

COMPREHENSIVE ABORTION CARE NEEDS AND OPPORTUNITIES IN FRANCOPHONE WEST AFRICA: **SITUATIONAL ASSESSMENT RESULTS**



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Abbreviations / Acronyms

ABBEF	Association Burkinabé de Bien-Etre Familial (Local IPPF affiliate)
ABPF	Association Béninoise pour la Promotion de la Famille (Local IPPF affiliate)
ABSF	Association Béninoise des Sages-Femmes (Benin Association of Midwives)
AFD	Agence Française de Développement (French Development Agency)
ARECA	Alliance pour la Recherche et le Renforcement des Capacités (Research Alliance and Capacity Building)
ATBEF	Association Togolaise pour le Bien Etre Familial (Local IPPF affiliate)
AWARE – II	Action for West African Region-II
CAC	Comprehensive Abortion Care
CAMEG	Central d'Achat des Médicaments Essentiels et Génériques et des Consommables médicaux (Benin's central government pharmaceutical procurement agency)
CARE	Cooperative for Assistance and Relief Everywhere
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CFA	Communauté Financière Africaine (currency used by the African Financial Community)
CHR	Centres Hospitaliers Régionaux (Regional Hospital Centers)
CHU	Centre Hospitalier Universitaire (University Hospital Center)
CMA	Chirurgical Medical Antenna
CPR	Contraceptive Prevalence Rate
CSPS	Centre de Santé et de Promotion Sociale (Health Center and Social Promotion)
DASPAJ	Direction de la Santé des Adolescents, des Jeunes et des Personnes Agées / Directorate of Adolescent Health, Youth and the Elderly
DELIVER	USAID-funded project to increase the availability of essential health supplies to clients and customers around the world
DGPS	Direction Générale de la Protection Sanitaire (Directorate General of Health Protection)
DHS	Demographic Health Survey

DSC	Direction de la Santé Communautaire (Community Health Directorate)
DSME	Direction de la Santé de la Mère et de L'Enfant (Directorate of Maternal and Child Health)
EmONC	Emergency Obstetric and Neo-Natal Care
ENSP	Ecole Nationale de Santé Publique (National School of Public Health)
Evidence2Action	USAID's global flagship for strengthening family planning and reproductive health service delivery
FCI	Family Care International
GIZ	German federal enterprise for international cooperation
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
ICEC	International Consortium for Emergency Contraception
ICPD	International Conference on Population and Development
IPPF- AR	International Planned Parenthood Federation – African Region
IVG	Interruption Volontaire de Grossesse (Voluntary Pregnancy Termination)
IWHC	International Women's Health Coalition
Jhpiego	International non-profit health organization affiliated with Johns Hopkins University
KfW	German government-owned development bank
MA	Medical Abortion
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Surveys
MOH	Ministry of Health
MSI	Marie Stopes International (Non- Governmental Organization)
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organization
OASIS	Organizing to Advance Solutions in the Sahel
PAC	Postabortion Care
PCCA	Projet de Prise en Charge Complete de l'Avortement (Complete Abortion Care Project)
PNDS	Plan National de Development Sanitaire (National Health Development Plan)

PNIC	Politique Nationale des Interventions à Base Communautaire (National Policy for Community-Based Interventions – Government of Togo)
PNP	Politics, Norms and Protocols
PNS	Politique Nationale de Santé / National Health Policy
PNSR	Programme National de Santé de Reproduction (Bénin's National Reproductive Health Program)
PRB	Population Reference Bureau
PSI	Population Services International
RH	Reproductive Health
ROSCI – SR-PF	Réseau des Organisations de la Société Civile en Sante de la Reproduction – Planification Familiale (Network of Civil Society Organizations in Reproductive Health and Family Planning)
SCADD	Strategy for Accelerated and Sustainable Development
SGOBT	Société de Gynécologie et d'Obstétrique du Bénin et du Togo (Gynecology and Obstetrics Society of Benin and Togo)
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCAT	Values Clarification and Attitude Transformation
VIES	Vision, Initiatives et Engagement pour la Santé (Vision, Initiatives and Commitment for Health)
WHO	World Health Organization
WiLDA	Women in Law and Development Africa

Executive Summary

Introduction

Unsafe abortion presents a global health challenge that leads to approximately 47,000 deaths,¹ and disabilities for an additional five million women each year. The West Africa region bears the largest burden. The World Health Organization (WHO) estimates that more than 1.8 million unsafe abortions are carried out in West Africa annually, with a case-fatality rate of 540 deaths per 100,000 abortions—by far the highest in the world. In particular, the francophone countries in West Africa have been overlooked, as donors and development partners have tended to focus more on English-speaking countries. Abortion-related efforts in francophone West African countries have mostly focused on postabortion care (PAC), a strategy to treat complications of incomplete and unsafe abortions already underway, but very few have directly addressed the provision of safe, induced abortion.

Ipas's woman-centered, comprehensive abortion care (CAC) model is an approach to service delivery that emphasizes rights, choice, access and quality.² The model focuses on women's individual physical and emotional health needs and circumstances and ability to access care. It includes safe, induced abortion; treatment of incomplete, missed or unsafe abortion (also called postabortion care or PAC); compassionate counseling; contraceptive services; related sexual and reproductive health services provided onsite or via referrals to accessible facilities; and community-service provider partnerships. It also includes a range of health services that help women exercise their sexual and reproductive rights and ensures services for young and unmarried women.

Ipas is working in collaboration with international and in-country agencies to assess needs and opportunities, strengthen partnerships, prioritize strategies, solidify commitments and mobilize support to move beyond PAC and implement comprehensive contraceptive and abortion care in francophone West Africa. To understand more about CAC needs and opportunities in francophone West Africa, Ipas conducted a situational assessment in March-May, 2015.

As a first step in the situational analysis, Ipas conducted a high-level environmental scan of Benin, Burkina Faso, Cameroon, Guinea, Ivory Coast, Mali, Niger, Senegal and Togo. The focus was then narrowed to Benin, Burkina Faso, Senegal and Togo, based on indications of positive movement and an increasingly enabling environment for CAC. Detailed desk reviews were conducted for each of these four countries, and in-country visits were conducted in Benin and Togo. Two Ipas researchers, in partnership with the Ministry of Health Family Health Division and other agencies, conducted key-informant interviews with government officials, health-care providers, lawyers and civil society leaders to better understand the current state of abortion policy, research and services and opportunities for expanding delivery of and access to CAC. Focus group discussions were conducted to understand some women's perspectives on abortion, and mystery client visits were carried out in pharmacies to assess provision of and access to misoprostol for abortion-related care.

Regional findings

The situational assessment demonstrated that, despite formidable barriers, there are some promising avenues for implementing CAC throughout francophone West Africa. All countries included in the assessment have ratified a number of international treaties that promote women's rights, including the Maputo Protocol, which explicitly includes a provision for safe and legal abortion. Most countries have

legal provisions for abortion, such as to protect the life and health of the woman or in case of rape. In most cases, the legal conditions have not been translated into actual services for women.

Health systems challenges such as a lack of service delivery guidelines and trained providers affect countries' ability to offer high-quality, comprehensive abortion care. Physicians and specialists are often clustered in urban areas. Most rural women will see midlevel providers and, sometimes, providers with no formal training at all. High out-of-pocket costs for care present a major barrier to women seeking high-quality abortion care as well as those needing appropriate treatment for abortion complications. Lack of equipment and medicines also present a challenge, as manual vacuum aspiration (MVA) and misoprostol are often not present in health facilities.

Misoprostol is becoming increasingly available, having been registered and included on the national essential drug lists of several countries in the past decade, but access to it often remains restricted by prescription requirements and lack of widespread knowledge about it. Knowledge of misoprostol remains concentrated among young, urban and well-educated women, with many other West African women not knowing to seek misoprostol or how to use it. Mifepristone is part of a few small pilot programs but is not registered or on the essential drug list of any country included in this analysis.

There is an overall paucity of research on abortion in the region, with the existing studies focusing on a few countries, leaving others with a stark lack of data to help describe abortion magnitude, incidence, service delivery and context. Of the four countries for which desk reviews were conducted, Senegal and Burkina Faso both had several recent, high-quality, peer-reviewed studies on abortion indexed in PubMed, while Benin had only one, and Togo had none.

Benin

Abortion is legal in Benin to preserve the life or health of the woman, in the case of severe fetal abnormality and in the case of rape or incest. The 2003 reproductive health law that describes these conditions does not limit provision to specific providers. However, the provisions for implementation, or *textes d'application* in French, the legal procedure necessary for the law to be properly interpreted and implemented, have never been written. The Ministry of Health issued *Safe Abortion in Benin: Standards and Guidelines* in 2011, which includes language on women's rights and safe abortion service delivery guidance. The document specifies that pregnancies up to 12 weeks of gestation can be terminated in any establishment that has a gynecologic service with sufficient technical ability to handle complications.³ Yet, this progressive document was never fully disseminated and remains poorly known throughout the health system.

Little research has been conducted on abortion in Benin, but the Ministry of Health estimates that abortion is responsible for 15 percent of maternal deaths in the country.⁴ There have been no studies of abortion magnitude in Benin since 1997. New research on abortion incidence, services, attitudes and social factors is needed to inform advocacy and programmatic interventions.

Benin suffers from a lack of trained providers, with only 23 percent of the population covered by access to emergency obstetric and neonatal care (EmONC).⁵ PAC is designated a "best practice" by the Ministry of Health to reduce maternal mortality, but PAC has yet to be scaled nationwide.

There are some strong and passionate champions for abortion access in Benin, but there remain important challenges to CAC provision, including uncertain political will and opposition from religious organizations, in addition to health systems challenges to high-quality service provision.

Burkina Faso

Abortion is legal in Burkina Faso to preserve the life and health of the woman, in case of grave fetal abnormality, or in case of rape or incest. The penal code and a 2005 reproductive health law specify that two doctors must attest to the necessity of a therapeutic abortion, while a state prosecutor must establish cause in the case of a rape.

The Ministry of Health says that more than one quarter of all maternal deaths in Burkina Faso are attributable to unsafe abortion—an extremely high proportion, especially compared to the global rate of 13 percent. Data from a recent study show that 105,000 abortions took place in Burkina Faso in 2012, with approximately 50 percent resulting in complications.⁶

Provider stigma and fear of prosecution were major barriers for women seeking care, leading to 41 percent of all abortions being carried out by traditional practitioners, 23 percent by women themselves, 25 percent by midwives and health assistants and only three percent by doctors.

A committed group has been advocating for safe abortion in Burkina Faso, but most of civil society has yet to focus on abortion. Very few of the nongovernmental organizations (NGOs) in the country, with the exception of L'Association Burkinabè pour le Bien-Être Familial (ABBEF), the local International Planned Parenthood Federation (IPPF) affiliate, and a few others, have directly addressed abortion. Most focus on promoting family planning and postabortion care, which are considered less controversial. Recently, a group of civil society and NGO leaders began meeting to organize activities to increase abortion access. They held a meeting in July 2015 to create a work plan for future activities. In 2008, ABBEF began a program called Complete Abortion Care, or PCCA by its French acronym, that includes the provision of misoprostol, MVA and Medabon (a combination of misoprostol and mifepristone) to clients seeking CAC. Marie Stopes International (MSI) offers clinical services in Burkina Faso and began marketing its brand of misoprostol, called Misoclear, in 2013.

Senegal

Although a reproductive health law was passed in 2005, it did not change the abortion law, which only permits abortion when three physicians agree that an abortion is necessary to save the life of the woman. The Ministry of Health's Division of Reproductive Health would like to see expanded legal indications for abortion and has created a multidisciplinary task force to draft new legislation and advocate for its adoption.

More than 51,000 abortions a year take place in Senegal, with more than half resulting in complications.⁷ Access to CAC is severely restricted. The Ministry of Health is trying to scale up PAC services throughout the country. PAC is not available at all levels of the health system, and access remains a problem at lower-level facilities due to lack of trained providers, lack of proper equipment and other challenges. Several concerted efforts at PAC scale-up have been made in recent years, making Senegal a model for PAC provision in the region. MVA and misoprostol are included in national norms and protocols for the treatment of incomplete abortion.

Strong religious and moral objections to abortion by conservative religious groups pose a challenge to liberalizing abortion laws and policies, but Senegal's active women's organizations, vibrant civil society, and strong health leadership are all strengths in the movement to increase access to CAC.

Togo

The 2007 reproductive health law authorizes abortion to protect the life and health of the woman, when the pregnancy is the result of rape or incest, and in the case of a severe fetal abnormality. Article 42 of the law says that all abortions must be prescribed by a doctor—a big obstacle in a country where there are fewer than 400 doctors.⁸ The law is not well known, and the provisions for implementation (*textes d'application*) have never been issued, leaving providers reluctant to perform abortions, even under legal conditions. In the absence of these texts, some barriers have been added to abortion provision that do not exist in the language of the law, such as requiring police involvement in the case of rape.

Research on abortion in Togo is scarce, but the methodologically-flawed 2010 Multiple Indicator Cluster Surveys (MICS) shows that nine percent of women aged 15-49 have experienced an induced abortion in their life⁹, with abortion more common among young people, women with some education, and women who live in wealthier households. In 2012, the number of abortions recorded in Togo's maternal health services was estimated at 6,976, of which 1,756 were estimated to have been induced versus spontaneous. Among these, 1,881 women were hospitalized, making abortion one of the primary reasons for hospitalization in the country.¹⁰

PAC was introduced in Togo in 2006, but its implementation is scattered and incomplete. Current PAC protocols include surgical methods but not misoprostol. Lack of trained providers makes PAC difficult to access in rural areas. CAC is essentially nonexistent in Togo, with no respondents reporting knowledge of its systematic provision in any health facility. When a pregnancy threatens a woman's health or life, she must find a way to access a doctor, as midwives and other provider cadres are neither trained nor permitted to induce abortion. Misoprostol was found to be out of stock in all pharmacies visited by an Ipas-commissioned mystery client, including at a main teaching hospital in the capital city. Knowledge of misoprostol among women is low; they instead use plants, bleach and other improvised methods to self-induce abortion.

Civil society and community engagement around abortion also is low. Comprehensive abortion care has yet to be incorporated into the reproductive health agenda in Togo.

Recommendations

Based on the situational assessment findings, the following actions are recommended:

- Engage with governments to increase their commitment to implementing comprehensive abortion care to the fullest extent possible.
- Engage with donors to increase their support for abortion care programs in francophone West African countries.
- Promote understanding of the local abortion law and legislative and ministry of health processes for implementing the existing law.
- Support the development, endorsement and implementation of provisions for implementation ("textes d'application") and development of standards and guidelines, integrated with other reproductive health guidelines, so that existing abortion and related reproductive health laws and policies can be fully implemented. In Benin specifically, the 2011 abortion standards and

guidelines document needs to be revised, adopted and fully disseminated to health systems officials, managers and providers.

- Partner with local organizations to conduct education on and dissemination of the abortion law, policies and standards and guidelines, so that providers, women and other stakeholders are aware of the legal conditions, service delivery guidance and women's right to comprehensive abortion care.
- Implement abortion values clarification and attitude transformation (VCAT) interventions to improve stakeholders' knowledge, attitudes and support for increased delivery of and access to comprehensive abortion care.
- Partner with local organizations to support local champions and cultivate new advocates to increase awareness of and support for CAC and hold the government accountable for ensuring delivery of and access to quality CAC.
- Support efforts to scale up CAC, and continue to scale up PAC, to all levels of the health system to ensure access to care for all women, and in a way that is integrated within broader sexual and reproductive health programs.
- Ensure that mechanisms for a sustainable supply of commodities and equipment are in place.
- Promote awareness of and access to quality mifepristone and misoprostol, through education and regulatory and distribution interventions, and ensure women's choice of uterine evacuation method whenever possible.
- In collaboration with in-country and international research partners and institutions, prioritize areas for further abortion research, including abortion magnitude and incidence studies, participatory research on abortion stigma, operations research on existing services and other topics to support advocacy efforts and program design.
- Connect key actors in francophone West African countries with colleagues in other countries to learn from their experiences successfully implementing CAC programs.

While cultural, religious and political opposition to CAC remains strong in some settings, there are clear and promising opportunities to expand comprehensive abortion services to the women in francophone West Africa who need them and are entitled to them by law.

Introduction

Globally, an estimated 21.6 million unsafe abortions occur each year, accounting for 13 percent of all maternal deaths.⁹ This leads to approximately 47,000 deaths, and disabilities for an additional five million women each year. A recent study found that, when practiced safely, abortion is about as safe as an outpatient dental procedure, with a case-fatality rate well below 1/100,000 abortions.¹⁰ And yet, legal, policy and programmatic restrictions on abortion drive the practice underground in many places, and the case-fatality rate increases to 220/100,000 abortions.⁹ The West Africa region bears the largest burden; the World Health Organization (WHO) estimates that more than 1.8 million unsafe abortions are carried out there annually, resulting in some 9,700 maternal deaths and a case-fatality rate of 540 deaths per 100,000 abortions, by far the highest in the world.⁹ Girls and women in francophone West Africa are among the world's most disadvantaged in their lack of access to contraceptives and comprehensive abortion care (CAC).

In particular, the francophone countries in West Africa have been overlooked by donors and development partners, who have tended to focus more on English-speaking countries. Understanding that unsafe abortion poses a high risk to women's health, efforts in francophone West African countries have mostly focused on postabortion care (PAC), a strategy to treat complications of incomplete and unsafe abortions,¹¹ but very few have directly addressed induced abortion. A great number of programs have been aimed at scaling up postabortion care (PAC) in the region.^{12,13} But while many programs have focused on PAC only, very little attention has been paid to improving women's access to safe, high-quality comprehensive abortion care (CAC), which would mostly eliminate the need for PAC.¹⁴

Ipas's woman-centered, comprehensive abortion care (CAC) model is an approach to service delivery that emphasizes rights, choice, access and quality. It takes into account women's individual physical and emotional health needs and circumstances and ability to access care and includes induced abortion; treatment of incomplete, missed or unsafe abortion (also called postabortion care or PAC); compassionate counseling; contraceptive services; related sexual and reproductive health services provided on site or via referral to accessible facilities; and community-service provider partnerships.¹⁴ It also includes a range of health services that help women exercise their sexual and reproductive rights and ensures services for young and unmarried women.

Although a few studies have been conducted in Burkina Faso, Cameroon, Ivory Coast and Senegal that shed light on the scope of the problems posed by unsafe abortion,^{12,13,15,16,17} reliable data on abortion are particularly difficult to obtain in francophone West Africa, where abortion remains highly stigmatized and is often practiced clandestinely. There is a vast unmet need for CAC, including contraceptive services, in francophone West Africa, where approximately three women die from maternal causes every hour.¹⁴ WHO reports that about half of maternal deaths worldwide occur in sub-Saharan Africa, where one in every 31 women risks dying from complications of pregnancy and childbirth during her lifetime.¹⁸ Access to reliable contraceptive methods could help women reduce unwanted pregnancies. According to a 2011 analysis for the Population Reference Bureau in nine francophone West African countries, 28 percent of married women of reproductive age want to avoid pregnancy but are not using any method of contraception—one of the highest rates of any region globally. Women in these nine countries average 5.5 births per woman, double that of women in Asia and more than three times that of women in Europe.

The population of West African countries is projected to double in 25 years. Young people aged 10-24 are currently the majority of the population.¹⁴

Ipas is renewing its focus on the francophone West Africa region because, when we review progress on the Millennium Development Goals (MDGs), these countries are lagging behind on maternal mortality reduction and other reproductive health indicators. From January 2015 through June 2016, Ipas is working in collaboration with international and in-country agencies to assess needs and opportunities, strengthen partnerships, prioritize strategies, solidify commitments and mobilize support to move beyond PAC and implement comprehensive contraceptive and abortion care in francophone West Africa. To understand more about the needs and opportunities for comprehensive abortion care in francophone West Africa, Ipas conducted a situational assessment in March-June, 2015.

The aims of the in-country situational assessments were to help Ipas better understand the specific needs, challenges and opportunities for comprehensive abortion care in Benin and Togo.

The specific situational assessment objectives were to:

- 1) Understand the broad sexual and reproductive health and rights context of these countries, including relevant policies, as well as the organization and functioning of health systems and community-level structures.
- 2) Assess the current need for comprehensive abortion care from the perspectives of women, the Ministry of Health and other governmental bodies, local civil society organizations and non-governmental organizations.
- 3) Explore the availability of and access to comprehensive abortion care, including uterine evacuation with MVA and medical methods, in order to assess current provision and gaps.
- 4) Understand what women and providers believe about abortion, where they get information about the legal status and safety of abortion, and how women obtain abortions.
- 5) Understand the current status of various stakeholders' (including women, the Ministry of Health and other government bodies, providers and others) commitment to work to support comprehensive abortion care service provision and access, as well as opportunities to increase this commitment.
- 6) Explore the institutional and policy-level barriers (procedural and informal) and community-level barriers to comprehensive abortion care.
- 7) Identify resource people and institutions such as community groups, governmental and nongovernmental organizations, professional associations and others with a willingness to work to increase access to comprehensive abortion care with whom Ipas could partner.

The precise needs in each country and the obstacles colleagues face in improving delivery of and access to comprehensive abortion care are varied and complex. The situational assessment utilized various qualitative methodologies, including key-informant interviews, focus group discussions and mystery client visits, to better understand these challenges and needs. The assessment findings were shared and discussed with in-country stakeholders to inform strategy setting, prioritization and implementation of next steps and resource mobilization with potential donors.

Methods and Limitations

Environmental scan

As a first step in the situational analysis, Ipas conducted a high-level environmental scan of Benin, Burkina Faso, Cameroon, Guinea, Ivory Coast, Mali, Niger, Senegal and Togo. The scan included legal indicators for abortion, evidence of political will to reduce abortion-related maternal mortality, ratification of treaties endorsing sexual and reproductive rights, and the status of induced abortion and postabortion care services. Data sources included: media reports, peer-reviewed articles, grey literature, websites and reports from colleagues and agencies. Based on the scan results and indications of positive movement toward an increasingly-enabling environment for CAC, Benin, Burkina Faso, Senegal and Togo were selected for more in-depth analysis.

Desk reviews

Ipas then conducted in-depth desk reviews of Benin, Burkina Faso, Senegal and Togo. The health system structure, demographic and women's health trends and current reproductive health service coverage were all explored, along with a deeper exploration of PAC and CAC services in those countries. On the basis of these desk reviews, Benin and Togo were selected for in-country situational assessments.

In-country situational assessments

In May 2015, an Ipas team of two researchers, in partnership with the Ministry of Health Family Health Division and other agencies, conducted in-country situational assessments of CAC needs and opportunities in Benin and Togo. This assessment used a mix of qualitative research methods that included in-depth interviews, focus group discussions and mystery client visits to pharmacies to obtain a broad understanding of the environment surrounding comprehensive abortion care. All respondents were adult (over 18 years old) stakeholders who were able to provide particular knowledge about an important aspect of comprehensive abortion care in their country, as well as informed consent.

The researchers conducted formal and informal key-informant interviews with ministry of health and other government officials, health administrators and providers, NGO leaders, lawyers and civil society leaders to better understand the current state of policy, research, services and community member perspectives and opportunities for expanding access to and delivery of comprehensive abortion care. Respondents were identified by the snowball method, using pre-existing key contacts to identify the first few stakeholders, and then asking those informants to identify subsequent interviewees. The two researchers followed a semi-structured, paper interview guide developed by Ipas staff and conducted interviews in person. The protocol was to ask all respondents to provide written, informed consent. Interviews were conducted in areas with auditory privacy to ensure confidentiality. The interview guide included questions about relevant socio-demographic background information (age, sex, professional position, etc.) as well as questions about their professional assessment of comprehensive abortion care. These latter questions focused on knowledge of and attitudes toward legal indications for comprehensive abortion care and ideas for expanding access to comprehensive sexual and reproductive health services. All respondents were asked to consent to audio recording; those who consented had their interviews recorded. Interviewers also took field notes during interviews. Eleven interviews were conducted in Benin, and 24 in Togo.

Ipas researchers conducted four focus group discussions, two in Benin and two in Togo, with seven to nine adult women of reproductive age (ages 18-49) from diverse backgrounds in each group. Respondents were identified by local organizations active in sexual and reproductive health, and purposive sampling was used to assemble the focus groups. A semi-structured, paper questionnaire developed by Ipas staff was administered in person, either by a member of the Ipas team or a local partner who spoke the local language. All respondents provided informed consent, and focus group discussions were in closed rooms to promote



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privacy. The question guide included questions about beliefs, attitudes and experiences with sexuality, pregnancy and abortion, knowledge of legal indications for comprehensive abortion care, attitudes toward accessing such care, community norms regarding abortion and ideas for improving access to comprehensive sexual and reproductive health services.

Mystery client visits to pharmacies and medicine sellers were carried out to understand whether medical abortion drugs were available, their cost and the accuracy of information provided about the medication and regimens. Informed consent, demographic and identifying information were not obtained from the pharmacists, medicine sellers and attendants. Ten mystery client visits were conducted in Benin and nine in Togo. Female and male field assistants visited a convenience sample pharmacies and drug shops that were accessible to Ipas researchers during normal business hours, and interacted with the pharmacist or attendant on duty. Field assistants recorded key aspects of the interaction, the reaction of the pharmacist or medicine seller and whether they were able to obtain accurate information about safe abortion and medication for a safe abortion or referral to a safe abortion facility.

The Ipas consultant conducted thematic content analysis of the mystery client data and retained illustrative quotes. The human subjects component of this assessment was reviewed and approved by the Allendale Institutional Review Board, USA. The results presented below include a regional overview drawn from the environmental matrix, short country-specific summaries for Burkina Faso and Senegal drawn from the desk-reviews, and longer country-specific analysis for Benin and Togo, integrating the results of the in-country assessments.

Limitations

The duration of the two country analyses was one week in each country, which may not have provided sufficient time to develop rapport with key informants necessary to improve the honesty of responses regarding abortion. This was partially overcome by relying on in-country colleagues to facilitate introductions. Focus groups were conducted in a mix of French and local languages, which was then interpreted back to French by community partners on the spot, perhaps losing some important nuances in

translation. Several respondents declined to be audio recorded, leaving handwritten notes the only record of those encounters. Audio recordings were not transcribed.

Regional Findings

Policy

Benin, Burkina Faso, Ivory Coast, Mali, Niger, Senegal and Togo have signed and ratified a number of important treaties on women's and human rights, including CEDAW, the ICPD Programme of Action and the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, better known as the Maputo Protocol (although some countries with reservations). The Maputo Protocol specifically includes a provision in favor of safe and legal abortion access. Many of these countries have passed national reproductive health laws, although most have not yet developed strategies and guidelines to implement those laws. Through their participation in the Ouagadougou Partnership, all of these countries have developed a national, costed implementation plan for family planning and have made commitments to increase family planning services.



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Abortion laws

Most countries in francophone West Africa have at least some conditions under which abortion services can be legally provided (see Table 1). However, even women who meet these legal criteria often cannot access safe abortion care. The laws in a number of francophone West African countries are relatively permissive and allow abortion for multiple indications including rape, incest and to protect the health of the woman. In all nine countries listed in Table 1, abortion is permitted to save the woman's life. Articles in the penal code are often at odds with international treaties signed and ratified by these countries as well as subsequent reproductive health laws and policies, leaving a great deal of ambiguity surrounding abortion. Governments need to clarify the existing legal grounds for abortion, develop service delivery standards and guidelines and clinical protocols and operationalize them by offering accessible, high-quality services to all women who are legally entitled. Relevant national guidance documents in francophone West African countries are listed in Appendix A.

Table 1. Abortion laws in francophone West African countries

Country	Legal indications for abortion				
	Life of the woman	Health of the woman	Rape	Incest	Fetal abnormality
Benin	X	X	X	X	X
Burkina Faso	X	X	X	X	X
Cameroon	X	X	X		
Guinea	X	X	X	X	X
Ivory Coast	X				
Mali	X		X	X	
Niger	X	X			X
Senegal	*				
Togo	X	X	X	X	X

* Although Senegal's criminal code completely prohibits pregnancy termination, the code of medical ethics allows abortion when three doctors testify that it is necessary to save the woman's life.

Health systems

The overall challenges that West African health systems face, such as lack of trained providers, poor supply chain management and shortages of supplies and equipment, affect all types and levels of health care in the region and have important implications for sexual and reproductive health.

Comprehensive abortion care services, when available, are likely to be clustered in capital cities and other urban areas. Gynecologists and other specialists work mostly in large teaching hospitals in the region's biggest cities, where there are often plentiful trained nurses and midwives as well. The further one gets from these urban centers, however, the fewer trained providers there are, with many rural health posts staffed only by auxiliary health professionals who lack even a high school education. Comprehensive abortion care is rarely integrated into routine training of health-care providers, which means that the presence of a provider does not guarantee access to CAC. Even when trained providers are geographically accessible, their services often remain out of reach for all but the most resourced women who can afford to pay out-of-pocket for services.

Facilities often lack basic supplies necessary for CAC and even PAC, such as manual vacuum aspirators (MVAs) and supplies needed to properly sterilize equipments. Problems with pharmaceutical supply chains may mean that misoprostol, even when authorized, is often absent from facilities' pharmacies. Pharmacists and their staff are not routinely trained on correct medical abortion dosages, regimens and related information, leaving women to turn to unofficial drug sellers, spiritual and herbal medicine practitioners, their partners, friends and family members to procure an abortion. Drugs purchased on the street, plants and roots inserted through cervix, cocktails of bleach, permanganate or other noxious chemicals and even physical trauma to the abdomen are all well-known ways that women attempt abortion throughout the region. These desperate attempts, unsurprisingly, lead to complications including sepsis, hemorrhage, permanent infertility and death.

Medical abortion has transformed the abortion landscape in many parts of the world, rendering clandestine abortions less unsafe and improving health outcomes for women in places like Latin

America.¹⁹ In francophone West Africa, however, access to medical abortion remains limited by supply challenges, such as those outlined previously, as well as lack of information among women. Misoprostol is approved to treat postpartum hemorrhage and is on the essential drug list of several countries throughout the region. In urban areas, misoprostol may be available at pharmacies, but stringent requirements for a prescriptions make this formal route very difficult. It appears, too, that knowledge of misoprostol is still limited among many francophone West African women, although there is evidence that knowledge is growing, especially among the urban elite. Among less-educated and rural women, knowledge of and access to misoprostol is likely lower.

Mifepristone is available in limited quantities in certain countries such as in Benin and Burkina Faso, but only in the capital cities as part of small pilot studies. Research studies are being conducted to assist the registration process and increase access. For example, the IPPF member association in Cameroon partnered with the obstetrics and gynecology association to implement a study on the efficacy of utilizing a misoprostol/mifepristone versus misoprostol-only regimen for the provision of abortion services. This study may be completed by early 2016, and it is hoped that it will initiate the process of registration of mifepristone in Cameroon.

Development organizations have recently sponsored regional and country-specific programs in francophone West Africa that aim to improve service delivery and access to contraception and postabortion care (PAC).^{12,13} These include multi-country USAID-funded projects such as AWARE-II, DELIVER and Evidence2Action, among others, and have helped promote progress on issues such as contraceptive supply chain management and improving emergency obstetric care. Abortion stigma among western development agencies and West African officials has meant that very little or no attention has been paid to improving access to CAC. In fact, one respondent in Togo who works for a USAID-funded project was so skittish about abortion that he consulted his USAID compliance documents before even agreeing to be interviewed about abortion for this situational assessment. As a result of this general unease with abortion, very few programs have been implemented in the francophone West African region to address abortion. The deleterious impact of unsafe abortion thus continues unabated.

There are some important opportunities to bring more attention to abortion services. Interventions to address CAC can capitalize on recent, high-profile initiatives, such as the Ouagadougou Partnership, that are mobilizing stakeholders to focus on family planning but do not yet touch on abortion.

Research and information needs

A few articles and literature reviews on abortion in francophone Africa have been published recently, and a number of country-level studies on abortion-related care, needs and perceptions have been conducted or are currently being planned. These include:

- Multiple studies by Gynuity Health Projects on the use of misoprostol for abortion-related care in francophone West African countries.^{21,22,23}
- An abortion incidence and consequences study in Burkina Faso and a study on abortion incidence in Senegal in April, 2015 (the first national study of its kind) by the Guttmacher Institute.^{13,15}
- An ethnographic study on the social aspects and decisionmaking process for abortion in urban Burkina Faso.²⁴
- Innovative methodological approaches to counting abortions by the Institut Supérieur des Sciences de la Population at the University of Ouagadougou.²⁵
- Through the Safe Abortion Action Fund, the IPPF member associations of Benin and Senegal have proposed to conduct studies on the magnitudes of unsafe abortion and the contribution of unsafe

abortion to maternal mortality. In both countries, government clearance to conduct the studies is being processed. Similarly, the IPPF member associations of Benin and Burkina Faso have conducted studies to explore abortion-related stigma faced by young people at individual, community and health facility levels. These findings are being used to reduce abortion-related stigma at all levels during a two-year project.

These studies, while informative, provide a scattered understanding of abortion in a few select countries in the region. Most were conducted in only a few facilities or in a large urban center, leaving the experiences of other women open to conjecture. The lack of up-to-date, systematic, comprehensive data makes it difficult to fully demonstrate the needs, opportunities and specific activities needed for intervention. Studies on abortion incidence and magnitude, attitudes towards abortion (both providers' and women's), abortion-seeking behaviors and the availability of and access to uterine evacuation and contraceptive services in each country would provide important information to guide programmatic interventions. Research on abortion stigma for women, providers and others at the individual, community and institutional levels would inform stigma mitigation efforts.

International NGOs working on abortion in francophone West Africa

An increasing number of international nongovernmental agencies are working on abortion-related care or broader sexual and reproductive health in francophone West Africa. These agencies include: Advance Family Planning, CARE, Equilibres & Populations, EngenderHealth, Family Care International (FCI), Guttmacher Institute, Gynuity, International Consortium for Emergency Contraception (ICEC), International Planned Parenthood Federation-Africa Region (IPPF-AR), IntraHealth International, Ipas, International Women's Health Coalition (IWHC), Jhpiego, Marie Stopes International (MSI), Médecins du Monde, Oasis, Pathfinder, Population Council, Planned Parenthood Global, PRB, PSI and WHO. Ipas has created a spreadsheet, available upon request, of international NGOs' activities in francophone Africa on sexual and reproductive health and rights issues.

Benin

Background

Benin is a small country of 10.2 million people, situated between Togo and Nigeria on West Africa's Atlantic coast. The population of Benin is very young, with 43.8 percent of the population under 15 years of age, and another 50 percent between the ages of 15 and 54.²⁶ The total fertility rate in Benin is 4.9, with large disparities in fertility based on wealth and level of education. Many Beninese women who want to avoid pregnancy are not using a modern contraceptive method. Benin's contraceptive prevalence rate (CPR) is low, with 9 percent modern CPR and 14 percent total CPR. As of 2012, only 7 percent of married women and 23 percent of unmarried sexually active women use modern methods. One-third of married women and half of all sexually active unmarried women have an unmet need for contraception. These levels represent a substantial increase since 2006, when 27 percent of married women and 35 percent of unmarried sexually active women experienced unmet need. Although Benin's government promotes family planning, the country will need to renew efforts to achieve its goal of increasing contraceptive prevalence to 20 percent by 2018.²⁷ The maternal mortality ratio in Benin is 328 per 100,000 live births.²⁸

Health systems

The Beninois health system was decentralized in 1995, and is now comprised of 77 health communes organized into 34 health zones. Different levels of care are provided at the primary level in *Unités Villageoises de Santé*, *Centres de Santé d'Arrondissement* and *Centres de Santé de Commune*, which are supposed to be the first point of contact with the health system. At the intermediate level, there are the *Hopitaux de Zone* and the *Centres Hospitaliers Departementaux*, which offer limited specialty services such as pediatrics and gynecology. At the highest level are the *Centres Hospitaliers Universitaires*, which are the teaching hospitals in large urban centers.

Priority-setting, technical decisionmaking, strategic planning and administration are performed at the central level by the Ministry of Health in Cotonou. The Directorate of Maternal and Child Health (*Direction de la Santé de la Mère et de L'Enfant* or DSME, by its French acronym) is in charge of reproductive health. This directorate is currently led by Dr. Olga Agbohoui-Houinato, who is a pediatrician by training. The DSME has been particularly concerned with reducing maternal mortality in Benin as part of MDG 5.



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There is an active private sector in health care provision in Benin, including NGO and religious health centers in addition to for-profit centers. These private facilities are, however, heavily concentrated in the Atlantique/Littoral part of the country, in or near the capital city.⁵ The Beninois health system relies largely on out-of-pocket spending. Household out-of-pocket expenditures accounted for 52 percent of health spending in 2006, with the rest coming from the state, technical partners and external donors. Government health expenditures are growing, however, with the total state budget for health increasing by more than 75 percent between 2003 and 2008.²⁹ Even with this increase, Benin is still falling short of its Abuja pledge to devote 15 percent of its annual budget to health spending, spending only 8 percent according to the 2009-2018 National Plan for Health Development (PNDS 2009-2018).³⁰

Reproductive health services are “scarcely accessible” to the women of Benin, due to lack of trained providers and the “low functional state of infrastructure and equipment due to poor maintenance.”⁵ Only 22.9 percent of the Beninois population lives in an area covered by access to emergency obstetric and neonatal care (EmONC). While external donors provide the bulk of funding for reproductive health commodities such as contraceptives, the Beninois government does have a contraceptive line item in its annual budget. However, in 2013, the government contribution to contraceptive procurement was \$120,000, while the donor contribution exceeded \$3 million.

The Ministry of Health has incorporated sexual and reproductive health strategies to reduce maternal mortality, including PAC, into several recent strategic planning documents. *Documenting Best Practices in Reproductive Health* from 2010 includes PAC as a best practice to improve maternal mortality. PAC is also designated as a “strategic axis” in the National Reproductive Health Program (PNSR).³¹ The National Plan for Health Development mentions abortion as a cause of maternal mortality.³⁰ There is also a National

Strategy for Maternal and Neonatal Mortality Reduction from 2006 that mentions abortion in passing, but does not include much abortion-specific language. The strategy identifies skilled attendance at birth, antenatal care, improving human resources for health, community-based care and health education, among other areas, for priority intervention.³²

Data on abortion

There are few recent studies on induced abortion in Benin, but the Ministry of Health estimates that 15 percent of maternal deaths are attributable to unsafe abortion.⁴ A few hospital-based studies performed in recent years have demonstrated that complications from unsafe, clandestine abortions remain an important threat to women's health.^{4,33,34} A recent study on abortion and Benin, from 2014, was a five-year study conducted in three hospitals. It found that 3,139 women were admitted with incomplete abortions, of whom 630 needed no treatment, 1,277 were treated with MVA, and 537 were treated with misoprostol. The gestational age of women presenting at the hospitals was mostly under 10 weeks (64 percent), with 14.9 percent at 11-12 weeks, 13 percent at 13-14 weeks, and 8 percent at 15-18 weeks.³⁵

The Benin Centre for Research in Human Reproduction and Demography (Centre de Recherche en Reproduction Humaine et en Démographie, or CERRHUD in French), in partnership with ABPF, the local IPPF affiliate, conducted a qualitative research study on abortion, the law and stigma in 2015. The report was unpublished at the time of this report but should be considered in future reviews of abortion research in Benin.

Reliable estimates of the magnitude of unsafe abortion are currently unavailable. A 1997 study estimated the abortion rate at 1.5 per 1,000 live births,³⁶ but an abortion magnitude study would be very helpful. Furthermore, there are no current published research studies about providers' and women's attitudes on abortion and women's abortion-seeking behaviors in Benin.

Laws and policies on abortion

The laws regulating abortion in Benin have been considerably liberalized over the past 15 years. Prior to 2003, abortion was regulated by the 1973 Code of Medical Deontology (Ethics), which specified that abortion was only legal in Benin to save the life of the pregnant woman and only when the attending doctor consulted with two other physicians who certified in writing that the abortion was medically necessary.³⁷ The portion of the Benin penal code (based on the Napoleonic penal code of 1810) which criminalizes abortion has never technically been repealed.³⁷

The first move to ease these staunch restrictions came in January 2003, when a new Sexual and Reproductive Health law was passed. Article 17 of this law uses the more progressive terminology of "voluntary interruption of pregnancy" (*L'interruption volontaire de grossesse* or *L'IVG*, by its French acronym), and specifies that abortion is legal: 1) to protect the life and health of the mother; 2) in case of rape or incest; 3) in case of grave fetal abnormality.³⁸ In addition to adding the new exceptions, this law eliminates the requirement that three doctors consent.

A further step toward improving abortion policy in Benin came in 2011, when the Ministry of Health, with support from Ipas, released *Safe abortion in Benin: Standards and guidelines*. This detailed document includes progressive language on women's rights and abortion (*IVG*), discusses the importance of safe abortion in public health and provides guidance on termination of pregnancies up to 12 weeks of gestation

in any establishment that has a gynecologic service with sufficient technical ability to handle complications.³

Although the 2003 Reproductive Health Law and the 2011 standards and guidelines have substantially reduced the *de jure* obstacles to CAC in Benin, these policies are not widely known or understood. A member of the Benin Association of Women Lawyers was not aware of any particular law on abortion, asking, “Now, do the physicians have, in their deontology code, some specific circumstances where they have to help a woman abort for medical reasons? I cannot tell you exactly.” According to a senior obstetrician-gynecologist and authority on abortion in Benin, the *textes d’application* (provisions for implementation) for the 2003 law were never written and disseminated, omitting a necessary step. And while *Safe abortion in Benin: Standards and guidelines* was signed by the Minister of Health, it was never fully disseminated, and many health-care providers and public health officials are unaware of its existence. Even an MOH Division of Maternal and Child Health official was unaware of this document that his own department had written prior to his arrival at the Ministry. Several respondents emphasized that any efforts to raise public awareness of the law and the standards and guidelines must take in account the low literacy rate, especially of women, particularly in rural areas, and make sure that policies are translated into local languages. But even well-educated, urban people are often not aware of the law and guidelines.

“I am sure that if I ask my wife she cannot tell you the content of the law. She’s an intellectual, but she couldn’t tell you the content of the law, because there is not really an effective way of diffusing these laws.” – An obstetrician-gynecologist who works with the Ministry of Health.

A senior obstetrician-gynecologist says that the current legal environment is sufficient for comprehensive abortion care and that further legal reform is not necessary, although the *textes d’application* are needed. His view was, however, in the minority among our respondents, most of whom felt that while many positive actions could take place with greater understanding and implementation of current laws, a full CAC program would not be feasible without additional legal reform or at least passage of *textes d’application*.

PAC provision

There are several government documents in Benin that guide the implementation and scale-up of PAC throughout the country. The most recent is the 2013 *PAC Roadmap*, which aimed to train 50 percent of the providers in 17 hospitals and 10 private health clinics, leading to the treatment of at least 80 percent of women who have had an incomplete abortion in those 27 facilities, according to the official algorithm.³⁹ The roadmap further seeks to integrate family planning, HIV testing and other reproductive health care with PAC.

As demonstrated by the fact that the PAC roadmap targets only 27 facilities nationwide, PAC has not yet been scaled up nationwide, and the extent to which women are systematically provided PAC remains an open question. PAC has been introduced into the curricula for training of doctors and midwives, using both medication and aspiration approaches. However, according to a leader of the Benin Association of Midwives, PAC is only systematically available in the intermediate and tertiary level health centers. It may be available in primary care centers as well, but only if there happens to be midwife there who was trained: “It’s all a question of training...It’s not everywhere.”

CAC provision

Safe abortion in Benin: Standards and guidelines outlines the levels at which specific abortion services should be offered. All health centers should be able to provide MVA, while intermediate health centers (*zone hospitals*) should be able to provide MVA, medical abortion and treatment for incomplete abortions. At the teaching hospital level, abortions through the second trimester can be performed, as well as treatment for the most serious abortion complications that cannot be handled elsewhere. Yet many respondents doubted the extent to which PAC, let alone induced abortion, is truly available in public facilities, especially those in rural areas.

There has not yet been an assessment to determine the extent to which CAC services are actually available to women in public health facilities. One prominent physician shared the opinion, which differed from that of the majority of people interviewed, that virtually all doctors and midwives in Benin are trained in PAC, which means that they are also providing CAC. He commented, “What do you understand by ‘PAC?’ Because when people talk about PAC, it’s to induce abortions. It’s a roundabout way of doing it.” Another prominent physician stated a different and more typical opinion, estimating that around 75 percent of women who seek induced abortion services in public facilities are turned away. Comprehensive abortion care thus seems to be available only sporadically in public health centers and may be largely dependent on the personal attitudes and skill level of the provider a woman happens to see.

By far the majority of respondents indicated that most abortions take place in private and NGO clinics. Little is known about the private clinics that offer abortions, or who performs abortions there. Respondents indicated that the quality of abortion services are often in direct proportion to the means of the women seeking services, with wealthier women able to seek out abortion services in well-equipped and high-quality clinics staffed by highly-skilled doctors and other providers, while poorer women are forced to resort to clinics staffed by less-skilled providers or even people with no formal training.

Self-induced abortions

In addition to facility-based abortions, many abortions in Benin are induced by women themselves outside of the formal health sector. Women in the focus groups, for example, explained that in their neighborhoods it is common for women to use plant stalks inserted into the uterus (*tiges*) to induce abortion or to drink herbal infusions (*tisanes*) made from leaves, roots and other natural products. Women said they most commonly learn of these methods from their friends, neighbors and traditional healers. The focus group participants agreed that the plants used for abortion can be commonly found around the city or purchased for a few hundred CFA at the market.



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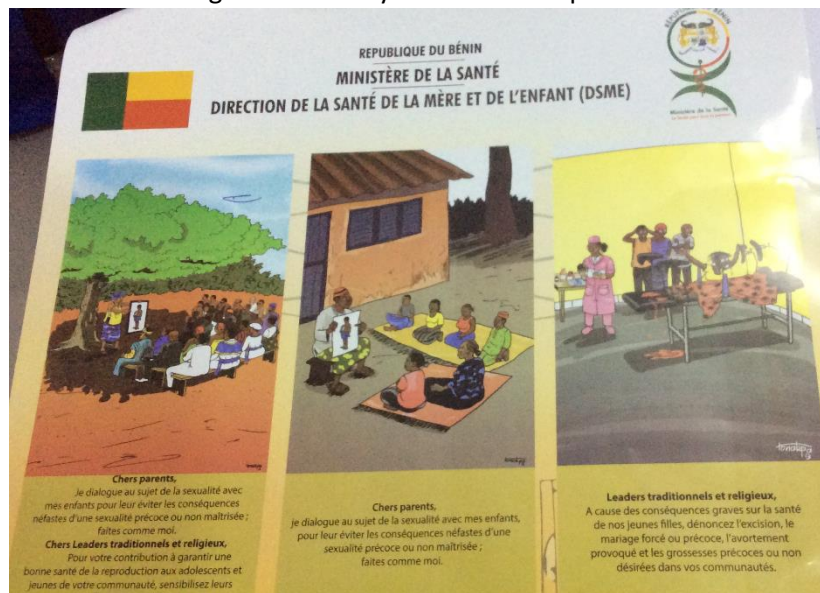
Misoprostol is registered in Benin and was placed on the essential drug list in 2014 for incomplete abortion and postpartum hemorrhage. Due to concern about unauthorized use, the Minister of Health changed misoprostol to prescription-only in 2007, according to a ministry health official. PSI has operated a program to sell misoprostol in Benin. Ipas’s mystery client visits to 10 pharmacies in Cotonou confirmed that it is very difficult for women to purchase misoprostol in those pharmacies without a prescription.

The Beninese mystery client was turned away from all six pharmacies she visited, and felt that many pharmacists used judgmental and stigmatizing language as they refused her. A mystery client visit conducted by a Caucasian American woman, however, ended differently, with the woman being offered a box of 60 misoprostol pills by one pharmacist.

Although most women may find it difficult to purchase misoprostol in pharmacies, it is easily available in Cotonou's markets. The same Beninese mystery client who was refused in the pharmacies was able to easily find and purchase misoprostol from three different market women. Reproductive health leaders in Benin expressed concerns about pharmacovigilance, counterfeit pills from neighboring Nigeria, as well as the degree to which medicines in the markets may be exposed to sunlight and other unfavorable conditions rendering them less effective.

“When I take the case of Cytotec, you can find it in the market. But it’s not good, because the storage is so poor and they expose it to the sunlight.” – Benin Association of Midwives leader

Despite the fact that misoprostol is available in the markets, most respondents seemed to think that, overall, most women's knowledge and use of the drug remains fairly low. Its use is perceived to be more common among young, urban women with higher levels of education who learn about the drug from their friends. Less-educated women, older women, and women outside the urban areas are thought to be much less likely to know about and use misoprostol. The Beninese mystery client, a progressive university student who volunteers with ABPF, the Benin IPPF affiliate, did not know about misoprostol before starting her mystery client assignment.



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“For some time now, there are some people who know miso a little bit. These are the young women, and they manage to go look for it and then they take it.” – Ministry of Health official

The official status of mifepristone is ill-defined. The drug is not officially registered or on the essential drug list, and is not procured by CAMEG, the central government pharmaceutical procurement agency. Yet mifepristone is specifically mentioned in *Safe abortion in Benin: Standards and guidelines*, which was endorsed by the Minister of Health. Using this as evidence that mifepristone is authorized in Benin, ABPF (L'Association Béninoise pour la Promotion de la Famille or ABPF, (the local IPPF affiliate) was able to secure an import license for Medabon. A pilot study on Medabon at ABPF and two Cotonou hospitals was

ongoing at the time of this situational assessment. Outside of these three health facilities, however, mifepristone does not appear to be available.

Community engagement

There has been little public community engagement on abortion in Benin. A leader of the Association of Women Lawyers, for example, expressed that while she and her association have worked on issues such as gender-based violence, they have never considered or been asked to participate in any abortion-related advocacy activities. The Ipas team was not able to uncover any civil society groups or NGOs other than ABPF actively working on abortion issues. There are, however, several professional associations that are working on abortion in Benin. Local, regional and international associations of gynecologists/obstetricians have been working on abortion in Benin, leading studies and providing important technical assistance to the DSME. The Benin Association of Midwives also has been active in promoting expanded abortion access, both clinically, through midwifery training, and through advocacy.

Although virtually every prominent respondent cited the sensitive, taboo and controversial nature of abortion, the attitudes expressed by women in the focus groups tended to be a lot more matter-of-fact. The women in the focus groups rarely invoked the loaded and stigmatizing language used by more professional respondents and spoke openly and without judgment about their own experiences with abortion, about where to get plants and medicines, and about abortion as something that is part of their lives and communities. The women in both Benin focus groups quickly reached consensus that abortion should be legalized and made safe.



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Organizations

There are fewer international organizations working in Benin than in many other West African countries. In addition to ABPF, PSI operates a social marketing program, but no other international NGOs are currently active in abortion work or sexual and reproductive health more broadly. There are a few local organizations active in the promotion of sexual and reproductive health, however, such as the Benin Association of Midwives and CeRadis, which has been active in the prevention of HIV/AIDS in Benin. International multilateral organizations and donors include the UNFPA, WHO, USAID, AFD and KfW, a German, government-owned development bank, among others.

Political will and commitment to implement CAC

The political will to implement a comprehensive abortion care program in Benin is promising, but there are challenges. There is a new coalition, headed by Dr. Olga Agbohoui-Houinato, Director of the Ministry of Health's Maternal and Child Health Division, that aims to expand the abortion law and increase

women's access to care. Dr. Agbohoui-Houinato favors addressing abortion from a public health perspective and encourages her department to do so. Benin benefits from a small and close-knit group of impressive champions for women's right to abortion that includes prominent obstetrician-gynecologists, midwives, health administrators and others who have made great progress, culminating in the the

publication of *Safe abortion in Benin: Standards and guidelines*, signed by the Minister of Health. However, the fact that the document has not been widely disseminated or implemented indicates that there are still important obstacles to be overcome and steps to take to increase access to care for women.

And there are still more obstacles. Social stigma and religious opposition are strong. There are currently no formal comprehensive abortion care programs at the government or community level. Government support is not solid. The President of the Republic has been lobbied but has refused to endorse abortion rights and remains in favor of the criminalization of abortion. Some ministry leaders are not in favor of expanding abortion access. The Catholic Church and Muslim groups have been vocal in their opposition to expanding abortion access and have previously hampered attempts to liberalize policy.

The previous Minister of Health demonstrated his support by writing in the preface of *Safe abortion in Benin: Standards and guidelines*, “To remediate [maternal mortality from unsafe abortion], and taking into account the upcoming MDG deadline, the Minister of Health of Benin must take concrete acts like using misoprostol and mifepristone necessary for medical abortion.”³ The views of the current Minister of Health, Dorotheé Akoko Kindé Gazard, are less clear. A Ministry of Health program that began in 2011 to “fight against induced abortion” included a component that “ensures the right to a child’s life from conception.”⁴⁰ Dr. Gazard’s representative was present for the program’s launch, but Dr. Gazard has never publically spoken of her position on abortion. In an interview she gave to PSI, she spoke of maternal health as a priority intervention area, but mentioned neither abortion nor PAC specifically.⁴¹

Opportunities for CAC implementation

Concrete actions can be taken to improve access to and quality of CAC throughout Benin. At the policy level, political will and government support need to be solidified and articulated. The standards and guidelines need to be revised in accordance with the WHO’s 2012 *Safe abortion: Technical and policy guidance for health systems, second edition* and other, more current clinical evidence. *Textes d’application* for the reproductive health law need to be written and validated. The law, standards and guidelines need to be fully publicized and disseminated to ministry officials, health administrators, providers, health workers, lawyers and community groups, and the health system needs to take responsibility for their implementation.

The health system can articulate and adopt a woman-centered, comprehensive abortion care program model that encompasses all of the essential elements, includes uterine evacuation using medical and aspiration methods and ensures all women’s, including young women’s right to care. A sustainable supplies and commodities plan can be put in place to ensure MA drugs and MVA are available in health facilities. Relaxing the prescription requirement for MA drugs could help women more easily access misoprostol in pharmacies, where the quality of the drug can be assured.

At the community level, there are important opportunities to raise awareness about PAC and safe abortion generally, and misoprostol specifically, to reduce women’s reliance on less-safe methods of self-induction and ensure that women know where to go for PAC and safe abortion services. Partnering with women’s groups like the Association of Women Lawyers, which is not currently implicated in abortion advocacy efforts, could raise the profile of the discussion. Women can be educated about their rights under the current law and women’s groups can hold the government accountable for providing safe and high-quality services. Strategies include translating the law into local languages and using radio and other media to reach more women.

It is also important to link key actors in Benin with those who have successfully integrated comprehensive abortion care into their service delivery systems and community mobilization activities in culturally and legally similar countries. Plans are underway to connect Benin and other francophone West Africa colleagues with their counterparts in Ghana and to bring a group of delegates to Ghana to experience and learn from Ghana's CAC program.

Strategic partnerships for CAC implementation

As the government body charged with addressing abortion and PAC, DSME, together with the new abortion rights coalition, could work together to lead CAC implementation for the country. Engagement with professional clinical societies, particularly those of obstetrician-gynecologists and midwives, is paramount given that these groups command great respect and are understood to be the key reproductive health experts in the country. ABPF is the leading NGO on CAC advocacy and service delivery in Benin and is therefore a vital partner for CAC implementation. New strategic partnerships are also needed. Engaging women's and legal groups would add important dimensions to a movement heretofore dominated by medical professionals. To improve social norms and attitudes on abortion, the media and faith leaders also need to be constructively engaged.

Limitations and cautions for CAC implementation

Although Benin is thought to be one of the most stable countries in the francophone West Africa region, presidential elections scheduled for 2016 have the potential to be contentious. Current president Boni Yayi is ineligible to run again, but some opponents suspect that he will try to change the constitution and seek another term, a charge that Yayi denies. Currently, these fears are based on little actual fact.

There is strong opposition to abortion from the Catholic Church, Muslim leaders and others who have religious or moral objections to abortion. Respondents disagreed about the degree to which abortion opponents are well organized. Deeply-rooted cultural notions about motherhood, gender roles and female sexuality render abortion a sensitive topic throughout the country and region.

Burkina Faso

Burkina Faso is a landlocked country in the Sahel region of West Africa that has approximately 18 million inhabitants; approximately half are between 15-54 years of age. The nation has undergone a series of coups d'état since independence in 1960, with the most recent taking place in 2015. The country currently is being run by a democratically-elected government.

Burkina Faso has one of the world's highest total fertility rates, and fertility actually rose between the 2003 and 2010 Demographic and Health Surveys (DHS). According to the 2010 DHS, the total fertility rate is 6.0 overall, and rises to 7.1 for women in the lowest wealth quintile.⁴² Contraceptive prevalence is quite low, at 16.2 percent nationwide and only 7.4 percent among women in the lowest wealth quintile. Unmet need for family planning is 17.8 percent.

Abortion is better studied in Burkina Faso than in most other West African countries, both from a clinical perspective and a social one. Gynuity Health Projects has conducted clinical studies on misoprostol in Burkina Faso, including one from 2012 that helped build the evidence base for the safety and efficacy of misoprostol to treat incomplete abortion in low-resource settings.

Faculty from Burkina Faso's main teaching hospital, the Centre Hospitalier Universitaire Yalgado Ouedraogo, have found that the unsafe abortion rate at that facility is 1/47 deliveries, with a mortality rate of 24 percent among women with complications seeking treatment.^{23,43} Several researchers from the Institut Supérieur des Sciences de la Population at the University of Ouagadougou have also conducted several studies on abortion, both independently and in collaboration with the Guttmacher Institute.⁶ The most recent of these studies have found that the incidence of abortion is rising in Burkina Faso, from about 87,000 abortions nationwide in 2008, to 105,000 abortions nationwide in 2012.⁶ The rates of abortion are higher in urban areas, with a nationwide abortion rate of 25/1000 women, which rises to 28/1000 women in the capital city of Ouagadougou.⁶ Approximately 50 percent of abortions result in complications. Of the women with abortion complications, only 40 percent receive PAC.²⁴ Only one-third of women know that abortion is legal in some cases, leading almost all abortions to be clandestine. There is also high provider stigma and fear or prosecution, leading women to avoid the formal health system. Forty-one percent of all abortions are carried out by traditional practitioners. Twenty-three percent of abortions were carried out by women themselves, while 25 percent were performed by midwives and health assistants, and three percent were performed by doctors. Poor women are the most exposed to most dangerous methods, with approximately 40 percent of abortions carried out using "potions" composed of things like bleach.^{6,25,44}

A recent ethnographic study on abortion decisionmaking in Ouagadougou found that "the poorest always pay more (cost and consequences), take longer to have an abortion, and have more exposure to the risk of unsafe abortion" compared to their wealthier counterparts. This study also found that women with abortion complications often wait to access services out of fear of being stigmatized at health centers, or of being prosecuted. This often extends to fear or disrespect and abuse at the hands of health-care providers, leading women to delay care-seeking in hopes that their issue will go away on its own.²⁴



Photo by Institut Olvido (CC BY-SA 4.0)

Another recent study confirmed the high costs of abortion as a barrier for poor women, concluding that “payments associated with induced abortion were catastrophic.”⁴⁵

According to Burkina Faso’s Ministry of Health, unsafe abortion is responsible for 28.7 percent of all maternal deaths in the country, a very high proportion.⁴⁶

Though there is a considerable body of evidence on the health, social and financial costs of unsafe abortion for women in Burkina Faso, the majority of these studies focus on Ouagadougou or Bobo Dioulasso, and little is known about abortion outside of these urban centers. Additional information on abortion throughout the country would help inform national strategies and program planning.

Policy

Articles 383-390 of Burkina Faso’s 1996 Penal Code prohibit abortion except to preserve the life or health of the mother, in case of rape or incest, or if the fetus will have a severe and incurable abnormality (and two doctors in a public facility must attest to this). In case of rape or incest, abortion is permitted through 10 weeks of gestation.⁴⁷ A reproductive health law (Law No. 049-2005/AN) was passed in 2005. Article 25 of this law reaffirms conditions of the penal code, and pregnancy interruption must take place in safe conditions. In the case of rape, the state prosecutor must establish cause.

There are strategic plans to ensure the availability of reproductive and contraceptive products (2006-2015), yet none mentions or incorporates abortion supplies. Burkina Faso has a number of programs and plans dedicated to reducing maternal mortality. These include a “Maternal Mortality Strategic Plan,” a “Maternal Mortality Road Map,” MDG 5 programs, the Campaign on Accelerated Reduction of Maternal Mortality (CARMMA), and the Strategy for Accelerated and Sustainable Development (SCADD, by its French acronym). The Politics, Norms and Protocols (PNP) for health has a PAC component, and the national PAC strategy has clear guidelines and includes a section on women’s rights.⁴⁸ The Evidence2Action program has been active in Burkina Faso in recent years, and supports the scale-up and consolidation of PAC programs.⁴⁹

The national PAC protocol specifies that MVA can be used for PAC through 12 weeks after last menstrual period. As of 2013, misoprostol was approved for postpartum hemorrhage but not for PAC. After 12 weeks, the protocol calls for curetage, electric aspiration, and oxytocic after cervical dilation. The protocol also calls for increased care as gestational age is advanced; postabortion family planning counseling/provision (difficult at the CSPA level, since they often lack family planning supplies); and integration with other RH services. Notably, this document also contains a section entitled “Women’s Rights” which affirms that “The right to health is enshrined in the constitution in Burkina Faso, regardless of age, religion, gender, etc...Patients have the right to discuss their concerns and their health status in an environment in which they feel confidentiality with a health technician.”⁴⁶

Health systems

The Burkinabé health system was decentralized in 1993, and now consists of 63 distinct health districts. The lowest level of care is offered at the Centres de Sante et de Promotion Sociale (CSPA), of which there are approximately 1,200 throughout the country, up from about 800 in 2000.⁵⁰ Intermediate-level care is offered at Centres Médicaux avec Antennes Chirurgicales (CMA), to which the CSPA refer cases needing higher-level care. There are 41 of these throughout the country (*note*: although the name includes

surgery, not all CMA have surgical capabilities). The tertiary level facilities are the Centres Hospitaliers Régionaux (CHR) and the Centres Hospitaliers Universitaires (CHU). There are nine CHR and three CHU in Burkina Faso. In addition to these public health structures, there are also a number of private, NGO and religiously-affiliated health centers in Burkina Faso. The Catholic Church runs some large hospitals and smaller clinics, NGOs like ABBEF and Marie Stopes have reproductive health clinics, and for-profit private clinics also operate (mostly clustered in big cities).

The Division of Family Health at the Ministry of Health and its subdirectorates the Division of Maternal and Child Health are primarily responsible for sexual and reproductive health services in Burkina Faso, though other directorates are also implicated in sexual and reproductive health. These include the Direction de la Santé des Adolescents, des Jeunes et des Personnes Agées (DASPAJ), the Direction de la Santé Communautaire (DSC) the Direction Générale de la Protection Sanitaire (DGPS) and the Ecole Nationale de Santé Publique (ENSP). Outside of the Ministry of Health, the Direction de Politique de la Population (under the Ministry of Finance) is also responsible for reproductive health matters.

Stockouts and lack of access have been common, but there are several strategic plans in place in Burkina Faso to try to improve contraceptive security and increase access to reproductive health care, the foremost of which are the Strategic Plan for the Securitization of Products for Reproductive Health and the Strategic Plan for Securitization of Contraceptive Products (2006–2015)¹⁸ Both of these documents discuss reproductive health generally but do not explicitly mention or incorporate abortion supplies into the plan.

In 2001, Burkina Faso signed on to the Abuja Declaration, pledging to increase state funding for health to at least 15 percent of the total annual state budget. Burkina has met this pledge, going from just seven percent of the state budget in 2000 to 12 percent in 2007, to 15 percent in 2009 (however, starting in 2008, this percentage included spending in other ministries related to health).³⁰ Since 2008, the government of Burkina Faso has included a line item in its annual budget for the purchase of contraceptive commodities. In 2013, this line item was for 500 million FCFA (about \$1 million USD).

Midwives are responsible for the majority of reproductive health care service provision in the country. According to Ministry of Health statistics from 2008, abortion complications account for 6.3 percent of women seeking care at district-level maternity facilities and 11.6 percent of women seeking care at the hospital level.⁵⁰ Misoprostol has been added to the national drug list, and MVA for PAC is being supported by the Directorate of Maternal and Child Health (a subdivision of the Division of Family Health). PAC is integrated into the National Health Strategy.⁴⁸ As of 2013, misoprostol was only approved for postpartum hemorrhage. Mifepristone is not currently on any official drug lists or procured by CAMEG (the government's central drug buyer).⁵¹ Medabon (a combination of misoprostol and mifepristone) is currently only available in limited quantities at the Association Burkinbé pour le Bien-Etre Familiale (ABBEF), the IPPF affiliate in Ouagadougou, as part of a pilot program since 2013.

Community

The ABBEF started a program in 2008 called *Projet de Prise en Charge Complète de l'Avortement* (Complete Abortion Care, or PCCA by its French acronym). Methods available include MVA, misoprostol and Medabon. The price for these services is 3,000FCFA (\$6 USD), including a postabortion contraceptive method, analgesics and antibiotics as necessary. Marie Stopes International (MSI) opened up a reproductive health clinic and social marketing program in Ouagadougou in 2009. In 2013, MSI-branded

misoprostol called “Misoclear” was introduced in Burkina Faso and labeled for the treatment of postpartum hemorrhage and postabortion care.⁵²

There are a number of other international organizations currently working on reproductive health in Burkina Faso, including Family Care International, Jhpiego, EngenderHealth, the Population Council, GIZ, USAID, UNFPA, AFD, WHO, PSI, Medecins du Monde, Equilibres et Populations and Pathfinder International. Several of these organizations contribute to a family planning steering committee that was created in 2011 in collaboration with the Ministry of Health to help meet the commitments that Burkina Faso made as part of the 2011 Ouagadougou Partnership. More recently, an abortion-specific advocacy partner network was created and is led by members of the Association of Women Lawyers in Burkina Faso. Burkina Faso also has a dedicated group of champions in the medical field and scholars in academia who support expanded abortion rights, but there has been very little community action on abortion. There is hope that this new advocacy partner network will begin to change this.

Senegal

Background

Senegal is a small country on the Atlantic coast of West Africa, with a population of 14,130,000 people. 45.5 percent of the population is under the age of 15, and another 51 percent is 15-54 years old. Overall life expectancy at birth is 63 years. Forty-three percent of the population lives in urban areas, with an annual rate of urbanization of 3.59 percent. Mothers’ mean age at first birth is 21.4 years.

The total fertility rate in Senegal is 5.3, rising to 6.3 in rural areas and falling to 4.1 in the urban areas. The maternal mortality ratio is 320/100,000 live births, and the contraceptive prevalence is 17.8 percent nationwide. About one-third of pregnancies are unintended. Of those pregnancies, almost one-quarter end in induced abortion.



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Authors of a recent Guttmacher study found that approximately 51,500 induced abortions were performed in Senegal in 2012, with 32 percent resulting in complications that required treatment in health facilities. The abortion rate in Senegal was 17 per 1,000 women of reproductive age (15-44), and the abortion ratio was 10/100 live births. Abortions were more common in the capital city of Dakar than in the rest of the country. Poor women experienced more complications from unsafe abortion and were less likely to obtain medical treatment than non-poor women. Poor rural women had only 44 percent of their complications treated, while non-poor urban women had 86 percent of their complications treated.

Senegal has a national postabortion care program, but needed equipment and supplies are not always available. Only 42 percent of women who experience abortion complications receive needed medical care. There have been several high-profile cases of infanticide in Senegal in recent years, which may be related to the lack of safe abortion services. Equity remains a problem, with well-trained private doctors charging up to \$375 dollars for safer abortion services, while poor women unable to pay such lofty sums are left to their own devices to procure abortions.

Adolescents are considered particularly vulnerable in a context marked by poverty, lack of information and unemployment. According to the DHS, 15.3 percent of all pregnancies are among adolescents aged 15-19, and contraceptive prevalence among this age group is 4.7 percent. Authors of a 2005 study found that early pregnancy, STIs, HIV infection and unsafe abortion are all serious problems for adolescents in Senegal, yet young people are reluctant to access formal health services due to stigmatization, shame and negative provider attitudes.

Policy

The laws concerning abortion in Senegal are quite unclear but are among the most restrictive in the region, and indeed the world. According to the Article 305 penal code and reproductive health law, abortion is criminalized in all circumstances with no exceptions and is not allowed to be considered as a form of contraception. A new reproductive health law was passed in 2005, with a great deal of controversy surrounding the drafting of the law. The final law did not include any language liberalizing abortion or creating exceptions for the life or health of the mother, rape, incest or fetal anomaly.

However, Article 35 of Senegal's Code of Deontology (medical ethics) does permit therapeutic abortion "if this intervention is the only likely way to save the life of the mother." The Code specifies that this can only be done when the attending physician gets the written agreement of two consulting physicians, at least one of whom is from a list of medical experts approved by the courts.

Legal reform is on the agenda for the Ministry of Health, which in 2013 created a task force for the legalization of abortion, in collaboration with several civil society groups. The task force includes legal experts, sociologists, physicians, midwives, journalists, human rights experts, researchers and academics, and was convened to lead advocacy for reform of the penal code and the reproductive health law to expand access to medicalized abortion. The task force has drafted an example law that corresponds to the Maputo Protocol. As of November 2015, revisions to the Penal Code had been submitted to, but not adopted by, the Council of Ministers.

Recent developments include a report by the International Federation of Human Rights and concern expressed by UN experts about the criminalization of abortion and the restrictive conditions under which it is available in Senegal. The UN experts urged the country to amend its legislation to decriminalize abortion and ensure that it is legally available in cases of threats to the life and health of the pregnant woman, rape, incest and serious impairment of the fetus.⁵³ The President made a public statement that abortion should be legal in certain cases of rape and incest.⁵⁴

Health systems

Postabortion care has mostly been available only at secondary and tertiary level facilities, and only by high-level providers such as physicians. MVA is not available at all levels of the health system, and access remains a problem because of lack of proper equipment and training at lower-level facilities.

Despite these gaps, according to some sources, Senegal has become "a leader in West Africa in the extension of postabortion care." There have been considerable efforts in the past several years at decentralizing PAC services to make them more available to women at lower levels of the health system.

Between 2003 and 2005, a Management Sciences for Health program introduced PAC in 23 Senegalese districts.

According to a 2014 study, misoprostol has been available in-country (and is included in the national norms and protocols) for gastric ulcers, postpartum hemorrhage and postabortion care since 2012. The Marie Stopes website indicates that misoprostol was registered in Senegal in early 2013. MSI is selling misoprostol under the brand name Misoclear in its facilities. The version of Senegal's essential drug list available on the WHO website does not include misoprostol for any indication.

Community

The Association of Female Doctors in Senegal is concerned about the growing use of products for self-induction of abortion in Senegal, saying that, "The [abortion] acts are becoming more and more serious. Before you had to look for someone to perform an abortion, but now with the internet, women look for information and try to do it themselves. So as doctors we are quite concerned."⁵⁵

Since 92 percent of Senegal's population is Muslim, religious beliefs present an important obstacle to the liberalization of the abortion law and policies.⁵⁵ However, the task force has done a great deal of work with religious leaders and has managed to gain support and understanding from many of the major brotherhoods.

There have been several high-profile cases of infanticide in Senegal in recent years, which many have connected to the lack of safe abortion services.^{56,57}

Senegal has a very active civil society, including many women's and human rights organizations and others who are lobbying for improved abortion laws, policies and access.

Togo

Background

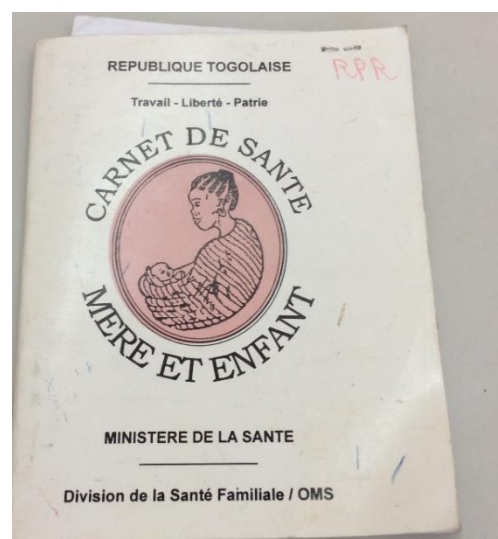
Togo is a small country of just under seven million people that is situated between Benin and Ghana on the Atlantic coast of West Africa. Over half of Togo's population is between the ages of 15 and 54, and 40 percent is under the age of 15.⁵⁸ The total fertility rate (TFR) in Togo reflects large social disparities. It is 4.7 overall, 3.5 for women in the highest wealth quintile, 3.7 in urban areas, 5.7 in rural areas and 6.3 for women in the lowest wealth quintile.⁵⁷ Disparities are also reflected in the adolescent pregnancy rate, which is nine percent for young women with a secondary education and 35 percent for young women with no education. The contraceptive prevalence rate is low—19.3 percent for all methods and 16.7 percent for modern methods, while unmet need for contraception is high at 34 percent. The maternal mortality ratio is also high in Togo, at 401 maternal deaths per 100,000 live births from 2007-2104.⁵⁹



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Health sector and reproductive health

Togo's health system is organized into three tiers: 1) The central/national level, charged with high-level coordination; 2) the intermediary/regional level, charged with administration and regional coordination; and 3) the district/prefect level, charged with executing plans and providing core services. Togo is divided into six health care regions that are further divided into 40 districts, in which 864 facilities provide services. The types of primary care facilities are health posts, Centers for the Protection of Mothers and Infants (*Les Centres pour la Protection des Mères et des Enfants*) and Peripheral Care Units (*Les Unités de Soins Périphérique*). Higher, secondary-level care is offered at Medical-Social Centers (*Les Centres Médico-Social*), while the highest level of care is offered at Regional Hospital Centers (*Les Centres Hospitaliers Regionaux*) and University Teaching Hospitals (*Les Centres Hospitaliers Universitaires*). At the central level, the Division of Family Health (*La Division de la Santé Familial*, or DSF by its French acronym) within the Ministry of Health is the main structure in charge of overseeing sexual and reproductive health programs, in addition to youth and nutrition services.⁶⁰



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A recent WHO assessment found that “Togo's health system is relatively well-equipped in terms of infrastructure, with 66.8 percent of the population enjoying access. Geographical, economic and social

disparities with respect to the delivery of and access to essential care nonetheless remain.”⁶¹ The WHO assessment determined that, among other challenges, the Togolese health system faces:

- Insufficient regulatory frameworks
- Non-compliance with legislation
- Weak leadership from the Ministry of Health, especially on priority sector reforms
- Deficient human resources in key positions of health administration

Togo is doing relatively well on increasing funding for health generally, and for reproductive health in particular. In 2011, Togo met its Abuja +12 pledge to devote 15 percent of public expenditures to health and spends six percent of the total health budget on addressing maternal and neonatal mortality.^{62,63} Despite this allocation, Togo frequently faces stockouts of reproductive health commodities.⁶⁴ In 2014, only 5.52 percent of the national budget, including both internal and external funds, was allocated to health. This percentage increased to 5.6 percent in 2015.⁶⁵

Togolese reproductive health programs are guided by a number of documents and strategic plans. The National Health Policy (*Politique Nationale de Santé*, or PNS by its French acronym) aims to reduce maternal mortality from 350 to 143 deaths per live births by 2022 by: 1) promoting emergency obstetric care via an optimal packet of obstetric interventions throughout the country; 2) reinforcing family planning services and promoting adolescent health through mobile strategies; and 3) reinforcing the fight against malnutrition and micronutrient deficiencies.⁶⁶ Maternal health is also outlined in the Reproductive Health Protocols (*Politique, Normes et Protocole en santé de la reproduction*, which was revised in October 2009 and includes specific protocols for emergency obstetric and neonatal care (EmONC).⁶⁷ Reducing maternal mortality is one of the primary objectives of the 2012-2015 National Plan for Health Development. In February 2015, the Government of Togo passed a Community-Based Intervention National Policy (PNIBC) to integrate new maternal and child health high-impact approaches including the distribution of injectables at the community level. The Togolese IPPF affiliate (L'Association Togolaise pour le Bien-Etre Familial, or ATBEF) led advocacy for this achievement with the support of the Opportunity Fund to accelerate Family Planning 2020's success.

Despite this abundance of plans and protocols, the ministry of health has not yet published comprehensive abortion care standards, guidelines and protocols, nor are there any plans or protocols to standardize PAC service provision or guide the scale-up of PAC services nationwide. A Division of Family Health official stated that they plan to do this soon and have asked UNFPA for technical assistance. This year, the midwifery school started providing pre-service training on MVA for PAC.

The majority of reproductive health care is supposed to be provided by midwives, overseen by gynecologists, but a lack of health personnel means that coverage by trained providers is inadequate and thus many rural women lack access to a provider trained in PAC.

Where midwives are not available, auxiliary birth attendants (*accoucheuses auxiliaires*) and permanent birth attendants (*accoucheuses permanentes*) are the only staff at health centers. All auxiliary birth attendants have received formal health training; however, permanent birth attendants have learned informally from family or friends to attend deliveries. According the president of the Togolese Midwives Association and director of the nation's midwifery school,

“Some birth attendants are trained...and were integrated into the PAC program. But those who were trained as they went along [on the job training, with no formal health training], no. And yet it is they who are the majority of health providers. For example, there are barely 900 midwives and between 400 and 500 formally-trained birth attendants. But there are more than 1,500 birth attendants with no formal training.”

She went on to say that there were only 23 gynecologists in the Togolese health system, many of whom live and practice in Lomé, the capital city, leaving the vast majority of Togolese women without access to one.

In addition to an inadequate number of trained providers, the provision of reproductive health services in Togo is hierarchical, with midwives often constrained by their superiors in the type of services they can provide. One midwife at a rural clinic reported that she was glad in some ways to be the sole provider of reproductive health services, saying,

“Here, it’s only me that does it, but in Lomé it’s doctors who do it... When I was in Lomé, there were things I didn’t do, but here, in front of the case, I have to do them.”

Access to CAC services is already extremely limited for women in Togo. The inadequate number of trained providers and low competency of midwives and birth attendants, compounded by midwives’ perception that they cannot provide CAC, amount to an even more severe lack of access to CAC services for women who live where there are no gynecologists. NGO representatives affirmed that many doctors are reluctant to embrace task shifting to midwives. Despite clear evidence and WHO guidance, several respondents, including MOH officials and midwives themselves, expressed concern about midwives’ ability to handle the increased responsibility of CAC service provision.

Data on abortion

Research on abortion in Togo is very scarce. There is only one peer-reviewed, English language study on abortion in Togo from the last 30 years.⁶⁸ Even in the grey literature, data are scant. The single peer-reviewed study, published in 2012, uses data from 1988, 1998 and 2002 to combine direct and indirect methods of estimating abortion incidence in Lomé to conclude that abortion seems to be increasing, especially among younger women. Between 1987 and 2002, the authors estimated that the abortion rate rose from 25.3/1000 to 29.6/1000 among women ages 15-34.⁶⁸

The only available data from the past decade come from studies available online in the French language, although these are not published in major journals, and from the most recent Multiple Indicators Cluster Study (MICS) in 2010.

A review of the methodology used in the 2010 MICS, and an interview with Yawo-Mensah Damessi, the demographer responsible for overseeing the abortion portion of that survey, raise serious concerns about the validity of the abortion data. This study used a survey methodology that simply asked women whether they had previously had abortions. This methodology is widely eschewed by abortion researchers, as it is known to produce underestimates of true abortion prevalence, as stigma and fear often lead to substantial underreporting in these contexts. Despite these critical flaws, the dearth of data from other sources makes the MICS estimates to some degree the only systematic data we have of abortion magnitude in Togo.

Overall, the MICS shows that nine percent of women aged 15-49 have experienced an induced abortion in their life,⁹ with abortion more common among young people, women with some education and women who live in wealthier households. Abortion is also more common among married women and women who have lived with a man. Women cite their primary reasons for seeking abortions as too-closely-spaced pregnancies, no current desire for a child, lack of financial ability to support a child, desire to continue studying, fear of parents, and partner's insistence (in order from most to least common).^{9,69}

Data from 1995 show that 24 percent of women aged 15-47 who came to family planning centers in Lomé had had an abortion.⁷⁰ Another study in 2000 found this number to be 28 percent, and a 2002 study cited 33 percent.⁶⁸ In 2012, the number of abortions recorded in Togo's maternal health services was estimated at 6,976, of which 1,756 are estimated to have been induced versus spontaneous. Among these, 1,881 women were hospitalized, which makes abortion one of the primary reasons for hospitalization in the country.¹⁰ Authors of an unpublished study in 2009 found that women were having more clandestine abortions earlier in their reproductive lifespan than they had previously, and that abortion was often used to delay the age at which women had their first child.⁷¹ A 2006 study found that the primary motivations for abortion in Lomé were: 1) economic; 2) to continue professional activities; and 3) conflict with partner or family. Fear and/or regret were higher among less educated women than among those with at least a secondary education.⁶⁹

Despite these indications that abortion is indeed a serious public health threat in Togo, the large gaps in research and lack of cohesive understanding of the scope of the problem present considerable challenges. We have little reliable data about how many abortions are being practiced, by whom and under what conditions, which was often cited by key informants in the situational assessment as a barrier to effective advocacy for increased provision of and access to comprehensive abortion care.

Laws and policies on abortion

Articles 42-44 of the Law 2007-005 on Reproductive Health were passed in January 2005 and override the previous laws governing abortion, which dated to 1920. This reproductive health law authorizes abortion to protect the life and health of the woman, when the pregnancy is the result of rape or incest and in the case of a severe fetal abnormality.

Article 43 specifies that any provider with training recognized by the government can provide an abortion, but article 42 stipulates that all legal abortions must be prescribed by a doctor. Since, according to the WHO's most recent data, there are fewer than 300 doctors in all of Togo,⁸ Article 42's requirement represents a formidable barrier to expanding access.

Despite the fact that this reproductive health law has been on the books since 2007, it remains poorly known and understood even by public health officials, providers and law enforcement professionals. A midwife who works outside of the capital told us:

"I don't know [the law] because before they said that they were going to publish an article on therapeutic abortions, but I never got the information."

A small project to translate the text of the law into local languages and disseminate it throughout the country was started by the local NGO Alliance for Research and Capacity Building (*Alliance pour la Recherche et le Renforcement des Capacités*, or ARECA). The booklets were produced, but the dissemination was not widespread, and very few Togolese women are aware of the legal conditions for abortion access.

“The law is not disseminated. And even the providers who are supposed to be applying it don’t know it. And those who know it don’t have the tools to apply it.” - UNFPA representative

Even those who know the law intimately tend to interpret it more conservatively than the texts of the law mandate. Although the law states that any trained provider can perform an abortion under the prescription of a doctor, an MOH official provided this reason for not training midwives to perform abortions:

“It is not officially said somewhere, because we have not yet done the textes d’application... because in other places it can be midwives, but here, it is only the doctors [who can perform abortions].”

Even though the law itself contains no provisions about what must be done to prove that an unwanted pregnancy was the result of rape or incest before an abortion can be performed, many officials and providers in Togo claim that prosecutorial involvement is necessary. Many respondents expressed the belief that a woman who was raped must submit to a medical exam to receive a medical certificate from a doctor that she can then take to the prosecutor to make a formal complaint. According to these respondents, the woman must then take formal permission from the justice system back to the doctor before an abortion can be performed. They acknowledged that this process could be expensive, time-consuming, stigmatizing and all-but-impossible for most women, especially those outside of Lomé, but many maintained that such formalities were necessary. For example, a senior gynecologist at one of Togo’s teaching hospitals and the national PAC focal-point said:

“If you come to see me for a pregnancy that came from an incestuous relation without proof, if I proceed to interrupt that pregnancy, on what basis can I justify that act if one day you or someone else goes to the police?”

In addition to fear of prosecution, others expressed the concern that, without such a high standard of proof, women could claim rape or incest anytime they wanted an abortion, which could lead to a loosening of morals and social structures. The fact that many women do not formally report rapes when they take place presents a challenge to providers, as a doctor at ATBEF reports:

“Another case that’s not yet very clear is the case of rape. Most often, when there’s a rape, people don’t come to report it. It’s when there’s a pregnancy that they come. So that means that we don’t really know if there was a rape or not... We do not yet have an established protocol for abortion in the case of rape, since at the national level, it’s not yet very legal. And since not everything has been signed, we’re afraid that if a problem comes one day, we’re not covered.”

A number of respondents said that much of the hesitation about and barriers to implementing the 2007 reproductive health law stems from the fact that the government never published the provisions for implementation (*textes d’application*). Apparently, legal abortions are rarely performed in Togo, even for women who meet the legal criteria. Key informants provided conflicting information about the current status of these provisions. Some claimed that they had never been written and others claimed that they had been written and submitted to the validation process but were stymied in the bureaucratic process. This issue will need to be addressed to improve access to CAC in Togo.

PAC provision

PAC was first formally introduced in Togo in 2006. Although some clinical guidance for treating incomplete abortion is incorporated into Ministry of Health documents such as the 2009 “Politique, Normes et Protocole” for Reproductive Health, and PAC is included in the national Roadmap to Reduce Maternal, Neonatal and Child Health, Togo has not developed any strategic documents to guide the scale-up of PAC provision nationwide.⁶⁷ As a result, progress on training providers and equipping facilities has been scattered. The DSF, the national PAC focal-point, providers and other key actors all express strong support for PAC and a desire to see it rolled out systematically countrywide, but recent movement has taken place sporadically and primarily when donors, NGOs or technical partners sponsor trainings and donate supplies. Although some Togolese providers were trained on PAC prior to 2006, since that year seven PAC trainings have taken place in Togo, sponsored by organizations such as ATBEF, the Evidence2Action project, Ipas, Plan Togo and WHO. A total of 107 providers have been trained through these trainings, 65 of whom are from Lomé or the surrounding Maritime region. The Savane region, the northernmost of Togo’s six health-care regions and the farthest from Lomé, has had no providers trained in PAC. It is also important to note that MVA, an essential part of PAC, is largely included in EmONC trainings. According to the DSF, the health system provided PAC to 654 women in 2013.⁷²

Even in and around Lomé, where trained doctors and midwives can provide PAC, provision is not standardized. As one senior gynecologist explained:

“Doctors, medical assistants, midwives, nurses. And I can’t hide it from you, in some health facilities, it is trained auxiliary birth attendants (accoucheuses auxiliaires) who provide PAC.”

According to the 2009 “Politique, Normes et Protocole” for Reproductive Health, ongoing or inevitable abortion should be treated with digital curetage, curettage or MVA. Misoprostol is only mentioned to treat postpartum hemorrhage. According to WHO, misoprostol and vacuum aspiration, not digital curetage or curettage, are the recommended methods for treatment of incomplete abortion.⁶⁵ That misoprostol is not widely considered for treatment of incomplete abortion was confirmed by several Togolese midwives, who said that they only use misoprostol to ripen the cervix for MVA but never on its own. They gave the impression that they were unaware that misoprostol could be used to treat incomplete abortion.

Although the cost of MVA varies, one midwife told us:

“An MVA costs about 6,000 FCFA. Now we prescribe xylocaine. All of that stuff, the gloves, the syringe, everything, costs about 6,500 FCFA. So plus the prescription, it can add up to 16,000 FCFA.”

All of the midwives interviewed had been trained to provide PAC, but many said that before they had been trained, they would have to refer cases to other facilities staffed by doctors. Since there are



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no formal patient transport mechanisms for referrals, this caused a delay for women to receive care. Facilities without trained PAC providers are no longer common in and around Lomé, but this remains a serious problem in areas far from the capital and rural areas.

Most PAC programs in Togo have not included adequate post-training clinical mentoring and support for providers. A midwife by training and PAC focal point at the DSF told us:

“Those who have been trained in PAC don’t do it anymore because of transfers and because of disinterest. No one ever came to see what they were doing, whether it’s good or not.”

CAC provision

Due to lack of CAC service delivery standards and guidelines, perhaps also provisions for implementation (*textes d’application*), limitations on midwives and other non-physician providers, negative attitudes towards abortion by health system officials and providers and other barriers, the Ipas team could not find any evidence of CAC being systematically provided anywhere in Togo. The DSF does not track how many legal abortions take place per year, but several sources estimated this number to be very low. Even at ATBEF in Lomé, there is no systematic provision of CAC, in stark contrast to the IPPF affiliates in neighboring countries.

CAC service provision is understood by many to be limited only to doctors, and therefore midwives and other non-physician providers are not trained to offer CAC. Most respondents expressed strong support for this restriction, with some stating that midwives could not be trusted to perform CAC. Some expressed strong concerns about the law being, as they said, “abused by women.” A trained midwife, gave the following example:

“[If a woman says her pregnancy was a result of rape,] and the pregnancy doesn’t show any sign of [spontaneous] abortion, the midwife cannot do that. That is like a voluntary interruption. The law does not permit us to do that... If we can respond to those requests, it’s going to become a routine... it’s going to become a habit, and that’s not good.”

The opposition to abortion was palpable among many of the health-care providers interviewed. Some providers claimed that their profession called them to protect life and not to end it. A medical assistant stated:

“They come to ask for an abortion, but we tell them that the character of the hospital is sacred, and that this is a practice we do not do at the hospital... We tell ourselves that at the hospital, we save lives...it’s like a blessed thing. So we cannot remove life, even if it’s an embryo or a fetus.



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Providers and clients alike confirmed that providers in public facilities generally refused to perform abortions, even for legal indications. One focus group member recounted a story from several years prior, when she sought an abortion. She said that she went to the facility “day after day” to find a provider to assist her, but that she was turned away so many times that she gave up and carried the pregnancy to term. And yet, a high-ranking source at the DSF claimed that he was unaware of eligible women being turned away from care. He told us:

I never heard of a woman who was eligible for one of these [legal] conditions for voluntary interruption and was blocked. I never heard of that.

Overall, the situational assessment team was not able to ascertain any formal provision of CAC in Togo, with abortion-related care restricted exclusively to the nation’s relatively nascent PAC services. It seems likely that many women who meet the legal conditions for induced abortion but can’t access safe services resort to clandestine, unsafe abortion or carry the unwanted pregnancy to term. Most respondents did not comment on or express concern about the life-threatening consequences for woman who resort to unsafe abortion when the health system and providers refuse safe services to which they are legally entitled.

Self-induced abortions and medical abortion

Although misoprostol is on the essential drug list in Togo (to treat postpartum hemorrhage), it is very difficult to find it in pharmacies or health facilities. Our mystery client visited nine pharmacies in Togo and found that all nine were experiencing stockouts of the drug. Even at the Centre Hospitalier Sylvanus Olympio, one of the nation’s premier teaching hospitals, the national PAC focal point said that misoprostol was not in stock. The situational assessment team found no evidence of mifepristone anywhere in the country.

Knowledge of misoprostol as a means to induce abortion appeared very low; none of the women in the focus groups reported having heard of it, though a few women did generically cite “pills” as a method of inducing abortion. A doctor from ATBEF reported that:

“There’s a certain category of women that know about the use of misoprostol for this intention (to induce an abortion)... educated women under 25 years old.”

Instead of misoprostol, women in the focus groups discussed the use of herbal infusions (*tisanes*) of herbs and roots, bleach, and “violent exercise.” The focus group respondents knew that these methods were unsafe but cited their low cost and ease of access as primary advantages. Women said that plants and other traditional methods cost 100-1000 FCFA (20 cents-\$2 USD), in contrast to curretage at a private clinic, which they said can cost 20,000-30,000 FCFA (\$40-60 USD).

Midwives and other providers are well aware that women resort to dangerous methods to self-induce abortions. One midwife told us,

“There is a tige [plant stalk] that we call babati, and when you break it, there is an acidic liquid that comes out, so when they put that in the vagina, it sometimes opens up the cervix and acts like an oxytonic. It can open the cervix with contractions and blood comes out... but it also causes complications, uterine perforations. We had a case like that here the other day. The cervix was torn to shreds!”

One respondent (who was not affiliated with PSI) said that PSI had tried to launch a program in recent years to import and sell the drug with social marketing, but the program faced opposition and too many bureaucratic obstacles and was eventually abandoned.

Community engagement

There does not yet seem to be much community engagement around abortion in Togo. Even among organizations and individuals who do not oppose abortion, there was little evidence of activism or even awareness of the issue. The Togolese branch of Women in Law and Development in Africa (WiLDAF), a women’s rights organization, admitted that they had not previously thought about abortion as part of their mission, a statement that was repeated by several other Togolese NGOs colleagues.

Also among international NGOs working in Togo, abortion is considered outside of the scope of work. One representative of an organization that receives funding from USAID hesitated before agreeing to be interviewed so that he could confirm he would not be out of compliance by discussing abortion.

There is a group of reproductive health organizations in Togo called the Network of Civil Society Organizations in Reproductive Health and Family Planning (*Le Réseau des Organisations de la Société Civile en Santé de la Reproduction-Planification Familiale*



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or ROSCI-SR-PF), but even members of this group expressed the idea that Togo was not yet ready to talk openly about abortion. The director of Vision, Initiatives and Engagement for Health (*Vision, Initiatives et Engagement pour la Santé* or VIES), a member of ROSCI-SR-PF said:

“For the moment, more than anything, there’s advocacy for the acceptance of family planning. The churches and the mosques don’t accept family planning, so we’re developing Biblical and Koranic arguments around that. Now, if we want to go right away with abortion, it will be difficult!”

The director of another ROSCI-SR-PF member, ARECA, echoed this idea, saying:

“Our role is much more to prevent abortion. We work much more in information and in access to contraception. The second thing is PAC...We really prefer to prevent the pregnancy.”

ATBEF colleagues expressed a “grand challenge” of ensuring that safe abortion is offered according to IPPF’s global strategy, but also made statements indicating institutional ambivalence toward abortion, such as:

“The majority of our providers are women, and we see that in matters of abortion, women are skeptical...The discussion of abortion is not an open discussion.”

Despite the fact that civil society is not yet mobilized around abortion in Togo, there are some indications that progress could be made. WiLDAF, for example, thanked the situational assessment team for bringing the issue of abortion to their attention and helping them to think about it in a new way. Several other informants echoed this sentiment, giving the impression that progressive Togolese civil society is not as much opposed to abortion advocacy as it is uninitiated.

The Togolese women who participated in the focus groups did not express stigma or opposition to abortion, and the majority favored legalizing abortion (though they warned that they thought this would be “impossible”). They openly shared stories of past abortion-seeking and even those women who expressed concern about abortion for religious reasons also expressed understanding for abortion-seekers, since “it is the woman who suffers.”

Organizations

Several international NGOs work on reproductive health in Togo, including Plan, PSI and JSI. Pathfinder International does not have permanent offices in Togo, but has programs there such as Evidence2Action. EngenderHealth has a country program office in Togo, but also has its regional headquarters for the Agir-PF program (funded by USAID) in Lomé. Local NGOs include ATBEF, ARECA, VIES and other members of the ROSCI-SR-PF. WiLDAF Togo has been active promoting women’s rights from a legal perspective. UNFPA and WHO are primary technical partners of the Ministry of Health in reproductive health matters, as well as funders of programs. In addition to Agir-PF, USAID has funded several other reproductive health projects in Togo in recent years, including the Health Policy Project and AWARE-II.

Political will and commitment to implement CAC

The political will to work on PAC is very strong in Togo. DSF, UNFPA and civil society leaders expressed a fervent desire for more funding and technical partnerships to promote PAC expansion in Togo. The reproductive health law has been on the books since 2007, and yet the government, NGOs, civil society groups and reproductive health networks have not taken any steps to implement the legal indications for abortion. Some leaders express outright opposition to CAC or continuously refer to PAC in place of CAC. Political will for implementation of comprehensive abortion care services is not yet apparent, and no respondent is currently championing women's right to access legal abortion services.

Limitations and cautions for CAC implementation

Because there is resistance among religious leaders and others even to less-controversial reproductive health topics such as family planning, many respondents said that they would expect opposition to a CAC program to be formidable. In addition to religious opposition, cultural taboos around sexuality in general and abortion in particular make it difficult to promote women's right to abortion. The prevalent belief that children are a gift from God stigmatizes abortions-seekers as refusing God's gift, while dominant cultural notions of women as mothers and caregivers stigmatizes abortion-seekers as rejecting this maternal role.

Opportunities for CAC implementation

To achieve the large reduction in maternal mortality outlined in the National Health Policy, the Togolese MOH will need to address abortion-related mortality and morbidity by increasing women's access to safe services authorized by law. A study tour to observe a successful CAC program in another West African country could provide an extremely useful model for implementation in Togo. Workshops on the reproductive health law and comprehensive abortion care service delivery can help stakeholders better understand their country's abortion law and policies and how they can be implemented to increase women's access to safe services. Abortion values clarification and attitude transformation (VCAT) activities are vital to include in every workshop and intervention to help stakeholders clarify their values and beliefs on abortion, explore alternative attitudes and actions and understand the consequences of failing to provide comprehensive abortion care.

CAC service delivery standards and guidelines need to be developed with clarification on the legal indications for induced abortion; recommended uterine evacuation methods; midwives' ability to perform induced uterine evacuation; and the roles of different provider cadres in different levels of the health system in performing elements of comprehensive abortion care, including postabortion care and postabortion contraception. The MOH can remove unnecessary burdens on women seeking care and ensure more equitable access to women outside of Lomé by implementing these standards and guidelines. In-country stakeholders can discuss the need for provisions for implementation (*textes d'application*), given that many other African countries' health systems that routinely offer CAC services do not have them in place.

Research on the magnitude and incidence of abortion and unsafe abortion's contribution to maternal mortality would also be an important step. Many informants identified the lack of current, local abortion research as a key obstacle to effective advocacy.

It also will be important to continue to train providers and scale up PAC, as an element of comprehensive abortion care, throughout the country. National protocols can be updated to align with WHO guidance to eliminate outdated uterine evacuation methods and promote recommended medical methods and vacuum aspiration.

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Misoprostol is already on the essential drug list, but a sustainable supply chain of MVA, misoprostol and even mifepristone needs to be put in place in facilities and pharmacies.

Another important step for CAC implementation is dissemination of the reproductive health law to health officials, providers, law enforcement and women in communities, in addition to facilitation of productive and respectful discussion on abortion in Togo. The law has already been translated into local languages and, in addition to written texts, radio and other mass media can be used to spread the information widely, including to women who have low literacy levels. The absence of current public discourse on abortion presents an opportunity to frame abortion as a health and human right issue and an important way to reduce maternal morbidity.

Strategic partnerships for CAC implementation

Any action on CAC in Togo should be undertaken in collaboration with the DSF, ATBEF and the ROSCI-SR-PF network of local NGOs. WiLDAF has not yet been involved in abortion work in Togo but expressed an eagerness to become involved and has a women's rights-based perspective that was unique among respondents. The UNFPA would be key to involve as well, as they work as technical partners with the DSF and fund many reproductive health programs in Togo.

Recommendations

Based on the situational assessment findings, the following actions are recommended:

- Engage with governments to increase their commitment to implementing comprehensive abortion care to the fullest extent possible
- Engage with donors to increase their support for abortion care programs in francophone West African countries
- Promote understanding of the local abortion law and legislative and ministry of health processes for implementing the existing law.
- Support the development, endorsement and implementation of provisions for implementation (“textes d’application”) and development of standards and guidelines, integrated with other reproductive health guidelines, so that existing abortion and related reproductive health laws and policies can be fully implemented. In Benin specifically, the 2011 abortion standards and guidelines document needs to be revised, adopted and fully disseminated to health systems officials, managers and providers.
- Partner with local organizations to conduct education on and dissemination of the abortion law, policies and standards and guidelines, so that providers, women and other stakeholders are aware of the legal conditions, service delivery guidance and women’s right to comprehensive abortion care.
- Implement abortion values clarification and attitude transformation (VCAT) interventions to improve stakeholders’ knowledge, attitudes and support for increased delivery of and access to comprehensive abortion care.
- Partner with local organizations to support local champions and cultivate new advocates to increase awareness of and support for CAC and hold the government accountable for ensuring delivery of and access to quality CAC.
- Support efforts to scale up CAC, and continue to scale up PAC, to all levels of the health system to ensure access to care for all women, and in a way that is integrated within broader sexual and reproductive health programs.
- Ensure mechanisms for a sustainable supply of commodities and equipment are in place
- Promote awareness of and access to quality mifepristone and misoprostol, through education and regulatory and distribution interventions, and ensure women’s choice of uterine evacuation method whenever possible.
- In collaboration with in-country and international research partners and institutions, prioritize areas for further abortion research, including abortion magnitude and incidence studies, participatory research on abortion stigma, operations research on existing services and other topics to support advocacy efforts and program design.
- Connect key actors in francophone West African countries with colleagues in other countries to learn from their experiences successfully implementing CAC programs.

In francophone West Africa, there are substantial cultural, social, financial, political, legal and geographical obstacles to expanding access to CAC. The progress implementing a CAC program will be slow at times and may be hard fought. Comprehensive abortion care in francophone West Africa has been neglected for far too long. However, with a concentrated investment in the region, truly transformative change for women’s health is possible.

Appendix A: Relevant national guidance documents in francophone West African countries*

Country	Relevant National Guidance Documents
Benin	<ul style="list-style-type: none"> <i>Protocoles de services de sante: Volet femme/Health care protocols: Section on women</i> (no date) <i>Avortement medicalisé au Bénin: Guides et standards/Safe abortion in Benin: Standards and guidelines</i> (2011)
Burkina Faso	<ul style="list-style-type: none"> <i>Soins apres avortement (SAA)/Postabortion care (PAC)</i> (no date) <i>Prevention et prise en charge des avortements a risque: Politique, normes et protocoles [Draft]/Prevention and management of unsafe abortions: Policies, standards and protocols [Draft]</i> (2011) <i>Politique et normes en matiere de sante de la reproduction/Reproductive health policies and standards</i> (2010) <i>Plan strategique pour une maternite a moindre risque/Strategic plan for safe motherhood</i> (2004)
Cameroon	<ul style="list-style-type: none"> <i>Politiques, normes, standards en sante maternelle/plannification familiale pour les formations sanitaires du Cameroun</i> (December 2015) <i>Post-abortion care: Reference manual/ Soins après avortement: Guide du reference</i> (no date specified) <i>Post-abortion care: Trainer's guide/Soins après avortement: Guide du formateur</i> (no date specified) <i>Soins obstetricaux, neonataux essentiels et d'urgence: Manuel de participant</i> (2014)
Guinea	<ul style="list-style-type: none"> <i>Normes et procedures en sante de la reproduction: Sante de la femme et de l'enfant, Volume 2/Standards and procedures in reproductive health: health of the woman and the child, Volume 2</i> (2010) <i>Standards de performance pour les soins obstetricaux et neonatals d'urgence (SONU)/Performance standards for obstetric and neonatal emergency care</i> ((no date) <i>Standards de performance pour les soins obstetricaux et neonatals d'urgence (SONU): Fiche de syntheses / Performance standards for obstetric and neonatal emergency care: Fact sheet</i> (no date) <i>Fiche d'observation pour les soins apres avortement (SAA) de qualite/Observation sheet for quality of postabortion care (PAC).</i> (no date) <i>Rapport mensuel de l'etablissement sur les soins apres avortement: Fiche de compilation des statistiques de services/Monthly report of the institution in postabortion care: Specifications for the compilation of statistics of services</i>(no date)
Ivory Coast	<ul style="list-style-type: none"> None identified
Mali	<ul style="list-style-type: none"> <i>Normes et protocoles des soins d'avortement [Draft]/Abortion care standards and protocols [Draft]</i> (2009) <i>Politique et Normes des Services de Sante de la Reproduction/Reproductive health care policies and standards</i> (2004)

Mauritania	<ul style="list-style-type: none"> • None identified
Niger	<ul style="list-style-type: none"> • <i>Plan national de plaidoyer en sante sexuelle et reproductive des adolescents et jeunes (SSRAJ) [Draft]/National advocacy plan for sexual and reproductive health of adolescents and young people (SSRAJ) [Draft] (no date)</i>
Senegal	<ul style="list-style-type: none"> • <i>Politique et normes des services de la reproduction/Reproductive health care policies and standards (2000)</i> • <i>Protocoles des services de sante de la reproduction/Reproductive health care protocols (2000)</i> • <i>Politiques et normes de services de sante de la reproduction/Reproductive health care policies and standards (no date)</i> • <i>Protocoles de services de sante de la reproduction au Senegal/Reproductive health care protocols in Senegal (no date)</i> • <i>Plan strategique de la sante de la reproduction 2011-2015/Strategic plan for reproductive health 2012-2015 (no date)</i> • <i>Traitement des complications d'avortement et soins apres avortement par l'AMIU/Treatment of abortion complications and postabortion care by MVA (no date)</i> • <i>Liste du materiel a fournir aux structures sanitaires pour l'integration des SAA de preference avant la visite d'installation/List of equipment to provide health facilities for the integration of PAC preferably before the installation visit (no date)</i>
Togo	<p><i>Politique, normes et Protocole en sante de la reproduction, planification familiale et infections sexuellement transmissibles de Togo/Policies and standards for reproductive health care, family planning and sexually transmitted infections in Togo (2004)</i></p> <ul style="list-style-type: none"> • <i>Normes sanitaires du Togo, tome I: Normes pour les structures de soins de sante/Health care standards in Togo, volume I: Standards for health care structures(2013)</i> • <i>Protocoles de sante de la reproduction (SR): Sante de la mere, sante de l'enfant, sante des jeunes et adolescent(es), sante des homes, tome I/Reproductive health (RH) care protocols: Mother's health, child health, health of youth and adolescents, men's health, volume II (2009)</i> • <i>Plan d'Action pour le repositionnement de la planification familiale au Togo 2013-2017 (2013)</i> • <i>Politiques de sante de la reproduction , plannification familiale et infections sexuellement transmissibles de Togo, 2^{eme} edicion / Reproductive health protocols, family planing and sexually transmitted infections in Togo, 2nd edition</i> • <i>Loi No. 2007 – 005 sur la sante de reproduction / Law No. 2007 – 005 on reproductive health</i>

* Full texts of all documents listed here are in Ipas's National Abortion Guidance Documents Repository.

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