Mozambique Country Report

NEEDS ASSESSMENT ON SAFE ABORTION ADVOCACY

FOR THE ASSOCIATION OF OBSTETRICIANS AND GYNAECOLOGISTS OF MOZAMBIQUE / ASSOCIAÇÃO MOÇAMBICANA DE OBSTETRAS E GINECOLOGISTAS (AMOG)

COMMISSIONED BY THE INTERNATIONAL FEDERATION OF GYNAECOLOGY AND OBSTETRICS (FIGO)

CONDUCTED BY: KIT ROYAL TROPICAL INSTITUTE – HEALTH UNIT

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Abbreviations

- AMOG Association of Obstetricians and Gynaecologists of Mozambique
- AMODEFA Mozambican Association for Family Development
- DHS Demographic Health Survey
- GDP Gross Domestic Product
- FIGO International Federation of Gynaecology and Obstetrics
- FP (PF) Family Planning (Planeamento Familiar)
- HIV Human Immunodeficiency Virus
- MCH Maternal Child Health
- MISAU Ministério da Saúde (Ministry of Health)
- MMR Maternal Mortality Ratio
- MOH Ministry of Health
- INE Institute National of Statistic
- INS Institute National of Health (Instituto Nacional de Saúde)
- KIT Royal Tropical Institute
- RMNCAH Reproductive Maternal Neonatal Child and Adolescent Health
- SDG Sustainable Development Goals
- SRHR Sexual and Reproductive Health and Rights
- SNS Sistema Nacional de Saúde (National Health System)
- THE Total Health Expenditure
- UNICEF United Nations Children's Funds
- USD United States Dollar
- VIP Voluntary interruption of Pregnancy
- VP Vertical Projects
- WHO World Health Organization

Glossary

Abortion: MISAU (2016) explains in the clinical norms that *"according to the World Health Organization (WHO), abortion is the interruption of pregnancy until the 20th or 22nd week and with product of conception weighing less than 500g; this classification is for developed countries. In underdeveloped countries such as Mozambique, abortion is considered until 28 weeks of pregnancy. This is due to our conditions of neonatal attention to foetus less than 28 weeks that are considered unfeasible."*

Post-Abortion Care: *"is an approach for reducing deaths and injuries from incomplete and unsafe abortions and their related complications. Post abortion care is an integral component of comprehensive abortion care and includes 1) Treatment of incomplete and unsafe abortion and complications; 2) Counselling to identify and respond to women's emotional and physical health needs; 3) Contraceptive and family-planning services to help women prevent future unwanted pregnancies and abortions; 4) Reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities; 5) Community and service-provider partnerships to prevent unwanted pregnancies and unsafe abortions, to mobilize resources to ensure timely care for abortion complications, and to make sure health services meet community expectations and needs."* (Ipas, 2017)

Women-Centred Comprehensive Abortion Care: means having an integrated and comprehensive approach to the provision of abortion services that takes into account various factors that affect women's mental and physical needs as well as the personal circumstances that led them to seek such care and their ability to access services. Such care includes a broad spectrum of medical and health activities that enable women to exercise their sexual and reproductive rights, such as access to immediate / current FP and post abortion, HIV risk assessment, violence, among others (MISAU, 2016). Ipas (2017) describes that CAC includes the following components:

- *Provide safe, high-quality services, including abortion, post abortion care and family planning;*
- *Decentralize services so they are closer to women;*
- *Be affordable and acceptable to women;*
- *Address the needs of women in the second trimester of pregnancy (at or after 13 weeks gestation) by providing services or referring;*
- *Understand each woman's particular social circumstances and individual needs and tailor her care accordingly;*
- *Address the needs of young women;*
- *Reduce the number of unintended pregnancies and abortions;*
- *Identify and serve women with other sexual or reproductive health needs;*
- *Be affordable and sustainable to health systems*

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Executive Summary

This report describes the needs assessment set out to provide better and more in depth understanding of the capacity of the Association of Obstetricians and Gynaecologists of Mozambique / Associação Moçambicana de Obstetras e Ginecologistas (AMOG) and in particular to identify the main abortion advocacy needs that a forthcoming multi country project can address. The assessment attempted to provide more clarity on how FIGO can effectively strengthen the capacities of the society. The assessment involved conducting a literature review, a survey of members of the society key informant interviews with stakeholders at various levels with the majority being associated with AMOG as well as a stakeholder workshop for AMOG members and partners.

The literature review, the key informant interviews and the workshop confirmed that despite the liberal abortion laws which came into effect at the end of 2014, unsafe abortion and its complications remains a major problem in Mozambique, endangering the lives of many women. Although the legal framework provides for abortion on request of the woman, the implementation of the law lags behind. As a result, many women in Mozambique still reverting to unsafe abortion. Especially in rural areas access to safe abortion is a concern. The lack of awareness among the public, about the law and where to find services, but also the lack of availability of services (including trained staff, supply of drug and equipment) are major contributing factors for women still opting for abortion outside the health system. Service providers personal values and believes, and their attitude hamper the accessibility of safe abortion services. AMOG played an important role in advocacy efforts, which influenced the current legal framework. However, more needs to be done to ensure full implementation of the laws and policies. Strengthening advocacy for safe abortion requires the engagement in dialogue with the general population, ministry of health at various levels, including, health care providers, the media and other stakeholders. AMOG's strength as a leader in technical knowledge offers the opportunity to influence and network with like-minded organizations to advocate for implementation of the law and ensuring safe abortion services are accessible to women who require them.

Building its base as a safe abortion advocate, the society will require to address the various and potential challenges as were identified during the key informant interviews and the two day's workshop. This could include the following:

1) Ensuring effective dissemination and implementation of the abortion law as well as the policies and guidelines
2) Ensuring awareness of the laws and safe abortion services, and transformation of social norms at community level and with health providers
3) Strengthening the safe abortion advocacy network, through improved partnerships and communication
4) Ensuring evidence for action and advocacy is gathered through systematic generation and use of data
5) Strengthening the capacity of AMOG to be effective advocates for safe abortion access for women in Mozambique

These recommendations, identified in collaboration with AMOG, are taken forward and translated into a preliminary action plan with tangible activities and outcomes. The action plan will be further developed in collaboration with AMOG and FIGO and be a source of inspiration for the development of a future program proposal for safe abortion advocacy in 10 countries (Kenya, Benin, Cameroon, Ivory Coast, Mali, Mozambique, Panama, Peru, Uganda, Zambia).

1. Introduction

This country report is the result of a needs assessment conducted by KIT Royal Tropical Institute with the Association of Obstetricians and Gynaecologists of Mozambique / Associação Moçambicana de Obstetras e Ginecologistas (AMOG) regarding Safe Abortion Advocacy. Mozambique is one of the ten countries participating in a broader Needs Assessment for an upcoming multi-country FIGO-led project that aims to increase the capacity of national obstetrics and gynaecology societies to become national leaders in safe abortion advocacy work.

1.1 Needs Assessment Purpose

This Needs Assessment is the first phase of an upcoming safe abortion project and it should provide a better and more in depth understanding of the capacities and needs of AMOG. Subsequently, it will 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 AMOG. 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.

1.2 Needs Assessment Objectives

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

- Insights into the situation of abortion in each country
- Understanding of the capacity and needs of each National Obstetrics and Gynaecology Society on abortion advocacy
- Plans of Action for each National Obstetrics and Gynaecology Society developed through a collaborative process
- Recommendations regarding 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 of character and aimed for a highly participatory approach. Constant mechanisms of communication and feedback with AMOG took place in order to create mutual understanding and formulate joint objectives. The following methods were used in order to meet the objectives of the assessment:

2.1 Desk study review

A desk study review on existing literature and evidence was committed between February and March 2018 through a desk review tool. Academic databases and grey literature were searched for the relevant themes as addressed in the assessment framework (inception report). AMOG and key stakeholders were requested for relevant input.

2.2 Online survey

An online survey, using Survey Monkey software, was sent out to all 75 registered members of AMOG to ask them about their membership of AMOG, the position of the society towards safe abortion and their own professional and personal position towards safe abortion. The email was sent out from the Survey Monkey software, with the sender email address of AMOG, on 21st February. Despite several reminders to attain more responses, only 26 responses came back of which 24 were complete (completion rate 92%; one respondents did not continue after question 10, one more did not continue after Q15). The survey remained open for 9 weeks and closed on 29 April 2018. Analysis was done using the survey monkey software. All answers that were provided on all questions were included in the analysis.

2.3 Key Informant Interviews

A total of 15 key informants were interviewed. They included representatives from AMOG, The midwifes association of Mozambique, International Centre for Reproductive Health (ICRH), Rede de Defesa dos Direitos Sexuais e Reprodutivos (DSR), Ministry of Health, Pathfinder, the medicine faculty and the association of traditional healers. The interviews were conducted either within their offices or AMOG's office. With permission, the interviews were recorded as well as taking of notes. These notes were extended using the tape recordings. The notes were collated and organized along thematic areas as outlined in the findings section. The findings were analysed taking into account the various perceptions regarding safe abortion.

2.4 Stakeholder workshop

A two days stakeholder workshop took place in Maputo on 22nd and 23rd of March 2018, with 20 participants on day 1 and 18 on day 2 (see programme and participants list in annex 1). The purpose of the workshop was to identify the needs of AMOG for abortion advocacy and develop a plan of action 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 by the end of the workshops participants have:

- Discussed and identified opportunities and barriers for providing safe abortion in the country based on the desk review presentation and own experience.
- 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.
- Explored the implications of the national abortion law and policies for access to safe abortion.
- The ability to explain the concept and levels of advocacy and identify challenges and barriers of abortion advocacy.
- Identified the strengths and weaknesses of the national society related to abortion advocacy.
- Formulated action points for an abortion advocacy programme.

2.5 Challenges and Limitations

One of the challenges perceived was the response rate to the survey. In general, as perceived by AMOG more often, there seems to be a low tendency in responding to emails in general. The team, in collaboration with AMOG, took several actions to mitigate the limitation of a low response rate. AMOG members that participated in the workshop and had not filled out the survey prior to attendance were requested to fill in the survey immediately upon arrival on a printed copy, and several reminders were sent to the members. While it was emphasized that AMOG is interested to hear the voices of all members, regardless of their position, it is expected that mainly those who have strong feelings about the topic took the effort to respond. With a total response rate of only 35% (26/75), this survey does not reflect the position of the majority of AMOG members, but still gives a good idea of the views of the respondents. All people who took the effort to fill in the survey were generally supportive of safe abortion. There were no strong opposing views.

The challenges experienced in relation to the interviewing were largely the time limitation to cover all the relevant key informants. Unfortunately we did not manage to interview any stakeholders from the Catholic Church, who were seen as the main opposing group. Efforts were made by AMOG to contact religious leaders, but without any success. This means that opposing views are not reflected in this analysis, other than the perceived position of this group by other key informants.

In terms of the workshop the attendance was largely by those who were in favour of safe abortion, and mainly by AMOG members. Although MOH was partly present during part of the workshop, as well as a representative from the legal department, the input from these important stakeholders could have been stronger, as some key MOH representatives were not there and participation of MOH in the workshop was a little bit more on the background.

3. Findings

3.1 Literature review

3.1.1 Maternal health and abortion, setting the stage at global level

Improving maternal health and reducing maternal mortality remains at the centre of global health initiatives. Globally, the annual number of maternal deaths reduced by 43% between 1990 and 2015 from 532,000 in 1990 to 303,000 in 2015 (WHO, 2015). During the same period the approximate global lifetime risk of a maternal death fell considerably from 1 in 73 to 1 in 180. Majority of these deaths are among women from Sub-Saharan Africa. Majority of countries in Sub-Saharan Africa did not meet the Millennium Development Goal 5 whose target was to reduce maternal mortality by 75% (of the 1990 maternal mortality ratio). More than 80 percent of an estimated 289,000 annual maternal deaths are due to obstetric haemorrhage, obstructed labour, hypertensive disorders (e.g., severe preeclampsia or eclampsia), complications related to abortion, and postpartum sepsis (WHO, 2014).

In an effort to accelerate the achievement to MDG 4 and MDG 5, the UN Secretary-General's Global Strategy for Women's and Children's Health was developed and a high-level Commission on Information and Accountability (COIA) set up to promote "global reporting, oversight, and accountability on women's and children's health (The Commission on Information and Accountability for Women's and Children's Health 2011). Building up onto these efforts, the Sustainable Development Goals (SDGs) have been set up to establish a transformative agenda for ending preventable maternal deaths. Target 3.1 of SDG 3 is to reduce the global MMR to less than 70 per 100.000 live births by 2030. Achieving this significant reduction will require an average of 7.5% reduction of global MMR annually between 2016 and 2030; more than three times the 2.3% annual rate of reduction observed globally between 1990 and 2015.

3.1.2 Key indicators Mozambique

Table 1: Demographic indicators for Mozambique

Demographic and socio economic information	Vital Statistics
Pop 2017: 28.86 million (INE, 2017) 47.8% male / 52.2% female (INE, 2017) 67% living in rural -/ 33% in urban areas (trading economics, 2016) Human development ranking 2015: 180/188 countries (INE, 2017) GDP per capita 411 USD (2016) Annual GDP growth rate 3.6% (INE, 2017)	Life Expectancy total: 57.6 years (WHO,2015) HIV prevalence 12.3% (adults 15 – 49 y – 206) (UNAIDS, 2016) IMR 53/$_{1000\ live\ births}$ 2015 (INE, 2017) MMR 489/$_{100.000\ live\ births}$ 2015 Delivery with skilled attendants: 54.3% (2012) (UNICEF, 2018) Fertility rate: 5.3 (INS, 2015) Unmet need for family planning (married women): 23%

Although the maternal mortality has dropped drastically from 1390/100.000 live births in 1990, in 2015 it was still very high with 489/100.000 live births. The fertility rate in Mozambique was 5.3, and the unmet need for family planning was 23% for married women (INS, 2015). In 2015, 46% of girls between 15-19 years reported to have had an unintended pregnancy, 38% gave birth, and the adolescent pregnancy rate was 137 live birth per 1,000 girls aged 15-19 (INS, 2015). Child marriage remains high, with 14.3% of girls between 20 and 24 reporting to be married before the age of 15 (UNICEF, 2015).

3.1.3 Abortion evidence

There is a lack of complete and reliable data to demonstrate the extent of the burden of safe and unsafe abortion. However, as per the 2011 Mozambican Demographic Health Survey, abortions are among the main causes of maternal death and at least 4.5% of all adolescents reported having terminated a pregnancy (DHS,

2011). Ustá, et al (2008) stated that unsafe abortions represented among 11–18% of all hospital based maternal deaths. According to the WHO, the main direct causes of maternal death are pre-eclampsia/eclampsia, severe bleeding, infection and obstructed labour, representing 75% of the deaths in Mozambique. Although common consequences of unsafe abortion are bleeding and infection, it is not specified what proportion of women suffered these consequences as a result of unsafe abortion (WHO, 2017).

Unpublished data from the records of Mozambican Association for Family Development (AMODEFA), offering safe abortion at their SRH clinic in Maputo, indicate that from 2010 to 2016 a total of 70,895 women had an induced abortion in this clinic, of which 43% were aged 15 to 24. In the first three months of 2017, 1500 women had an induced abortion at this clinic, of whom 27.9% were below 25 years. These data show the high demand for safe abortion among young women (Frederico, 2018).

In 2004 admissions for post-abortion care represented more than 55% of all gynaecological complications in Mozambique (Djedje, 2005). The consequences of unsafe abortion frequently seen are haemorrhages, anaemia, uterine infections, sepsis, genital trauma and fistula. These are common reasons for women to look for post abortion care. The physical consequences affecting women who search for clandestine abortion are dire. Often women have to undergo surgical interventions to save their lives after post-abortion complications, which can result in infertility or in some cases, women lose their lives (Muchango 2004, WLSA 2011, Thonneau N.D.).

Social exclusion, and being abandoned by the partner, sometimes because of infertility are among the social consequences of abortion. Furthermore, increased institutional costs for the health facilities and for the health system were described as financial consequences of abortion (Thonneau, 2001).

3.1.4 Reasons for abortion

There are different reasons why women opt for abortion, such as societal and economic factors. The decision if and how to terminate a pregnancy depends on a variety of factors at different levels. At the individual level common influencing factors are marital status of women, rape or incest, economic dependence and education level. Other factors include support from male partner and parents support. Societal factors that influence the decision include social norms, religion, and the stigma of premarital and extra-marital sex (Frederico, 2018). Quotes from women interviewed by Frederico have been selected and listed in the annex, to illustrate the decision making process and how this is influenced.

Unwanted pregnancy is a significant contributing factor to the prevalence of abortion, making Mozambique's statistics on contraceptive prevalence and unmet need particularly concerning (Pathfinder, 2016). Presently in Mozambique, the contraceptive prevalence rate is 12 percent, and unmet need for contraception, as per the INS (2015) is 23%. The DHS 2011 found that 85% of births were planned. However, 12% were not and 3% were unintended births (DHS, 2011). Determinants of unintended pregnancies include, low access to contraceptives and contraceptive fail mainly in rural areas, violence against women, and lack of social support of pregnant women. (Pathfinder, 2016).

3.1.5 Reasons for unsafe abortion

Many women undergo an abortion in illegal and unsafe circumstances for a variety of reasons, such as legal restrictions, the fear of stigma, and a lack of information about the availability of safe abortion services care. In a recent study it was found that lack of money, and fear of stigma indeed were reasons for looking for abortion outside of the health facility in Mozambique (Federico, 2017).

MISAU indicates that the most vulnerable group is adolescents who get pregnant at a young age (between 15 and 19). Their autonomy is compromised and decisions are made by the husband (if married), parents or other male adult family members. In addition, the health system is deficient, family planning services are limited, poorer women cannot afford to pay for abortion services (which are supposed to be free of charge, but are often

charged for). Mainly the misinformation of the women and community members, limits the access to safe abortion.

3.1.6 Legal and Political Context

National laws and policies on abortion

Mozambique ratified the Maputo protocol, committing to *"take all appropriate measures to... protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."* (Human Life International, 2007). In line with this commitment, Mozambique developed different policies allowing safe abortion on request of the woman. The regulations are formed by the revised Penal code (Law 35/2014) and the Ministerial Diploma 60/2017, which approves the clinical norms. According to the revised Penal Code (law 35/2014 of 31 December) signed into law on 18 December 2014, abortion is legal on request of the woman within the first 12 weeks of pregnancy. In cases of rape and incest, within 16 weeks. In case of serious malformation of the foetus or transmittable disease, within 24 weeks, and if there is an unviable foetus, abortion is allowed at any time.

After the revision of the penal code it was expected that the law would be implemented in 2015, but missing the regulations allowing providers to understand how to put the law in practice, there was a delay. In 2017 the Ministerial Diploma 60/2017 was approved, as well as the clinical norms (Normas Clínicas sobre Aborto Seguro, Cuidados Pós-parto).

However, now that the regulations and policies are in place, there is still a lack of implementation of the law, partly due to a lack of public awareness and well as a lack of training and understanding of health professionals about these regulations. Since 2017, training of service providers is being conducted at central and local levels, this means that conditions for the implementation of the law are being prepared.

Legal circumstances permitting abortion

According to revised Penal Code (law, 35/2014 of 31 December, article 168), abortion it is not punishable if it is done by a doctor or another recognized health professional and with the consent of the pregnant woman, when, according to the state of knowledge and experience of medicine. Abortion must be performed at officially designated facilities by qualified practitioners. Before the abortion, verification of the circumstances that make the abortion not punishable will be certified by a medical certificate, written and signed before the intervention by two health professionals, other than those by whom, or under whose direction, the abortion will be effected.

As per the revised penal code, consent shall be provided in a document signed by the pregnant woman. Where possible minimum three days before the date of the intervention. Where the pregnant woman is less than 16 years of age or psychically incapable, consent may be given by the legal representative, upward or downward slope or, failing that, any relatives of the collateral line.

Legal implications of illegal abortion

Who purposely causes a woman abortion, using violence or drink/herbs, or medicine, or any other means, outside of the law, or performing abortion without the consent of the woman is punishable;

If the crime is committed with the consent of the woman, shall be punished with imprisonment for up to one year;

The woman who consents shall be punished with the penalty of seeking abortion herself, followed by the same abortion;

If, however, in the case of the preceding number, the woman commits the crime to conceal her dishonour, the penalty will be that of imprisonment until one year.

The doctor, pharmacist, nurse or any other voluntarily contested for the execution of this crime, indicating or providing the means, incurs the penalty of imprisonment, aggravated by the general rules.

Penal Code (law, 35/2014 of 31 December, article 166)

If consent cannot be obtained and the realization of the abortion takes place as a matter of urgency, the doctor will decide conscientiously against the situation, whenever possible, from the opinion of another or other doctors.

Role of legal institutions

In Mozambique, the health facilities' medical councils, health inspection and national directorate of public health play an important role in the legal implementation of the abortion laws and the police and courts are the custodians of the law on behalf of the government. In case consent can't be given by a legal representative, the health facility's medical council has the power to analyse case by case. The health inspection and the national directorate of public health (Inspecção de Saúde, Direcções Nacional de Saúde Pública e de Assistência Médica) and approved health facilities are responsible for preventing abortion from becoming a tool for family planning. Courts and police have authority to judge and act in accordance with the penal code, in case of unlawful abortions.

3.1.7 Abortion stigma

General attitudes towards abortion

Stigma negatively affects women's ability to obtain safe abortion care. Women seeking abortion are self-stigmatised because of social, cultural and religious influences. The fear of prosecution affects medical health professionals and limits willingness to provide care. Even when services are provided within the law, even where abortion laws are liberal, they are often misrepresented or misunderstood, and regulations to guide effective service delivery may be non-existent or unknown (IPAS, 2016). Mozambique is a very patriarchal society and traditions weigh very high. The position of women is subordinate to the men, influencing women's ability to exercise agency. This impacts on women's rights and colours the attitudes towards abortion. Religious communities and traditional leaders have accused women's associations of advocating "immorality" and "wanting to destroy the family". Many think that abortion will be used as a tool for family planning. These factors, lack of autonomy and fear of stigma, cause women to delay in looking for abortion services (Africa for women's rights, 2012).

Gender inequality

Gender inequality is one of the determinants for abortion. It refers to the power inequality between men and women and is reflected in cases in which the partner makes the decision to terminate the pregnancy. In Mozambique, the contextual environment of male machismo also makes it more socially and culturally acceptable for men to reject responsibility for a pregnancy. In case men reject responsibility for a pregnancy, women decide to interrupt the pregnancy and it must be performed without the knowledge of her parents, in order to avoid exclusion from the parents (Frederico, 2018).

In comparison to boys and young men, girls and young women are exposed to sexual abuse and exploitation in school and at home. Women lack autonomy to make decisions regarding their reproductive health, especially if younger or married (Frederico, 2018). Muchango (2017) states that women who resort to unsafe abortion are significantly younger, are not in stable relationships and are disadvantaged in terms of education, housing and family. Women are generally attributed lower socio-economic status in Mozambique.

3.1.8 Service Delivery Environment

General health services and infra structure

As stated by Health Policy Project (2016) in Mozambique the total health expenditure (THE) was 6.98% of gross domestic product (GDP) in 2014 and the total health expenditure per capita was US$40 in 2013.

In 2015, external donors funded 75% of the overall government budget. Organizations funded by US government funds, working with safe abortion will be affected by the Global Gag Rule (Mexico City Policy), which strips

foreign nongovernmental organizations of all US health funding if they use funds from any source to offer information about abortions, provide abortions, or advocate for abortion. This affects activities such as training of providers, promotion of the safe abortion law, Ministerial Diploma and Clinical norms, and work engaging with community members in dissemination of access to services.

There is a severe shortage of health facilities and staff, especially in rural areas. In 2011, Mozambique counted 83.6 health professionals per 100,000 Mozambicans (Health Policy Project, 2015). The number of hospitals increased from 53 in 2013 to 58 in 2014. In addition Mozambique counted 1233 health centers, which increased to 1277 in 2014 (INE, 2015).

Availability of safe services, methods and providers

Not all health facilities are authorized or equipped (or staffed with trained health workers) to perform abortions, and so, there is still a deficiency of functional safe abortion services (Frederico, 2018). Guidelines, including a list of Essential Equipment, Supplies and Drugs for safe abortion exist but from the desk review it remains unclear to what extend implementation started in all the indicated facilities (see textbox). At the time of report writing, training of providers are ongoing, as well as the assessment of equipment and drug needs, this means that conditions for the implementation of the law are being prepared.

The clinical norms aim for women-centered abortion care, which has three essential elements: **Choice,** includes the right to freely determine when you will be pregnant, to continue or terminate the pregnancy, the right and opportunity to choose between different options after receiving careful and complete information; **Abortion Access,** includes having a voluntary abortion service equipped with trained, competent and up-to-date staff in modern and recent clinical technologies, easily accessible and non-discriminatory; **Quality services**, that is to say integrated services that respect women, with confidentiality conditions, designed to meet the needs of the woman and that use approved standard norms and have an adequate referral system (MISAU, 2016)

Regarding availability of trained healthcare providers, the review of literature did not yield any results that could indicate the existence of trained providers to practice safe abortion in all the health facilities, however, training of safe abortions providers at the central and local levels is ongoing. Doctors and nurses are being prepared to perform safe abortion services according to the Clinical Norms. Whilst from interviews it becomes more evident that safe abortion services are not available in many health facilities, in theory abortion should be provided in the Central, General, Provincial and district hospitals, health facilities with maternal and child health services; by the doctors and nurses of maternal child health (midwifes). In case of complication, the nurse can refer the women to doctors. Providers who have conscientious objection should refer women to other providers, as explained by MISAU (2016) in clinical norms. Doctors and other health professionals, who consider themselves to be conscientious objectors may refuse to

Facilities and providers for safe abortion service

In the Type II / III health centers by the Elementary and Basic Nurses and Midwives and Basic SMI Nurse;

At Centers of type I Health by the Medical Technicians and SMI nurses (basic / intermediate);

At Hospitals Districts / Rural by the Elementary and Basic Nurses and Midwives and Basic SMI Nurse, Surgery Technicians, Graduated in Surgery, Licensed Nurses in Maternal Health and General Practitioner;

In Reference Hospitals (Provincial, General and Central) by the Elementary and Basic Nurses and Midwives and Basic SMI Nurse, Surgery Technicians, Graduated in Surgery, Licensed Nurses in Maternal Health and General Practitioner and Gynaecologists / Obstetricians;

In the Private Units, as a Small clinics with nurses and medical technicians;

In the Medical Clinic with Surgery / Medical or General Clinic technicians, with a team of other health care providers;

At High Level Clinics, With a Specialist Physician or General Practitioner with a team of other health workers;

In the Hospitals with a medical specialist (gynaecologist / obstetrician), General Practitioner and a team of other health workers.

MISAU (2016) Ministerial Diploma 60/2017

perform medical acts which, although permitted by law, are contrary to the providers' conscience, except when the abortion does endanger the woman's life and when treatment of abortion complications is required.

The conscious objection from managers, health providers and professionals, the lack of information, the unavailability of drugs and equipment's, the lack of information of women, and other factors are among the constraints during the implementation of safe abortion services.

Financial access to services

User fees are fixed for everyone, with general health services free of charge for children under five, pregnant women, people over 60 years old and those with disabilities, as well as treatment of tuberculosis, malaria, HIV and chronic diseases (Pose, 2014). The new abortion regulations indicate that safe abortion and post abortion care should be free of charge. However, there seem to be some irregularities with fees as exemptions are not always respected or properly understood. Often health workers do charge for providing abortion, official data related to the value charged were not found.

Unsafe service provision outside of formal health facilities

In Mozambique, different actors provide unsafe abortion in different locations such as in the community, often at home. It is also provided by traditional midwives, community health workers, Elementary Polyvalent Agents and the nurses outside the health system, those providers use methods such as suction, herbs, concoctions, coca cola. Misoprostol is now more widely used and less severe consequences are seen as a result of the use of Misoprostol outside of formal health facilities (MISAU, 2016).

The lack of knowledge about the provision of safe abortion and the consequences of unsafe abortion among women contributes to the frequent occurrence of unsafe and illegal abortion outside health facilities. Patients are highly dependent on the health providers' commitment, professionalism and accuracy. Providers often do not inform and refer the women to the reference health facility or do not advise them about the legal procedures, resulting in a break between law and practice that encourages illegal and unsafe procedures. The reasons for this are not clear. It might be due to a lack of knowledge among health providers too. The distance from the communities to health facilities that provides safe abortion (Central, Provincial and District health facilities) is also one of the determinants for women to look for unsafe abortion (Frederico, 2018).

3.1.8 Advocacy activities and actors

In Mozambique, the actors actively supporting safe abortion are the Health Ministries, the DSR network members and the donors. Mozambique's strongest individual safe abortion advocate is Dr. Pascual Mocumbi, former health minister and prime minister. Mocumbi was concerned with the consequences of unsafe abortion, women were suffering. Therefore, in 1987 he ordered main hospitals to provide safe abortion. This was an important step towards ensuring a safe abortion environment in Mozambique (Sayagues, 2014).

The Mozambican Sexual and Reproductive Rights Network (DSR), which is composed of 17 civil society organizations (including AMOG) fighting for sexual rights and freedoms, have performed several activities advocating for safe abortion. This includes training of journalists, production of brochures, lobbying MPs and subsidies for TV spots. The DSR also participated in the 55th session of the African Commission on people and Human´s Right. In this session the DSR recommended that the Mozambican Government should approve the Abortion Law in order to reduce the number of unsafe abortions and morbid- mortalities in Mozambique. The health ministry and the association of Obstetrics and Gynaecology both were called for decriminalisation of abortion. With success; on 11 July 2014, parliament approved the new penal code allowing the safe abortion services. Yearly, the International Safe Abortion day (28 September) is celebrated by the DSR (WLSA, 2014, Sayagues, 2014).

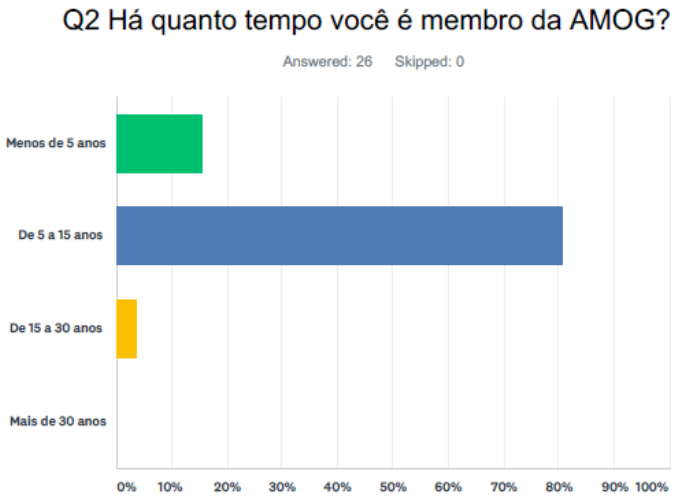
In Mozambique, there are actors passively opposing safe abortion such as religious actors, traditional leaders, some political actors and general public. In 2007, a Catholic bishops said in a letter that "*abortion was a sin and a foreign import, that it corrupts youth and trivialises the sacred power of procreation*." An example from Gaza province demonstrates how individuals can influence abortion access. Here, nurses were trained to provide safe abortion and community activists were promoting family planning and safe abortion. However, when a Catholic health director was appointed, he stopped the provision of services (Sayagues, 2014).

3.2 Online Survey

While there were only 26 responses to the survey, this represents a response rate of 35% of the 75 people to whom the survey was sent, which gives a good idea and provides some valuable information about the position AMOG takes and communication to its members. An overview of the outcomes of all questions of the survey can be found in Annex 3.

3.2.1 Member characteristics of respondents

The number of years of experience as a gynecologist was evenly distributed among the respondents, with 27% less than 5 years, 31% 5 – 10 years and 19% 10 to 15, and 23% more than 30 years of experience. The majority had been a member of the society for 5 to 15 years (21 respondents).



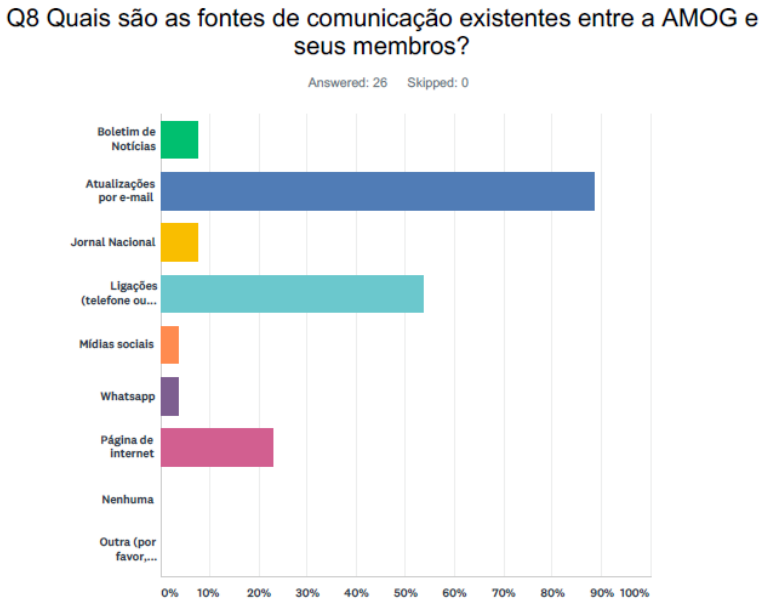
Most of the respondents (54%) felt moderately involved, whilst 31% said they were very involved with the Association, including through regular meetings (50%,) conferences (58%) and trainings (42%). Most respondents attend AMOG activities often (31%) or Sometimes (35%). 77% of respondents indicated to be a member of any other professional body, in most cases being the Medical Council.

3.2.2 Communication between AMOG and its members

A vast majority answered to receive communication of AMOG through mail updates (88%), 54% said that they receive communication through calls, and 23% get information through the internet page of AMOG. Other routes of communication (newsletter, national journal, social media, and WhatsApp) are recognized as such only by a minority of the respondents. Communication is received weekly (31%), or monthly (35%), whilst 12% perceive that the communication is irregular.

46% said communication is acceptable, but can be strengthened, whilst others find it already good (31%), and another 23% of respondents perceive the communication as poor. Comments provided included: "Improve content, greater focus for training"; "Not yet clear how important AMOG is"; "There must be another type of involvement of its members"; "Discuss more and make everyone participate in all events"; "There must be a

fixed medium and a regular frequency where members can inform and update their activities"; "To make communication more frequent and regular"; "AMOG can become more involved in continuing education."



3.2.3 About AMOG' position towards safe abortion

Most respondents answered that AMOG does have a clear position towards safe abortion (92%). Most respondents commented that AMOG is in favor of safe abortion and even considered AMOG a champion in Safe Abortion advocacy. Another comment was included which translates as follows: *"In fact, a large part of society is unaware of safe abortion, hence the existence of a large number of clandestine abortions at least in my workplace. The most informed people have divergent opinions ... some believe it to be a crime, others think it is a way to avoid human complications and losses."*

All respondents indicated to agree with the position of AMOG (87% strongly agree, 13% agree). The vast majority feels informed about the position of AMOG (22/23), mainly through emails, meetings and trainings. 83% also feels that they are well informed by AMOG about new policies and guidelines about abortion (again through the same means – emails – meetings – trainings). Despite this, all respondents feel they would like to receive even more information about themes related to safe abortion.

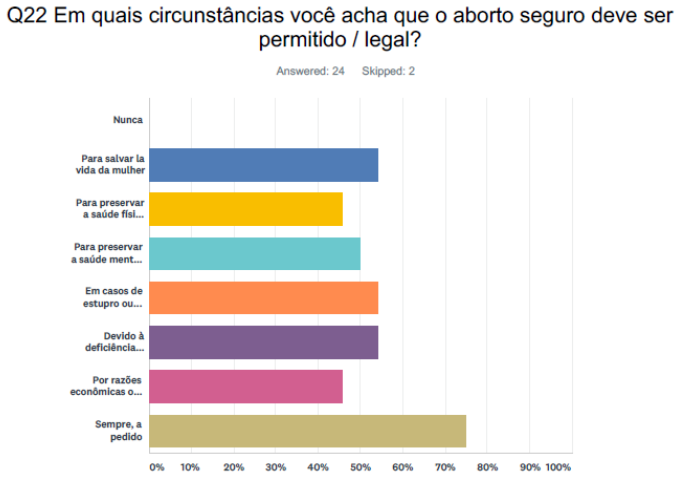
3.2.4 About respondents' position towards safe abortion

There was quite some variety in how informed respondents felt about the following topics:

	Not informed	A little informed	Moderately informed	Informed	Very informed
National laws on abortion:	0%	25%	12.5%	37.5%	25%
International guidelines on safe abortion	8.3%	25%	25%	33.3%	8.3%
National policies on safe abortion	0%	20.8%	25%	29.2%	25%
Practical information related to the practice of safe abortion	0%	17.7%	12.5%	37.5%	33.3%
International guidelines on PAC.	8.3%	20.8%	16.7%	33.3%	20.8%

National policies on PAC	0%	16.7%	12.5%	45.8%	25%
Practical information related to PAC	0%	8.3%	20.8%	45.8%	25%

A majority felt that abortion should always be permitted on request (75%), all other indications were given by about half of the respondents. Nobody answered that abortion should never be permitted.



All respondents agreed with:

- Health workers opposing to perform safe abortion should be obliged to refer women to other health workers that will perform a safe abortion (37.5% agree, 62.5% strongly agree)
- Health workers have role to play as advocates for safe abortion (37.5% agree, 62.5% strongly agree)
- Health workers should be obliged to provide post-abortion care to all women, no matter if the abortion was legal or not (25% agree, 75% strongly agree)

A vast majority of the respondents agreed with the following statements:

- Safe abortion is part of healthcare and should not be separated from the rest of medicine (21% agree, 71% strongly agree)
- Post abortion care is part of healthcare and should not be separated from the rest of health care (29% agree, 67% strongly agree)
- Health workers should have the right to decide whether to perform or not safe abortions according to their personal values and positioning towards abortion (50% agree, 34% strongly agree)

The majority disagreed with:

- Health workers should report to the respective authorities cases with signs of illegal abortion (62% Strongly disagree, 24% disagree)
- Specialized health workers (Obs-Gyn) should be obliged to perform safe abortions in cases where it is permitted by law (33% strongly disagree, 25% disagree)

And all disagreed with:

- Safe abortions should be only performed in private clinics, not in the public health system (96% strongly disagree, 4% disagree)

All respondents said to support AMOG in advocacy for safe abortion.

"I insist on the dissemination of information to the general population. At my place of work, only last year we had 4 maternal deaths due to complications of illegal abortions, namely, perforations, severe anemia and sepsis ... things that could have been avoided if the women had information and felt the will to practice abortion in the Health Unit." – Respondent survey

3.3 Key Informant Interviews (KII)

A total of 15 key informants were interviewed for this assessment. They included representatives from AMOG, The midwifes association of Mozambique, International Centre for Reproductive Health (ICRH) and Rede de Defesa dos Direitos Sexuais e Reprodutivos (DSR) (the SRHR network), Ministry of Health, Pathfinder, Medical Council, the medicine faculty and the association of traditional healers (*Table 2*).

Table 2: Key Informant Interview participants

No.	Association/ Society/Organisation	No of Respondents
1	AMOG	7
2	Midwifes association of Mozambique	1
3	ICRH	1
4	Ministry of Health	1
5	Pathfinder	1
6	Medical Council	1
7	Medicine faculty	1
8	Association of Traditional Healers	1
9	DSR	1
	TOTAL	**15**

Data collected from the key informant interviews were analysed based on the following broad thematic areas:

- Safe abortion environment
- Professional associations' position on safe abortion
- Level of influence on policy change
- Relationship between professional societies
- Personal position on safe abortion
- Obstacles to safe abortion advocacy
- Opportunities for strengthening safe abortion network
- Current role in safe abortion advocacy.

3.3.1 Safe abortion environment

In December 2014 a revised version of the penal code was signed into law, permitting abortion on request and herewith liberalizing the abortion law in Mozambique. All respondents indicated that the safe abortion environment has improved since the law has been changed, but that the implementation is still lagging behind, and the impact of the law change is not yet felt. One respondent (gynaecologist) said that abortion used to be the 3rd or 2nd cause of institutional maternal mortality, now it is the 6th or 7th cause. However another responded said that complications after abortion done in the community, remain the first cause of appointment for gynaecological emergencies. Lack of implementation of the law and guidelines, as well as lack of drugs, medical equipment and need for training and supervision were highlighted by most respondents. Training is ongoing, but none of the respondents could indicate where the training had been materialized or where services are available. Several partners are involved in implementation at provincial level.

Respondents agreed that informing the people is the missing step to be done. Unawareness and lack of information of the population about the law and where to get services.

"Now women, especially young women, students, use very much emergency contraception, which is not very well guided, they just use it and take it, and sometimes they come to hospital with complications. So, information is still the problem, 80% can read something, or the neighbour can read…" (Gynaecologist)

What came up in most interviews was the discrepancy between the coverage and access in rural versus urban areas. Services and misoprostol are being less available in rural areas. None of the respondents could clearly indicate in which of the areas in the country services were actually functional.

Although abortion service should be free of charge, health providers charge for abortion. This confirmed was most respondents, some indicated that the underlying factor is the low salary of health workers. One interviewee indicated: *"women must pay 600 MT/ almost 10 USD."* Consciousness objection and fear of health workers for judgement by the society is another huge barrier to access, as one respondent said: *"Health professionals, we have 50% who are in favour and another 50% are against safe abortion."*

The interviews revealed that women often opt for unsafe abortion because they think it is cheap and more confidential outside of hospital. Auxiliaries, untrained cadres working at health facilities are commonly mentioned as providers of unsafe abortion, but also traditional healers.

Misoprostol is widely used and available at pharmacies (some pharmacists are trained). Cost of misoprostol was indicated to be around 30/35 USD, whilst another respondent said it was 100 Meticas (<2 USD). Most of the interviewees highlighted the fact that the use of misoprostol outside of the health facilities has reduced the severity of the consequences of unsafe abortion. But complications, like heavy bleeding, are still seen if misoprostol is not well used (doses, gestational age). Sepsis, infection, perforation and bleeding or anaemia are mainly seen as consequences, sometimes resulting in the uterus having to be removed or infertility.

One respondent indicated that costs for unsafe abortion varies sometimes by gestational age (eg. 1500 Meticas [25 USD] for 1 month vs. 4000 Meticas [65 USD] for 3 months).

"I attended one girl who was having fever and bleeding and not smelling good. I found a big needle inside the uterus, she was 16, and everything was smelling, I gave medication, luckily I didn't have to remove the uterus.."

"Some of the women, because they don't want to be known, they don't go to the hospital immediately. And when they come late, sometimes you have to remove the uterus and some have infertility after this, some even die."

All respondents agreed that Post Abortion Care is accepted and available in all peripheral health facilities, and it is part of the training curriculum of nurses.

Unsafe abortion providers, don't face many consequences, *"women will never tell who did the abortion."* And there are not many examples of women or abortion providers being prosecuted for unsafe abortion.

3.3.2 Position on safe abortion by different institutions

Ministry of Health agrees with safe abortion and the health minister supports this law and its implementation as safe abortion is going to save lives.

> *"We are the leaders, we have to lead others to implement the policy which was developed here in the health ministry, of course following the orientation of WHO."*

AMOG is in agreement with the current law. They are not in favour of promoting abortion as such, but they see it as a right of the women. They believe in the importance of stopping unsafe abortion and played a big role in getting the current abortion laws in place.

> *"We are not promoting abortion, we promote family planning, but if somebody comes with unwanted pregnancy, we have to help the woman and ensure access to safe abortion. We also have the obligation to promote family planning."*

Pathfinder is actively involved in implementation of the regulations, though training, conferences, and value clarification workshops for safe abortion in Maputo and Matola city.

> *"We as gynaecologists, obstetricians, we want to defend a woman's life, this is our position, that we have to defend life. We cannot allow women dying because of lack of access to safe abortion."*

Midwives association of Mozambique is in favour of the liberal abortion laws and actively addresses the needs, and rights of women to access safe abortion services among the midwifes of the association. This includes addressing consciousness objection.

ICRH agrees with safe abortion (but having challenges with implementation as a result of the Global Gag Rule).

The position of AMETRAMO (traditional healers association) does not allow abortion and it is a taboo among members of the association. They see themselves as "traditionalists" and their cultural believes do not accept abortion. The key informant suggested that some members of the association may know some herbs which can cause abortion, although they would never say that they do so.

3.3.3 Personal position of key informants

All respondents said to be in support of safe abortion, if this is requested by the woman. Almost all respondents did make the emphasis that they would rather not see abortion happening, and surely not as a method of family planning, which was one of the worries highlighted. However, there seems to be an overall agreement that it is important to provide safe abortion services, as the woman will otherwise resort to unsafe options. Several respondents highlighted that they would try to persuade a woman first to keep the pregnancy, and only support if the woman insists.

"We don't promote abortion, we promote health. If a woman is in any danger because of her health situation, and it is her decision, yes, we want to avoid it, we have to help."

"Personally I agree that abortion is not family planning, a life is a life, a life has to be saved. But of course I have to respect when a woman comes to me and says, 'I am not prepared to have this baby, please help me'. If I don't help she is going to ask another [..] for help, and I don't know how he is going to help this woman.. that is why.."

"I think safe abortion must exist. It is not worth bringing into the world an unwanted child because she was been raped, or because it was incest, perhaps for lack of information."

3.3.4 Relationship between professional societies

The DSR network is recognised by most respondents as the key network fighting for improved availability of safe abortion. Being led by local civil society makes the initiative more effective and legitimate. AMOG is a member of the network, and it was perceived by some respondents that their role could be more active within this network.

AMOG and MOH have a good relationship and there is a MOU between them to strengthen SRHR.

3.3.5 Level of influence

Some respondents commented that it is hard to know the level of influence. "*Policy makers will say yes, but at the end of the day nothing happens*."

AMOG was seen by the respondents as a strong advocate, having influenced civil societies and parliamentarians to realize the change in the law and writing guidelines on safe abortion. The DSR network is seen as influential network, with ICRH being highlighted as a strong member (although now compromised by the US government funding constraints). Ipas used to be an active advocate until 2014, since then they are still working in partnership with MOH, but no physical presence in Mozambique. Pathfinder, was seen as influential, giving both financial and technical support to MOH in implementation of the law. AMMCG, a women lawyer's organization, was mentioned by some interviewees, noting they had influence on the development of the current law.

3.3.6 Obstacles for safe abortion advocacy

The Mozambique civil society remains very conservative, mainly motivated by religion or fear, and there is a lot of societal pressure. Mozambique has an inequitable society in terms of gender balance, which is a constraint for the roll out and acceptability of the law.

"A lot of work still needs to be done with community leaders, police before we can speak of a supportive environment. It may take 10 years."

The need for advocacy with health workers and addressing attitudes and consciousness objection was mentioned several times. But also the income for health workers was seen as a challenge.

"Once it is known abortion is free of charge, health facilities will be losing income."

Some respondents felt that nobody is really proactive in advocating, neither from stakeholders who are in favour, nor from those against. The ones opposing safe abortion are not identified as organized groups, but most respondents felt that it is the religious groups that don't accept (Catholics and to a lesser extend Muslims). AMOG was seen as an important advocate, although it was felt that there is still a lack of capacity within the association to advocate, especially due to the lack of funding, but also due to the lack of an executive to focus on advocacy. Additionally the absence of an advocacy strategy and the lack of training in advocacy were mentioned as important barriers for advocacy. Moreover, the lack of data which can be used to advocate and demonstrate the impact of unsafe abortion on maternal mortality was a key issue mentioned frequently.

On major obstacle influencing the financial capacity of programmes funded by the US Government which was felt by many key informants is the withdrawing of funds to programmes working with abortion. USAID is a big donor (support in supervision) pressure. For example, the SRHR focal person from MOH gets her salary from USAID, which means that her ability to advocate for safe abortion is influenced.

3.3.7 Opportunities for strengthening safe abortion network

The current law and policy is a key opportunity for advocacy to implement safe abortion services. Nobody is actively blocking the process, and there are opportunities for funding (eg. IPAS in some provinces). FIGOs potential support for advocacy is also seen as an opportunity. All key informants highlighted that there were opportunities to strengthen the network and expressed openness towards improved collaboration with the various stakeholders. The role of MOH in this network, being supportive of safe abortion was seen as a strong opportunity and it was felt that they should take the lead in training and dissemination of the guidelines. Furthermore, several key informants suggested that activities like organizing value clarification workshops, conferences and training activities on safe abortion are possible opportune platforms for advocacy.

3.3.8 Current role in safe abortion advocacy.

AMOG, as a member of the DSR network has been heavily involved in lobbying for safe abortion and to get the current law (a lot was done in the 90's). Interviewees overall agreed that AMOG's current role as abortion advocates remains of importance, but could be strengthened (as highlighted in the challenges section above).

Gynaecologists mainly felt that it is their role to continue to provide services and organize meetings, but it was also felt by some of the members, that AMOG members could be trained better to improve capacity for advocacy on safe abortion. Some AMOG members emphasised that they play an important role as a clinician in rolling out and implementing the abortion policy.

> *"My role is to protect the patients, and to guarantee that abortion will not be a threat for her life. I am not in a position to judge…"*

Various respondents said that the role of the media is very limited, abortion is not openly talked about.

DSR plays the most active role currently, producing a guide on abortion, for activists, giving a friendlier format to the law, preparing an abortion awareness campaign, and a theatrical play, which will be recorded on video and play in the local languages, and they are currently producing a video with witness testimonies about safe abortion. On the international day of safe abortion September 28 they made a video, to do advocacy on safe abortion.

3.4 Stakeholder workshop

During the two day workshop key challenges to ensuring a safe abortion environment for women in Mozambique were identified, and what role AMOG can play as advocates for safe abortion.

Themes highlighted as key issues to be considered by AMOG in the way forward include; **1) effective dissemination and implementation of the abortion law as well as the policies and guidelines, 2) transformation of social norms at community level, 3) improved partnerships and communication – network strengthening, 4) generation and use of data, and 5) strengthening the capacity of AMOG to be effective advocates.** See annex 6 for a summary of the main points identified, leading up to the development of the action plan.

Regarding the suggested working definitions for safe, less safe, least safe and unsafe abortion, the participants felt that, whilst the classification of less safe abortion is very applicable in Mozambique with the common use of Misoprostol given by non-registered practitioners, this is not appropriate to consider introducing in Mozambique at this point in time, as the laws have only just changed, and don't acknowledge these classifications.

Another concern raised was the communication about the definition of abortion as described in the clinical norms of Mozambique up to 28 weeks. This could indeed be medically justified, and should remain as such in the clinical norms, but the participants agreed that it is important to ensure careful communication about this cut off age to the general population. Especially considering the frequency of unsafe abortion, Misoprostol might be used in informal setting for women of higher gestational age, putting the woman at a high risk of complications.

3.4.1 Social Networks

During group work social networks for safe abortion were identified. Annex 4 provides a summary of allies and networks where potential allies could be found. This should be seen as a dynamic table. Along the way new allies can be identified and potential allies can move. Participants also identified important stakeholders who they did not consider as allies for advocacy, but who are key in supporting the advocacy network, or who are important stakeholders to address advocacy efforts to.

3.4.2 Strengths, Weaknesses, Opportunities and Threats

The main outcomes of the SWOT analysis can be found in Annex 5.

3.4.3 Action plan

As a final exercise, groups started on defining objectives and activities for an action plan on safe abortion advocacy. The action plan has the overall objective to improve the capacity of AMOG on abortion advocacy to then, ultimately, increase the access to safe abortion and reduce morbidity and mortality as a result of unsafe abortion. Activities should serve to reach the objectives and will include the different advocacy levels and social networks addressed during the workshop.

After the stakeholder workshop the consultancy team continued to develop the action plan, including deliverables. The action plan will continue to be developed in consultation with AMOG and FIGO.

A preliminary action plan can be found in Annex 6.

4. Conclusions

The literature review, the key informant interviews and the workshop confirmed that despite the liberal abortion laws which came into effect at the end of 2014, unsafe abortion and its complications remains a major problem in Mozambique, endangering the lives of many women. Although the legal framework provides for abortion on request of the woman, the implementation of the law lags behind, with as a result, many women still reverting to unsafe abortion in Mozambique.

The main challenges highlighted by this study on which safe abortion advocacy should focus in Mozambique include the following:

Lack of awareness about the law, by the general population as well as by service providers. There is little communication about the new law and women are ill informed about their rights to safe abortion, or where to find the services.

Lack of implementation of the law, the policies and guidelines. Training of health care providers is ongoing, but there seems to be a lack of overview of which facilities are actually providing the services and have received the training. There is a need for monitoring and supervision and there seems to be a lack of equipment to provide safe abortion. Although Misoprostol is widely available in pharmacies, this is not always the case (in sufficient quantities) at the health facilities where safe abortion services ought to be available. Access at **rural areas** seems to be more of a concern compared to access in cities.

Availability of free, accessible and acceptable safe abortion services remains a key challenge, besides the technical implementation of the services, the **social norms and attitudes of health care providers** still remain a major barrier, with **consciousness objection** of health providers at the one hand, and health providers seemingly receiving an additional income by **charging for abortion** services on the other hand.

Social and gender norms and the patriarchal society, constitutes to a lack of agency of women, and keeps stigma related to unwanted pregnancy and abortion alive and form major barriers for access to safe abortion.

Lack of access to family planning is an important underlying issue and a major determinant of unwanted pregnancy, which needs to be considered in a comprehensive advocacy approach.

Lack of reliable data from health facilities and research is a concern, as the real extend of the problem is actually not really known, especially in the rural areas. Where data is available, this is often not shared and distributed well.

The capacity of AMOG in terms of time and resources could be strengthened to reinforce their key position as expert advocates for safe abortion, engaging in dialogue with the general population, ministry of health at various levels, including, health care providers, the media and other stakeholders.

5. Recommendations for future program

Building its base as a safe abortion advocate, the society will require to address the various and potential challenges as were identified during the key informant interviews and the two day's workshop. This could include the following:

- Ensuring effective dissemination and implementation of the abortion law as well as the policies and guidelines
- Ensuring awareness of the laws and safe abortion services
- Transformation of social norms at community level and with health providers
- Strengthening the safe abortion advocacy network, through improved partnerships and communication
- Ensuring evidence for action and advocacy is gathered through systematic generation and use of data
- Strengthening the capacity of AMOG to be effective advocates for safe abortion access for women in Mozambique

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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 on day 2 we had to finish early, some components were skipped (including the session on power)

Time	Content	Facilitator
Day 1		
8.30– 9.10	Introduction: Welcome and prayers Getting to know each other, expectations, purpose, objectives, agenda, facilitator's participant roles, group norms, evaluation process, housekeeping	Dr. Nafissa Osman Bianca/Arsénia
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	Arsénia
10.20-10.35	**Break**	
10.35 -11.00	Presentation and discussion results of group work dialogues	Arsénia / Bianca
11.00-11.30	Implications of national abortion laws on access to safe abortion.	Arsénia / Bianca
11.30-12.30	Share positions and personal beliefs and discuss professional responsibilities	Arsénia / Bianca
12.30-13.30	Lunch	
13.30-14.00	What is advocacy: concept, levels and challenges	Arsénia / Bianca
14.00 -14.30	Advocacy perspective, risks and benefits in advocacy	Arsénia / Bianca
14.30-15.00	Roles in advocacy	Arsénia / Bianca
15.00-15.15	Break	
15.15 -15.45	Roles in advocacy continued	Arsénia / Bianca
16.45-16.15	Advocate for safe abortion care	Arsénia / Bianca
16.15- 17.10	Social networks and reaching different audiences	Arsénia / Bianca
17.15 –17.30	Evaluation of the day	Everybody
Day 2		
8.30-9.00	Welcome Recap of day 1 by 2 volunteer participants identified day before	Two volunteers
9.00-9.30	Address parked issues	Arsénia / Bianca
9.30 – 10.00	Presentation of achievements weaknesses barriers and opportunities of abortion project	Dr. Momade Usta
10.00-10.30	Break	
10.30-11.30	strengths, weaknesses, opportunities and threats of the national society for abortion advocacy	Arsénia / Bianca
11.30-12.30	Develop an action plan for abortion advocacy in small groups	Eulalia/Arsénia/Bianca
12.30-13.30	Lunch	
13.30-14.45	Continue develop action plan	
14.45-15.00	Break	
15.00-16.00	Presentation and discussion action plans in plenary	Arsénia / Bianca
16.00-16.30	Evaluation and goodbye	Arsénia / Bianca

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. Dr. Nafissa opened the day and welcomed the participants on behalf of AMOG.
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.
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 AMOG.
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
- 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

Participants

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22	Sally Griffin (day 1) Joelma Joaquim Picardo (day 2)	j.joaquim@icrhm.org.mz	ICRH (International Centre of Reproductive Health)

Annex 2 Women's perceptions and experiences of unsafe abortion

Source: Frederico et al, 2018

Quotes from women about factors influencing their decision for abortion following an unwanted pregnancy:

"(It) was at the time that I was taking pills that I got pregnant, and I induced abortion because I was not prepared (for motherhood)." (24 years)

"Maybe I would be abandoned and it would be the same. (Sigh)... I learned with my first pregnancy." (23 years)

"I got pregnant when I was 20, and I had a baby. When I became pregnant again, my daughter was a child, and I could not have another child." (23 years)

"He said that he recognizes the paternity, but it is not to keep that pregnancy." (22 years)

"I am staying at Mom's house; it is not okay to still be having babies there." (23 years)

"At home, we do not have any resources to take care of this child!" (20 years)

Quotes from women about factors influencing their decision for abortion following a desired pregnancy:

"They (parents) decided while I was at school. If (it) was my decision I would keep it because I wanted it." (18 years).

"Because my son's father did not accept the (second) pregnancy. There was a time, we argued with each other, and we terminated the relationship. Later, we started dating again, and I got pregnant. He said it was not possible." (21 years)

"I talked to him, and he said okay we are going to have an abortion and I accepted." (22 years)

"I told him I was pregnant. First, he said to keep it. (Next) He was different. Sometimes he was calling me, and other times not. I understood that he did not want me." (20 years)

"So I went to talk with my older sister, and she said eee, you must abort because daddy will kick you out of our home." (20 years)

"As I am an orphan, and I live with my uncle, they were going to kick me out. No one would assist me." (20 years)

"He (the father of the child) came to my house and took me back to his house. It was that moment when I aborted." (21 years)

Influence of decision making for place of abortion

"I went to talk to her (friend), and she said that "I have an aunt who works at the hospital, she can help you. Just take money"." (20 years)

"I Already knew who could induce it (abortion). No, I knew that person. I went to the hospital, and I talked to her, (and) she helped me." (22 years)

"She (mother) was the one who accompanied me. She is the one who knows the doctor. We went to the central hospital, but he (the doctor) was very busy, and he told us to go to his house." (17 years)

"I heard that to induce abortion at the hospital it is necessary for an adult to sign a consent form. I was afraid because I did not know who could accompany me. Because at that time I only wanted to hide it from others." (22 years).

"The abortion was done here at home. They just went to the pharmacy, bought pills and gave them to me." (18 years)

About payment:

"First we got there and talked to a servant (a helper of the hospital). The servant asked for money for a refreshment so he could talk to a doctor. After we spoke (with servant), he went to the doctor, and the doctor came, and we arranged everything with him." (22 years)

"We went to the health center, and we talked to those doctors or nurses I mean, they said that they could provide that service. It was 1200 mt (17.1 euros), and they were going to deal with everything. They did not give us the chance to sign a document and follow those procedures." (20 years)

Annex 3 Overview of outcome online survey

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

Annex 4 Social Networks

Allies already actively advocating for safe abortion (= DSR members)	Potential Allies to advocate together with AMOG for safe abortion	Stakeholders not necessarily becoming allies in safe abortion advocacy, but important to engage with (including donors)
DSR	Teacher's organization	MISAU (national, provincial, district)
WLSA	Prof. org. midwifes	FIGO
Pathfinder	University student organizations	UNFPA
DKT	Nat. journalist org.	Ipas
Women's forum	Traditional healers	IPPF
AAMCJ	Traditional midwifes	Pharmacists association
HOPEM	Youth organizations	Pharmaceutical supply companies
APARMO (midwifes society)	Female organizations	Ministry of gender and social action
Horizonte Azul	CBO's	Ministry of Education
ICRW	Neighborhood secretaries	Ministry of Justice and police
Coalizao'	Office of first lady	Ministry of Inferior
Nweti,	Office of wife/husband governor	Ministry of youth
AMODEFA	Mozambique org. of jurists	Civil Society (those who are already allies MISAU)
Muleide		Religious leaders
Lambda		

Annex 5 SWOT analysis

SWOT analysis of national society capacity for safe abortion advocacy	
Strengths • Strong at mentoring • Technical capacity for safe abortion • AMOG is a group of experts of the subject good at training providers – resulting in quality of the service • Wealth of information • Strong experience within the association, among members • Research capacity - many researchers among the group	**Weaknesses** • Financial resources • Training and advocacy (we need a training) • Follow up of training – really weak. • Communication not always strong/frequent • Difficulties to deal with media and lack of good communication between AMOG and media • AMOG has no power in the health unit where services are provided. AMOG cannot impose (MOH and AMOG to join efforts?) (implementation of MOU between AMOG and MOH)
Opportunities • Make the information public (use media - TV, meetings, churches) • Use adolescents and youth for advocacy • We could associate with other groups in the civil society, to assist with dissemination of the message • We are expert in the field and can use the media to make info available. It is an opportunity to have good relations with the media. • Updating of members of AMOG – Training them more – they can share info with communities. • Improve relationships with partners – especially SRHR partners. • AMOG to be more proactive • Disseminate info within and outside health system. AMOG members should disseminate the message at all levels, even within our own health unit. (no money needed). Then also spread to women's organization. Female leagues	**Threats** • Religious groups/ leaders opposing abortion • Opponents have strong capacity in mobilizing the population • Opponents have strong capacity in sensitizing because of influence of the church • Lack of publication of information – use of protocols is very weak (protocols are in the room but not used/ • Coordination and communication between MOH/AMOG • Traditional healers often first point of contact • Conscientious objection • Availability of misoprostol in health facilities (easy accessible to use outside facility for unsafe abortion)

Annex 6 Country action plan

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

The key points discussed which formed a basis for the action plan include:

1. **Laws, policies implementation:**

- Laws and policies are written, but not known, used or implemented by health professionals, as the communication about the adjusted laws and policies, and the implementation of it is lagging behind
- The adjusted abortion law and policy, is that it is not defining at which level of health facility abortion can be provided.
- Lack of information by the public. The interpretation of the abortion law and relevant documents, by the general public is a delicate issue and needs to be guided with care

Identified needs for improvement

- Lobby with MOH for improved dissemination of information of the laws and policies both among service providers as well as with the general public
- Clarifications of the above

2. **Services and guidelines implementation:**

- Guidelines are printed but not in use – training ongoing
- Lack of readiness of health facilities to provide quality safe abortion care (especially in rural areas – lack of mapping)
- Financial constraints to implement (global GAG rule) and low salaries of health providers, who charge for safe abortion, whilst it should actually be free of charge (including referral without additional cost)

Identified needs for improvement

- Going to the hospitals to communicate about the abortion law and its implications.
- Clarify who can carry out safe abortion and at what level of the health facility

3. **Social norms:**

- Contributing factors to the demand for safe abortion and the barriers to access:
  - Unintended pregnancy
  - Access to and use of contraception
  - Sexual and Gender Based Violence (SGBV)
  - Stigma within the community and by health professionals – and conscientious objection
- Adolescents seen frequently with request for abortion or post abortion care
  - Sexual education for boys and girls (done by teachers in schools, focus on biological aspects, not comprehensive) and parent – teen communication often weak

Identified needs for improvement

- Manage public perceptions and provide information on where services are available

4. **Partnership – network**

- Strong opponents (religious groups and leaders)
- UNFPA and WHO support the government position towards safe abortion, and give technical guidance, but there seems to be room for improved partnership between UN agencies, MOH and AMOG.

Identified needs for improvement

- Engage with AMOG members, media, SRHR partners, civil society, adolescents and youth for advocacy and strengthen the partnership with MOH and UN agencies.

5. Data

- Lack of systematic collection of data and research, as well as use of data for advocacy

Identified needs for improvement

- Advocate for generation and better use of data

6. AMOG capacity as advocates

- AMOG commented on, and influenced the development of the new abortion law (within DSR network)

But, lack of skills and training on advocacy, communication with other stakeholders, including the media and low influence of AMOG on MOH.

Identified needs for improvement

- Train AMOG members on publicly speaking about abortion and be strengthened in influencing others
- Use of different tools for advocacy: Educational material, audio-visual, cartoons, dialogue, TV, church meetings.