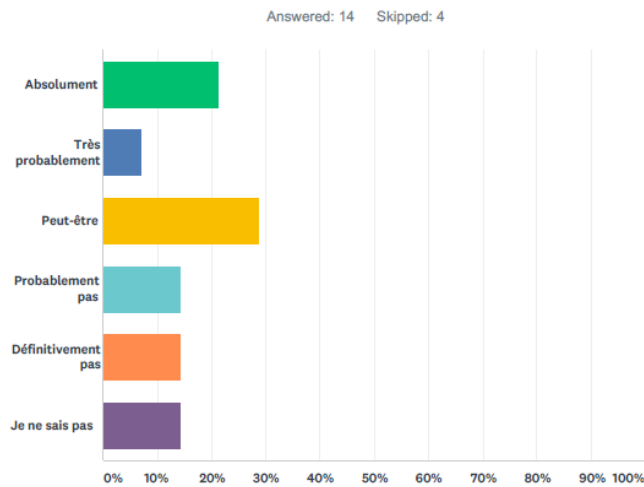
- That safe abortions should be performed only in private clinics and not in the public health system (57.1% disagree, 35.7% strongly disagree).
- That specialized health workers (gynaecologists and obstetricians) should be required to perform safe abortions where permitted by law (35.7% disagree, 42.9% strongly disagree).
- Health workers who oppose safe abortions should be required to refer women to other health workers who practice safe abortion (42.9% disagree, 14.3% strongly disagree).

On the following statement there was a variety of opinions and a significant majority for the agreement or disagreement was not found:

- Safe abortion is part of health care and should not be separated from the rest of medicine (14.3% strongly agree, 28.47% agree, 7.1% neutral, 35.7% disagree, 14.3% strongly disagree).

Members shared very different opinions in terms of supporting SOMAGO in advocacy for safe abortion (21.4 absolutely, 7.1 most likely, 28.6 maybe, 14.3 probably not, 14.3 definitely not, 14.3 I do not know).

## Q24 Souhaitez-vous soutenir la SOMAGO dans le plaidoyer pour l'avortement sécurisé?



### Summary

The response rate of the survey is very low and it is difficult to generalize the results to all members of SOMAGO. However, it shows that communication between members can be strengthened and that the most common means of communication are by email, the website and WhatsApp. Among members of SOMAGO it is not well known if the society has a position on safe abortion. The majority wants more information on safe abortion and shared that they do not feel well informed about safe abortion policies, standards and procedures. For post-abortion care, they feel better informed. A majority would like the legal situation to be changed to allow abortion due to a foetal malformation. Half of respondents don't agree that health workers who oppose safe abortions should be required to direct women to other health workers who practice safe abortion. In addition, SOMAGO members have very different points of view about their support for SOMAGO in advocacy for safe abortion.

Therefore, communication could be improved by further using email, website and WhatsApp to share SOMAGO's position on secure abortion. It is necessary to clarify the position of society and its members on safe abortion to increase their commitment to advocate for this important public health issue.

### 3.3 Interviews with key stakeholders

A total of 10 interviews were conducted for the needs assessment. The interviews were made with representatives of the Malian gynaecology obstetrics society, International Planned Parenthood Federation (IPPF)AMPPF, MSI, national midwifery order, the National Assembly (Health Commission), the national health directorate (Ministry of Health) and the Ministry of Security, national human rights commission (Table N° 4).

*Table N°4 Interview participants*

No.	Association/ Society/Organization	No of Respondents
1	Members of the society	3
2	MSI	1
3	IPPF/AMPPF	1
4	National order of midwives	1
5	The National Assembly (Health Commission)	1
6	The National Directorate of Health (DNS)	1
7	National Commission for Human Rights	1
8	Ministry of Security	1
	TOTAL	<b>10</b>

#### Safe abortion environment

##### *Legal framework*

The 2002 reproductive health law states: «Any abortion that involves the use of means or substances to cause the premature expulsion of the foetus, regardless of the time of pregnancy or this expulsion is performed for any reason other than:

- Safeguarding the life of the pregnant woman
- When the pregnancy is the consequence of a rape or an incestuous relationship, at the express request of the pregnant woman (Law 02-044 Reproductive Health, 2002) ».

Several participants noted a number of problems with the legal framework. The first problem shared is that the law lacks an implementing decree and this makes it unclear. One participant said that the law is empty because of the lack of an implementing decree. They explained that this absence causes difficulties because it is not clearly described when, how and who can practice the abortions.

*«Without an implementing decree the law is not complete. The decree gives the details of the implementation. The decree describes who intervenes and it allows to know where one can put feet or not» (Ministry of the security)*

The reasons given by the participants for the lack of an implementing decree are that abortion is a taboo in Mali and that no one wants to talk about it.

Another difficulty is that the 2002 RH law does not state that abortion is allowed in the case of foetal malformations. Nevertheless, many gynaecologists perform abortions in case of foetal malformation and say that they perform these types of abortions as it is in line with the code of ethics. One participant explained that the developers of the law did not include this condition because they were afraid that the authorization would lead to the selection of embryos for example on the basis of sex. In addition, another difficulty noted is that there is no coherence between the penal code, the RH law and the code of ethics. This can cause confusion and difficulties, as in the sense that the doctor relies mainly on the code of ethics and justice, especially on the penal code. For these reasons the harmonization of documents will be important.

A last difficulty described by the participants is the ignorance of the RH law by the different key actors like gynaecologists, police, the justice etc. One participant shared that the law was not well

disseminated but that often the gynaecologists are in their own environment and do not seek to understand the law. Some participants noted that the law itself is restrictive and needs to be revised.

Participants described that the procedure to follow in case of abortion within the legal framework sets barriers to access to the said service. They shared that in cases of rape and incest, the woman / girl must proceed to a complaint with the police and then it is the police who will send the woman / girl to the head of the health facility in the commune, often the CSREF. Several participants shared that this process takes time and that it is often difficult to prove a case of rape or incest. For «therapeutic abortions», 2 ultrasounds should be done in 2 different places. Although this procedure is described by the participants, it is not clear in the real world how this is happening as there is no implementation decree.

#### *Population/Request*

Several participants shared that they think the demand for abortion is there. They said that abortions are done within the legal framework and outside the legal framework, but law and other socio-cultural factors make abortions clandestinely/hidden. Some participants said that there is some «hypocrisy» in Mali: everyone knows that abortions are done (clandestinely) but no one does or says something and prefers to hide for example behind religion.

*«There is the hypocrisy that accompanies the debate: They call us to go praying because there is a girl who is dead. When we ask what happened, they will say stomach ache, headaches, but we all know that these are abortion cases. We know that it exists. Should we stay in this situation or change the situation to save lives? ». (National Commission for Human Rights)*

#### *Post-abortion care*

Regarding post-abortion care, participants were much more open. Everyone says they offer these services, and several participants said that the majority of health care providers have had post-abortion care training. Participants explained that in Mali, there are post-abortion care units (SAA), each commune (CSREF) has a SAA unit. These units are specialized in post-abortion care. In Bamako, the Gabriel Touré hospital has a SAA / PF / MLDA unit.

#### *Positions on safe abortion according to different institutions*

National Directorate of Health (DNS): The DNS recognizes that illegal abortions are a great danger in Mali and that there are many girls or women who lose their lives because of abortion. The DNS participant explained that abortion is not a priority at the DNS and that there are not many policies on adolescent and child reproductive health. He sees this as a major deficiency in the health system and believes that activities at this level need to be strengthened. In addition, he thinks that the law is insufficient and that the moment has arrived where every woman can decide when to have children.

*«You have to legalize abortions because right now people are already doing abortions every day. That's why you have to create a good law and framework to reduce the consequences. We have to start now, we have to say [to the population] if you want to or not, the abortions are already done, but it's badly done! ». (DNS)*

He explains that opinions differ at the DNS: not everyone is pro-abortion. However, he thinks that the problem of abortions is so huge that he thinks actions must be big too and for that he wants to be engaged in advocacy activities.

Several other participants confirmed that the DNS / Ministry of Health (MOH) is open about safe abortion and that they do not need to put much pressure to convince them, but that the problem lies mainly in the hands of the National Assembly.

Ministry of Security: The participant from the Ministry of Security said the position of his ministry is necessarily to follow the law. However, in his personal capacity, he thinks that the penal code must evolve. He does not think the law should be completely liberalized because he does not want the door open for everyone. Nevertheless, he believes that the Penal Code should also authorize abortions in case of rape and incest or when pregnancy affects the (mental and physical) health of women.

SOMAGO: The Society does not have a clear position on safe abortion. Officials shared that the company has several thematic groups but yet, none on secure abortion as the subject had never been raised or discussed. In the society, not everyone is ready to play a role in advocating for safe abortion. Different positions are observed and a member of the society says he thinks that if one wishes to have more members engaged in advocacy the focus should be on the prevention of unwanted pregnancy. However, there are participants who are ready to play a role in advocating for safe abortion.

The National Assembly (Health Commission): During the discussions with the Health Commission of the National Assembly it became clear that the chairman of this committee does not support abortions. He thinks it's more important to work on FP, education and improving the economic situation than on safe abortion.

*« If a girl do not have to sleep for a pair of pants or a shirt, she will not get pregnant (...). In addition, girls who have been to school do not become pregnant ».(National Assembly).*

They shared that they do not see the need to change the law because no one wants to hear about abortion and that the figures on maternal mortality related to abortion are not true. In addition, they said that anyone from the National Assembly, who will stand before his community to say that he wants to make the law in favour of safe abortions, will never be elected again.

Marie Stopes International (MSI):MSI shared that they are pro-abortion and they see abortion as women's right. Their mission is: « children by choice and not by chance ». They have a coordinator for advocacy for safe abortion, advocacy strategy and advocacy activities at national and regional level.

AMPPF: The position of AMPPF is that you have to go to safe abortion to save lives. However, they have decided to work legally and for that, they do not do abortions but post-abortion care.

National Commission for Human Rights: The national human rights commission has shared that they do not yet have a clear position on abortion because they didn't yet have time to debate about this subject. However, they shared that when you're a human rights defender, you cannot be against safe abortion; like the right to life, health and physical well-being (also mental) are part of human rights.

National order of midwives: The participant from the national order of midwives shared that they do not have a position or general vision on abortion.

### Professional attitudes

The opinions of gynaecologists on abortion differ: there are gynaecologists who support abortion and others who don't. Most gynaecologists have said that they perform abortions only within the legal framework (incest, rape or when a woman's life is in danger; also in cases of foetal malformation. There are several different reasons for not doing abortions (outside the legal framework): religion, personal values, fear of the law and fear of the community. Common Malians see abortion as a bad thing, a sin equivalent to homicide. This is strongly rooted in beliefs and positions and professional responsibilities fail to get people adopt appropriate attitudes. A gynaecologist explained that he agrees to do the abortions, but only in the legal framework. He says that the law is in line with what is described in

Islam; it seems that abortion without reasons is forbidden, but for therapeutic reasons, rape and incest, it is allowed by Islam. Another gynaecologist said he was doing abortions outside the legal framework but stopped doing so now.

*«I realized that the law prohibits abortions and that the older you are, the more responsible and wise, so I respect the rules now. (...) But if it was my own daughter who became pregnant, I would accept abortion for the future of my daughter! ». (Member of SOMAGO).*

In addition to religion and personal values, fear prevents providers to perform abortions or makes that abortions are done clandestinely. Fear because of the law: to be penalized and to go to prison or disciplinary council but also the fear for the population itself.

*«I myself do not want to do abortions just at the request of a woman. It's not part of my values: you have to kill no one. In addition, I am afraid that the society will stigmatize me and that I will lose my prestige and lose the customers»(member of SOMAGO)*

The DNS shared that healthcare providers are often even scared to do therapeutic abortions. He explains that often society is even against therapeutic abortions: it is God who forbids it. This fear explains why statistics often don't include therapeutic abortions.

#### Relationships between different professional societies

During the interviews, it appeared that there are several organizations working on abortion. However, collaboration lacks between them. MSI shared that there is a thematic group on abortion composed of Population Services International (PSI), IPPF, Care Mali; but they do not meet regularly and they do not have a plan of action. They thought that SOMAGO can play a big role in strengthening or revitalize this thematic group. Several other participants shared that it will be important to strengthen collaborations between different organizations and partners.

#### Level of influence

During the interviews, several participants declared that no one is « ready to carry the flag» and to say openly that they are advocating for safe abortion. It is especially the fear of the reaction of the population and religious leaders that culturally abortion is not accepted.

*« There are activities on safe abortion, but nobody has the courage first to carry the flag and to say it's me the leader! Meetings are held with lawyers and the civil society but in the current political context they are afraid to be stigmatized and they are very afraid of the reaction of the population ». (MSI)*

It is the DNS that explains that in Mali the judgments of others are very important and that these judgments weigh very heavily. Nobody wants to stand alone in front of the population. It is for this reason that several participants have declared that collaboration between the different organizations and structures is necessary: a multi-sector struggle. Several respondents said that the society is in a good position to advocate for safe abortion and can have an influence. As this is their area of expertise and they know the reality.

#### Opportunities to strengthen networking on safe abortion

All participants said that working with different organizations, structures and institutions will be a great opportunity to make an impact. In addition, as described above, several participants shared that

working with SOMAGO on safe abortion will be a great opportunity. They said that working with women's associations will be very important.

*«If we change the law to please donors, without involving women .... Nothing will change; it must come from the grassroots! ».*

Participants also said that it is important that the media be involved. Probably, in the beginning the private media will be more interested in the subject than the public media. One participant said that midwives should be included in advocacy because women often have a lot of confidence in midwives.

One female participant said that Mali has signed many international documents that say abortions should be allowed, like the Maputo protocol. She explained that it is an opportunity that Mali has ratified these documents without any reservation and that the recommendations of the African commission on human and peoples' rights (recommendations 16 of Article 14 and 16) can be used as an advocacy tool. In addition, she explains that the national human rights commission reports annually on the human rights situation in Mali for the National Assembly and the ministries. She thinks that in collaboration with SOMAGO they can include the topic of abortion also in this report.

The DNS participant explained that they are perspectives of changes in DNS level and that this will be an opportunity for advocacy for safe abortion. There will be a new division for reproductive health of adolescents and children and they will develop plans and strategies. When they develop these plans and strategies, it will be important to work together with SOMAGO and other partners.

#### Current role of some actors in advocacy for safe abortion

Few activities were shared during interviews in the field of advocacy for safe abortion.

*« This is the first time to see that there is someone who argues for safe abortion » (Midwifery Order).*

MSI developed an advocacy strategy for safe abortion but yet, no activities are being implemented. In addition, the implications of this strategy are unknown, as its development process is.



### 3.4 Stakeholder Workshop

During the various sessions of the workshop, five general themes emerged: improve the legal dimensions; transform social norms at all levels; improve partnership and networking, ensure a process of generating and using evidence for action, strengthening the company's capacity for safe abortions.

During the workshop it was discussed that SOMAGO prefers to change the general objective of the project to: contribute, through advocacy, to a reduction in maternal deaths through the reduction of unsafe abortions. It was found that, with an advocacy objective to increase access to safe abortion, the community may misunderstand, which may be causing difficulties. Participants identified the different activities during the workshop for the reduction of unsafe abortions, as described below. The final action plan for SOMAGO is strongly based on these identified activities.

#### 1. Improve legal dimensions

- Improving knowledge of this 2002 reproductive health law
  - o RH law dissemination days for care professionals, Ministry of Justice, Ministry of Health, DNS / and Parliamentarians.
  - o Rereading or revision session of the RH law with the above targets
- Adoption of a new law - order / decree
  - o Integration of the recommendations following the rereading of the 2002 RH law/decree of application (meeting of sensitizations).
  - o High-level advocacy session: meeting with political decision makers, religious leaders, community for a new understanding and acceptance of the adopted new law
  - o Harmonization between the penal code (2001) and the RH law

#### 2. Transforming social norms at all levels

- Community approach
- Communication for social and behavioural change.
  - o On FP, sexuality, but also on abortion (after a little time on abortion)
- In schools develop a comprehensive education program on sexuality.
- Consultation meeting with religious and community leaders on sexuality (on FP and abortion).

Important Note: You have to do step by step, start with the FP and then continue with the abortion for fewer risks of stigmas.

#### 3. Improve partnership and networking

Identification of key partners: Reproductive health division (DSR), PSI, MSI, High impact health services - USAID project (SSGI), AMPPF, National federation of community health associations (FNASCOM), Office for social development and solidarity economy (SDSES), National directorate for the promotion of woman, child and the family (DNPFEF), the community, the African gynaecology obstetrics' society (SAGO), FIGO, health professional orders, Malian midwives' association (ASFM), civil society (community and religious leaders), Ministry of Education and Ministry of Justice. Through data, document review, National directorate for health (DNS)/Regional directorate for health (DRS)

- Organization of a consultation framework for an exchange with identified partners
  - o Invitation
  - o Exchange on the problematic of unsafe abortion
- Identify which partner can do what in the SOMAGO / FIGO project.
  - o Develop advocacy tools

- Form a pool of advocates
  - Advocate according to targets
  - Set up a networking system (champions at community level)
  - Identify and network favourable groups.
- 4. Ensure a process of production and use of evidence for action**
- To assess the state and extent of abortions (quantitative & qualitative)
    - Analyse available data on abortion
    - Exploration study at national level
  - Make information available at all levels (dissemination)
    - Production of communication tools (brochures, posters, spot etc.)
    - Holding conferences (every year: 2)
    - Chat / debate (2 / years)
  - Ensure completeness of data on abortion (monitoring and evaluation) (DNS)
- 5. Strengthening society's capacity for safe abortions (to make it visible and accessible)**
- Value clarification within SOMAGO (personal ethics & beliefs)
    - 01 gynaecologist per health facility as trainer in medical responsibility at the level of the regions and hospitals of Bamako
  - Strengthening advocacy skills
    - Train SOMAGO members in the development of advocacy strategies for the community (religious leaders, traditional communicators, and media).
    - Train SOMAGO members in developing an advocacy strategy for decision-makers (political and institutional).
  - Exchanging experiences among members of the society
    - Update/ site reinforcement
      - Development of a team / web master?
      - Request support from FIGO?
    - Organization of Conferences / Postgraduate Studies
    - Secretariat reinforcement

### Networking

During the group work, networking for safe abortion was identified. Appendix 3 provides a summary of allies and networks where potential allies could be found. This should be seen as a dynamic table. New allies can be identified and potential allies can move.

### Strengths, Weaknesses, Opportunities, and Threats

During the workshop, participants identified SOMAGO's strengths, weaknesses, opportunities and threats in advocacy for safe abortion. Their status, their position (between the community and the politicians) and their experiences on unsafe abortion are seen as strengths, among other things. However, the weaknesses noted are: their ignorance of the abortion law and conventions, the lack of financial resources and the fact that their own values on abortion are not yet clarified.

The identified opportunities are that human resources are qualified to perform abortions and that there are several organizations and partners present in Mali that can play a role in advocacy for abortion. The identified threats are related to community values, the legal framework and the ambiguity about who offers/will offer abortion services. The main results of the SWOT analysis are given in Annex 4.

### Action plan

As a final exercise, the groups began to define the objectives and activities of an advocacy plan for safe abortion. The overall goal of the Action Plan is to improve SOMAGO's capacity to advocate for abortion in order to increase access to safe abortion and reduce the morbidity and mortality resulting from unsafe abortion. Activities should be used to achieve the objectives and will include the different levels of advocacy and social networks discussed during the workshop.

Following the stakeholder workshop, the team of consultants continued to develop the action plan, including the deliverables. The action plan will continue to be developed in collaboration with SOMAGO and FIGO.

A preliminary action plan can be found in Appendix 5.

## 4. Conclusion

The literature review, the online survey, the interviews and the workshop with the different stakeholders show that in Mali unsafe abortion and its complications are a big problem. Abortions endanger the lives of many women. It is for this reason that it will be important to advocate for reducing unsafe abortions.

This study shows some of the challenges that society might face during advocacy:

- **Lack of data on safe abortion:** National level studies on abortions and its complications are not available. Only small scale studies or estimates are available. In addition, health care providers often do not register (medical) abortions for fear of being arrested. Therefore sufficient and reliable data that can be used to advocate for safe abortion lacks.
- **Inconsistency of the legal framework:** The various documents describing the conditions of access to abortion services are not aligned. The 2002 RH law, the penal code and the code of ethics evoke different circumstances. This causes confusion for the different actors involved. In addition, the application decree of the 2002 RH law misses, which leaves doors open for contradictory interpretations of the law.
- **Ignorance of the law and guidelines:** The various relevant actors (communities, healthcare providers, security forces) are generally unaware of the law and the guidelines on safe abortion.
- **Religious and Cultural Influence:** The discussions and vision on safe abortions are strongly influenced by religion and culture. People are afraid of being judged and are therefore afraid to stand in front of the public to talk openly about abortion, which makes discussions difficult.
- **The different positions in Malian society:** Positions of SOMAGO's members of on safe abortion differ a lot. There are members who wish to play a role in advocacy for safe abortion while others have they do not want to be involved. In addition, several members declared that their values are not yet clarified at the abortion level.
- **Lack of a clear position on safe abortion:** SOMAGO does not have a clear position on safe abortion, which can limit the visibility of the society as a key player in the field of safe abortion.

To strengthen advocacy and reduce unsafe abortion, different stakeholders need to work together at all levels to influence access to safe abortion. SOMAGO can play an important role in bringing together different stakeholders. In addition, because of their technical knowledge and experience they will be able to influence decision-makers on safe abortion.

## 5. Recommendations for the future program

By building its foundations as a safe abortion advocate, the society will need to address the various potential challenges identified during key informant interviews and the two-day workshop. This could include the following:

1. Strengthen the management and organization of SOMAGO as a valuable advocate for safe abortion
2. Establish a coordinated and dynamic network of associations that support safe abortion
3. Transform social and gender norms at all levels regarding safe abortion, in the context of Malian law
4. Ensure that the legal framework on abortion is consistent while raising awareness among stakeholders and at all levels for a harmonious interpretation of legislation.
5. Ensure a process of generalization and use of data for monitoring and planning services.

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## Annex 1: Program and participants of stakeholder workshop

Due to time constraints the program was adapted during the days. Starting time was later and some workshop components were skipped. (Marked in italics)

Time	Content
<b>Day 1: 25 April</b>	
8.30– 9.10	Introduction: Welcome and prayers President society Getting to know each other, expectations, purpose, objectives, agenda, facilitator’s participant roles, group norms, evaluation process, housekeeping
9.10-10.20	Presentation preliminary country results; validation of analysis; dialogue about reasons for abortion and what needs to improve to meet women’s need for safe and legal abortion
10.20-10.35	Break
10.35 -11.00	Presentation and discussion results of group work dialogues
11.00-11.30	Implications of national abortion laws on access to safe abortion.
11.30-12.30	Share positions and personal beliefs and discuss professional responsibilities
12.30-13.30	Lunch
13.30-14.00	What is advocacy: concept, levels and challenges
14.00 -14.30	<i>Advocacy perspective, risks and benefits in advocacy (shortened)</i>
14.30-15.00	Roles in advocacy
15.00-15.15	Break
15.15 -16.00	Roles in advocacy continued
16.00-16.25	<i>Power dimensions in advocacy</i>
16.25-17.15	Advocate for safe abortion care
17.15-17.30	Evaluation of the day
<b>Day 2: 26 April</b>	
8.30-9.00	Welcome and prayers Recap of day 1 by 2 volunteer participants identified day before
9.00-10.00	Social networks and reaching different audiences
10.00-10.30	Break
10.30-11.00	Address parked issues (none parked)
11.00-12.30	Presentation of achievements weaknesses barriers and opportunities of abortion project. Then: strengths, weaknesses, opportunities and threats of the national association for abortion advocacy.
12.30-13.00	Lunch
13.00-15.00	Develop an action plan for abortion advocacy in small groups
15.00-15.15	Break
15.15 -16.00	Continue develop action plan
16.30-17.00	Presentation and discussion action plans in plenary
17.00-17.30	Evaluation and good bye

## Elaboration on Content of the workshop

The workshop contained eight components:

1. **Introduction:** a session where the background and objectives of the needs assessment and the stakeholder workshop were explained, logistics of the facilitations process, roles and group norms were discussed. Professor Benjamin Hounkpatin opened the day.
2. **Presentation of draft country results and identification of women's needs for safe and legal abortion:** a session where the preliminary results of the desk review on country background, legal and political context, abortion stigma, service delivery environment and advocacy activities in the country were presented and validated with the participants. In a second part of the session case studies about women having obtained unsafe abortion were discussed and analysed in groups. Needs from the perspective of the woman were identified with respect to availability, access to and quality of safe abortion services, environmental and legal dimensions.
3. **Share positions and personal beliefs; discuss professional responsibilities:** a session where personal barriers and motivations to provide safe abortion were explored, with the emphasis that everybody has a right to personal beliefs, which are not questioned. Personal beliefs were benchmarked against professional responsibilities and FIGO's resolution on conscientious objection was discussed in the light of remaining barriers (such as limited professionals available in the country).
4. **What is advocacy and why providers as advocates:** a session to define advocacy and emphasize health providers' unique strength for advocacy, based on: first-hand experience, trustworthiness, extensive network, intermediary client-provider, prestige and status.
5. **Three roles of an advocate:** a session to explore one's advocacy role as an educator, witness or persuader within different advocacy scenarios: provider-client, provider-provider, provider-professional network, provider-media, provider-policymaker.
6. **Social networks and reaching different audiences:** a session to explore social networks for advocacy on safe abortion, identify current and potential allies and ways to reach them.
7. **Strengths, weaknesses, opportunities and threats (SWOT) analysis:** to the abortion advocacy capacity of CNGOB.
8. **Development of an action plan:** a session to, based on the outcomes of the previous session components, identify objectives and activities for the next proposal on safe abortion advocacy.

The following sources were used for development of the workshop activities:

- Ipas | Providers as advocates for safe abortion care: A training manual. 2009  
[http://www.ipas.org/en/Resources/Ipas Publications/Providers-as-advocates-for-safe-abortion-care-A-training-manual.aspx](http://www.ipas.org/en/Resources/Ipas%20Publications/Providers-as-advocates-for-safe-abortion-care-A-training-manual.aspx)
- Ipas | Abortion attitude transformation: A values clarification toolkit for global audiences. 2011  
<http://www.ipas.org/en/Resources/Ipas%20Publications/Abortion-attitude-transformation-A-values-clarification-toolkit-for-global-audiences.aspx>

## Workshop participants

- Les gynécologues obstétriciens provenant des établissements de santé de :
  - Bamako :
    - Commune I
    - Commune II
    - Commune III
    - Commune IV
    - Commune V,
    - Commune VI
    - CHU Gabriel Touré
    - CHU Point G
    - Hôpital du Mali
    - Luxembourg
    - Centre chérifla
    - Clinique Wassa
  - Et les régionaux
    - Kayes (Hôpital de Kayes)
    - Koulikoro (CHU de Kati, Csréf de Kati et Kalabancoro,)
    - Ségou (Hôpital de Ségou)
    - Mopti (Csréf de Mopti).
- Une représentante de l'association des sages-femmes du Mali (ASFM)
- Une représentante de l'ordre des sages-femmes du Mali
- Le président du conseil de l'ordre des infirmiers du Mali.
- Un représentant PSI Mali
- Un représentant de Marie Stopes International.
- Un représentant USAID /SSGI

## Annex 2: Overview of outcome online survey

The summary of responses to the online survey comes in an additional file, in PowerPoint format.

## Annex 3: Networking

Level	Actors	How to reach them
International Actors	FIGO	
Professional networking	<ul style="list-style-type: none"> <li>- The Order of Midwives</li> <li>- Association of Midwives</li> <li>- Professional Order of Health</li> </ul>	<ul style="list-style-type: none"> <li>- Mail</li> <li>- In-person displacement</li> <li>- Meeting</li> <li>- Workshop</li> </ul>
Level of National Policy	<ul style="list-style-type: none"> <li>- The National Assembly (Health Commission and President)</li> <li>- Ministry of Health / DNS / DSR</li> <li>- Ministry of Population</li> <li>- Ministry of Women, Child and Family</li> <li>- Ministry of Youth</li> <li>- Ministry of Culture and Religion</li> <li>- National Centre for Information, Education and Communication for Health (CNECS)</li> </ul>	<ul style="list-style-type: none"> <li>- Meeting</li> </ul>
Level of local policy	<ul style="list-style-type: none"> <li>- High council of communities</li> <li>- Town hall</li> <li>- Cabinet</li> <li>- Governor</li> <li>- Prefect</li> </ul>	<ul style="list-style-type: none"> <li>- Meeting</li> <li>- Consultation</li> </ul>
NGOs & bi and multilateral	<ul style="list-style-type: none"> <li>- MSI</li> <li>- PSI</li> <li>- AMPPF</li> <li>- Groupe PIVOT santé population</li> <li>- Coalition of civil society organizations for the repositioning of PF</li> <li>- USAID</li> <li>- UNFPA</li> <li>- SWEDD Project</li> <li>- Coordination of Women Associations and NGOs of Mali (CAFO)</li> </ul>	<ul style="list-style-type: none"> <li>- Meeting / Meeting</li> <li>- Consultation</li> <li>- Conference</li> </ul>
Legal Network	<ul style="list-style-type: none"> <li>- Associations for defending human rights (Wildaf, demaïso, legal clinic, AJCAD)</li> <li>- President of the High Islamic Council</li> </ul>	<ul style="list-style-type: none"> <li>- Mail</li> <li>- Displacement</li> </ul>
Religious Network	<ul style="list-style-type: none"> <li>- Muslim associations</li> <li>- Association of Muslim Women</li> <li>- RIPOD (network of Islam population and development)</li> <li>- Christian religious leaders in churches</li> </ul>	<ul style="list-style-type: none"> <li>- Contact meeting</li> <li>- Imam's home visit</li> <li>- Meeting of the mosque committee</li> </ul>
Community	<ul style="list-style-type: none"> <li>- Community Leaders (Elected, Village Chief)</li> <li>- National Network of the Youth of Mali</li> <li>- Network of traditional communicators for the development of Mali (RECOTRADE) - Making contact</li> </ul>	<ul style="list-style-type: none"> <li>- Contact meeting</li> <li>- Correspondence</li> <li>- Debate</li> </ul>
Media	<ul style="list-style-type: none"> <li>- Journalist</li> </ul>	

## Annex 4: SWOT analysis

<b>SWOT analysis of the capacity of the national society in advocacy for safe abortion</b>	
<p><b>STRENGTHS</b></p> <ul style="list-style-type: none"> <li>- Primary prevention (Family planning)</li> <li>- The values /status of gynaecologists.</li> <li>- SAA focal point exists in the structures</li> <li>- Sharing information</li> <li>- Experiences on clandestine abortion and complications.</li> <li>- Good relationship with financial technical partner, and institutions</li> <li>- Knowledge of the field</li> <li>- Intermediary between the community and the policies</li> </ul>	<p><b>WEAKNESSES</b></p> <ul style="list-style-type: none"> <li>- Lack of knowledge of abortion conventions and laws</li> <li>- Insufficient financial resources for the implementation of activities</li> <li>- Insufficient communication of information from certain international meetings in which some members of SOMAGO took part</li> <li>- Hard to reach: religious &amp; political leader because lack of strategy</li> <li>- Laws not adopted</li> <li>- Own values are not yet clarified (socio-cultural influence).</li> <li>- Lack of time</li> <li>- Limited knowledge on international laws / conventions / advocacy methodology.</li> </ul>
<p><b>OPPORTUNITIES</b></p> <ul style="list-style-type: none"> <li>- Qualified and competent human resources</li> <li>- Presence of the associations, financial technical partner, CNJ (national youth council), media, Ministry for the promotion of women, children and the family (MPFEF).</li> <li>- Existences of the national policy for gender</li> <li>- Magnitude of complications related to abortion</li> <li>- WILDAF etc. and other legal framework are defending the abortion already</li> </ul> <p>Do more :</p> <ul style="list-style-type: none"> <li>- Preventive: Sex Education - Comprehensive Education: Technical Committee included in the training of pupil will be developed</li> </ul> <p>Public to better reach:</p> <ul style="list-style-type: none"> <li>- Pupil</li> <li>- Social Network Users</li> <li>- Sex Professionals</li> </ul>	<p><b>THREATS</b></p> <ul style="list-style-type: none"> <li>- Insufficient legal framework: law does not allow safe abortions in a very broad setting.</li> <li>- Lack of services and identified providers: to offer services</li> <li>- Community &amp; Religion</li> </ul> <p>Because :</p> <ul style="list-style-type: none"> <li>- Religious leaders have popular uprising ability (98% is believer)</li> <li>- Community: the burden of cultural values</li> <li>- Providers: refusal to provide services because of their intimate conviction (even if the law allows).</li> </ul> <p>External environmental threats:</p> <ul style="list-style-type: none"> <li>o Professional health orders (opposition)</li> <li>o Ethics committee (opposition)</li> <li>o Executive and Legislature power (refuses initiatives for the law)</li> <li>o Community &amp; religion (opposition and aggression)</li> </ul>

## Annex 5: Country action plan

A preliminary country action plan will come in a separate file in excel format.