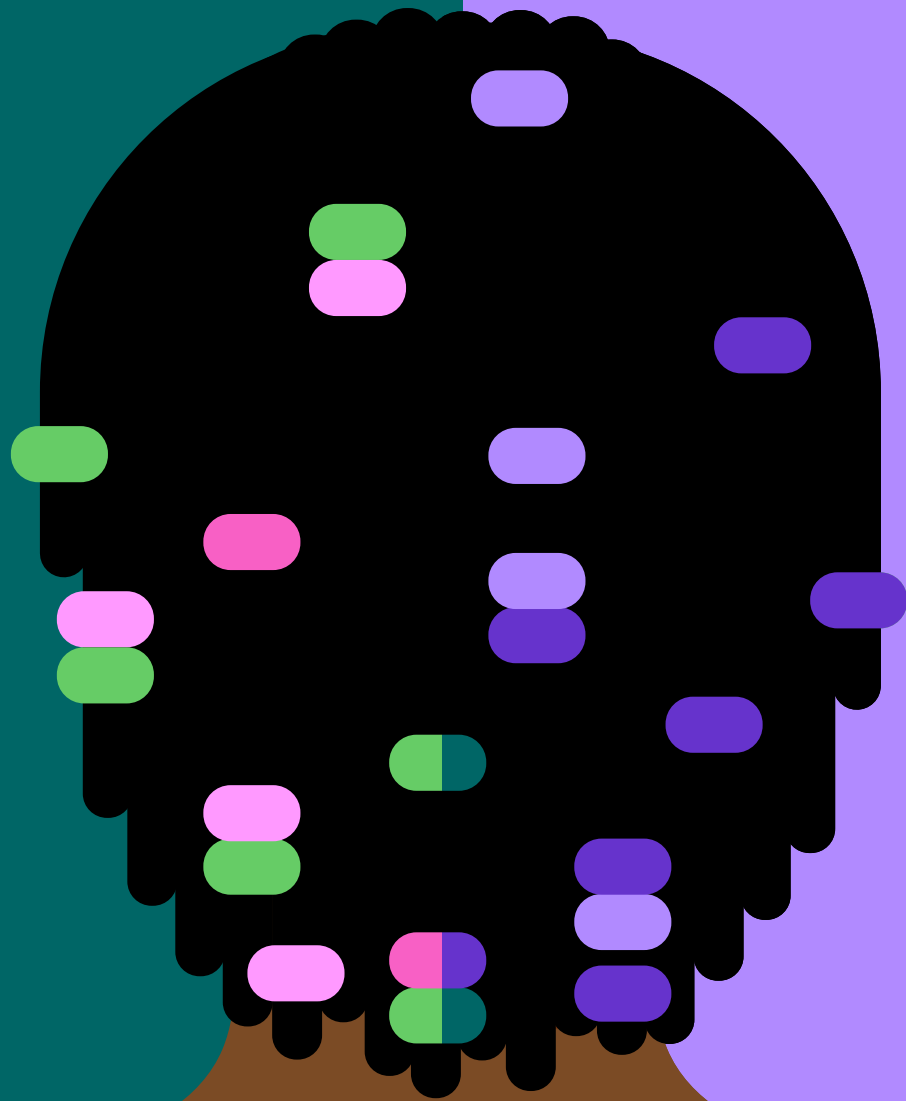




THE MAZE WOMEN FACE: STUCK BETWEEN RIGHTS AND REALITY

**Access to safe and legal
abortion for women and
girls, victim-survivors
of sexual violence**

A comparative study in West
and Central Africa 2025

Rutgers



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Table of contents:

Acknowledgements	3
Executive summary	7
Introduction	16
About the study	20
- Why this research matters	22
Findings	26
- Legal and policy frameworks, their evolution and gaps	27
- Takeaways	27
- Summary of results per country	29
- Similarities and differences legal frameworks	34
- Implementation gaps and other barriers faced by victim-survivors	38
- Takeaways	39
- Benin	39
- Conclusion	49
- Burkina Faso	50
- Conclusion	59
- Cameroon	60
- Conclusion	67
- Côte d'Ivoire	68
- Conclusion	77
- Togo	78
- Conclusion	90
Discussion: How exclusion mechanisms deny the right to safe abortion	92
- Delayed accountability and responsibility of the state	93
- Complex access procedures	96
- Information exclusion, a cross-cutting barrier in all countries	98
- Patriarchal social control: stigma and enforced silence	99

Conclusion	100
Recommendations	102
Annexes	110
- Annex 1	110
- Methodology	110
- Country selection strategy and study area	113
- Target population and sampling	114
- Data collection	115
- Data analysis approach	117
- Ethical approvals and protection policies	118
- Annex 2	120
- Legal and policy frameworks documented in the five countries	120
- Annex 3	131
- Study objectives	131
- Annex 4	132
- Abbreviations and acronyms	132
- List of tables	133
- List of figures	133
Bibliography	134

Executive summary

Despite legal frameworks that allow access to safe abortion, victim-survivors of sexual violence in West and Central Africa continue to face overwhelming barriers. This study reveals a huge gap between rights on paper and lived realities in five countries, showing how overlapping systems of law, healthcare and social norms create a maze of obstacles that prevent women and girls from accessing justice, support and care.

This study reveals a huge gap between rights on paper and lived realities

First systematic, comparative study in the region

A preventable crisis

Every year, around 25 million unsafe abortions occur worldwide (WHO). The consequences are devastating. Over 20,000 women and girls die and many more live with lifelong physical or medical complications. Women, girls, communities and health systems also bear high social and financial costs. These outcomes are not inevitable. They result from gender inequality, stigma and restrictive legal frameworks that limit access to safe, timely care. While entirely preventable, unsafe abortion remains a leading cause of maternal mortality in countries with restrictive abortion laws; where abortion is broadly legal, most abortions are safe.

In West and Central Africa, the risks are especially high. In 2029, an estimated 2.3 million unsafe abortions were performed in West Africa and 1.1 million in Central Africa, making these regions among the riskiest in the world for women and girls to experience unintended pregnancy.

Behind these statistics are countless individual stories of women and girls who became pregnant through sexual violence, including rape and incest, and were denied safe options as permitted by law. Victim-survivors of sexual violence are routinely failed by inadequate law implementation, incomplete policies, inaccessible services and profound information gaps. Many do not even know they have a legal right to a safe abortion. At every turn, they face stigma, discrimination and blame for circumstances beyond their control.



Benin
Burkina
Faso
Côte
d'Ivoire
Togo
Cameroon

Uncovering the maze women face

This is the first systematic, comparative study in the region examining how legal frameworks, administrative systems and social norms interact to shape victim-survivors' access to safe abortion. It highlights both persistent barriers and examples of progress that could inform reform, while foregrounding the lived realities of victim-survivors, which too often remain hidden.

The study was conducted by Rutgers and CERRHUD in five countries* – Benin, Burkina Faso, Côte d'Ivoire, Togo and Cameroon. While the countries share similar institutional contexts, they diverge in legal and policy trajectories.

The research draws on the unique contribution of young, in-country researchers, whose contextual knowledge and perspectives ensured that the voices of young people are central to the evidence.

* Selected through the Ado Avance Ensemble partnership, coordinated by Rutgers in collaboration with partners in West and Central Africa.

Findings: The gap between laws and realities

The study explores barriers to accessing legal abortion across different levels of governance and implementation. It shows how gaps accumulate from top to bottom: ratifying an international human rights framework without follow-through, administrative paralysis, uneven institutional adoption and ultimately victim-survivors' journeys that end in denial and danger.

A huge gap exists between rights on paper and lived realities

Legal frameworks and political intent

The five countries studied have all ratified the Maputo Protocol. Full domestication of Maputo Protocol article 14(2)(c)*, authorising medical abortion to victim-survivors of sexual violence, is rare with only Benin having fully domesticated this article.

In all five countries, legal provisions criminalising 'the promotion' of abortion create fear among government and civil-society actors limiting communication and action.

Policy and systems gaps

Where national guidelines for safe and legal abortion exist, they are often unclear or contradicting other guidelines. Sexual and gender-based violence guidelines and sexual and reproductive health guidelines frequently remain unaligned. The absence of operational guidance, like in Togo for instance, leads to paralysis in health and legal systems.

Policy adoption by implementing organisations

Hospitals, clinics and courts interpret laws and policies inconsistently and staff are often unaware of the latest laws or miss guidelines on how to implement them. Victim-survivors' experiences therefore vary depending on which institution they approached: some provide compassionate care, while others deny services outright. However, innovations such as digital platforms connecting women to safe providers and professional associations creating referral pathways show what is possible when institutions actively strengthen implementation.

Implementation in practice and victim-survivors' lived realities

Victim-survivors and their families often lack information on the laws meant to protect them. Stigmatisation of victim-survivors and victim-blaming in families, communities and institutions further hinders effective care-seeking. When victim-survivors do disclose and seek care, the administrative, legal and financial hurdles are enormous, and procedures to obtain authorisations for abortion tend to take far too long. These barriers, frequently force them to resort to unsafe, clandestine abortions or forced motherhood, turning legal rights into privileges accessible only to the most informed and resourced.

*Authorising medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus.

Discussion: Interconnected exclusion mechanisms

The study shows that access to safe abortion for victim-survivors of sexual violence depends not only on legal frameworks but on a complex system of barriers that together create a maze of exclusion. These barriers can be grouped into four interconnected mechanisms.

1. Delayed accountability

All states in the study have ratified the Maputo Protocol, recognising abortion in cases of rape, incest, and risk to the woman's health and life. Except for Benin, they have not fully domesticated these provisions into national law or operationalised them. Ratification without effective implementation leaves victim-survivors unable to exercise rights that exist only on paper, while accountability mechanisms remain weak.

2. Procedural complexity

Victim-survivors must navigate demanding and often contradictory processes: obtaining police reports, securing medical certificates, seeking judicial authorisation – leading to delays that are retraumatising and incompatible with the time-sensitive nature of pregnancy. A few civil society initiatives to address these challenges are showing possible ways out of this complexity.

3. Information gaps

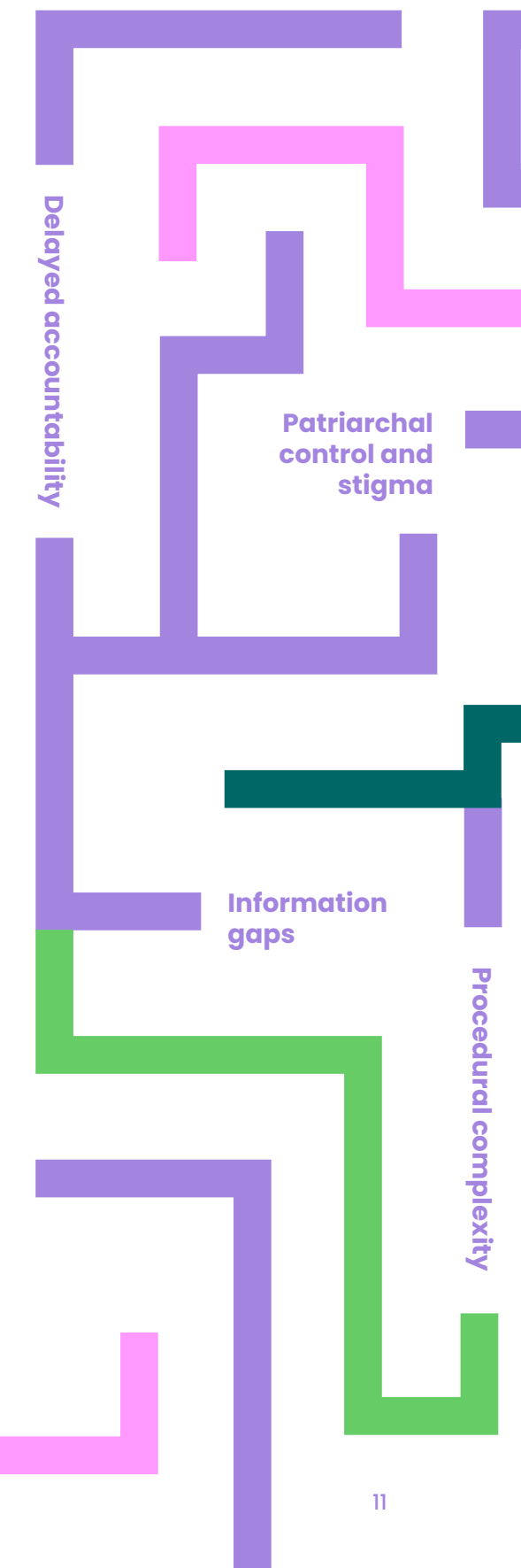
Even when legal grounds exist, victim-survivors often lack knowledge of their rights and are not properly referred to care. Healthcare providers themselves are frequently uncertain about the law; guidelines are unknown or non-existent and communication to communities about safe abortion is minimal. Many victim-survivors therefore turn to unsafe options simply because safe, legal avenues are unknown.

4. Patriarchal control and stigma

Harmful gender norms perpetuate blame and silence. Survivors face stigma and intimidation from perpetrators, families, communities and even health workers, which discourages reporting and seeking care.

Together, these mechanisms create a systemic maze that denies victim-survivors access to the rights they are entitled to rather than enabling them.

25 million
unsafe abortions
every year worldwide
(WHO)



Conclusion

This study reveals a stark paradox. Across the five countries in West and Central Africa, laws exist on paper granting victim-survivors of rape and incest the right to safe abortion, yet those rights remain out of reach. Victim-survivors are lost in a maze of delays, complexity, silence and stigma.

The consequences are devastating: maternal mortality, preventable injuries and countless futures cut short. But this is not inevitable. Systemic change is urgent and achievable.

Positive developments in policies, awareness, and service delivery show that progress is possible. While these efforts remain uneven, they signal that coordinated action and sustained commitment can make a real difference.

These are stepping stones to a better future but are not enough to end the maze. Governments, civil society, health care providers and communities must do more.

1.1
million
unsafe
abortions
each year in
Central Africa

2.3
million
unsafe
abortions
each year in
West Africa

These estimates are based on data from the report *From Unsafe to Safe Abortion in Sub-Saharan Africa – Slow but Steady Progress* by the [Guttmacher Institute](#).

Recommendations

Ending the maze requires bold and coordinated action. While the full report contains a comprehensive set of recommendations, the following highlight the most urgent priorities for governments, health systems, civil society and communities. These actions are critical to remove barriers, uphold rights and ensure that victim-survivors of sexual violence can access safe and legal abortion in practice, not just on paper.



Remove procedural barriers

Separating medical procedures from legal procedures allows to remove procedural barriers while protecting victim-survivors from further harm.



Make information widely accessible

Information on safe and legal abortion should be made easily accessible, which includes the removal by governments of legal barriers to awareness-raising.



Address stigma and discrimination

A fundamentally stronger effort is needed by governments, civil society and communities to combat and prevent sexual and gender-based violence and hold perpetrators accountable. This includes tackling prejudices, stigma and discrimination rooted in inequitable gender norms.



Follow successful reforms

Benin, Ethiopia, and the Democratic Republic of the Congo have reformed abortion laws by removing judicial prerequisites, recognising moral distress, or accepting a woman's report as sufficient evidence of rape. Other governments could follow these examples to create a more accessible, humane, and responsive framework for victim-survivors of sexual violence.



Align abortion and gender-based violence policies

Harmonise abortion and sexual and gender-based violence policies and ensure coordinated medical, social and legal support for victim-survivors.

The maze ends here

The Maze Women Face: Stuck Between Rights and Reality shows that while laws exist to guarantee safe abortion, victim-survivors of sexual violence face systemic barriers that trap them in a maze of delays, stigma and exclusion. Behind every statistic on unsafe abortion is a woman whose choices are constrained, whose health and life are at risk and whose dignity is compromised.

This is not inevitable. Together, we can turn evidence into action so that every woman's path leads to a safe choice, wherever she turns. No woman should risk her life to navigate the maze. Every victim-survivor deserves to be seen, heard, trusted and supported. Choice is dignity. And it is within our power to make it real, for all women and girls, everywhere.

Victim-survivors are lost in a maze of delays, complexity, silence and stigma.

Every victim-survivor deserves to be seen, heard, trusted and supported.

No woman should risk her life to navigate the maze.

Laure, a testimony of sexual violence from Togo

The story of Laure, from Togo, is a compelling example of this tragic reality. Every way she turned for help she faced an obstacle course blocking her way.

Laure^a, is a 16-year-old girl living in Togo who was raped by a neighbour. A health professional told us her story. She said that Laure had immediately informed her mother about the rape. A few days later, her mother was advised by a friend to take her daughter to a health centre. The mother had to wait three days to obtain permission from the father before she could do so. The examination, carried out more than five days after the assault, was unable to find any evidence of assault. Laure did not receive the emergency contraceptive pill because it was too late for the pills to be effective. Two months later, she returned to the health centre because she had not had her period. Her mother requested abortion care. The centre manager then initiated legal proceedings, but two months later there was still no response. Laure's mother therefore opted for a clandestine abortion for her daughter.

- ^a Pseudonyms are used throughout this report to preserve the anonymity of the participants who are victim-survivors of sexual violence.

Introduction

When a young woman in West or Central Africa becomes pregnant after rape or incest, her path should lead to care, safety and support. Instead, too often, she finds herself trapped in a maze: an exhausting obstacle course of stigma, silence, procedural delays, often resorting to an unsafe abortion. This is despite the fact that all countries have legal provisions in place to allow these adolescent girls and young women to access safe and legal abortion on these grounds if they do not wish to continue with the pregnancy.

Laure's experience is not an exception. This study documents the maze many women and girls face when they fall pregnant in the aftermath of sexual violence. It investigates why, despite legal reforms and international commitments, victim-survivors of sexual violence in five countries in five countries in West and Central Africa – Benin, Burkina Faso, Côte d'Ivoire, Togo and Cameroon – are often still denied the safe abortion care they are entitled to.

Many unsafe abortions occur among adolescents and young women. These are not abstract figures. They are lived realities: girls and women who had no other option than forced to drink unsafe concoctions, seek clandestine providers, or suffer lifelong injuries and preventable deaths.

This comparative research, conducted by Rutgers and CERRHUD in cooperation with partners in the region and by young researchers, brings together victim-survivors' testimonies, provider experiences and legal and policy analysis. It sheds light on how laws and commitments unravel in practice for women and girls. It shows how four exclusion mechanisms – lack of accountability, procedural complexity, information gaps and patriarchal stigma – systematically erode rights.

The study also highlights pathways forward. From Benin's groundbreaking reform to grassroots innovations, change is possible. With political will and investment, governments can turn evidence into action and ensure every woman's path leads to a safe choice.





About the study

This is the first systematic, comparative study in West and Central Africa examining how legal frameworks, administrative systems, and cultural norms shape the access of victim-survivors of sexual violence to safe abortion. It highlights persistent barriers and examples of progress, and foregrounds women's and girls' lived realities, which too often remain hidden or silenced.

The study shares insights while amplifying the voices of women, healthcare providers and advocates. It aims to inform policymakers in the five countries studied, as well as international stakeholders, including funders and donors.

Rutgers commissioned the Benin-based research centre CERRHUD to conduct the study, collaborating closely with their team. A unique feature of the research is its collaboration with five young, in-country researchers, whose perspectives ensured youth voices were central to the evidence.

The study focuses on five countries – Benin, Burkina Faso, Côte d'Ivoire, Togo and Cameroon – which share similar institutional contexts but differ in legal and policy trajectories. Using a qualitative, comparative approach, the research combined:

- In-depth interviews with victim-survivors of sexual violence and their relatives.
- Key informant interviews with healthcare providers, legal experts, policymakers, media and community actors.
- Desk review of laws and policy documents, including their alignment with international commitments such as the Maputo Protocol.

This research documents and analyses access to legal and safe abortion for victim-survivors, focusing on pregnancies resulting from rape and incest. It examines how laws and policies are implemented, identifies barriers, assesses the influence of social and cultural factors, highlights inequalities affecting vulnerable groups, and showcases organisational innovations that could improve care.

The study was conducted as part of the Ado Avance Ensemble programme, which supported adolescents and young people (10–19 years) in exercising their sexual and reproductive health and rights, and addressing key challenges that affect them. The programme was funded by the EU and implemented by a consortium coordinated by Rutgers, including ABBEF, ABPF, AIBEF, ATBEF, CAMNAFAW, DKT International and Ipas.

More details about the research team, positionality and methodology can be found in [Annex 1](#).

Why this research matters

This research addresses the intersection of two key challenges affecting adolescent girls and young women in West and Central Africa: unsafe abortion and sexual violence. Despite the urgency, these issues are rarely studied together, and data on pregnancies resulting from sexual violence are limited due to underreporting. Understanding this intersection is essential to inform policy and programmatic responses.

Unsafe abortion in West and Central Africa

Women and girls in Sub-Saharan Africa face some of the highest risks of unsafe abortion globally. An estimated 42% of pregnancies are unintended, and approximately 37% of these end in abortion. Restrictive laws and pervasive stigma mean that 77% of abortions are unsafe, contributing to an estimated 185 deaths per 100,000 abortions—around 15,000 deaths annually in sub-Saharan Africa alone.¹

Adolescents are particularly vulnerable due to low contraceptive use, limited sexuality education, unequal gender norms, and exposure to sexual violence.^{2,3,4} Sexually active adolescents have the highest abortion rates among women of reproductive age but rarely have access to legal or safe services, often resulting in severe complications or death.⁵

In West and Central Africa, 85% – 88% of abortions are less safe or unsafe. Central Africa (including Cameroon) has the highest abortion-related mortality in sub-Saharan Africa (≈260 deaths per 100,000 abortions), followed closely by West Africa (≈225 deaths per 100,000 abortions).⁶

In this region, women and girls face some of the world's highest risks of unsafe abortion.

Pregnancies in Sub-Saharan Africa



42%

of pregnancies are unintended

37%

of these unintended pregnancies end in an abortion

Health consequences of unsafe abortion

Women and girls who rely on unsafe abortion methods, and who often seek care late when complications arise, face immediate health risks such as haemorrhage and infection, lifelong injuries including uterine perforation, and, in the worst cases, death.⁷

Sexual and gender-based violence

Gender-based violence affects one in three women in sub-Saharan Africa (UNFPA).⁸ Sexual and gender-based violence is also widespread in humanitarian contexts,⁹ and has lasting health and social consequences, including unintended pregnancies. Although accurate data on pregnancies resulting from sexual violence are limited, available studies reveal an alarming reality. In Cameroon, a 2008 study found that 24% of girls and women who were raped became pregnant because of the rape.¹⁰

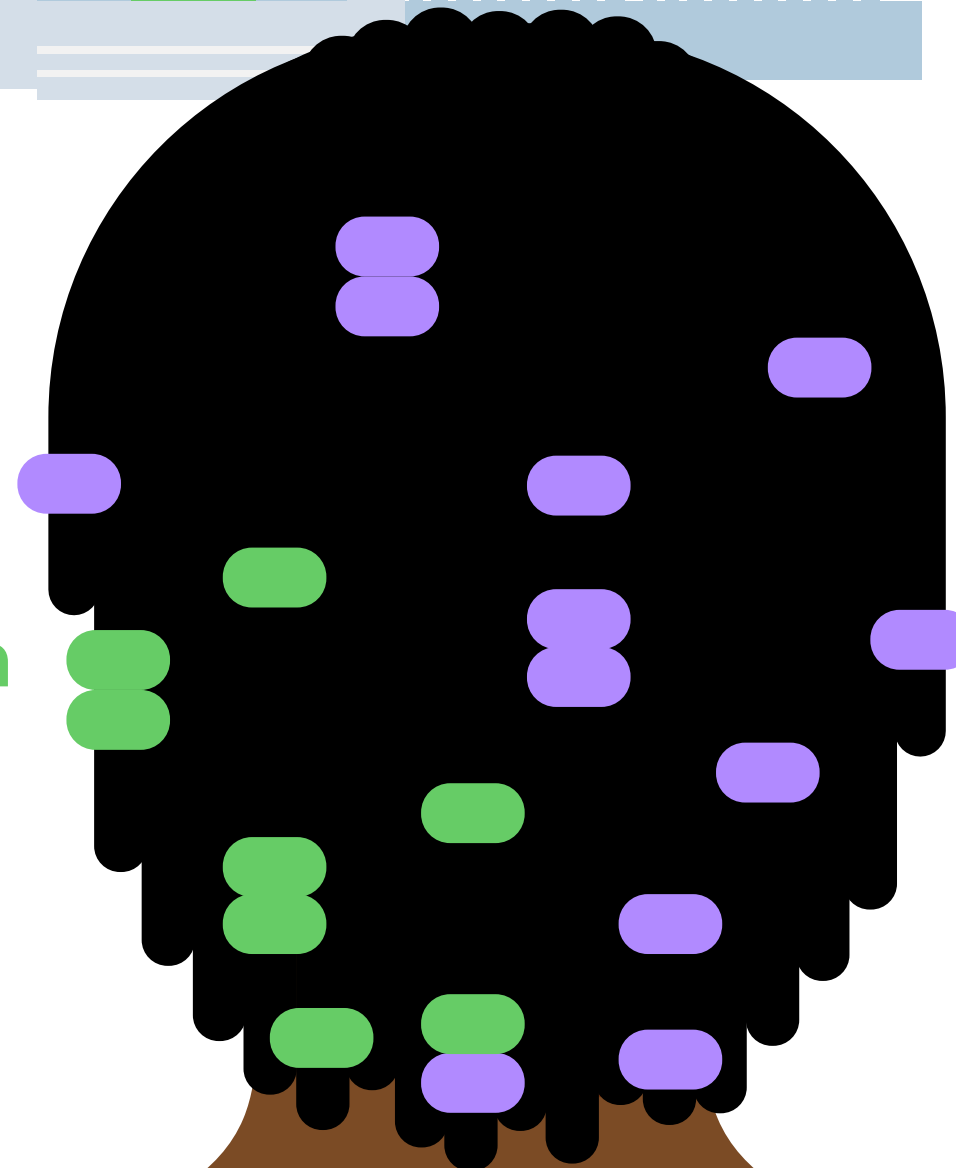
Pregnancies resulting from rape or incest often end in unsafe abortions, whereas others are carried to term due to lack of choice.^{11,12,13}

Studies in Cameroon and Burkina Faso have shown that pregnancies resulting from rape are highly likely to result in clandestine abortions, even though legislation officially allows abortion in such cases.^{14,15} In conflict situations in Africa, clandestine abortions among victim-survivors of sexual violence are also very common.¹⁶

Access to safe and legal abortion after rape and incest, although possible on paper, remains very limited and understudied.



Pregnancies resulting from rape and incest often end in unsafe abortions



Legal context and access to safe abortion

The five countries examined offer a unique lens to understand these dynamics. They share institutional characteristics, including French civil-law-based legal systems, centralised administrative structures and coexistence of Christianity, Islam and traditional religions.

All have ratified the Maputo Protocol, which recognises in its article 14(2)(c) the right to medical abortion in cases of sexual assault, rape, or incest, and when the pregnancy endangers the mental or physical health of the mother or the life of the mother or foetus.¹⁷ Yet, the common legal foundation has produced divergent legislative and administrative approaches: some countries, like Benin, have expanded access, while others remain restrictive.

Gaps in the evidence

A review of the literature highlights persistent gaps. Sexual violence and abortion are often studied separately, and few studies examine their interconnections. Comparative, multifaceted research on factors influencing effective access is scarce, limiting understanding of why some legally favourable contexts fail to deliver safe abortion services while others develop effective compensatory mechanisms.¹⁸

This study is the first systematic, comparative effort to examine these interwoven legal, policy, and cultural factors in West and Central Africa.

Legal and policy frameworks, their evolution and gaps

Takeaways

The comparative analysis of abortion laws in Benin, Burkina Faso, Cameroon, Côte d'Ivoire and Togo highlights six key lessons:

International frameworks matter. All countries have moved away from very restrictive colonial laws, with the Maputo Protocol paving the way to expanding grounds for legal abortion.

Harmonisation remains slow. With the exception of Benin, most states have yet to fully align national laws with the Maputo Protocol, even after 15+ years.

Policies and guidelines lag behind laws. Without clear implementation frameworks, legal reforms remain largely ineffective, as seen with Togo's stalled reproductive health law.

Information barriers persist. Criminal code restrictions discourage communication about safe abortion, leaving providers and the public in uncertainty.

Contradictions across legal texts. Unaligned criminal, health, and SGBV frameworks undermine access to abortion for survivors of sexual violence.

Legal timelines clash with biological realities. Lengthy procedures often outlast gestational limits, effectively denying survivors their rights.

Findings

Introduction

This section presents the findings of the analysis of legal and policy frameworks, tracing their development and identifying remaining gaps. The following section on implementation gaps and other barriers examines how these challenges play out in practice for victim-survivors in the five countries studied, and how they are compounded by additional barriers.

This progressive approach reveals how gaps accumulate from one level to the next, creating systemic mechanisms of exclusion that transform proclaimed rights into privileges reserved for the most informed and socially advantaged.

The **Maputo Protocol**, formally the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, is the first binding human rights instrument in the world to explicitly recognise abortion as a woman's right under specific circumstances. Adopted in 2003 by the African Union, it commits States Parties to protect women's health and reproductive rights. Article 14(2)(c) requires governments to authorise medical abortion in cases of sexual assault, rape, incest, or where a pregnancy endangers the life or physical and mental health of the woman, or the life of the foetus. The Protocol therefore establishes a clear legal obligation to provide safe abortion in these situations, moving beyond vague protections to concrete rights. While widely ratified, implementation across Africa remains uneven, with many countries failing to align domestic law and health systems with these commitments.

Summary of results per country

Benin

Benin has undertaken a gradual path of legal reform marked by two clear stages. The 2003 Law on sexual and reproductive health moved away from the total criminalisation inherited from the 1920 French Penal Code by authorising voluntary termination of pregnancy under three conditions:

1. When continuing the pregnancy endangers the life and health of the pregnant woman
2. At the request of the woman when the pregnancy is the result of rape or incest
3. When the unborn child has a congenital malformation.

In 2021 this part of the law on sexual and reproductive health was amended, because maternal mortality remained high and because, in practice, even women who met the conditions mentioned above still did not have effective access to safe and legal abortion.

The 2021 reform establishes a markedly broader legal framework in comparison with other countries in West and Central Africa, now allowing voluntary termination of pregnancy in four situations: danger to the life or health of the woman; rape or incest; serious foetal malformation; and distress (material, educational, professional or moral distress) before 12 weeks of gestation. This move is expected to significantly improve access to safe abortions in Benin and reduce maternal mortality. It was followed by an implementing decree 1,5 year later clarifying the main conditions for application of the amended law.



Despite this progress in Benin, gaps remain: the standard operating procedures for the prevention and response to gender-based violence updated in 2023 mention 2021 Law on sexual and reproductive health in general terms, yet the option of abortion in cases of rape or incest is not mentioned. This could reflect a lack of communication and alignment between sectors or be the result of tensions surrounding the abortion provisions in the amended law on sexual and reproductive health.

A table presenting the legal and policy framework in Benin regarding abortion can be found in [Annex 2](#).

Burkina Faso

The current legal framework, codified in Articles 513-13 and 513-14 of the 2018 Penal Code, authorises 'voluntary termination of pregnancy' under three conditions:

1. Threat to the mother's health (without gestational limits)
2. Serious incurable foetal abnormalities (without gestational limits)
3. Rape and incest (14-week time limit)

The 2018 Burkinabe Penal Code largely complies with the requirements of the Maputo Protocol, authorising abortion for rape, incest, danger to maternal health and serious foetal malformations. However, one gap remains: the mental health of the pregnant woman is not explicitly mentioned as a ground for access to safe abortion, contrary to the content of the Maputo Protocol.

In the 2021 Manual on Post-Abortion Care/ Safe Termination of Pregnancy, a procedure is detailed including the legal steps required for access to legal abortion after rape and incest which requires *"the materiality (significance) of the distress"* to be established through *"an investigation by the public prosecutor followed by a favourable written opinion if the distress is confirmed"*. The difficulty of proving rape- especially after the observed late reporting of sexual violence cases in Burkina Faso forms a major hindrance to establishing proof for the materiality of distress. Furthermore, there are no guidelines available on the criteria and time limits for the public prosecutor to establish the materiality of distress.

There are a few additional challenges in Burkina Faso regarding the legal and policy framework. For example: as the table in [Annex 2](#)

shows, there is a lack of alignment between different laws and protocols. The laws and procedures relating to sexual violence against women and girls fail to mention that rape and incest constitute legal grounds for abortion. As one research participant explains:

"These texts provide a legal arsenal, but they are not harmonised. When you try to compare them, you realise that they don't say the same thing. If they don't say the same thing, everyone can use the text that suits them to defend themselves. We would like to see harmonisation, so that we can use what has been harmonised and also apply it, and so that women are in any case able to use it."

President of a professional association, Ouagadougou, Burkina Faso.

The data gathered through interviews in Burkina Faso indicates that civil society is actively trying to make clearer guidance available for the judiciary and is making a case for extending the 14-week gestational

limit for abortion after rape and incest.

A table presenting the details of the legal and policy framework in Burkina Faso regarding abortion can be found in [Annex 2](#).

Cameroon

Cameroon ratified the Maputo Protocol in 2012 but currently still has a more restrictive legal framework than the Protocol recommends. The reservations that Cameroon made with the ratification of the Protocol includes a statement on abortion, claiming that 'The acceptance of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in African should in no way be construed as endorsement, encouragement or promotion of [...] abortion (except therapeutic abortion) [...].'¹⁹

The Penal Code that was subsequently revised in 2016 includes two grounds for legal abortion in its article 337, stating that therapeutic abortion^b is only permitted in two situations:

1. In cases of rape with certification from the

^b Therapeutic abortion means abortion for medical reasons, and this is the terminology used in the Cameroonian context for legal abortions.

public prosecutor

2. In cases of grave danger to the mother's health

The document "Norms and Standards in Reproductive Health and Family Planning" of March 2018 broadens these grounds by adding a third condition: cases of severe foetal malformation incompatible with life. The document also specifies the conditions for application by defining gestational limits: before 12 weeks in cases of rape or for medical reasons, and between 12 and 28 weeks in cases the evolution of the pregnancy constitutes of life-threatening risks for the mother, rape also being mentioned here, and in cases of severe foetal malformations.

Two main shortcomings in the harmonisation with the Maputo Protocol can be recognised. Firstly, incest is not recognised as a legal ground for therapeutic abortion in national legislation. This omission creates a discrepancy with the country's international commitments and limits the protection of victim-survivors of intra-family sexual violence. Secondly, there are no clear guidelines for magistrates. Victim-survivors' access to services depends heavily on the individual assessment by magistrates, in the absence of precise instructions harmonising judicial decisions. This situation creates significant legal and administrative uncertainty.

Nevertheless, the alignment of national laws with articles of the Maputo Protocol including Article 14(2)(c) on abortion and its full implementation is a priority for civil society in Cameroon, in particular for the Cameroon National Association for Family Welfare (CAMNAFAW) – a non-governmental organisation which has, together with partners, insisted that a plenary session of the National Assembly be devoted to this issue. And with success, at the end of the National Assembly's session held on 27 March 2025, parliamentarians urged the government to draft a law on reproductive health, to incorporate the provisions of Article 14 into national laws and to revise the Penal Code to facilitate access to abortion in cases of rape, incest or danger to the mother.²⁰ The drafting process is currently ongoing.

The table presenting the elements of the legal and policy framework documented in Cameroon can be found in [Annex 2](#).

Côte d'Ivoire

Côte d'Ivoire has undergone remarkable adaptations in the legal framework on abortion, particularly between 2019 and 2024. Whereas until 2019, abortion was only allowed to save the life of the mother, in 2019, 8 years after the country ratified the Maputo Protocol, the revised Penal Code finally authorised abortion under strict circumstances:

- To save the life of the mother and in cases of rape

Introduced on 11 June 2024, Law No. 2024-358, which modified the Penal Code, further harmonised national laws with the Maputo Protocol. The law introduced incest as a legal ground for abortion, as well as the risks to the mother's mental and physical health. In addition, procedural changes were introduced to clarify procedures in cases of rape.

This development brings Côte d'Ivoire almost into compliance with the Maputo Protocol. However, the country does not fully comply with the Protocol, as it does not explicitly mention pregnancies that pose a risk to the life of the foetus as a legal ground for abortion.

The development of policies and implementation guidelines to ensure the law can be correctly implemented is ongoing.

The table presenting the elements of the legal and policy framework documented in Côte d'Ivoire can be found in [Annex 2](#).

Togo

Togo presents the most striking paradox among the five countries studied. It has a progressive legal framework but a total lack of operationalisation for 18 years now. Following Togo's ratification of the Maputo Protocol in 2005, the Reproductive Health Act No. 2007-005 of 10 January 2007 authorises abortion:

1. In cases of rape

2. In cases of incest

3. When there is a threat to the mother's health and serious foetal malformation (no gestational limits are mentioned in legal texts)

This legal framework evolved over a long period, starting with total criminalisation of abortion under the French Penal Code of 1810, which was slightly untightened in 1920 by a French law that limited abortion to cases where the woman's life was in danger. In 1984, a specific anti-abortion law came into force, condemning anyone contributing to the abortion of a girl enrolled in school or a vocational training centre (1 to 5 years' imprisonment plus a fine of 500,000 to 1,000,000 West African CFA francs).

The Maputo Protocol, signed in 2003 and ratified in October 2005, served as a catalyst for progressive change. This came to fruition in 2007 with the Law on reproductive health authorising the termination of pregnancy in cases of rape or incest; in cases where the life and health of the pregnant woman are at risk; or where there is a high risk that the unborn child will suffer from a serious illness.

However, no implementing decrees have been issued since the law was enacted in 2007. Nevertheless, Law No. 2022-020 on the protection of learners against sexual violence briefly refers to the fact that learners can access voluntary termination of pregnancy after rape, but the September 2023 protocol on GBV excluded any reference to the option of safe abortion.

The table presenting the elements of the legal and policy framework documented in Togo can be found in [Annex 2](#).



Similarities

and differences legal frameworks

Similarities: converging trajectories under international influence

The five countries studied have remarkably similar trajectories regarding political intent, characterised by a gradual shift from total criminalisation inherited from colonial penal codes to permitting abortion on restricted grounds. This convergence can be largely explained by the influence of international legal instruments, particularly the Maputo Protocol, which has served as a common reference point since its ratification by the 5 countries, the earliest in 2005 (Benin, Togo) and the latest in 2012 (Cameroon).

This research shows that national medical organisations often contributed to these changes: the National College of Gynaecologists and Obstetricians of Benin, the Society of Gynaecology and Obstetrics of Cameroon and their equivalents in other countries have played decisive roles in advocacy and policy formulation. These professional organisations have systematically mobilised alarming health data on maternal mortality that they witness in their daily work to justify legal reforms. Similarly, in some countries, organisations such as International Planned Parenthood Federation member organisations and other allies, have advocated in various ways for better access to safe abortion to prevent maternal mortality from unsafe abortions. The production of evidence has been a key element of these processes, for example through Ipas²¹ and a CERRHUD study on abortion in Benin.²²

Similarities: uncertainties regarding the legality of disseminating information

The analysis reveals that several countries have introduced restrictions on public communication about abortion, albeit to varying degrees. In Burkina Faso and Cameroon, all acts likely to encourage abortion are strictly prohibited. The Penal Code of Burkina Faso stipulates that any person who, by any means of dissemination or publicity, incites abortion shall be punished by imprisonment for two months to two years and a fine of one million (1,000,000) to two million (2,000,000) West African CFA francs corresponding to 1800\$ to 3600\$ approximately (Penal Code, Law No. 025-2018/AN, Article 513-15). In Cameroon, it is illegal to engage in acts likely to cause or promote abortion, whether oral, written or in the form of distribution of potentially abortive material (Law No. 90-035). In Côte d'Ivoire, specific restrictions apply to healthcare personnel. The Penal Code provides for penalties against healthcare professionals who prescribe or promote abortion (Penal Code, Law No. 2019-574, Article 426). In Benin, despite its progressive 2021 Law on sexual and reproductive health, the country's Penal Code still contains ambiguities about what can and cannot be communicated about abortion. Article 19-I of the 2021 law, referring to its Penal Code (Article 519), prohibits offering services to perform voluntary termination of pregnancy in public, at a meeting or through the distribution of written documents. The same penalties apply to persons who promote means, objects and processes related to voluntary termination of pregnancy. In its 2007 law on reproductive health, Togo does not stipulate any specific restrictions on information in its legal texts

but prohibits the sale of abortion products. The lack of clarity surrounding prohibitions on incitement to abortion and its promotion leads to uncertainty about what can and cannot be said in public about abortion and makes reproductive health providers afraid to explicitly educate and refer people regarding safe abortion and the abortion laws. The information available in the public sphere is therefore limited. Those who dare to address the subject do so by speaking very strictly about the legal conditions that allow access to legal abortion and by warning about the consequences of unsafe abortions and the prevention of unintended pregnancies. CSOs have to be careful not to be accused of promoting abortion or specific methods. Some effective community awareness has involved improving understanding of the issue through media and community leader interventions and strengthening their capacity to address the issue in their communities, always from an informative and non-promotional perspective.

Similarities: the challenge of harmonising national laws and procedures

Despite sometimes progressive legal and policy frameworks, all countries struggle to translate political intent into effective operational mechanisms. Togo, having failed to develop implementing decrees for the 2007 law on reproductive health for 18 years now, represents an extreme case of chronic administrative paralysis.

A review and comparison of documents also shows that there is no harmonisation between procedures describing the treatment of sexual and gender-based violence and the laws and procedures establishing the conditions of access to abortion. This demonstrates the complexity of inter-sectoral coordination and often results into those working with victim-survivors of gender-based violence lacking essential information on abortion laws. And conversely, those working on access to safe abortion may lack essential information on the treatment prescribed for victim-survivors of gender-based violence.

The lack of clarity surrounding prohibitions on incitement to abortion and its promotion leads to uncertainty about what can and cannot be said in public about abortion and makes reproductive health providers afraid to explicitly educate and refer people regarding safe abortion and the abortion laws.

Differences: pace and ambitions

Despite these convergences, countries differ significantly in the pace, scope and strategies of their reforms.

Based on the analysis of the data, three models emerge:

1 The recent **revolution model** (Benin) is characterised by rapid and ambitious legal transformation. The 2021 law marks a complete break with the past by considering socio-economic distress, going beyond the requirements of the Maputo Protocol.

2 The **model of continuous evolution** (Burkina Faso and Côte d'Ivoire) favours an incremental approach spread over several decades. Burkina Faso illustrates sequential progress over 60 years (1960–2018), while Côte d'Ivoire introduced its modernisation over five intensive years (2019–2024).

3 The **institutional blockage model** (Togo and Cameroon) reveals different avoidance strategies. Togo has had a progressive framework in place since 2007, although it has not been operationalised, while Cameroon has had a restrictive but stable framework since 2016, with recent moves towards alignment with the Maputo Protocol.

In addition, the conditions for authorising abortion reveal different conceptions of reproductive autonomy and the role of the state. Benin has adopted a unique comprehensive approach by including socio-economic distress with precise definitions (indigence, risk of job loss, interruption of studies, psychological imbalance). This approach reflects a broad conception of reproductive and social justice. Burkina Faso and Côte d'Ivoire follow a conformist strategy to align with the Maputo Protocol, without going significantly beyond African Union standards. This approach prioritises international legitimacy over legal innovation. Cameroon, which had limited alignment with the Maputo Protocol, is currently beginning to follow this path. Finally, Togo presents the paradox of a legal framework that is relatively

liberal on paper (no gestational limits, three conditions for authorisation) but non-existent in practice, suggesting a façade strategy to satisfy international commitments without bringing tangible change.

Underlying these different models are different balances and tensions between politicians who legislate and society. Most of those who make the laws on abortion are careful not to debate it, fearing political and social opposition. This is to the detriment of women's health. Others have shown more courage by proposing new and progressive laws, such as in Benin, which have met with opposition and misunderstanding from society, meaning that laws are drafted but their effective implementation remains complicated due to these tensions.

Differences: Barriers related to gestational age

The analysis also reveals that countries have different conceptions of reproductive timing, translating in very different gestational limits until which abortion is legally allowed:

- **Burkina Faso:** a differentiated approach based on grounds (no limit for medical grounds, 14 weeks for rape and incest);
- **Cameroon:** a graduated approach based on time (12 weeks for health risks and rape, then 12–28 weeks depending aggravated risks);
- **Côte d'Ivoire:** no explicit limits in the 2024 law, implementation guidelines yet to be published
- **Togo:** no limits in any legislation.
- **Benin:** 12 weeks for distress grounds, no gestational limit indicated for other grounds.

The mismatch between biological constraints and administrative timelines is a universal systemic barrier, regardless of the level of legal progress. Legal deadlines (from 14 to 28 weeks in cases of rape) contrast with the timelines of judicial procedures that almost always exceed these limits in all countries studied according to the data obtained. This mismatch is not accidental but highlights a bureaucratic conception of time that ignores biological and psychological urgency. This discrepancy turns procedures into insurmountable obstacles that render rights meaningless in practice, even in the most favourable legal contexts.

Differences: Risks and ambiguities for health personnel

The widespread lack of legal protection for providers (except in Benin and, to some extent, Cameroon) reflects how the system does not recognise the extent of potential societal and political resistance to those carrying out abortions. This means helping victim-survivors to access their rights can become a professional risk, creating a systemic deterrent for professionals that can limit the provision of services regardless of the legal framework.

Benin is the only country that anticipates societal resistance against providers, with its explicit protection provisions.

In addition, in most countries, laws and medical codes of ethics also make it possible for health professionals to refuse to perform an abortion on grounds of conscientious objection, unless faced with an emergency. These clauses do not protect the rights of victim-survivors sufficiently, in fact governments herewith shift the burden of decision making onto frontline professionals, resulting in heterogeneous practices that fragment access to abortion rights according to the individual beliefs of health care providers rather than legal rights. Whereas officially those professionals with conscientious objection are required to adequately refer patients to colleagues who do provide these services, in practice this can lead to delayed care and a denial of rights, as the next section of the report shows for Burkina Faso.

In the context of abortion, conscientious objection refers to the right of healthcare professionals to refuse to participate in providing abortion services if doing so conflicts with their personal, moral, ethical, or religious beliefs.

Implementation gaps and other barriers faced by victim-survivors

Looking at how laws relating to abortion and SGBV are applied on the ground in each of the five countries, there is a striking gap between legal provisions and the realities experienced by victim-survivors of sexual violence. In this section of the report, we look at victim-survivors' experiences and the micro-level of implementation of laws and policies by the people they meet when seeking medical, legal and social services.

The prescribed versus the real victim-survivor's trajectory

A model to study the micro-level implementation of laws and policies around SGBV and legal abortion is by looking at the prescribed versus the actual victim-survivor's trajectory.^c The prescribed trajectory is a model that shows all the steps that victim-survivors need to take if they want to obtain a legal abortion after rape or incest.

Although the design of the prescribed trajectory may vary from country to country, and although it is not necessarily a linear process, it is generally based on the following steps:

- Access to information (without access to information, all other steps become impossible)
- Reporting to the police
- Medical care (including obtaining a certificate to proof rape/incest) (*not required in Benin*)
- Psychological care
- Administrative and/or legal procedures to obtain authorisation for an abortion (*not required in Benin*)
- Voluntary termination of pregnancy in accordance with the law (*according to the law in Cameroon this step is not possible for victim-survivors of incest*)

^c This model was developed by CERRHUD for the purpose of this study

Using this model allows to capture both the steps that are officially required (as prescribed by laws and policies) and to compare them with the actual experiences of victim-survivors along this trajectory. This comparison allows to identify the gaps between policies and their implementation, to analyse the consequences of these gaps for victim-survivors, to establish the factors explaining these gaps, and to highlight creative responses by civil society organisations in response to some of the systemic and procedural flaws observed. This chapter foregrounds the experiences of victim-survivors, those who need these services and are directly affected by the implementation gaps. But it also highlights the roles played by health care providers, police officers, social workers and judges, amongst others.

Comparing victim-survivors' journeys with the prescribed trajectories in each country reveals that only a few victim-survivors access the full range of prescribed services, with most of them experiencing disruptions at critical stages. This seriously compromises their access to legally recognised rights and may lead to risks of untreated STIs, lack of psychological support and the use of unsafe abortion methods with all the risks this entails.

We describe this process by country highlighting the gaps and disruptions that turn access to a relatively straightforward medical procedure into a maze in which it is very easy to get stuck.

Takeaways

Victim-survivors of sexual violence face overlapping barriers that prevent access to safe and legal abortion. These barriers arise before care-seeking begins, through stigma, fear and lack of information, and persist when survivors try to obtain medical or legal support. As a result, very few girls and women who become pregnant after rape or incest can access safe, legal abortion in the countries studied.

Key barriers include:

- **Reporting obstacles:** Low awareness of rights, stigma, fear of blame or reprisal, family or community pressure, and perpetrator intimidation all discourage or delay disclosure.

- **Medical and legal barriers:** Survivors who do report face disbelief, lack of referral, misinformation or refusal by health workers, corruption, lengthy procedures, and high costs. Gestational limits often expire before authorisation is granted.
- **Systemic gaps:** Laws exist on paper but are poorly implemented, and abortion rights are rarely mentioned by frontline actors.

Benin shows a potential pathway forward, with access granted on grounds of 'moral distress,' which bypasses lengthy legal procedures. However, this option is limited by gestational cut-offs and late disclosure by adolescents.

Learning from promising practices in Benin and other initiatives across sub-Saharan Africa is vital to reduce barriers and ensure timely, dignified care and justice for survivors.

Benin

"Once we were at the prosecutor's office, the perpetrator was arrested. The prosecutor asked us to go home and come back a week later. So, after a week, we went back, and the prosecutor asked the rapist if he knew the girl and had been intimate with her. In front of the prosecutor, he quickly replied yes. The prosecutor asked him why he had denied it after the girl became pregnant. He lowered his head and did not answer. The prosecutor told him that his case was serious. He told him that if he did not go to see the girl's parents, he would be locked up and could remain there for the rest of his life. The prosecutor insisted that the fact that he raped a girl who was an apprentice, that he got her pregnant and that he refused to accept the pregnancy, were all serious offences against the law. The prosecutor said that if he would make him go to prison, he risked never getting out. Then he told the perpetrator to settle things amicably by coming to our house, the victim's parents' house."

Mother of Stéphanie, a 17-year-old victim-survivor, Cotonou, Benin



Interviews with victim-survivors and their relatives in Benin paint a complex picture of how cases of sexual violence are handled by victim-survivors, their relatives and those who are supposed to provide them with information and services. Stéphanie, whose mother is quoted above, was an apprentice seamstress. Sent to deliver an order to a customer, she was raped by him. She never sought help even though she was bleeding after the violent assault. When an aunt noticed four months later that Stéphanie was pregnant, her mother beat her severely in a fit of anger. When her family finally learned the whole story, Stéphanie was taken to the juvenile police, investigations were carried out and the perpetrator was arrested, leading to the intervention of the prosecutor reported above.

Stéphanie ends up giving birth, supported financially by her mother, who was subsequently struggling to pay back the loans taken out to cover the medical expenses incurred during the birth. Meanwhile, there was never any visit made by the perpetrator to the parents of Stéphanie

as the prosecutor had proposed. The intervention by the prosecutor had focussed solely on keeping the young man out of jail, recognition of fatherhood and negotiation with the parents. Stéphanie had not been asked about her opinion. Neither Stéphanie nor any of her family members knew about Benin's abortion laws, that permit a safe and legal abortion for a pregnancy resulting from rape or incest. They were also not informed about them when they were in contact with the police or social services.

This is just one example among many that shows the gaps between the law and the reality experienced by victim-survivors of sexual violence. Below, these gaps are analysed, based on the experiences of nine victim-survivors of rape or incest in Benin, their relatives and other key informants. The analysis exposes a striking contradiction between institutional advances and the persistence of deep barriers to implementation that fragments victim-survivors' effective access to their rights.

Disparities in access to information

The victim-survivors' experiences revealed various obstacles, starting with a lack of information and awareness (girls and women, and those around them, are often unaware of the importance of seeking medical care immediately after sexual violence) and a lack of knowledge of their rights (such as the right to safe abortion). Not having access to this information, or having incorrect or incomplete information, hinders access to comprehensive post-rape care.

According to community and religious leaders who have received training from civil society organisations on the abortion provisions in the amended Law on sexual and reproductive health, there is a need for much greater awareness of these provisions. As one of them said:

"The main problem I see in my country is the glaring lack of information."

Male participant in a group discussion with community leaders, Athiême, Benin

While some community leaders are trying to ensure that accurate information reaches everyone, they are hampered by financial obstacles in reaching the most remote areas:

"There are difficulties we encounter that are related to the location of the villages, so to achieve our objectives, we try to reach these villages, but we are unable to go further afield due to a lack of transport."

Male participant in a discussion group with community leaders, Athiême, Benin

Several other key informants also expressed the same need for better access to information on the abortion law.

The lack of information also affects service providers: In one case documented as part of this study, a judicial police officer, just like the prosecutor cited above, did not mention the option of safe and legal termination

of pregnancy to the victim-survivor or her relatives, but instead encouraged confirmation of paternity by the perpetrator. In other cases, health professionals, confronted with a pregnancy due to rape, failed to mention the option of safe pregnancy termination, and automatically initiate prenatal care. This means that the support provided to victim-survivors is compromised by the lack of information provided by first responders.

Clearly, there are significant gaps in knowledge and awareness about abortion laws among the community. Those who run centers dealing with cases of SGBV, as well as those working in the legal field, health professionals and social workers either lack information or are inclined to withhold it from victim-survivors and their families, thereby undermining their right to health and justice. If decision-makers and rights holders were better informed and if decision-makers (beyond medical personnel) received sufficient guidance (including values-based training), victim-survivors would benefit from a more supportive environment in which to make difficult decisions.

Outcomes for victim-survivors in Benin

The summary below gives an overview of the actual experiences documented among women and girls who are victim-survivors in Benin.

In the study sample of nine Beninese victim-survivors, this led to:

- Three cases of pregnancy carried to term (including forced marriage or financial arrangements with the perpetrator). For one of the victim-survivors this also meant having no prospects of returning to school, for another survivor this meant living with extreme financial insecurity together with her newborn, and in one case the newborn died after a few months.
- Three cases of unsafe abortion (one with serious complications, one without complications and one followed by a safe abortion procedure)
- Three safe abortions (at the insistence of the victim-survivor or her family, and not on the advice of a professional).

None of the nine women reported the sexual violence to the police or visited a health centre within 72-hours and they were therefore unable to receive medication to prevent pregnancy (emergency contraception), immediate treatment for STIs, nor did they receive direct psychological support.

The examples from Benin also show that in the three cases of safe abortions, the new criterion of (moral) distress was used to gain access to abortion and not the rape criterion – in one case because the victim-survivor did not want to report the sexual violence as the perpetrator had disappeared. In another case, the father took his daughter directly to a health centre to have an abortion, and in another case the parents went to a private clinic and did not want to accuse the perpetrator (a religious figure) because he was a poor man. In all cases the people involved opted for an abortion, without wanting to be engaged in any other legal procedures.

The use of moral distress as a ground for abortion under the revised abortion law in Benin saves the doctor or midwife administrative work (issuing a medical certificate takes at least two hours, according to one doctor, and a heavy and recurring involvement in court proceedings). It also spares the victim-survivor from going through legal proceedings that can be time-consuming, require testimony, risk exposing her situation to a wider audience, and risk to be unsuccessful. Yet it is unclear whether victim-survivors helped on this ground receive screening and treatment for STIs and whether they receive appropriate psychological care (psychological care is supposed to be provided to all patients who have undergone an abortion in accordance with the 2023 implementing decree of the Law on sexual and reproductive health, but it must be adapted to trauma care for rape victim-survivors).



Sexual violence is just one form of gender-based violence that leads to unintended pregnancies

A few other case studies of women who sought abortion care in Benin documented in this study show the complexity of the relationship between SGBV and unintended pregnancies. These cases highlighted forms of SGBV other than rape and incest that lead to unintended pregnancies and subsequent quests for abortion. Examples included: a woman being in a consensual sexual relationship, but whose relationship turned violent after her partner found out she was pregnant, leading her to want to terminate the pregnancy. In other cases, the sexual relationships were consensual, but when pregnancy ensued, paternity was repeatedly denied and the women abandoned, leading to a wish to terminate the pregnancy. In other cases, women were completely left to fend for themselves and their children economically, then another pregnancy occurred. These types of spousal neglect led to the wish to terminate pregnancies. While all these cases are linked to GBV, they are not necessarily recognised by the law as grounds for abortion, as laws focus exclusively on rape and incest. They can be treated in Benin as cases of economic or moral distress but do not stand a chance of accessing legal abortions in the other countries studied. These observations require a rethinking of abortion laws focusing solely on rape and incest as grounds for abortion and not on other forms of SGBV.

Social and cultural barriers to timely access to services and rights

Late reporting

Another major obstacle is late reporting. Although there is no official deadline in Benin for when an abortion can be performed in cases of rape or incest, this appears a complicating factor for all those involved. Late reporting of sexual violence is linked to social norms. It occurs because victim-survivors, like Stéphanie, expect to be beaten, not believed or blamed for what happened to them. Furthermore, the analysis reveals how perpetrators use intimidation strategies that exploit the specific vulnerabilities of adolescent girls. Or as one key informant puts it:

When I found out I was pregnant after the rape, I was so scared. I thought that if I had an abortion, I would die or never have children again. So I decided to keep the baby.

"There are also cases involving threats, where after the dirty work is done, they pull out a fetish and tell you that if you reveal anything or say their name, you will die."

Key informant working in social protection in the Mono department, Benin

Fear of violence, fear of stigmatisation, dependence on the family home and mistrust of the judicial system make these threats particularly effective in encouraging adolescents to remain silent for as long as possible about sexual violence and the resulting pregnancies.

When a pregnancy is reported at a moderate stage, after three or four months, it appears from our data that no medical, social, or legal professional addresses the issue of legally possible voluntary termination of pregnancy. However, in Benin, the law does not mention a gestational limit for abortion in cases of rape or incest. The practices of professionals therefore suggest a lack of information or a taboo surrounding abortion at this stage of pregnancy.

Family beliefs and abortion control

Furthermore, the fact that abortions performed in unsafe conditions have left such deep scars in family histories sometimes leads to abortion being considered taboo in certain families, according to women community leaders in a discussion group in Athième.

"For example, in my family, we don't have abortions. In my husband's family, I don't know if it's allowed or not. But for the people in my house, if you do it, it's a curse. For that reason, we don't do it in our family because one of our aunts did it and died on the spot, and since then it has become forbidden in the family."

Focus group participant with women community leaders, Athième, Benin



In addition to fear of death, concern about future infertility contributes to opposition to abortion in cases of rape and incest. This fear is based on past experiences of abortions performed in unsafe conditions, leading to serious complications affecting fertility. Among adolescents, family beliefs and misinformation often replace medical information, compromising their reproductive autonomy and limiting access to safe care.

These examples demonstrate the power of intergenerational mechanisms for transmitting beliefs and knowledge. The prohibitions often imposed by male heads of household are intended to preserve control and ensure the well-being of the family, but they are ill-suited to the present day (new laws, greater awareness of sexual and gender-based violence, and the availability of safe abortion methods). They prevent women and girls from making informed choices in the face of sexual violence and unintended pregnancies.

Furthermore, some families prefer not to report the crime to protect their reputation, in cases of incest, or that of their daughter, believing that revealing the rape will reduce her chances of marriage. On the other hand, there is a certain degree of understanding and support for abortion in cases of incest, which is much less prevalent in cases of rape. This is obviously linked to the need to protect the reputation of families.

"My mum told me that you could die during an abortion. She said it was dangerous and could make you infertile. My aunts said the same thing. They told stories about girls who had abortions and died, or who could never have children again. When I found out I was pregnant after the rape, I was so scared. I thought that if I had an abortion, I would die or never have children again. So I decided to keep the baby. Even when the nurse at the centre explained that it was safe now, I couldn't believe her. My mum's words were stronger."

17-year-old victim survivor, Benin

Explanatory factors: Policy and systems level gaps

Our analysis of gaps at legal-, policy and systems-level helps explain the origin of some of the gaps observed. A range of potential obstacles emerge between political intentions, the laws and policies put in place, and the implementation of these laws.

Implementing a new law requires major financial, human and other resources. The Government of Benin has taken strides in translating the law into operational documents, establishing an organisational structure, securing financial resources to support the implementation of comprehensive reproductive health care, and training health professionals in the new protocols. Many training and education institutes now include modules on legal abortion in their reproductive health training programmes.

It takes time, however, for training and resources to reach everyone. So, some health care providers have yet to receive training, and some need more training to be willing to perform abortions. Uncertainty about who is authorised to provide this care and who is not continues to cause confusion on the ground, as does the possibility of conscientious objection to providing care. Officially, if a healthcare provider objects to providing abortion care, the new law clearly states that it is mandatory to refer the patient to another provider who does offer such care, but this referral does not always happen.

Many of the financial resources needed to develop guidelines, train health personnel, communicate the law, train community workers and cover the costs of care for poor women come, at least in part, from national NGOs through various foreign financial sources (bilateral relations, international non-governmental organisations, international philanthropic organisations). This raises questions about how sustainable these funds are, for example when donor interest wanes or other health priorities become more urgent. The Beninese government is addressing this by developing a public financing strategy offering free care in the public sector. A health professional explains this policy:



"The ministry provided us with the first package. Currently, services [abortions without additional tests] are free in public health centres."

**Health professional, public facility,
Cotonou, Benin**

This national directive on free care will need a government budget allocation to offset the costs of care, demonstrating the political will to remove financial barriers to accessing safe abortion.

Confusion about who is allowed to communicate about the new abortion law and how to do so seems to be particularly present among social workers and the police. As a result, very few people working in these centres communicate confidently about the legal possibility of having an abortion. In this regard, they are sometimes not helped by their superiors, as this testimony shows:

"There is the legal aspect. Okay? But we organised an awareness-raising session. A legal representative from the Ministry of Social Affairs was there. So we were briefing each other on the points to be covered. Then she said, for example, not to talk, not to go out into the field. [...] Do you see what I mean? Was she saying this because she had a personal conviction that she was letting show?"

**Key informant in social protection in the
Mono department**

And this leads to uncertainty among social services agents:

"For example, when you have someone come to you and it [abortion] is not the primary issue she brought up. I ask myself, am I in the position [to bring up the subject]? Can I talk to her about it? If I do, am I fulfilling my role? But when she

leaves here, what will she say? 'I went to him to ask for help and he told me to have an abortion?'"

**Key informant in social protection in the
Mono department**

The uncertainty among social protection staff stems from fears of promoting abortion, which is against the law, lack of support from management, as mentioned above, and the fact that the 2023 Standard Operating Procedures (SOPs) for preventing and responding to gender-based violence do not refer to the right to abortion.

Together these findings show that in Benin, many steps have been taken at the policy and systems level to enable the successful implementation of the amended law on abortion. However, specific obstacles remain to make sure all sectors involved in the care for victim-survivors are well informed, confident and comfortable regarding the law.

Explanatory factors: Gaps in policy adoption

The implementation of policies and programmes on the ground is the responsibility of different institutions and organisations in Benin. The extent to which different organisations have adopted the policies is mixed. Although professional organisations, and many CSOs are actively committed to implementing the new law and have financial support from international donors to do so, in public health centres getting access to safe abortion care is often still challenging. Implementation is sometimes being resisted based on the religious beliefs of staff. One health care provider in Benin testifies to this resistance: *"Even before the law came out, I already said that I would never do such a thing [...] if the problem arises, I can help the person, I can assist them, but not by performing the procedure"*. This attitude can be explained by deeply held religious beliefs: *"We [healthcare providers] who are Christians have not really accepted this law [...] what we hear in church is that it is a sin because, according to what we are told, having an abortion is killing a child who wants to be born"*.

Furthermore, the hierarchy does not always support policy implementation at the institutional level, as one hospital manager shared: *"We cannot force someone to perform a safe abortion. All we can do is raise awareness so that people adopt a contraceptive method."* These data show how personal convictions can undermine the initial political intent and block policy implementation, hence access for victim-survivors and other abortion care seekers.



Conclusion

In Benin, despite progressive abortion legislation, more needs to be done to ensure that victim-survivors of sexual violence receive appropriate care, including psychological care; are well informed of their rights; and are supported by society to seek help. We have identified significant gaps in communication about the amended abortion law (despite considerable efforts by the government and CSOs). The social environment of victim-survivors often steers them towards solutions that are not in their best interests, such as forced relationships with the perpetrators of violence and carrying to term forced pregnancies. Using grounds of moral distress is now an option for victim-survivors in Benin who do not wish to report cases of sexual violence and engage in cumbersome legal-administrative processes. However, despite this option now being available, unsafe abortion continues to take place. Importantly, using moral distress as a criterion for access to abortion deprives survivors of the psychological support that is recommended and essential for many survivors to cope with the consequences of their trauma. This could also lead to fewer perpetrators being held to account for the violence they commit. But the option does significantly lighten the burden on women and allows them to take control of their lives and make decisions for themselves. It enables the pursuit of health in a context where the pursuit of justice is often out of reach (e.g. lengthy procedures, when perpetrators flee, when medical forms are not filled out correctly, when medical proof is not available, or when the police ask the victim-survivor to pay their transport costs to investigate a case).



Burkina Faso

Amina did not know what to expect from healthcare services after being sexually assaulted. She thought that you only needed to go to a health centre if you were in pain.

"After the rape, they [raped girls and women] can go to the hospital if they are in pain or not go if they are not in pain."

Amina, 16-year-old survivor, Ouagadougou, Burkina Faso

Amina went to school until she became pregnant, but she did not seem to know anything about the need to screen for STIs, emergency contraception or psychological care after rape. If she had known, she might not have gone, because she was so ashamed that she didn't tell anyone that her paternal uncle had raped her. "I just cried a lot and didn't talk about it." When her father's second wife discovered that Amina was pregnant (her own mother was no longer there), Amina fled the house, fearing serious consequences, as she was unable to tell her about the origins of her pregnancy. She took

refuge with her employer, a seamstress and lived with her until she gave birth. Amina's father and his wife only found out very late, when she was eight months pregnant, that her uncle (her father's older brother) was responsible. When the contractions started, her boss sent Amina home to give birth. On the way back, she gave birth and was told she couldn't stay at the family home with her child. Amina was taken to the bus station but with nowhere to go, she ended up talking to the police, who referred her to social services, where she and her son were taken care of. Her son was eventually adopted at the age of eight months. Amina says she would have chosen abortion if she had known about the law, which she only learned about through the researcher's questions during the interview. She would have chosen abortion because, she says, "if I had known, I would have terminated the pregnancy and I wouldn't have suffered so much." To date, her relationship with her father remains complicated, "but he has forgiven her," according to her father's second wife, indicating that victim blaming was at play within the family.

Amina's case highlights some of the complexities surrounding sexual violence in Burkina Faso. We have documented six complex stories (most of the victim-survivors were minors at the time of the sexual violence) and spoken to three of their relatives. In two cases, the perpetrator was a family member. Shame and cultural norms mean that teenage girls tend to flee their homes without seeking medical care or reporting the crime to the police. They are also not encouraged to do so by those who support them after they flee, as we see in Amina's story, where her employer does not help her to get access to medical or legal services. Abandonment by family members, forced expulsion to give birth elsewhere, infanticide to purify the family name, and unprosecuted offenders appear common, excluding victim-survivors from all medical, psychological and legal support.

The main reason for these situations is a lack of access to information about the law and the steps to be taken, as well as very specific cultural and gender norms that seek to promote concealment and judge victims rather than believe and support victim-survivors. However, rape and incest are legal grounds for a safe abortion before the end of the 14th week of pregnancy in Burkina Faso. Nevertheless, the legal deadline of 14 weeks is often exceeded due late discovery and reporting of sexual violence related pregnancies and a lack of timely legal case handling, making it almost impossible to seek legal recourse for an abortion after sexual violence in Burkina Faso. Below these barriers are analysed in-depth, based on the experiences of six survivors, their relatives and key informants in Burkina Faso.

Disparities in access to information

Data from Burkina Faso highlights several obstacles, primarily a lack of information and awareness, as well as a lack of knowledge about rights. As in Benin, the lack of access to reliable information or the dissemination of incomplete or inaccurate information affects all subsequent steps necessary to benefit from the full range of care and services.

Most girls and women in Burkina Faso are unaware of their rights related to safe abortion²³ and GBV. Girls and women, and

those around them, are often unaware that it is important to seek immediate help after sexual violence, and that they are entitled to protection and safe abortion. Several key informants emphasised that indeed a lack of information is a major barrier:

"The main obstacle is the lack of awareness of the law. The law is not sufficiently publicised. Women are often unaware of their rights regarding safe termination of pregnancy."

Key informant from the Ministry, Regional Health Directorate, Ouagadougou, Burkina Faso

The lack of translation of the law into local languages is also seen to be an important factor. As one respondent stated:

"So as long as this law is not translated into our various national languages and broadcasted on our radio stations, people in the different communities will not find information about it."

Key informant from the Ministry of Health, Ouagadougou, Burkina Faso

The six accounts of Burkinabé victim-survivors highlight this gap in information. Four of the six survivors never sought any services provided for survivors of sexual violence and all four of them carried their pregnancies to term. The following quote is illustrative:

"I didn't know that in Burkina Faso the law allows abortion in cases of rape or incest. That as soon as you found out you were pregnant, you could have it terminated. If I had known and terminated it, I wouldn't have suffered so much."

Victim-survivor, 16 years, Ouagadougou, Burkina Faso

I didn't know that in Burkina Faso the law allows abortion in cases of rape or incest. That as soon as you found out you were pregnant, you could have it terminated. If I had known and terminated it, I wouldn't have suffered so much.

All the survivors said, after learning about the law during the interview, that they would have considered a safe termination of pregnancy if they had been better informed about the law.

Insecurity adds to vulnerability

Data obtained from civil society actors highlights vulnerability of girls and women in crisis-affected regions of Burkina Faso. They are more exposed to sexual violence and suffer from the deterioration of health and other essential services linked to insecurity: facilities are closing and travelling to facilities further away is often dangerous and costly. The situation forces girls and their families to deal with these situations on their own. Post-rape care is often inaccessible, and pregnancies resulting from rape are often discovered too late to allow for a legal termination, as described by this journalist who recounts the reality faced by women.

"Our security situation has exacerbated all the other obstacles. That's it. Perhaps we haven't documented it enough, but there have been many rapes during this period of security crisis [...]. Someone who is in a locality far from Kaya, someone comes and drives you out of your village, you are raped, you walk for three days to find a town, then you continue the process, you arrive in a city, [...] as everything is mentally disorganised, the person discovers the pregnancy late, and as these are people who live in rural areas, access to information is often not as easy. Then she discovers she is pregnant, and it may be four months, two months, and maybe she discovers she is five or four months pregnant, and it really is rape. So, these are some of the situations that are a bit difficult. So, the security crisis has further exacerbated things."

Journalist in Ouagadougou, Burkina Faso

The security crisis in Burkina Faso is clearly not just an additional obstacle for victim-survivors but is radically transforming the dynamics of access to rights by creating new forms of vulnerability and disrupting traditional protection mechanisms.



Social and cultural barriers to timely access to services and rights

Protecting the reputation of the family

In Burkina Faso, many girls and young women who become pregnant after rape or incest are either forced to marry or abandoned (temporarily) to preserve the reputation of the family. For example, some interviews revealed the creation of a system of family mediation that bypasses official channels to preserve social and family cohesion at the expense of the individual rights of women and girls.

"The social environment can have an impact [...] you prefer to hide. In our community, when a girl is raped, it's a shame for the whole family. People will say it's because she was out late, she was dressed badly, she was asking for it. The parents prefer to settle it within the family. They go to the boy's family, they

talk. Sometimes they ask for money to make up for the offence, sometimes they force the marriage to hide the shame. But going to the police means that the whole neighbourhood will know. And then the girl will never be able to get married. Who would want a girl who has been raped and of whom everyone knows she was raped? We prefer to keep it secret and settle it between families.

Community leader, participant in a discussion group, Ouagadougou, Burkina Faso

This testimony reveals a view of sexual violence as a "family offence" rather than an individual crime, where redress is aimed at restoring family honour rather than justice for the victim-survivor. Forced marriage to the perpetrator highlights how the search for protection of the family-honour can turn into further victimisation. Similarly with cases of incest, several interviewees emphasised that the survivor is likely to be expelled from her home to avoid shame and protect family relationships. One religious leader explained this logic as follows:

"In our customs, situations of incest are dealt with meticulously and with great care. Because it can cost the lives of family members. Wanting to keep survivors in the family, can create problems. Because you have broken the law of the dead ancestors. And it can be very costly for the family. It is this humiliation that requires the survivor to leave the family to purify the air and the blood."

Male participant in a discussion group with religious leaders, Ouagadougou, Burkina Faso

The above quote conveys a strong sense of victim blaming and punishment of victim-survivors of incest, instead of targeting the perpetrator. In some families, traditional rituals are recommended and the victim-survivors' return is possible at some point. However, infanticide was also often referred to as the only "solution" to family reunification:

"In our community, you have to leave home to seek help elsewhere [...] Yes, I gave him up for adoption [...] because the child couldn't stay with me [...] In our family and in our community, it's forbidden. The child cannot come home with me. If I go with him to the village, they will kill him."

19-year-old survivor, Ouagadougou, Burkina Faso

In other cases, it is the despair of the expelled survivor that can lead to infanticide, as this survivor describes:

"They said I went out with men and got pregnant, that my child had no father. I was in a lot of pain, they insulted me. I often thought about killing the child because I couldn't take it anymore. My grandmother even abandoned me alone in her room to come to Ouaga. So I decided to go and throw the child away, which I did. But since social services took me in and looked after me, if I went back there without the child they would question me, so I went back to look for the baby, whom I found still asleep. I then contacted the lady who had accompanied me to social services to explain my situation, and she agreed to let me stay with her."

16-year-old survivor, Ouagadougou, Burkina Faso

It was found that due to abandonment and despair, social services often have to take in survivors in Burkina because they have nowhere else to go.

Explanatory factors: Policy and systems level gaps

The barriers identified above (information gaps, insecurity and socio-cultural barriers), make that the survivors interviewed never really progressed along the prescribed services trajectory for obtaining safe legal abortion care. They only accessed social services and psychological counselling. However, interviews with other stakeholders showed how other barriers emerged for those who *do* seek medical and legal services. Our analysis of the central and peripheral levels of implementation helps explain the origin of some of these barriers observed.

At the central level, two findings stand out. On the one hand a lack of coordination between different sectors involved in SGBV case handling and safe abortion procedures hinders access to safe abortion for victim-survivors. Referral to safe abortion services was uncommon at least from the social centres that provided shelter to victim-survivors. Rather they were focussed on family mediation.

Yes, I gave him up for adoption [...] because the child couldn't stay with me [...] In our family and in our community, it's forbidden. The child cannot come home with me. If I go with him to the village, they will kill him.

On the other hand the government of Burkina Faso has developed substantial technical resources to support the implementation of the safe termination of pregnancy. The central document is the reference manual "Post-abortion care and care for safe termination of pregnancy authorised by law", developed in August 2021 by the Family Health Directorate. A key informant from the Ministry of Health describes the use of these protocols:

"Yes, we have the reference manual for post-abortion care and safe termination of pregnancy in accordance with the law. We have decision-making tools. [...] They have been made available in most health facilities"

Key informant 1 from the Ministry of Health, Ouagadougou, Burkina Faso

The administration has also developed algorithms to facilitate the application of procedures by providers who are not given specialised training. The same key informant explains this innovation:

"We have developed algorithms for the safe termination of pregnancy in accordance with the law, based on different situations. And we have distributed them to virtually all health facilities"

Key informant 1 from the Ministry of Health, Ouagadougou, Burkina Faso

This strategy aims to address training gaps by providing standardised practical guidelines. In theory this is a very important resource to enable health care providers to provide safe and legal abortion care.

Explanatory factors: Gaps in policy adoption

Interviews with key informants confirm that some professional organisations (such as the midwives' association) and CSOs, often supported by international funds, have made significant progress in advancing knowledge about the abortion law in Burkina Faso.

However, the 14-week time limit for authorising safe abortion is still a major obstacle that often prevents survivors from getting authorisation for safe abortion in time. As this employee of an NGO testifies:

"However, in practice, the 14-week time limit for authorising voluntary interruption of pregnancy is a major obstacle that often prevents survivors from receiving authorisation in time [...] we are advocating with other actors and other components of civil society for this time limit to be reviewed."

Key informant working at a national NGO, Ouagadougou, Burkina Faso

A tragic story illustrating this problem is that of a woman displaced by internal conflict who was able to escape thanks to the intervention of the army. She then wandered around the North for a long time before discovering that she was pregnant by the men who had killed her husband and raped her and her daughters. She was already more than 14 weeks pregnant, and no one could help her.

"They said there's nothing more we can do. The woman says she would rather die than know that her husband's killer, her rapist, her daughters' rapist, is the father of her unborn child. The woman took her own life. You can see the tragedy we are facing. This is a testimony I heard during a recent meeting."

Key informant from a national NGO, Ouagadougou, Burkina Faso

As illustrated above, even in cases involving women and girls who do not live in conflict zones, reporting is often very late due to the stigma SGBV survivors face. This significantly reduces their chances of accessing a safe and legal abortion within the legal limit of 14 weeks. CSOs in Burkina are trying to improve the legal handling of such cases, to ensure a quick turnaround for those cases reported in time:

"There are [recent] efforts being made at the judicial level to speed up procedures."

Magistrate, Ouagadougou, Burkina Faso

There also appears to be a lack of coordination and alignment between the different structures. For example, social centres play an important role in receiving young victim-survivors, offering psychosocial support and referral to SRH or prenatal care, without mentioning the option of safe abortion. Their institutional mandate focuses on supporting GBV victim-survivors, not referring to safe termination of pregnancy. In the social centre emphasis is placed on family mediation, as is the case with community leaders.

According to a key informant from a professional organisation, although many professionals have been trained to provide safe abortion care, this is not enough to address all the barriers to seeking help and care. A lack of training can lead to victim blaming instead of appropriate referral:

"... there are obstacles at every level of the process, from the judicial police officers to the justice system. If the survivor is not lucky enough to come across someone who is properly informed, she is always the one who suffers discrimination at this level. This is also true at the level of health services... it's true that the ministry and organisations have made efforts to train all these actors in caring for survivors. Unfortunately, however, there are still people who are against [abortion], and there are also people who have not been informed about the law. So, if by misfortune, survivors come across these people, they will have difficulty accessing safe abortion services."

Key informant from a professional association, Ouagadougou, Burkina Faso

The same key informant talks about victim-survivors who are sent back and forth between health centres. Even when they have legal authorisation to access safe abortion services:

"It's true that there are still many shortcomings ... I know of two cases of women who called me with complaints. [...] One of them was sent from one facility to the other. She went to one facility with her paper (legal authorisation) and it was really like ping-pong. They told her: no we don't do that here, you have to go elsewhere. In the next facility she was not helped either; the doctor played along and waited for his colleague from the next shift, and the midwives said it wasn't their job, and so on. The woman went to three different facilities and still hadn't found a solution. The problem persists. Medical personnel invoke conscientious objection. We said no, even if you have a conscientious objection and you don't want to perform the procedure, you are not the only service provider in the field. You have colleagues and you must pass the service on to someone who is able to do it."

Key informant from a professional association, Ouagadougou, Burkina Faso

In summary, whereas important guidelines have been put in place in Burkina Faso and CSOs continue to advocate for improving policies (broadening the 14 weeks gestational limit for accessing safe abortions) according to the data obtained, significant gaps in implementation still prevail. The most important gaps come about because of the security-situation, but also because gestational limits are too narrow, because there is a lack of cross-sectoral alignment and referral and because of the fact that healthcare workers struggle with their personal values and beliefs, hampering timely access to safe abortion care for victim-survivors.

Conclusion

The experiences of victim-survivors in Burkina Faso analysed in this study show how the lack of information on how to deal with cases of sexual violence and on abortion laws (which also affects victim-survivors, health personnel and other key service providers) severely hinders victim-survivors' access to healthcare and justice.

The data also showed that many cases are never reported due to harmful social and gender norms that aim to protect the family and the survivor's future in ways that are detrimental to the well-being of adolescent girls, such as expelling them from their homes or forcing them to marry the perpetrator. It was also found that social services play a key role in supporting victim-survivors, but also that the social and health system is sometimes not equipped to deal with these cases in an impartial and comprehensive manner that respects all legal options (including abortion). The option of abortion was not disclosed to the young victim-survivors who sought help.

For the few victims who did take steps to access safe termination services in accordance with the law, it has been found that the procedures prescribed for legal abortion in cases of rape and incest appear to be too complex and unfeasible within the permitted gestational limit (14 weeks of pregnancy) and that conscientious objection equally hampers access to timely legal abortion care. Thus, in addition to all the social, family and health system-related obstacles, the 14-week gestation limit is a major barrier to the provision of effective care.

The data revealed that infanticide and suicide were the most harmful outcomes of the barriers faced by victim-survivors in Burkina Faso.

Either the child dies or she and I both die. I only had two options in my head. It was either I have an abortion, or I die with the pregnancy.

Cameroon

One of the rape victim-survivors we met in Cameroon, Chantal, told us a harrowing story of incest (from a very young age by several perpetrators) and rape (at the age of 18). She discovered she was pregnant as a result of the rape but never reported it to the authorities. She already had little support from her family because she had previously had a child out of wedlock. At the time, she did not even know what rape or incest were, or that they were punishable offences. She was determined to end the pregnancy, the result of a relationship she had never wanted, even if it meant losing her life. She told us:

"Either the child dies or she and I both die. I only had two options in my head. It was either I have an abortion, or I die with the pregnancy. [...]. Honestly, that's what was going through my mind. [...] Having a child with someone, a child you have from a rape. I wondered how... I couldn't even imagine how...."

Chantal, 37-year-old survivor, Cameroon

Finally, despite numerous attempts, including using sharp objects to try to expel the foetus, Chantal's mother was informed by someone that her daughter was pregnant and might try to terminate the pregnancy, so she stopped her. Chantal eventually had a daughter, who died of fever after eight months. She was accused of negligence by the medical staff, and was deeply hurt by this accusation because, according to her, she had done everything she could to raise the money needed for her daughter's follow-up care.

Chantal told us that she did not know what rape was before. So she could not seek official help without knowing. In addition, she was not supported by her mother, who beat her once when she told her that she had been sexually harassed at home by her uncle (her mother's younger brother). This meant that she could not confide to her mother because she was afraid that her mother would not believe and support her. Now in her thirties, she says that even if she had known what sexual violence was, she might not have gone to the hospital anyway, knowing that all the steps she would have to take there would be far too expensive for her.

Chantal's example^d powerfully shows that seeking care is extremely difficult for women and girls who are not informed about GBV and SRHR and are unaware of existing laws and policies. It also shows how hard it is for girls and women to seek help when they are marginalised within their families, when they have experienced or witnessed discrimination against victim-survivors before, and when they face serious socio-economic barriers. In this chapter these and other barriers are further explored. As victim-survivor testimonies show, and as one of our key informants working at a youth-led SRHR organisation in Cameroon said, victim-survivors face "a real obstacle course"^e in Cameroon; obtaining appropriate care, justice and support are extremely difficult.

Disparities in access to information

Almost everything starts with information and understanding. Chantal, when she experienced incest and rape, knew it was wrong, but she did not know how to name it and did not know that it was punishable by law. Similarly, the data showed that knowledge of the fact that abortion is permitted on certain grounds, including rape, in Cameroon was not widespread. As in the other countries studied, a lack of knowledge about the law, or a fear of what can be communicated publicly about it, prevents civil society actors and civil servants' staff from openly discussing abortion. Some courageous organisations have started to communicate more on this issue, especially through social media, but they are aware that young people living in more remote, rural regions are especially missing out on information. "The biggest challenge is financial. We don't have enough resources to travel, to even go to remote areas to talk about safe abortion," according to a key informant from a youth organisation in the South and Central region.

Aside from the fact that abortion is not an easy topic to obtain information about in Cameroon, awareness of what to do in cases of sexual violence (namely seeking timely

post-rape care and reporting the case to the police) was not widespread. Corruption was mentioned as a common practice that could prevent survivors from accessing their rights. A police officer in the Southern region shared that when certain family members want an incest case to remain confidential, they bribe the doctor not to mention any proof of it on the medical certificate, thereby blocking the legal proceedings. Furthermore, when it comes to a court case, richer families were expected to win.

Professionals also often lack the right information or let their personal and religious values heavily influence how they interpret information and whether they share it with victim-survivors. The police officer mentioned above said on several occasions: "Rape is not allowed, abortion is not allowed. Both are punishable under the Penal Code." When digging a bit deeper it became clear that he believes that abortion to protect the mother's life can be legitimate, but that he is opposed to abortion in cases of rape, despite the law. Although the police have no decision-making power in this matter (it is the prosecutors who decide) such beliefs influence their case handling and hamper the sharing of correct information.

Another factor explaining the limited access to information about abortion laws in Cameroon was shared by a reproductive health expert working in a regional organisation. He emphasised the biased interpretation of the legal framework around abortion by some lawyers. According to him, some lawyers, because of their beliefs and norms, threaten members of organisations campaigning for access to safe abortion with prosecution for inciting people to abort.

In summary, the findings show that there are still major barriers to rendering information on abortion laws and reporting SGBV widely available and to reach everyone with this information, without the information being distorted by personal beliefs and values. Similarly, people need to be able to trust the procedures they are informed about, before being able to act upon it.

^d Although Chantal's experiences took place a while ago, the challenges she encountered are similar to those with more recent experiences with sexual violence and subsequent unintended pregnancies in Cameroon, as the remaining parts of the chapter show.

^e "C'est un véritable parcours du combattant"



“We have a problem in our communities. It’s the silence, I would say the complicit silence of families, in which young girls who are victim-survivors of incest live.”

Social and cultural barriers to timely access to services and rights

Social taboos lead to silence

In addition to the lack of information among the general population, there are specific harmful social norms that prevent survivors from reporting sexual violence and seeking care. According to the following two informants, ‘silence’ is an important factor among survivors themselves and their families:

“It’s a very taboo subject in our community; girls don’t talk about it.”

Key informant from a youth association in the South and Centre region



“First of all, I have to tell you that we have a problem in our communities. It’s the silence, I would say the complicit silence of families, in which young girls who are victim-survivors of incest live. Generally, these families find it difficult or even refuse to report these cases. That’s a difficulty we encounter.”

Key informant in social protection in the Mvila department, Cameroon

The findings reveal the sophisticated social mechanisms that keep victim-survivors silent, exploiting the specific vulnerabilities of adolescent girls and their fear of family exclusion. These factors, combined with a lack of information and awareness, make that girls and women never seek appropriate services, or do so very late.

“My daughter was 14 when it happened. She didn’t say anything for months. She was afraid we would scold her, that we would say it was her fault. The man who raped her told her that if she spoke, he would hurt the whole family. She believed him. He also told her that no one would believe her because she was too young and he was respected in the neighbourhood. When I found out she was five months pregnant, I first thought she had a boyfriend she was hiding. I scolded her harshly. I told her she had dishonoured us. It was only later that she told me everything, crying. Then I realised what I had done, but it was too late for an abortion. We didn’t even know it was possible. No one had told us there were laws about it.”

Mother of a survivor, Cameroon

This harrowing story reveals the effectiveness of the perpetrator’s control strategies employed through direct intimidation (threats against the family) and using one’s status to question the victim’s credibility when she would denounce the abuse (differential social status). The mother’s initial reaction illustrates how gender norms, which dictate that girls under a certain age should not engage in sexual activity, inadvertently risk diverting the attention away from perpetrators.

Protection of family reputation

Silence is not only imposed on girls by perpetrators, but silence is also often promoted within families when situations of incest occur.

"When my little sister tried to say that our father was touching her, no one believed her at first. My mother said she was lying, that she wanted to hurt the family. My uncles said we shouldn't tarnish the family name over children's stories. When she got pregnant, we couldn't deny it anymore. But instead of protecting my sister, the family tried to cover it up. They said we had to deal with it internally, that reporting it would destroy our reputation. When my mother finally reported it, the whole family rejected her. They said she had destroyed the family honour. Now, even after my father was convicted, the families avoid us. My sister and my mother have become outcasts. And my sister was already seven months pregnant when we finally acted. It was too late for an abortion."

Sister of a victim-survivor, Cameroon

These experiences demonstrate how the logic of family protection can have negative consequences for the victim. The extended family system protects the perpetrator in order to preserve the collective reputation. The stigma that follows reporting transforms the victim into a 'pariah' and shows that the social system punishes disclosure more severely than the assault itself. This systematically discourages access to rights, psychological and medical care.

Punishing survivors

In the case of Chantal, shared at the beginning of this chapter, and in other cases, girls and women revealing incest, or rape fear not to be believed, and are actually beaten by their mother when they disclose assault. Violence against the victim-survivor when she discloses is a recurring theme. Witnessing such beating is likely to discourage other girls and young women from disclosing sexual violence to their parents and seeking support. One of the victim-survivors of incest shared how during a family meeting following her

disclosure, older female relatives shared having experienced similar situations when they were young. The message they communicated that it was something normal and needed to be accepted. These insights – the fact that experiences of sexual violence are normalised – partly explain the recurring inaction within families when sexual violence is being disclosed.

Consequences for victim-survivors

Among nine victim-survivor stories documented in Cameroon, the majority never sought psychological, medical or legal assistance. In two cases pregnancies were ended through unsafe abortions, one of which resulted in the death of the young woman, whose story was narrated by her friend. In five other cases, the girls and young women gave birth. Two other victim-survivors did not get pregnant after sexual violence but lived with untreated STIs for a while until they got medical and psychological support from a local organisation. Beyond these first-hand narratives, many key informants referred to unsafe abortions being the most common outcome for victim-survivors who fall pregnant after rape and incest. They shared that it was rare to find a victim-survivors who had benefitted from the services theoretically in place for victim-survivors.

"We realise that many girls who have been raped do not themselves know how to access abortion services. Most of the time, they end up having clandestine abortions because they do not know that they can receive abortion services as victims of rape."

Key informant from a youth organisation in the South and Centre region, Cameroon

Explanatory factors: Policy and systems level gaps

The Cameroonian administration appears to have a fragmented and poorly coordinated institutional architecture for providing access to justice for victim-survivors of rape and incest, despite the ratification of the Maputo Protocol. Several ministries (Public Health, Justice, Women's and Family Promotion)



are involved in the post-law administration of the law, but coordination is weak. Some key informants explain this by referring to the values held by authorities, who are not supporting safe and legal abortion:

"For many decision-makers, abortion is a taboo subject, so many authorities do not dare to speak out on the issue."

Key informant from a youth association in the South and Centre region, Cameroon

There is no structured programme dedicated to voluntary termination of pregnancy for survivors, with an informal collaborative approach rather than an organised institutional framework. This leads to a lack of human, information and financial resources to translate the law into a reality. Key informants state that much more training and clarity on the law is needed.

"We have proposed that we train magistrates to try not to complicate the Maputo Protocol [...] We have even said that we will negotiate the penal code to adapt it to the Maputo Protocol."

Key informant, Ministry of Justice, Cameroon

This statement reveals that magistrates do not currently have the required skills and need training to carry out their mandate. Magistrates play a key role in granting authorisation for post-rape abortion.

The Cameroonian administration also lacks trained professionals to perform voluntary terminations of pregnancy for survivors. This shortage of qualified people, combined with an uneven geographical distribution of personnel is another major obstacle to survivors' access to services. This geographical fragmentation is particularly critical in a context where therapeutic abortion requires specialised technical skills that only certain gynaecologists, competent midwives or trained general practitioners can provide in accordance with national standards.

Regarding financial resources, the Cameroonian administration has not allocated a specific budget for voluntary termination of pregnancy for survivors of rape and incest. This lack of structured public funding is a fundamental shortcoming in the transformation of political intent into an operational programme. The costs of the administrative and medical process are entirely borne by the survivors, creating inequality of access based on financial capacity.

Without financial support from the government, survivors must bear all the costs, from initial medical consultations to the procedure itself, including legal fees. This contravenes the principles of accessibility to SRH services for victim-survivors of violence.

Information resources for personnel working within the framework of laws on voluntary termination of pregnancy are limited and fragmented. Several technical documents have been produced, but their coordination and dissemination are inadequate. The main document used is the manual "Normes et Standards en Santé reproductive et planning familial au Cameroun" (Standards and Norms in Reproductive Health and Family Planning in Cameroon), produced in collaboration with the United Nations Population Fund and the Cameroon Association for Social Marketing. This document is the primary official source of information for health care professionals. However, according to the data collected, there is insufficient specialised training based on these protocols for frontline professionals.

The Cameroon Society of Gynaecology and Obstetrics has recently developed an essential information resource to compensate for these shortcomings to facilitate access to voluntary termination of pregnancy for victim-survivors. A member of a local NGO explains:

"Following a rape, we work with what is called the Referral Pathway, which was produced by the Cameroon Society of Gynaecologists. This describes the different stages to follow when women who have been raped need access to safe abortion services."

Member of a local NGO, Cameroon

Although it is a civil society initiative, this guidance document is increasingly being used and rolled out in training courses for healthcare providers organised by SOGOC.

Explanatory factors: Gaps in policy adoption

Despite several challenges, the Cameroonian context is a prime example of how, in the absence of policies and procedures, initiatives from the private sector and NGOs step in to fill the void. These organisations play an essential role in improving access to care and rights for survivors in the country, for example by closely following legal procedures, to that the authorisation for therapeutic abortions are delivered in time. These kinds of initiatives illustrate how peripheral innovations correct systemic dysfunctions. However, dependence on private initiatives creates inequalities in access.

And even after getting the certificate, access to safe and legal abortion for victim-survivors is not always straightforward. In addition to challenge at the level of the police and courts, challenges also remain at the level of health care services where conscientious objection and stigmatising attitudes regarding victim-survivors stand in the way of victim centred care.

Conclusion

In Cameroon promising initiatives are developed by civil society organisations to enable survivors to access appropriate care and, if they want to, services for safe and legal abortion after rape or violence. However, many girls and women are prevented from reporting rape or incest in the first place due to numerous barriers and unequal access to information and support mechanisms. This leads them to seek unsafe abortions that guarantee confidentiality and allow them to control their expenses (if there are no complications), but which may put their lives at risk. Apart from a few individuals and CSOs that are genuinely committed to the issue, the social environment is not conducive to enabling survivors to achieve justice and get appropriate medical and psychological care. The stigmatisation of victim-survivors and the taboos surrounding abortion are still major challenges for Cameroonian girls and women in accessing appropriate care and justice.

Côte d'Ivoire

Bella, a 15-year-old girl who had been in her father's care since she was 10 because her parents no longer lived together, was repeatedly raped by her father. It all started when she was 14. Bella tried to alert her aunt, but to no avail. However during a visit from her mother, who found her at home ill and struggling to walk, Bella told her mother, who lived elsewhere, what had happened. When her mother reported the assault to the family, she was subjected to intense pressure to cover up the incident, which was considered shameful. Despite everything, Bella's mother took her daughter to hospital and then filed a complaint. The father was arrested, tried and convicted. The girl received medical, psychological and legal support. However, the mother was rejected by part of her family and by Bella's father's family who, as she told us several times, "chased her away like a sheep". When asked if she has received any support from the community, Bella's mother replies that this is far from the case. She says that, on the contrary, some people tend to persecute her, while they keep saying that she was wrong to report her daughter's father.

In this case, Bella did not become pregnant and received appropriate medical care thanks to her mother's swift response. The legal proceedings proved effective. However, the example highlights the persistent stigma attached to survivors of sexual violence, particularly incest, which can discourage them from reporting it. This is a recurring theme that was frequently mentioned in the interviews in Côte d'Ivoire. Bella's mother told us that normally, in this kind of situation, people like her are paid by the perpetrator or his relatives "to keep their mouths shut". But she says she could never accept such a thing, given that her daughter's life was in danger.

In Côte d'Ivoire, it was difficult during the study to meet victim-survivors themselves. However, we were able to document four case studies directly with victim-survivors or their relatives and several others indirectly. The cases provide good insights into some of the challenges faced in Côte d'Ivoire by victim-survivors of rape or incest and their relatives.

In two of our four documented case studies with victim-survivors, pregnancies occurred

as a result of violence suffered by the girls, and were only discovered at a late stage. In one of these cases, the relatives were completely unaware of what to do in the event of rape. In the other case, the 13-year-old girl had not reported anything and only discovered she was pregnant at five months. Even after the discovery, she did not talk to anyone because she had no one she could trust. She also expressed concern about not speaking out immediately after the incident, wondering, "Who will believe me now?" She said it happened in an abandoned school, she screamed and bled, and the man knew very well that it was rape. After giving birth, she suffered from a fistula, which led to additional stigma and greater isolation. Over time, she received help and free surgery, after which she was cured. The perpetrator was brought to the social centre and told to pay weekly for the upkeep of the baby. He was unable to do so, which made it a struggle for the young mother. Eventually, the child went to live with the perpetrator's older brother, far from his mother. It is now difficult for his

mother to talk to him on the phone because he has forgotten his mother tongue and only speaks the language of his paternal family.

The diverse experiences documented in this study reflects the many obstacles faced by survivors in Côte d'Ivoire.

Disparities in access to information

In Côte d'Ivoire, sexual violence has drawn greater attention over the past decade. According to interviewees, people are increasingly aware of what it is, and various organisations and structures have been set up to support and guide survivors towards justice and healthcare. But there are still many challenges in reporting sexual violence, as we will see below. Our data show that abortion and the laws surrounding abortion remain highly controversial leading to a dearth of information:

The maze women face: stuck between rights and reality

"For me, the challenges are on several levels. But the main challenge is at the community level, deconstructing negative thinking about abortion at the community level. Because for communities, when we talk about abortion, it's a heated discussion, it's a mess."

Director of a national NGO, Abidjan, Côte d'Ivoire

"It's still a taboo subject [...] We can't talk about it."

Female participant in a focus group of women leaders, San Pedro, Côte d'Ivoire

Abortion is a taboo subject among the Ivorian population, making it difficult to disseminate information on safe and legal abortion. Many respondents working in NGOs reported difficulties in bringing up the subject at community level, and the laws surrounding abortion are not well known. Although, people are often aware that abortion is possible when the mother's life is in danger, the 2024 changes to the law (which allow abortion in cases where the woman's mental health is at risk, or in cases of incest) are not widely known by health professionals and the general public. The same is true of the previous amendment in 2019, which included rape as an exception in the law. This doctor reported that he was not informed and, to his knowledge, others were even less so:

"We ourselves are not informed. We went to school, we studied medicine, but we are not informed about the laws that govern this. No one in the population is informed. They know absolutely nothing. They know nothing about any of this."

Chief doctor at a health centre in San Pedro, Côte d'Ivoire

According to most of the people interviewed, there is an urgent need to inform the public and professionals alike about the law on abortion.

Social and cultural barriers to timely access to services and rights

Dynamics discouraging reporting: power relations

Although information about sexual violence seems to be better disseminated than information about abortion, there are many other barriers to reporting and seeking help after sexual violence. One factor that prevents reporting is the power that perpetrators of sexual violence often hold over their victim-survivors:

"And usually, [...] it's guys in the family who do it, who abuse people. [...] Even in our religious circles today, there are lots of them. There are young girls who go to church and are abused by people in the religious sphere. They're gurus, so they can't talk about it. So we hide to go and do it [have an abortion] in clandestine places. And well, sometimes it happens, sometimes it goes wrong. So I would say that the situation is complicated [...] And it's difficult for these women to talk about it and especially to report it [...] you can't just go and say, 'I've been abused'. That's the difficulty today. Our awareness campaign focuses on reporting. Because it's usually uncles and cousins who abuse people. We need to be able to tell people that even if it's an uncle, they have to report it. [...] So it's complicated. Girls are afraid to talk about it. And then often there are threats and pressure from the family, so they end up keeping the children even when they don't necessarily want to."

Blogger, Abidjan, Côte d'Ivoire

The female blogger emphasises that campaigns on sexual violence need to focus on encouraging people to report cases, as not reporting them is a major obstacle to supporting victim-survivors and ending SGBV.

Dynamics discouraging reporting: solving it in or between families

As described in the opening case study about

Bella, the fact that families and community members oppose reporting perpetrators of incest, and that preference is given to discreet resolution of these problems, often within the family and sometimes between families is a key barrier to reporting. As one regional health administrator explained: *"When there are cases of incest and so on, we tend to try to reach an agreement within the family, rather than focusing on [...] how the victim-survivor of the attack feels."* This is a recurring theme in the data collected, with many harmful consequences for survivors: not securing justice, sometimes not receiving essential medical and psychological care, not feeling supported, having to continue living close to the perpetrator, who may continue to engage in the same practices. This way of resolving problems is primarily to avoid tarnishing the family name. And this is not only common practice in cases of incest; in fact, according to this female leader, rape cases also tend to be resolved in the same way, particularly in villages:

"If it's in a village where everyone knows each other, we're neighbours, maybe your son raped my daughter today and I sent your child to prison, it becomes a matter of settling scores afterwards. So when it's like that, we ask for forgiveness and people cover it up. But maybe when it's in the city, the parents go straight away, they send the girl to the hospital to check if the child has been raped. If the child has been raped, the perpetrator is brought in on the first day to be interviewed, that's what has to be done."

Woman participant in a focus group for women leaders, San Pedro, Côte d'Ivoire

However, this described divide between rural and urban areas does not necessarily reflect the findings from urban settings. In urban areas, too, survivors remain silent for fear of being *"stigmatised for life"* and therefore do not necessarily report cases of sexual violence, as shown below.

Stigmatisation of victim-survivors when they report abuse

When perpetrators are reported, survivors (rather than perpetrators) may face serious repercussions, as we saw in Bella's mother's

When there are cases of incest and so on, we tend to try to reach an agreement within the family, rather than focusing on [...] how the victim-survivor of the attack feels.

account at the beginning of this chapter. The family members of her ex-husband, whom she reported, and members of the community harassed her because of what she did. The following is another account of stigmatisation:

"[...] we know very well that there are people who continue to hide because there are people who say that they don't want to be stigmatised for life [...] They prefer to keep quiet so as not to attract people's attention [...] because if you confess, you risk getting into real trouble [...] I was involved in a case that really sickened me. It was in the commune of X, where a poor woman who identified her abuser was insulted by the community. She was considered a bad woman, especially since she had even taken him to court. When she came back, she couldn't even go out in the neighbourhood anymore. So, the only thing to do was to do everything we could to get her out of the area. Because [people were asking] why did she go and complain? Why did she go and show her abuser? Because he [the abuser] was someone well respected in his community. She was a victim of her own community and no longer felt free."

Director of an NGO, Abidjan, Côte d'Ivoire

This testimony reflects the harmful social consequences for survivors when they report a rapist. They cannot count on community support, especially if the perpetrator has a good reputation. In addition, witnessing such reactions within the community discourages other women from bringing perpetrators to justice, out of fear of stigmatisation.

The same person suggests that it is better for survivors who come forward not to insist on reporting the perpetrator:

"If someone comes to you and says, 'I was raped and I don't want to identify the person even though I'm in pain,' all you can do is take care of her and move on."

Director of an NGO, Abidjan, Côte d'Ivoire



This suggested approach contrasts with the current provisions of the law, which stipulate that in cases of rape, doctors may only perform abortions *"after receiving proof that a judicial investigation has been opened for rape and at the written request of the victim-survivor."* In cases of incest, it is also stated that the doctor may only perform an abortion *"after receiving proof that legal proceedings have been initiated by the public prosecutor."* According to some, these requirements discourage women from reporting their attacker, that clandestine abortion is an easier option.

In addition to the lack of support or refusal to report the perpetrators, victim-survivors may even be blamed for the assault, as the blogger attests:

"[...] they are ridiculed. As I just said, they are told that it is their fault. So, when you tell a young girl that it is her fault that she was raped, then the other girl next to her has been through the same thing, she cannot come forward and say so. Today, people say that rape victims are the ones who asked for it. That's a difficulty [...]"

Blogger, Abidjan, Côte d'Ivoire

When victim-survivors are discouraged from reporting the crime, the status quo can be maintained in favour of the perpetrators of violence.

Another incentive for family members not to report sexual violence is the tendency to give money to the survivor's family to keep

them quiet. Bella's mother, in the opening case study, testified that in such situations, people like her are paid "to keep their mouths shut". This suggestion is confirmed by other interviewees, such as the female blogger who also opposes this practice:

"And then, generally, people like to negotiate. So, since it's family, they say we'll give 500,000 (in West African CFA francs, approximately 900\$). But can 500,000 pay for someone's honour? I don't think so. And then there is all this difficulty, there's the damage to the family of the uncles who aren't even ashamed of abusing people. And then, we give up. People are afraid to report these people because most of them are rich."

Blogger, Abidjan, Côte d'Ivoire

This argument highlights the influence of power and money in sexual violence. Another key informant suggests that when the family cannot be swayed by the power and wealth of the perpetrators, the authorities can: *"There are often many arrangements with the authorities."* (Director of an NGO, Abidjan). Another informant, a gynaecologist, corroborates this, noting that even if a case reaches the courts, families can still try to make it disappear:

"I told you earlier that we issue a certificate of sexual violence. It is the judge who determines whether it is rape or not. It is not the doctor. So that means that we give the document to the courts, or if the parents make arrangements, it doesn't even get there. At the moment, they no longer come to see the doctor in such cases; they sort things out in town, either traditionally or through another structure. That's what makes it a bit complex. People make agreements between the justice system and even the medical profession. That's the problem."

Gynaecologist-obstetrician, Gontougo, Côte d'Ivoire

This doctor refers to how intra- or inter-family

arrangements lead to a breakdown in the service chain, with cases being dropped instead of going to court and informal, unsafe abortions being sought and provided by some doctors instead. Although there may be other socio-cultural and economic barriers, the above highlights some of the societal barriers that frequently emerge in the data and prevent many cases of sexual violence from being reported and many survivors from accessing appropriate services.

Shame and underreporting

It seems clear that social and cultural constraints can significantly conceal the true extent of the problem of rape and incest, as explained by the same gynaecologist:

"Patients don't come to the hospital because they are ashamed; they don't want to come and let people know what happened. So, this cultural and social aspect means that the figures we have are not the real figures. What we see in the hospital is perhaps just the tip of the iceberg. Rape can even happen within the family, and you'll be told not to go [to the hospital]. Rape can be the result of a forced marriage. There are no limits. There are cases like this that don't come to light."

Gynaecologist-obstetrician, Gontougo, Côte d'Ivoire

Although this section focuses on how the law is implemented at a micro level and how it benefits survivors, it is important to recognise that many cases of rape and incest in Côte d'Ivoire never enter the official system.

Outcomes for survivors

Survivors who are pregnant as a result of rape or incest tend to give birth because of the problems they face, as explained above. Sometimes, if the perpetrator is known, and because of family negotiations, he is held responsible for financing the child's care. In other cases, particularly when the perpetrator is unknown, some families take in children born as a result of sexual violence, in accordance with their traditions. The general trend is to disapprove of abortion.

As some men from community and religious backgrounds argue, the child could "become the next president, you never know". Shortly afterwards, in the same focus group discussion with male leaders, they however raised the fact that the child could just as easily become a "gangster", particularly in a situation where the mother was traumatised and unable to love her child. They acknowledged that in fact many cases like these are dealt with discreetly by mothers and daughters, using traditional methods to "terminate" the pregnancy.

"I would say that traditionally, we have abortion measures. The child [...] if she tells early, in our community, I think that if she tells early, mothers have secrets. If we know there are plants, we will give them to her [...], she will drink them, and it will end."

Male, focus group with community leaders, San Pedro, Côte d'Ivoire

In the same focus group discussion, it was suggested that fathers only find out about such cases when the abortion attempt goes wrong. A gynaecologist also reports that rapes are often not reported within the 72-hour time limit and that they only meet survivors when they have already taken abortion drugs and are bleeding.

"And in these conditions, people do not come directly to the public hospital. If the pregnancy is already there, they quickly go to other facilities in the suburbs, where they seek advice and counselling. They obtain the (abortion) product. Then they only come here when they start bleeding."

Gynaecologist-obstetrician, Gontougo, Côte d'Ivoire

Many key informants therefore indicate that clandestine, non-medical abortions are a way of discreetly dealing with these pregnancies at the family level. According to doctors, cases only reach the hospital as post-abortion care cases, or when families have not found a solution:

"And things are settled within the family. So there are lots of cases of incest, lots of cases of rape, which remain within the community. Between families, it's settled there. And when someone arrives at the hospital here, at the level of the legal and judicial authorities, it's because they couldn't reach an agreement. In the village, they couldn't agree. It's because one side refused to admit what happened."

Doctor, head of a health centre, San Pedro, Côte d'Ivoire

But passing the legal route would not have been an alternative: this doctor who spoke as a general practitioner and head doctor at his health centre said he knew nothing about the abortion law. Other sources of information have stated that police officers, who are not informed about exemptions for abortion in cases of rape and incest, need training. According to a representative of a women's legal association, even when everything goes well in terms of reporting and referral of pregnant survivors, delays in access to safe and legal abortion are to be expected, with the result that abortion will no longer be a legal option and the pregnancy will be carried to term:

"In cases of rape, a judicial investigation must be opened. This is really the start of the investigation. In such cases, questions of time limits arise, since pregnancy lasts nine months. [...]. This raises the question of the applicability of the law."

Woman, representative of a women's rights association, Abidjan, Côte d'Ivoire

This limited application of the laws relating to abortion is examined in more detail below. We explain the obstacles survivors face if they go to a health centre, social centre or the police for support.

Explanatory factors: Policy and systems level gaps

This chapter shows the significant challenges at play, exposing how existing legal provisions on abortion in Côte d'Ivoire that exist on paper are far from a reality in the lives of survivors of rape or incest. Recent legal changes (in 2024) and renewed attention to access to safe and legal abortion by courageous civil society actors may take time to translate into reality on the ground. In the next section the focus is on what has already happened in terms of policies and adoption of the policies. To what extent has the abortion law already been translated into concrete guidelines? And to what extent are the country's medical staff ready to adopt the newest political intentions? These questions are answered based on interviews with stakeholders at different levels of the abortion ecosystem.

First, what came out strongly is that good progress has been achieved with the institutional and organisational architecture for combating sexual violence in Côte d'Ivoire. Over the last decade, various resources have been invested. A major victory was the advocacy campaign by civil society organisations to ensure that survivors of sexual violence do not have to pay for the medical certificate required to initiate legal proceedings after rape or incest. The remaining challenges relate to the reporting of cases (as seen above) and the involvement of post-rape healthcare providers in referral for legal abortion. The latter is difficult because the laws and procedures are not currently known by many of the professionals who are essential to the enforcement of the law.

Although rape is a legal ground for abortion in Côte d'Ivoire since 2019, and incest and mental health as grounds for legal abortion were added in 2024 amendments of the country's criminal code, many key stakeholders are unaware of these laws or lack detailed instructions for their implementation. Healthcare providers do not yet have access to policy guidelines that clearly translate the law into agreed procedures. In fact, healthcare providers operate in an information vacuum that begins at the administrative level:

"For now, I think that as far as abortion is concerned in our country, as far as I know, there has not yet been anything legal as such."

Regional health administrator, San Pedro, Côte d'Ivoire

"[...] even the health providers themselves who are supposed to offer safe abortion are not always well informed. [...] And then often it is the technical nature of the procedure itself that they do not know [...] Providers are not informed that they have to do it and what the conditions are for being able to do it."

Key informant at the National Programme to Combat Gender-Based Violence, Abidjan, Côte d'Ivoire

Many testimonies show that even for those who are aware of the amendment to the Penal Code, there are still many uncertainties that prevent anything from being implemented in practice. One of the key hurdles is the absence of a law on sexual and reproductive health, which has been pending for a long time. In the absence of this law and an implementing decree on the grounds for legal abortion, healthcare providers do not know what the guidelines are and to what extent the law protects them when providing comprehensive abortion care authorised under the articles of the criminal code. As recognised by a key informant at the Ministry of Health, it is vital to have clear guidelines, to stipulate each exemption and defining gestational limits; explain how healthcare providers can offer these services while ensuring that they comply with the law; to clarify how to deal with conscientious objection; and to specify what time limits are acceptable for issuing medical certificates and whether these certificates should be free of charge, etc.

"[...] the policy document needs to be revised since the law has changed. And then these documents need to be made accessible. Meaning, if the issue is safe abortion, those concerned need to have access to information about what can be done. [...] So there is still a lot to be done."

Representative of the Ministry of Health, Abidjan, Côte d'Ivoire

According to other specialists, there is also significant uncertainty regarding the exact requirements for opening legal cases, as this participant attests:

"In cases of rape and incest, there is talk of opening a legal case. So this also remains a barrier, as nothing is said very precisely about the level of the legal case in question."

Key informant at an international NGO, Abidjan, Côte d'Ivoire

In addition to this lack of guidelines, there is a lack of training of health workers in training institutes and in the field for staff already in service:

"[...] they know nothing about the framework within which they work. They have no knowledge of the law. That's what they learn at school. And when people are in the field, in the in-service training for health care providers, the law is never mentioned. Almost never. When we have to do trainings, it's purely medical."

Chief doctor in a health centre, San Pedro, Côte d'Ivoire

Hence currently it appears that the amended Penal Code has not been widely disseminated and that even the 2019 amendment adding rape as a condition has not reached all levels of administration and implementation.

Furthermore, budgetary constraints are evident at the operational level, where the

lack of equipment and medicines was a recurring theme in conversations with health professionals. This observation illustrates the gap between making of the laws and the level of resources actually allocated to implement them.

Explanatory factors: Gaps in policy adoption

Unlike other countries studied, limited data were obtained on how health centres on the ground in Côte d'Ivoire actually engage in safe abortion care for pregnant victim-survivors of rape or incest. Most of the centres visited do not offer abortion care in accordance with the law in cases of rape or incest and are often unaware of the legality of such care. However, professionals were aware that abortion services were possible when it could save the life of the pregnant woman and testified that these services were occasionally offered, and they offered post-abortion care. Yet some CSOs are adapting quickly to the changes in the law, based on their organisational mission and partnerships with international organisations active in the field of SRHR.

Other information gathered showed how the police was not aware of their role in handling rape cases and that they suggested the survivor should seek help from an NGO instead.

Paradoxically, some human rights organisations do not engage with these laws protecting victim-survivors at all. They refuse to communicate information about legal abortion and only accompany survivors until they give birth. This approach reveals conservative ideological positions that persist despite legal progress.

Conclusion

Côte d'Ivoire offers a unique opportunity to observe institutional adaptation dynamics in real time, demonstrating the challenges of translating major legislative changes into operational reality. The Ivorian experience currently reveals an institutional paradox: while the June 2024 reform is a major step forward for the rights of girls and women, most of the professionals directly concerned remain poorly informed, as does the general population. Even the fact that pregnancies resulting from rape can be terminated without legal repercussions is often poorly understood, despite this exception already being included in the Penal Code in 2019. Despite some innovative communication initiatives, information is not yet widely available, and health professionals lack information and guidelines to ensure that legislative changes translate into reality for victim-survivors of sexual violence.

Limited data was obtained on how the amendments to the Penal Code are currently being addressed by the police, judicial system and social centres. A lot will depend on the issuing and spreading of adopted policy guidelines and the ability of CSOs to inform, explain and maintain contact with key public sector stakeholders around the implementation of the abortion laws.

The biggest challenges to be addressed, based on the data collected in Côte d'Ivoire, are:

1. The lack of sufficient communication about the amendment to the Penal Code aimed at health professionals, administrative and police personnel and the public.
2. The absence of a sexual and reproductive health law that clearly communicates the provisions on abortion and the lack of an implementing decree.
3. The handling of cases of incest and rape within families, neighbourhoods and communities with the intention of protecting the family name, and protecting powerful individuals, at the expense of the health and rights of victim-survivors (despite institutional advances on the issue of gender-based violence).
4. The strong stigma attached to victim-survivors who report cases of sexual violence, which acts as a mechanism for maintaining the status quo and silencing other victim-survivors of sexual violence.

Given these difficulties, unsafe abortion is sadly still the most accessible option for survivors who become pregnant as a result of rape or incest in Côte d'Ivoire currently.



Researchers involved in the study

Togo

The below case study touches on many of the dynamics we see the victim-survivors of sexual violence facing in Togo. This is the story of a courageous young woman who received some initial help and ultimately succeeded, to some extent, in bringing her attacker to justice, but who encountered terrible challenges in the aftermath of the rape:

Gislène, a 19-year-old university student, lived with her uncle and aunt in Lomé. She had been approached by a young man who wanted to date her. But Gislène was cautious; her uncle was very strict and if he saw her even talking to a man, she would be reprimanded. She did not want to get into trouble. However, the man continued to insist, and she eventually gave in and went to his house. That's when things quickly took a turn for the worse:

"He said that if I didn't let him do it, he would use force. We started struggling and, as he was stronger than me, he got the upper hand and did it to me. It was my first time, and he was the one who took my virginity."

She explains that she couldn't tell her uncle because he was so strict, nor his wife. However, when she arrived on campus, she told a friend, who told her about an organisation that could help her. When she went there, she received a lot of moral support, was welcomed with understanding and given information on what she could do to pursue the attacker. She was also taken to hospital where she was tested for HIV, and a medical file was opened following the examination. She then went to the police station, together with a representative of the organisation, where she was also well received. She was asked to call the rapist, and he agreed to meet her. A meeting was arranged as a trap so that the police could arrest him. Once at the police station, he called his family, who begged Gislène, asking her to forgive him so that he could be released:

"His family was crying and kneeling down so that we could settle the matter amicably. So, there was pressure coming from them, and if you're not mentally strong enough, you might withdraw your complaint."

The perpetrator was sentenced to prison but only served six months. After six months, the judge handling his case was transferred to another city, so she called Gislène to ask if she still wanted to pursue the complaint. The judge pressured Gislène to settle the case and suggest a fine so that the rapist could be released. The process was complicated: she had to pay for the rapist's food in prison and the transport costs for his transfer to another prison; there were numerous hearings she had to attend. She eventually settled for 500,000 West African CFA francs (approximately 900\$). As part of the agreement, she managed to negotiate that the rapist's family be moved away and that she would never have to see them again.

"They kept coming to my house, threatening to kill me, so I said I didn't want to see them again or answer any questions about what happened."

The impact on Gislène was enormous:

"I was very afraid to be alone; I didn't go to university regularly for fear that someone would kill me there and no one would even know."

Initially, she had proposed the judge a fine of 1 million West African CFA francs (around 1800\$), but the judge convinced her to lower the amount:

"The judge said to reduce it because they didn't have any money, and also that whether it was a million or 500,000, it wasn't going to heal me."

"It's as if the family came to complain to the judge and it's a bit like the judge took their side and spoke in their favour. At least he [the rapist] learned a small part of the lesson, so before he wants to do that again, he'll think twice."

Medically, she says she did receive proper care. She also received psychological support from the association that helped her after the rape. At the hospital, she was informed that she could become pregnant.

"Since I didn't go to the hospital right away, I wasn't given the morning-after pill. So I started thinking about what I would do if that happened. First, I couldn't accept what had happened to me. Then I was under a lot of pressure from all sides, and I couldn't bear the thought of having someone [a baby] who would remind me of what happened every day. Even if I managed to give birth, I couldn't love the child."

Gislène was not informed about the legality of abortion, but fortunately she did not become pregnant. However, she then became pregnant following a second experience of sexual violence. Her uncle had kicked her out of the house, holding her partly responsible for her experience of the first rape because, in his view, she should never have gone to the man's house in the first place. After being thrown out, she was unable to find a room to rent. As the academic year was about to begin, a friend allowed her to move in with him, which was a great relief for Gislène because, following threats from her rapist's family, she was afraid to stay alone. However, she made it clear to her friend that she did not see herself in a relationship with him. Yet one day, he crossed these boundaries against Gislène's will:

"I also want to make it clear that I wasn't completely over my previous rape and, despite all my new boyfriend's efforts, I couldn't bring myself to love him. I just appreciated what he did for me, so we agreed that we wouldn't have sex because I didn't like being touched by men anymore."

"Then one day, I was lying down and he came and touched me. I didn't know what to do, so I just watched him until he penetrated me. That's when I came to my senses and told him to stop, and he agreed. After a month of this, I noticed that I hadn't had my period, so I went out and bought a pregnancy test, and it was positive."



Since the relationship was against her will, Gislène was distressed by "the way the pregnancy came about." And, still trying to come to terms with her experience of rape, she did not want to keep the baby. She was also unsure whether to consider the assault as rape and therefore did not report the incident, as well as not wanting to report a 'friend' who had tried to help her by giving her shelter. So, she approached the organisation that had previously helped her, to mediate between her and her partner.

As a last resort, Gislène ended up going to a clandestine abortion provider who gave her pills and an injection. The medication did not work the first time. A second attempt was needed to successfully induce the abortion. She spent around 100,000 West African CFA francs (approximately 180\$) on the entire treatment.

Afterwards, she felt guilty from a religious point of view, but she is also very clear in her opinion on the importance of having the option of legal abortion after rape:

"A child born as a result of rape should always be aborted. Because if the victim is not mentally prepared and the environment does not support you, if you are not mentally strong, you will become depressed, and if a child is born while you are depressed, it is too complicated. If you do have an environment that understands and supports you, you can try to keep the pregnancy."

Gislène's story illustrates the many difficulties faced by survivors of sexual violence in Togo. Among the major obstacles are lack of family support to ensure timely reporting of rape, death-threats from the perpetrator's family, and judicial pressure, influenced by the perpetrator's family, to settle cases amicably. Gislène also suffered rejection and even expulsion by her relatives, as well as psychological problems that severely affected her daily life. Her second experience of violence, this time within her close circle, further complicated the situation, making it difficult for her to report the crime again. In addition, she encountered limited access to safe abortion, which led her to resort to a clandestine abortion. Finally, she conveys

the risk of carrying a pregnancy resulting from rape, while in a state of psychological distress, suggesting this poses an additional threat to the well-being of survivors. For victims of rape or incest in Togo, the situation remains complex and the procedure for accessing safe abortion is long, complicated and mostly impossible for victims, as shown in this chapter.

Disparities in access to information

According to some people interviewed in different parts of the country, there is growing awareness, thanks to community campaigns, of the importance of taking survivors to a social or health centre so that they can receive appropriate medical and psychological care:

"[...] we prefer not to talk about it. But I think the current reaction of parents is linked to the campaign against sexual violence, which says: 'It's a crime, you have to report it because survivors suffer serious psychological problems afterwards.' That's what brings a lot of parents here. So, they come just to see if it's really true, just to confirm: is there really sexual assault? That's often the case. Secondly, to get help. But the idea of filing a complaint is not really a priority. I would say that here, I've only seen one person who was really keen to file a complaint."

Medical assistant, private health centre, Lomé, Togo

In line with this statement, other interviewees shared that, particularly within Muslim communities, parents are primarily concerned with ascertaining whether their daughter is still a virgin, to preserve her value within the context of marriage. However, this verification and medical treatment is as far as most people go. They don't intend to report cases due to the social barriers to reporting sexual violence, and the complex legal procedures that may prevent families from keeping the case secret from outsiders. Furthermore, according to interviewees, laws on access to safe abortion are rarely known to community members, and many of them advocate for much greater awareness

among girls, women and the community. An 18-year-old survivor, who has also been a victim-survivor of sexual exploitation since the age of 16, testifies: "I didn't know that when you are a victim of rape, the law allows you to have an abortion. For me, I thought it was forbidden, which is why I wanted to do it clandestinely." She underwent a clandestine abortion, with the involvement of her parents, when she was seven months pregnant, a very risky procedure. The available data show that information on the abortion laws is hardly known.

Social and cultural barriers to accessing timely services and rights

There are several socio-cultural barriers and taboos preventing the reporting of sexual violence in Togo. Four recurring themes in the data are presented below. These are: talking about sex with parents as a taboo; victim blaming; physical violence against victim-survivors, and a preference for resolving problems within the family. Many of these factors have been identified in the other countries, whereas the first – on how talking to parents about sexuality is a strong barrier – comes out most strongly in the data from Togo.

Talking about sex with parents as an insurmountable taboo

It is common for parents and children in Togo not to discuss issues related to sexuality. This inability to communicate can be a crucial obstacle to starting the process of seeking care and taking all the other necessary steps. As Gislène explains when reflecting on the issue of sexual violence in the community:

"Not everyone can talk about it like that, I mean be open about how things happened at the time. [...] If you're not mentally strong, you might not want to talk about it, either to your family or to friends, because where we come from, in Africa, we don't talk about sex. You're not allowed to use certain words in front of your parents or ask certain questions. Now, when you're a teenager, instead of being advised not to do this or that, no, we're not told anything. Now it's up to you to go to them and say, 'Someone touched me? No, that's not possible. We're not allowed to discuss certain things.'"

22-year-old survivor, Gislène, Lomé, Togo

The blame is
always placed on
the girl.

This highlights an additional socio-cultural barrier that was not identified in the other four countries (which does not mean that it is absent there). It could partly explain why many girls and young women did not report the incidents immediately. They often only informed their parents when the pregnancy was confirmed. In the absence of communication with their parents, adolescent girls and young women tend to seek help from their peers rather than adults, in part because of this taboo and fear of judgement. This also means that they often have limited access to information through their parents on SRHR, about legal procedures and the medical risks associated with sexual violence.

Victim blaming

In Togo, girls and young women are often held responsible for what happens to them. This blame causes them to doubt themselves and discourages survivors from reporting violence: if their loved ones do not believe them, how will the authorities react? A medical assistant says that instead of supporting survivors, people deprive them of support by holding them responsible:

"[...] they'll say, 'What were you doing there? Who called you there? If you didn't go, then this would not have happened. So, the blame is always placed on the girl. And so, when that's the case, they don't want to continue with the procedure and do everything to get justice for her. No, because we think it's her fault."

Medical assistant, private health centre, Lomé, Togo

And indeed, this reaction can also be found at the level of the authorities:

"The police officer told me that I was partly responsible for what happened to me because I went to the party voluntarily."

Survivor, 18 years old, Lomé, Togo

Another major challenge is the widespread perception that a relationship reported as

violent is nothing more than normal sexual intercourse:

"It's easier to believe it's rape when it's a minor, she's still innocent. But when she grows up to be a teenager or a young woman like that, people think it was just normal sex."

Survivor, 18 years old, Lomé, Togo

The example shows how the victim-survivor's profile determines the perception of her credibility, as well as the reaction of her parents and relatives to the rape. This attitude is culturally accepted and can be seen in the behaviour of relatives and service providers.

Physical violence against survivors

However, victim blaming is not just verbal. In some cases, it can turn into violent aggression by parents against the survivor, as witnessed in some of the other countries, and as this testimony from a sister of a victim-survivor shows:

"Even though the girl said she had been sexually assaulted, her parents were not convinced. [...] The parents kept claiming that the girl had gone to stay with her boyfriend, and they were beating her and shouting at her. The screams alerted the neighbours, and they became quickly aware of what had happened."

Notes from an informal exchange with the sister of a 14-year-old victim-survivor, Lomé, Togo

Another victim-survivor reported that she had been beaten by her mother at the age of 12-13 when she told her that she had almost been sexually abused by a classmate. This taught the young girl a clear lesson: she could not talk openly about such experiences with her mother. When, later in life, she was raped several times and sexually exploited for two years, she knew she would receive no support from her mother. "[...] so when I was being threatened, I was very afraid to tell her." The girl did not know that abortion was legal following rape and ended up having an unsafe abortion.

It's easier to believe
it's rape when it's
a minor, she's still
innocent. But when
she grows up to
be a teenager or a
young woman like
that, people think
it was just normal
sex.



Researcher involved in the study

Preference for resolving problems within the family

In Togo too, many cases of incest and sexual violence are resolved within families, rather than being reported. This is to protect a girl's reputation and her chances of marrying; as well as to protect the family from stigma and avoid conflict within families or with members of the village or neighbourhood. As one school principal explains:

"[...] you see, our communities have a system. It can happen. And if it's within the family, they will protect it. It won't come out. Because sometimes people think it's a humiliation for the victim, but also for the family. And very quickly, the family of the perpetrator also gets involved and starts negotiating, so these cases don't come to light."

School principal in the Savannes region, Togo

The same witness talked more about this idea of protection of the girl's and family's reputation:

"We think that by doing this, we have protected the child. There are cases like this. You must understand that religion has become so ingrained that to get married, a woman must be a virgin [...]. That's how it is in the Koran. Women must not have sexual relations until they are married. So those who are truly religious follow this logic."

School principal in the Savannes region, Togo

The same informant shared that more educated parents and those who are very religious (Muslims) are more likely to take legal action after sexual violence than most people in his region.

Who is most vulnerable to sexual violence?

According to the data obtained in Togo, those most vulnerable to sexual violence and unsafe abortions are orphans, domestic workers, girls and women with disabilities, internally displaced women and refugees as the quotes below show:

"We have a lot of displaced people and some people take advantage of the situation, of the vulnerability of these displaced people. Sometimes women are forced to accept what they don't want. Maybe it's the man of the house who gets up, leaves his room and goes into the room where the woman is, the poor woman who fled because her husband was killed, and she came to stay with her children. He will say 'If you don't give me sex, you leave my house.' Even though she is already a refugee. She has no choice."

Representative of a women's NGO, Savanes region, Togo

"Women with disabilities, domestic workers and orphans are the most vulnerable in this situation. For them, reporting is not an option. Who would believe you?"

Representative of an organisation supporting victim-survivors of GBV, Lomé, Togo

Their vulnerability often leaves these victim-survivors with no choice but to remain silent and not seek support.

Outcomes for survivors in Togo

In Togo, eight stories victim-survivor stories were documented. All were survivors of rape, five of them became pregnant. Among those five girls and young women, three had clandestine abortions (including one who was seven months pregnant), one had a safe abortion in a neighbouring country with the support of an organisation, and the other gave birth to a girl. She explains the harmful consequences of her rape: *"Today my daughter is seven years old, but every time I see her, she reminds me of the horror my uncle put me through. It still hurts."*

Today my daughter is seven years old, but every time I see her, she reminds me of the horror my uncle put me through. It still hurts.

Explanatory factors: Policy and systems level gaps

The above has shown that there are significant challenges at stake in Togo, as existing legal provisions on abortion exist on paper but are far from the reality of victim-survivors' experience of rape or incest. In particular because the laws are unknown and not operationalised by the government, but also because of all kinds of social and cultural norms that hinder reporting and promote family-level solutions. For those who do seek help, other barriers emerge and this section explores those barriers and explanatory factors at the levels of policies and systems and at the level of implementing organisations. The data used for this analysis is based on interviews with stakeholders at different levels.

A major obstacle is the lack of power or will of the government to operationalise a safe abortion policy in Togo. Unlike other contexts, no programmes or operational guidelines have been developed to translate the political intent of the 2007 Reproductive Health Law into concrete actions. A participant who contributed to the drafting of this law reveals this institutional shortcoming:

"Since the enactment of the RH law in 2007, advocacy activities have been undertaken without success to draft implementing regulations to provide guidance to health personnel and other actors on when and how to provide abortion services while complying with the legal framework in force."

Key informant who participated in the drafting of the Reproductive Health Law, Lomé, Togo

This analysis highlights the absence of an administrative mechanism to implement the policy, 18 years after the passing of the Reproductive Health Law, creating a significant institutional vacuum.

In addition to the lack of a dedicated programme for access to safe and legal abortion care, there is no government funding allocated to implementation in Togo. However, since 2018, there has been a national post-abortion care programme supporting services women who have had a

miscarriage or an induced abortion. Health centres are provided with human resources (trained health providers, supervision missions and regularly organised refresher workshops), material resources (medicines and equipment for surgical methods) and financial resources. Even in the Savannes region, facing a security crisis due to incursions by armed groups, health centres are regularly supplied to be able to provide post-abortion care.

"We have received a large number of kits... these are basic emergency kits. They contain everything we need to treat an incomplete abortion. These kits enable us to treat girls who have had clandestine abortions and then arrive at the hospital so that we can complete the procedure."

Healthcare provider, Savannes region, Togo

The irony is that, especially in a context of conflict and displacement where sexual violence is commonplace, girls and women must attempt an unsafe abortion before they are entitled to care.

A positive development is that since September 2024, Togo has adopted a national protocol for the holistic care of victim-survivors of GBV, and a manual that offers a package of services to victim-survivors of violence, including sexual violence. However, in the latter, no mention is made of safe abortion care for pregnancies resulting from rape or incest, despite this being allowed according to the Reproductive Health law from 2007. Only the need to monitor the pregnancy until delivery is mentioned in the protocol. The testimony of a key informant who participated in the development of this national document shows how difficult it is to reach a consensus on this issue in Togo:

"When we proposed the integration of safe abortion services into the national protocol for holistic care for victims of gender-based violence, it caused quite a stir. The administrators did not agree because it is a sensitive issue. If a rape victim is to be offered safe abortion



[according to them] the decision must come from the top, from the country's highest authorities."

Gynaecologist, Lomé, Togo

The lack of clear policies dedicated to comprehensive and legal abortion care is also reflected in a dearth of official information resources for health professionals on legal voluntary termination of pregnancy. Unlike post-abortion care, which has had established protocols in place since 2018, there are no operational guidelines, clinical protocols or administrative directives for voluntary termination of pregnancy under the legal conditions of the Reproductive Health Law. This absence creates procedural uncertainty among providers. A gynaecologist testifies to this shortcoming:

"We don't have a protocol to follow, nor do we have an official document like we do for post-abortion care. When we receive cases, we share them among the college gynaecologists where the tendency is to say that "the law doesn't allow it, so we don't offer the services..."

Gynaecologist, Lomé, Togo

The quote shows that the situation forces professionals to informally consult among their peers, who generally prefer not to get their hands dirty on this issue.

The dissemination of public information on legal abortion also faces significant administrative and social constraints - Article 38 of the Reproductive Health Act requires prior approval from the "competent public authority" for any "anti-conception propaganda". However, there is no clear mechanism for obtaining such approval for

legal voluntary termination of pregnancy, creating legal uncertainty and leading to structural self-censorship. This legal constraint leads to self-censorship among those working in the field. One activist explains these restrictions:

"You can raise awareness about sexual violence, but in all the services available, you can't talk about abortion, because people will say you're promoting abortion."

Activist, Lomé, Togo

The media are also subject to these information constraints. A journalist confirms this dynamic:

"I covered a workshop on assessing the abortion ecosystem in Togo and shared the article in a group. And guess what? I was called all sorts of names by the community and my colleagues."

Journalist, Lomé, Togo

This reaction exemplifies the systemic barriers to the dissemination of information on legal abortion.

Paradoxically, the data reveal that information about clandestine abortion is circulating informally like in many contexts where legal abortion is inaccessible. One student recounts: *"With 10 nivaquine tablets, a large bottle of Guinness or Sédaspire at 75f, you can have an abortion without anyone knowing"* (Student, Lomé). This information asymmetry illustrates the failure of the administration to disseminate legal resources while allowing dangerous information to proliferate.

In response, CSOs are developing alternative information resources on social media to ensure that young people have access to quality information. Civil society is also trying to push for appropriate guidelines and protection for medical staff. A gynaecologist in Lomé describes their efforts to fill the gap: *"We participate in many workshops where we discuss how to speed up the implementation of the Reproductive Health Law to protect us in the exercise of our duties."* (Gynaecologist,



Lomé). These initiatives reveal an informal mobilisation to fill the administrative void.

When there are glaring gaps at these levels of policies and systems preparedness to implement the law, there are obviously many gaps in how different organisations (public, non-governmental and private) can implement existing laws.

Explanatory factors: Policy and systems level gaps

Fragmented services

Faced with informational vacuums, the data collected reveals the emergence of substitute actors, mainly CSOs that assume responsibilities that would normally fall to the public administration. However, these actors face the same administrative obstacles as the public sector. A leader of an activist organisation explains this:

"Yes, they say that the law allows abortion in cases of rape and incest, but in practice, tell me where we can go to access this service. Since we started supporting victims, they have been sending us from one department to another, from one piece of paperwork to another, and in the end, no authorisation is granted."

Key informant at an NGO, Lomé, Togo

This situation means non-public sector actors do their utmost to provide alternative support, for example by managing online platforms where adolescents can access information in complete confidence, ask questions and receive appropriate guidance. Some even help victim-survivors to cross the border into Benin to get safe and legal abortions, as we documented for one of the survivors. But it should be noted that the polarisation is at stake in the CSO sector. Some organisations maintain an unapologetic stance, explicitly refusing to provide information about abortion and only providing support until the birth. This conservative position persists despite the legality of safe abortion since 2007. A representative of one of these organisations explicitly confirms this: *"We cannot talk to women about abortion. Abortion is prohibited in Togo."* (Interview, head of a CSO, Togo). This total refusal to recognise legal exceptions leads to an information deficit that hinders victim-survivors' access to their rights. In the case of religious centres, a social worker explains: *"When a victim walks through the doors of our centre, it means she will continue with the pregnancy until the baby is born. This is the only option available to her if she wants to receive support from the centre."* (Social worker at a religious centre, Lomé). This approach makes continuing with the pregnancy an absolute condition for receiving support.

Togo has recently established public centres providing holistic care for victim-survivors of GBV, but their capacity is limited. As one

The maze women face: stuck between rights and reality

centre manager describes: *"Here we have no health care providers or police officers directly on site. They must be referred to other services for continuity of care"* (Head of a public centre for GBV, Lomé). This fragmentation of services illustrates the lack of a truly integrated approach to assist victim-survivors and creates what one informant describes as an "institutional merry-go-round" for victim-survivors.

Time-related problems are particularly evident in the handling of individual requests at the judicial level. A prosecutor reveals this: *"There is no official procedure. Since I have been practising, I have never received a request for a termination of pregnancy from a girl who was a victim of rape"* (Prosecutor, Savannes region, Togo). A social worker testifies of the detrimental delays observed:

"In the national protocol for the care of victim of GBV that we use here, the procedure to follow when a girl becomes pregnant is not mentioned. We do not know the procedure to follow, we have not received any training, so when it happens we inform the judicial police officer and wait for authorisation from the public prosecutor... Out of three requests already made, we have not received any response, and some girls have had to keep the pregnancy, while others have found unsafe means to terminate it."

Social worker at a centre providing care for victims of gender-based violence in the Maritime Region, Togo

This slow response to handling victim-survivors' cases means that a legal right becomes a practical impossibility, as the administrative process is incompatible with the period when a pregnancy can safely be terminated.

Overall, in the daily practice of local institutions, there is significant variation in the adoption of the law with some outright rejecting to work with the content of the law. Those trying to implement the legal framework for victim-survivors- amidst procedural uncertainty- face insurmountable barriers. This translates into a lack of access to rights enshrined in law for adolescent girls and women who have become pregnant because of sexual violence.

Conclusion

In Togo, access to safe and legal abortion for victim-survivors of sexual violence is almost non-existent. The experiences of victim-survivors show that there are many social, cultural, administrative and informational barriers that prevent them from reporting cases of sexual violence. This leads victim-survivors, in some cases, to resort to unsafe abortions. But our research shows that, even when some have the courage to report cases to health centres and the police, they face many difficulties in accessing the services provided for by law. At every level of the trajectory, there are huge obstacles due to the lack of guidelines for those responsible for implementation, due to the stagnation of the political process of transforming laws into policies. This lack of guidelines leaves many professionals in limbo, while information dissemination is hampered by unclear legal restrictions. Once again, victim-survivors find themselves stuck in a complex maze, as has been described in relation to the other four countries.

The most significant challenges to be addressed in Togo, based on the data, are:

1. The absence of implementing regulations for the 2007 Reproductive Health Law
2. The lack of alignment of protocols for responding to GBV with the content of the Reproductive Health law
3. The handling of cases of incest and rape within families, with the intention of protecting the family's reputation at the expense of the health and rights of victim-survivors
4. The strong victim-blaming victim-survivors face if they report cases of sexual violence, which acts as a mechanism to silence other victims of sexual violence and discourage them from taking any action.

Considering these difficulties, many victim-survivors opt for unsafe abortion when they become pregnant because of rape or incest in Togo. If they resort to this option, they risk not receiving the necessary medical and psychological care, and the perpetrators go unpunished.



Delayed accountability and responsibility of the state

The first mechanism of exclusion reveals political avoidance strategies. All the 5 countries have signed and ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) between 2005 and 2009, more than 15 years ago. Article 14(2)(c) of the Maputo Protocol obligates State Parties to protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

But in most countries the reform of national laws to comply with the Maputo Protocol article on access to safe and legal abortion took long or is still ongoing. Currently only Benin fully complies and goes beyond the Maputo Protocol article, having established additional grounds (material, educational, professional or moral distress) for accessing legal abortion. Burkina Faso's laws are closely aligned with the Maputo Protocol, only that 'mental health is not explicitly mentioned as a ground for abortion in national laws. Togo has similarly laid down the same conditions as Burkina Faso in the reproductive health law of 2007, except for foetal diagnosis.

In Côte d'Ivoire, in 2024, 15 years after the ratification of the Maputo Protocol, the Penal Code was aligned to the Protocol. Although it was not until 2019 that rape was recognised as a ground for abortion here. In 2024, the amended Penal Code introduced the concepts of incest as a legal ground for abortion, as well as the mother's mental and physical health. However, the country does not fully comply with the Protocol, as the Penal Code does not explicitly mention pregnancies that pose a risk to the life of the foetus as a legal ground for abortion. Cameroon so far presents the largest gap between national laws and Maputo Protocol Article 14(2)(c), it only allows therapeutic abortion in cases in which the life of the mother is at risk, or in cases of rape.

Discussion: How exclusion mechanisms deny the right to safe abortion

This research highlights the widespread lack of access to safe and legal abortion care for victim-survivors of sexual violence (rape or incest) who became pregnant because of such violence and the obstacles they encountered in five countries in West and Central Africa.

The study's comparative analysis reveals that access to safe abortion for victim-survivors of sexual violence does not depend solely on the existence of favourable legal frameworks. Rather, it relies on a complex system based on four interconnected exclusion mechanisms: delayed accountability on the part of most of the states concerned (except Benin); procedural complexity; information gaps; and patriarchal control mechanisms. Together, these mechanisms systematically erode legally recognised rights leading most victim-survivors to be denied these rights.



Delayed accountability vis-à-vis international commitments made since 2005–2009 excludes victim-survivors from accessing their rights.

The data show that national legal reforms took long and are not enough since implementation of reformed the laws is lagging in all countries to the extent that victim-survivors still cannot or can hardly access legal and safe abortion on these grounds when pregnancy follows rape or incest. States have been formally ratifying the Protocol, which has contributed to international appreciation and credibility, but it was followed by avoidance and delays. The studied countries did not take all the necessary steps in time to operationalise the legal reforms. Togo is a prime example of this avoidance strategy, despite a Reproductive Health Law adapted to the Maputo Protocol since 2007, implementation was stalled due to a lack of implementation guidance.

This avoidance illustrates what scholars have conceptualised as "decoupling": where laws or policies can be adopted without being

implemented and effective.²⁴ The adoption gives a certain legitimacy, but at the same time this strategy allows states to postpone the potential domestic political costs and economic costs associated with their operationalisation. One reason being the lack of support from national constituencies or a lack of priority identified. Other research has confirmed that the adoption of international human rights standards can paradoxically serve to legitimise non-compliance with those same rights by creating a façade of compliance.²⁵

In the geopolitical context of the regions studied, this avoidance strategy is part of a pattern of dependence on international aid, which creates perverse incentives. By ratification and window-dressing, states can maximise benefits (international legitimacy, funding) while minimising costs (confrontation with local resistance) through

this decoupling strategy. In addition, the weakness of democratic accountability mechanisms in several countries in the region facilitates this strategy through the absence of sufficient internal pressure to effectively implement policies.

On the positive side, recent analyses and ongoing developments presented in this study show that advocacy efforts by civil society organisations – active in the field of sexual and reproductive health rights (SRHR), maternal health and women's rights – as well as professional organisations (gynaecologists, midwives) tend to play a major role in holding states accountable for domesticating and actually implementing the Maputo Protocol.²⁶ Although these efforts take time to bear fruit – especially given that the Maputo Protocol is already 22 years old – they are having a concrete impact for victim-survivors. For example, these actors are

contributing to improved laws and policies or new clinical guidelines and referral pathways for safe abortion, as the data reveal. Yet the data also show that governments need to do much more to effectively implement Article 14(2)(c), of the Maputo Protocol. Without central-level government intervention and a true commitment to implementation, victim-survivors remain dependent on fragmented and unequally dispersed initiatives to access their rights. Furthermore, the lack of adequate funding for training the relevant actors, providing the necessary equipment and conducting targeted information campaigns particularly condemns the most vulnerable girls and women to resorting to dangerous practices.

Hence delayed accountability vis-à-vis international commitments made since 2005–2009 excludes victim-survivors from accessing their rights.

Complex access procedures

The second mechanism of exclusion reveals how the multiplicity of administrative and judicial steps required for safe abortion access transforms the process into a lengthy ordeal that compromises legal protections through its complexity.^{27,28} As shown in Cameroon and Burkina Faso, for example, rape victim-survivors have the right to access legal abortion but in reality rarely do so due to very demanding procedures. As a result, many of them resort to unsafe abortions.

As victim-survivors move along the expected service chain – access to information, reporting, medical examination, psychosocial support, investigation, judicial authorisation, and medical care – they face major barriers at every stage.

For example, the mismatch between biological and administrative timelines forms one of the significant barriers in victim-survivors' search for justice and care. In Burkina Faso the legal limit for an abortion after rape and incest is 14 weeks of pregnancy, hereafter abortion is no longer allowed. Yet judicial proceedings, almost always exceed this limit. In Cameroon, where the legal limit is 28 weeks, judicial responses still tend to be available way too late, at 32–35 weeks of pregnancy or later, or never, making the process of needing legal authorisation practically impossible. This mismatch exposes a bureaucratic conception of time that ignores biological and psychological urgency, transforming procedures into insurmountable obstacles that render rights meaningless in practice.

Other complexities include a lack of information among some key actors in the service chain, a lack of clear procedures and coordination as well as institutional fragmentation: victim-survivors must navigate between police services, health facilities, courts and social services, often without effective coordination nor a clear understanding of their respective roles. The data has shown that this "institutional journey" along the service chain forces victim-survivors to repeat their traumatic testimony and run the risk of victim-blaming at each stage, creating systemic re-victimisation that discourages them from pursuing legal action.



In the contexts studied, these complex procedures are compounded by overburdened and underfunded judicial systems that turn delays into structural obstacles. These dysfunctions are exacerbated by the legacy of colonial administrative systems characterised by extreme centralisation.

However, a few African countries such as the Democratic Republic of Congo (DRC), Ethiopia and Benin are leading the way in developing more accessible procedures for victim-survivors.^{29,30,31} In DRC and Ethiopia, a judicial procedure proving rape or incest is not required when victim-survivors seek access to safe and legal abortion care. Their testimony stating that they are a victim is enough. These commendable initiatives remove the burden of proving rape and incest from women seeking abortion and significantly increases the chances for victim-survivors to receive timely safe abortion care.³²

Another promising solution for victim-survivors could lie in the example of the amendment of the Reproductive Health Law in Benin in 2021. According to Article 17.2 of this

law, the voluntary termination of pregnancy can now be carried out at the request of the pregnant woman when the pregnancy is likely to aggravate or cause a situation of material, educational, professional or moral distress incompatible with the interests of the woman or the unborn child. The concept of "moral distress" is entirely relevant in cases of rape and incest, as the mother is highly likely to experience stress and develop psychological problems that could have a significant impact on her and her offspring's lives if the pregnancy is carried to term. The procedures for asking an abortion on these grounds are less complex and some victim-survivors of rape in Benin are currently using this option to have a safe and legal abortion after rape or incest.

Although this could be a fairer approach for victim-survivors of sexual violence, decoupling legal from medical procedures, it should be noted that this solution has three potential drawbacks:

- Asking for abortion on the grounds of moral distress does not automatically include screening for STIs and does not automatically guarantee access to

appropriate social and psychological support if the victim-survivors does not express the real reason for her abortion request.

- In Benin, the time limit is currently 12 weeks of pregnancy for moral distress criteria, which remains a constraint as some adolescent girls and young women discover their pregnancy late or delay seeking help for various reasons, including fear of victim-blaming and expecting a lack of support.
- This approach can lead to greater impunity for perpetrators of violence, as legal proceedings are not mandatory, meaning that violence could easily continue.

Despite these drawbacks, it is important to note that, in the current context in the countries studied, where most rape and incest cases never reach the courts or where legal procedures require extensive time and financial resources, having the option of 'moral distress' available to victim-survivors offers an important solution to victim-survivors.

Information exclusion, a cross-cutting barrier in all countries

The third mechanism of exclusion concerns limited, incorrect or fragmentary access to information, which hinders the exercise of reproductive rights. Deprived of knowledge about laws protecting victims of sexual violence and about safe and legal abortion, victim-survivors and their supporters are unable to assert their rights and access health care. This lack of information often leads to dangerous choices, such as resorting to unsafe abortions, forced motherhood or even forced marriages with perpetrators, as shown by the data in this study.

The lack of information affects post-rape care, abortion care and legal procedures alike. Some countries, such as Côte d'Ivoire, Togo and Benin, are making progress in raising awareness on sexual violence and the need for reporting, but many of the actors involved in the chain of services in these countries, as in the other countries, remain poorly informed or reluctant to refer victims for legal termination of pregnancy, due to a lack of alignment between the laws and policies on sexual violence and those on abortion.³³

Besides the fact that the laws and policies themselves sometimes contain confusing contradictions, barriers to information about abortion can be explained by several other factors. Widespread gaps in knowledge about abortion laws are observed all across Africa^{34,35,36} stemming from weaknesses in information ecosystems, the digital divide, legal illiteracy, and a lack of investment and political will to disseminate this kind of information.³⁷ In addition, rumours can lead to misinformation³⁸ and opposition from religious leaders makes it difficult for authorities to speak freely on the subject, even if they are willing to do so.³⁹

The issue of abortion therefore remains highly political. If healthcare providers, who are normally key sources of information in the health sector⁴⁰ are not informed about (updated) laws or policies, there is

inevitably a lack of political will or political fear behind it.⁴¹ As seen in Côte d'Ivoire, for example, many key stakeholders, including healthcare providers, were unaware of the recently amended law (in 2024), but were also unaware of the previous law in force before this change. Since 2019, rape had already been a legal ground for accessing safe abortion, but few health care providers seemed aware of this.

In Benin it became clear that social service workers wondered whether it was their role to broach the subject of abortion with clients who came to see them about sexual violence for fear of being accused of promoting it. Their standard operational procedures for the management of SGBV do not mention abortion. Despite expanding access to medical abortion, Benin has also prohibited promoting and proposing abortion (Article 19-1 of the 2021 law), making communication about abortion a difficult issue for all stakeholders involved. In all five countries, it is common for the Penal Code or other laws to explicitly prohibit the promotion or offering of abortion methods. As a result, these legal prohibitions cause fear around communication about abortion. In addition, some medical codes of ethics completely prohibit abortion or are not aligned with the most recent laws, providing further cause for confusion.

These tensions create a paradox: abortion is partially authorised, but access to information remains hampered by the law or by a lack of clarification. This discrepancy transforms a theoretical right into a de facto privilege, accessible only to women who are part of specialised networks where such information is shared, have access to medical training, or are legally informed. Failure to inform the public, healthcare providers and government officials about the implications of a new law is a common obstacle to the implementation of new laws.⁴²

Patriarchal social control: stigma and enforced silence

The fourth mechanism of exclusion shows how a selection of harmful social norms and gender norms act as control mechanisms that are often as effective as formal legal prohibitions. Throughout this research, which aimed to investigate the barriers to accessing safe and legal abortion for victim-survivors of sexual violence, it became clear that the focus could not only be on legal and policy implementation gaps, but that the data collection also had to focus on understanding why some girls and women never report sexual violence in the first place and therefore fail to receive safe and legal abortion care.

It is well known that factors such as stigma and shame, threats of reprisals by perpetrators, and fear of rejection by their families and communities influence girls' and young women's failure to report cases of sexual violence to health services and judicial authorities.⁴³ In this study, as in others, there is often a preference among families for traditional modes of reconciliation, often shaped by patriarchal logic.⁴⁴ The same trend is observed in cases of incest. Although these choices are motivated by a desire to preserve the family reputation and coherence and avoid abandonment or public shame for the victim-survivor, they do not appear to meet her psychological and health needs. On the contrary, they contribute to normalising violence against women⁴⁵ and to maintaining a social order in which men are very unlikely to be convicted, let alone prosecuted, for sexually violent behaviour.

Worse, very disturbing examples of victim-blaming were documented, from violent beatings, family- and community rejection to verbal abuse,

While such practices are well known, the testimonies of victim-survivors documented in this research remain extremely disturbing, as they show how victim-survivors are blamed and silenced. On the other hand, interviews with committed members of civil society and women's rights activists show that they are actively working to change these norms, as in other countries.⁴⁶ It is mainly on social media that the most promising discussions and innovations in this domain take place, even if, for the moment, their impact remains marginal in the lives of many of the teenage girls and young women in this study, who are frequently confronted with situations of great vulnerability.

“These legal prohibitions cause fear around communication about abortion.”



Our analysis identifies four interconnected mechanisms that perpetuate this exclusion:

Delayed accountability – Across all countries, inaction often reflects a strategic choice rather than technical incapacity. Authorities’ failure to enforce legal protections leaves survivors waiting, sometimes until access is biologically or practically impossible.

Complex procedures – Administrative and bureaucratic hurdles turn access to justice into an obstacle course. In most countries, long delays collide with gestational limits, effectively nullifying legal rights. Benin offers a rare exception, where simplified procedures now allow access without initiating legal proceedings.

Information exclusion – Survivors face systemic information barriers, whether through explicit legal prohibitions, legal ambiguities or weak dissemination. By controlling knowledge, states appear compliant with international commitments while neutralising their real-world impact.

Social and patriarchal control – Perhaps the most potent barrier is societal. Stigma, victim-blaming, normalisation of sexual violence and intimidation by perpetrators silence survivors and deter them from seeking help.

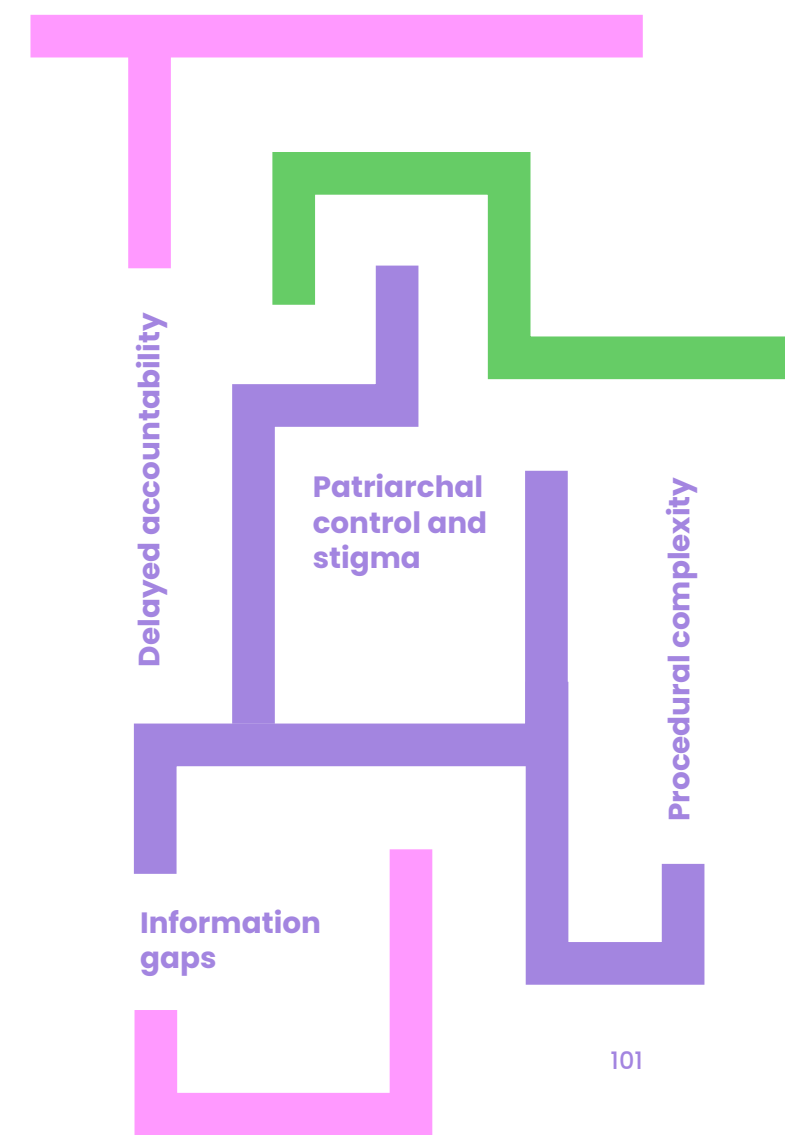
Despite these obstacles, the study also uncovers sources of hope and innovation. Digital platforms, professional associations providing referral pathways, survivor-centred advocacy, and legal reforms such as those in Benin demonstrate that meaningful change is achievable. These efforts, though currently localised and fragmented, highlight pathways for scaling up solutions.

The findings make clear that piecemeal reforms are not enough. Lasting change requires systemic approaches that simultaneously tackle the four dimensions of exclusion. Cross-country learning and collaboration can amplify local innovations, replicate successful interventions, and accelerate legal and policy reforms across the region.

Ultimately, *The maze women face: stuck between rights and reality* underscores a moral and practical imperative: governments, civil society, healthcare providers and

communities must act decisively to ensure that no woman or girl remains trapped in this maze. This includes guaranteeing timely access to safe abortion care, providing unrelenting support to victim-survivors and intensifying efforts to prevent sexual violence altogether. The path forward is urgent, but the innovations and lessons highlighted by this study show that a future in which reproductive rights are real, not just theoretical, is within reach.

Act decisively to ensure that no woman or girl remains trapped in this maze.



Conclusion

This study, *The maze women face: stuck between rights and reality*, uncovers a stark and troubling paradox: in the five West and Central African countries examined, legal frameworks nominally grant victim-survivors of rape and incest the right to safe abortion, yet in practice, these rights remain largely inaccessible. The maze of legal, social and institutional barriers traps women and girls, preventing them from obtaining essential medical care, psychological support, and justice.

Recommendations

Ending the maze that confines victim-survivors of rape and incest in silence and denies them healthcare and rights needs to happen now and requires bold and coordinated action. The following recommendations are addressed to governments, health system actors, civil society, communities, international organisations and donors. These actions are critical to remove barriers, uphold rights and ensure that victim-survivors of sexual violence can access safe and legal abortion and other services in practice, not just on paper.

1 Uphold international commitments

Governments that have ratified the Maputo Protocol should uphold their international commitments by effectively translating these into national laws and policies. Delays in doing so harm victim-survivors of rape and incest.

- Article 14(2)(c) of the Maputo Protocol authorises abortion in specific cases to protect the reproductive rights of women and girls. Countries that have ratified this protocol should ensure that their national legislation complies with these provisions and that no other legislation contradicts or impedes women and girls from exercising this right
- Fully domesticating the Protocol without further delay is crucial to ensure the health, well-being and justice of all women and girls concerned.
- It is essential to enhance the effectiveness of accountability mechanisms within the African Commission on Human and Peoples' Rights, and to address the political avoidance seen in several countries. This could be realized through more targeted reporting and assessments of the implementation of laws related to safe abortion, in accordance with the Maputo Protocol.



2 Ensure effective implementation of laws and policies

It is essential that governments take responsibility for the effective implementation of legislation on safe and legal abortion by ensuring adequate budgets, clear guidelines, ongoing training for key actors involved and a more effective delegation of tasks.

- Up to date and clear implementation guidelines are needed for laws and policies to be applied effectively and respond adequately to the needs of women and girls. The development and dissemination of such guidelines, as highlighted in this report, is urgent and should not be postponed.
- Quality training for key actors involved—healthcare personnel, police, and legal professionals among others—to ensure they uphold the rights of victim survivors confidently and competently in their roles.
- Adequate funding is needed to make services available in urban and rural areas and to support women and girls who cannot access safe abortion services due to the financial burden this represents.



4 Align abortion and gender-based violence policies

Harmonise abortion and sexual and gender-based violence policies and ensure coordinated medical, social and legal support for victim-survivors.

- It is important that Ministries of Health, Gender, Social Affairs and Justice harmonise sexual and gender-based violence (SGBV) guidelines with reproductive health laws and the Penal Code, explicitly including the right to legal abortion and referral options in accordance with the law in SGBV guidelines.
- Integrated gender-based violence response centres should be scaled up to provide comprehensive, services to victim-survivors including referral to safe abortion care when desired.
- Effective collaboration and coordination between medical, social and legal services in the response to sexual violence are essential to ensure continuity of care and provide adequate support to victim-survivors, including rapid referrals.

3 Remove procedural barriers to accessing safe abortion in cases of rape or incest

Separating medical procedures from legal procedures allows to remove procedural barriers while protecting victim-survivors from further harm.

- Care and justice pathways for victim-survivors of sexual violence should be achievable and victim-centred. The numerous and unnecessary procedural obstacles, such as short gestational limits, the requirement for medical evidence of rape, and the need to obtain judicial authorisation before safe abortion, make seeking care complex, lengthy, traumatic or just impossible. By separating medical from legal procedures, many of these barriers will be removed.

5 Follow successful reforms

Benin, Ethiopia and the Democratic Republic of the Congo have removed the requirement for prior judicial proceedings, recognised moral distress as a legitimate ground for access to care, or accepted the woman's report as sufficient evidence of rape. Other government could follow the example of these reforms which create a much more accessible, humane and respectful framework for legal abortion, thereby responding more effectively to the urgent needs of victim-survivors of sexual violence.

6 Make information accessible

Information on safe and legal abortion should be made easily accessible, which includes the removal by governments of legal barriers to awareness-raising.

- To prevent unsafe practices, it is crucial to actively disseminate information on the dangers of unsafe abortion and the legal and safe options available.
- Articles in the Penal Code or other legislation that explicitly prohibit the promotion or provision of abortion methods, lead to fear to communicate among SRH actors and therefore should be adapted.
- Given the significant information deficit, it is crucial to establish multiple channels and platforms in various languages. This includes training community workers as information relays, displaying posters in health centres, conducting public campaigns (particularly targeting rural and vulnerable populations), and integrating information on SGBV reporting and safe, legal abortion into school-based relationship and sexuality education. These measures are essential for reducing unsafe abortions.
- The messages and language used on these sensitive topics should be carefully selected. Concepts must be accurately translated to align with local understandings, ensuring that the information is acceptable and comprehensible across various settings.

7 Prevent SGBV and address stigma and discrimination

A fundamentally stronger effort is needed by governments, civil society and communities to combat and prevent sexual and gender-based violence and hold perpetrators accountable.

- Victim-blaming at family and community level is one of the most persistent barriers for victim-survivors to accessing services. It is rooted in rigid and inequitable gender norms. Stigma does not only lead to the social isolation of victim-survivors and underreporting, but also to discriminatory practices in institutions, which can hinder or block access to care and justice. Public authorities and civil society have an important role to play in challenging prejudices, combating victim blaming and continuing the fight for just and equitable societies.
- In addition, it is important to involve religious and community leaders more closely in raising awareness on SGBV, SRH, and safe and legal abortion.
- To combat stigmatising behaviour within government institutions, personnel involved in the management of cases of sexual violence and abortion, whether medical, social or legal, should receive specialised training. This training should focus on a gender-transformative approach and trauma-informed care, adopting a victim-centred approach.
- Establish strong alliances between governments, professional associations, legal experts, (young) academics, NGOs working in the fields of SRHR and GBV to jointly, with communities, address the root causes of SGBV and reduce the stigma surrounding unsafe abortion.

8 Provide easy access to emergency contraception

To prevent unintended pregnancies following sexual violence, it is essential to promote and ensure easy access to emergency contraception. This includes raising awareness among girls and women not only on the importance of reporting gender-based violence but also on the critical need of acting quickly after it occurs, especially in situations where they have limited support or where medical services are too far away or too expensive. Pharmacies can play a crucial role in ensuring this access as well as in referring victim-survivors to other services, such as STI and HIV-testing, psychological, medical and legal care.



9 Collect more evidence to know how to prevent SGBV and unsafe abortions

Sexual and gender-based violence, as well as abortion, are highly taboo and stigmatised topics, on which there are still significant data gaps in the countries studied. Furthermore, these topics are often studied in isolation from each other. Carefully designed research projects that invest in an in-depth understanding of contextual dynamics and adhere to the highest ethical standards are necessary to develop evidence-based solutions and monitor change.

Meaningfully involve young women to formulate appropriate abortion policies and evidence-based interventions

The majority of victim-survivors are adolescent girls and young women, yet they tend to be silenced in the processes of developing policies and interventions that concern them.

- Governments, professional associations, legal experts, academics and NGOs working in the fields of SRHR and SGBV need to form strong alliances with young women and other young people to develop evidence based, context-specific interventions to combat SGBV and unsafe abortions. Meaningfully involving young people is crucial for a comprehensive understanding of the issues and for designing responses that are adapted to young people's realities.
- Listening closely to girls and women reveals that unintended pregnancies result from rape, incest and other forms of gender-based violence, including forced marriage, denial of contraceptive use and intimate partner violence. The narrow focus of national laws on rape and incest forces girls and women in these challenging circumstances to resort to unsafe abortions when they seek to terminate a pregnancy. The real-life experiences of women and girls call for more inclusive abortion policies. One way to address this is to include distress as a ground for exemption in abortion legislation, as Benin did in 2021. This approach is well aligned with the health and justice needs of girls and women, while requiring parallel efforts to prevent gender-based violence.

Prioritise and invest in SRHR in national policies and global strategies, ensuring access to the full range of SRHR services

Gender equality and SRHR are of key importance to achieving the Sustainable Development Goals.

- National governments should continue to prioritise and invest in SRHR and combating SGBV. They should integrate SRHR in national health policies, including the full range of SRHR services and care. This will strengthen information sharing for women and girls. And it will ensure that when barriers are lifted and more women and girls can access services, those services are actually available and of improved quality.
- International donors and funders should support these efforts by supporting SRHR programmes, in partnership with national stakeholders. They should ensure these programmes are comprehensive, including SRHR information and education and access to the full range of services, to ensure highest effectiveness.



CARE

Annexes

Annex 1

Methodology

Study design

This research compares access to safe abortion for victim-survivors of rape or incest in five countries in West and Central Africa. The study is qualitative, exploratory, policy-oriented, comparative and grounded in a feminist research approach. It centers the experiences of women seeking safe abortion care and aims to understand how legal frameworks, administrative systems and cultural norms interact to shape victim survivors' access to safe abortion in order to formulate recommendations to remove barriers and ensure that victim-survivors of sexual violence can access safe and legal abortion services. The specific situation in each country is first analysed as an in-depth case study and then compared with the others to identify factors that explain the differences observed. Complex social phenomena such as access to reproductive rights can only be understood by carefully examining their context. Case studies are particularly appropriate when the boundaries between the issues and the context are not clear⁴⁷.

To this end, the study adopts a perspective that combines rigorous analysis of relevant documents (existence of laws, guidelines, procedures) with an understanding of the lived experiences of stakeholders (victim-survivors of sexual violence, professionals, decision-makers). This dual approach recognises that access to rights depends on both the existence of formal documents and the actual political, socio-economic, social and cultural context that influences their implementation. In addition, the choice of a comparative method is necessary given the

complexity of the subject studied. It allows these phenomena to be examined along three axes: horizontal (comparison between countries), vertical (interaction between local and national levels) and transversal (changes over time).⁴⁸ This method highlights national specificities and the effects of more general mechanisms, providing a solid basis for formulating recommendations tailored to the different contexts and the overarching context.

Research team and positionality

This research was commissioned by Rutgers and partners under the Ado Avance Ensemble programme and conducted jointly by CERRHUD and Rutgers. It aims to contribute to the evidence base regarding key issues that concern adolescent girls and young women in countries in West and Central Africa and to inform programme and policy recommendations.

The commissioning party (Rutgers), Ado Avance Ensemble programme partners and several of the (young) researchers represent institutions committed to sexual and reproductive health rights and justice. The study follows a feminist approach, focusing on amplifying marginalised voices, critically analysing power structures and advocating for justice and systemic reform.

The research was conducted by a large team with five young researchers (with medical and social sciences backgrounds, mixed gender), one in each country studied, at the forefront. The primary objective of engaging young researchers was to ensure

meaningful and inclusive youth participation in matters that concern them. This research furthermore offered the opportunity to strengthen young people's research capacity on sensitive issues like abortion and SGBV. These are not easy topics to research, so extensive training, daily debriefings and psychological support were provided. The young researchers were recruited by CERRHUD and accompanied, in each country by a national Co-Principal Investigator identified by CERRHUD and a focal point assigned by Ado Avance Ensemble country partners. The young researchers received training in the research methodology, tools and ethics, including protocols for conducting research with vulnerable populations and using distress protocols. A psychologist from Cameroon joined the team to train the young researchers and larger team in interviewing survivors, recognising distress and referral and was available for counselling support to the young researchers. The young researchers worked on the tool refinement and contextualisation, data collection, country-level data analysis and dissemination. This regional report builds on national reports prepared by in-country teams with support from CERRHUD and Rutgers and was authored by the two organisations.

Theoretical frameworks

This research draws on two complementary frameworks to analyse the gap between policy intentions and effective access to safe abortion services.

Policy implementation analysis

The first framework, developed by Berman⁴⁹ and adapted by Dossou et al.,⁵⁰ allows to examine the complex process of how public policies are implemented (Figure 1).

This framework distinguishes four levels where policy implementation can be distorted or blocked: political intent (adoption of laws), administration (translation into concrete programmes), adoption by field organisations (hospitals, courts, NGOs), and micro-implementation (what happens when beneficiaries try to access services). As Berman notes, "implementation is a process of mutual change"⁵¹, where each level can transform the initial objectives according to its own logic and constraints.

The maze women face: stuck between rights and reality

This framework is particularly relevant for studying the implementation of abortion laws, a sensitive subject where resistance is often expressed indirectly. For example, a magistrate might comply with the law while adopting such a slow pace of processing so that the legal deadlines for abortion are exceeded before authorisation is granted. This renders the law meaningless in practice.

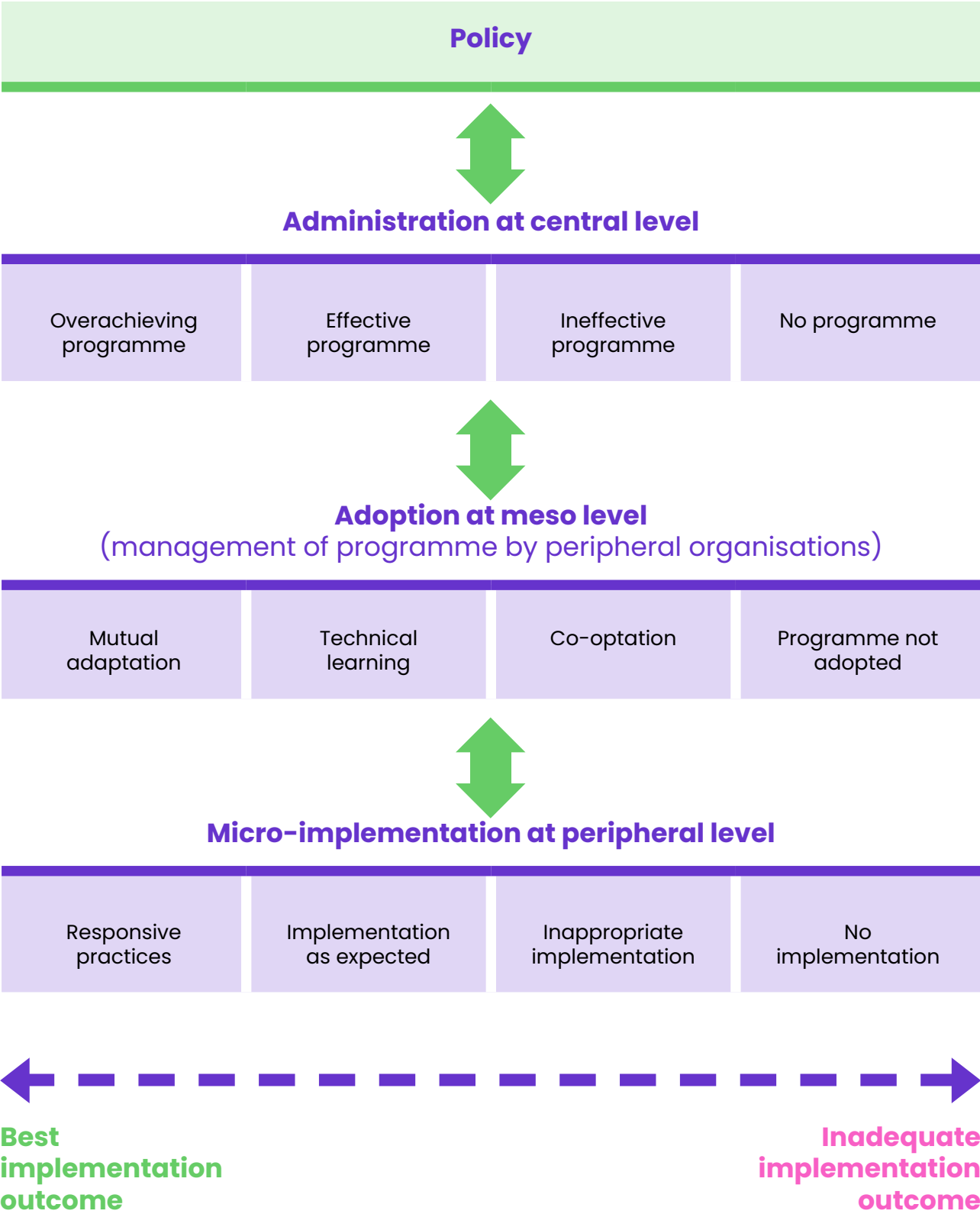


Figure 1: Berman’s policy implementation analysis framework adapted by Dossou et al. (2021)

The prescribed vs the real victim-survivor’s trajectory

The prescribed trajectory is a model developed by CERRHUD based on previous research experiences. It reconstructs, step by step, the path that a girl or woman who is a victim-survivor of sexual violence must follow according to laws and procedures to access safe and legal abortion: from the first interaction with service providers to the medical abortion, including reporting the crime, obtaining a medical certificate and securing legal authorisation for abortion. The model of the prescribed trajectory also considers the fact that a woman seeking care must first be informed of her rights and health and be supported by those around her to effectively access care. These are considered the two very first steps of the trajectory. For each step, the prescribed trajectory allows for the examination of the actors involved, and the services expected according to laws and policies. This trajectory is then compared with the real-life experiences of victim-survivors. The discrepancies between prescribed and real trajectories are then explained.

The combination of these two frameworks allows for a multi-level analysis. The Berman framework adapted by Dossou et al. reveals why systems malfunction, while the focus

on individual trajectories allow to show concretely what these malfunctions mean for people trying to exercise their rights. This dual perspective avoids the pitfall of a purely technical analysis that ignores lived experiences, as well as the pitfall of a purely descriptive approach that fails to grasp the systemic mechanisms at work.

Country selection strategy and study area

This study was conducted in five countries: Benin, Burkina Faso, Côte d'Ivoire and Togo in West Africa, and Cameroon in Central Africa. These countries were selected using a convenience sampling strategy based on the areas of intervention of the Ado Avance Ensemble programme (2022–2025), which offered an established network of partners with contextualised knowledge that could facilitate access to relevant stakeholders, support the implementation of the research and guarantee the uptake of findings. The following table presents the geographical distribution of the selected study areas in each country:

Table 1: Geographical distribution of study areas by country

Country	Study areas	Region/department
Benin	Lokossa–Athiémé	Mono Ouémé
	Adjohoun–Bonou–Dangbo	
Burkina Faso	Centre Central–West	Centre Central–West
Cote d’Ivoire	Abidjan	Gontougo San Pedro
	Gontougo	
	San Pedro	
Cameroon	Soa	Centre South
	Ebolowa	
Togo	Savannah	Savannah Kara Maritime
	Kara	
	Greater Lomé	

These areas were selected based on operational feasibility criteria (presence of Ado Avance Ensemble programme, local partners) and contextual representativeness (urban-rural diversity expected to impact access to services). This approach allows for an in-depth analysis of how access mechanisms operate across different regions, however the research cannot claim representativity for all regions within a country.

The substantial differences between laws and their implementation within the sample of countries provide ideal variation for studying the subject and understanding the range of factors that might impede access to safe and legal abortion in the different countries.

Target population and sampling

Study population

The study targets an ecosystem of actors involved in access to safe abortion, adopting a systemic approach to capture the multi-level interactions influencing effective access to services. This population is structured around four main categories of actors involved, namely:

- People from institutional entities: representatives from the ministries of health, justice and social action, programme managers and decision-makers in reproductive health, and health professionals trained and untrained in safe abortion
- Civil society actors: members of NGOs with expertise in SRH or specialising in combating GBV, representatives of professional health associations, young activists and peer educators
- People from community backgrounds: community and religious authorities, representatives of the judicial system and law enforcement agencies, representatives of social services, specialised journalists
- Rights holders or relatives: survivors of sexual violence aged 15 and over and relatives of survivors (family, support persons) from various socio-economic backgrounds and different geographical areas.

The study combines purposive sampling and snowball sampling to optimise access to the different categories of people concerned. Purposive sampling ensures the intentional selection of key information sources representing the diversity of people concerned and institutional positions in each national context. The snowball sampling facilitates the gradual identification of survivors and hard-to-reach stakeholders through existing networks, particularly AAE programme partners (ABBEF, ABPF, AIBEF, CAMNAFAW, ATBEF).

Inclusion and exclusion criteria

The inclusion criteria were as follows:

- For institutional sources of information: direct or indirect responsibility for access to safe abortion, at least two years' professional experience, informed consent to participate
- For survivors: women and girls aged 15 and over who have experienced sexual violence (rape or incest), ability to talk about their experience without significant risk of the interview doing psychological harm, informed consent (or informed assent and parental consent for minors), residence in the study areas
- For community leaders: recognised leadership position in the community, religious and ethnic diversity, balanced gender representation.

Exclusion criteria included inability to give informed consent and being at high risk of psychological distress from participating in an interview, assessed by host organisation staff and the researchers on beforehand and monitored by the same.

Target sample and achievements

The study planned a sample of 100 individual interviews (20 per country), 15 focus groups with community authorities (3 per country) and 50 in-depth interviews with survivors and relatives (10 per country). Actual achievements vary significantly depending on the context. The following table shows these achievements by country:

Table 2: Breakdown of interviews conducted by country

Country	Institutional and civil society representatives	Focus groups (community and religious leaders)	Survivors and relatives	Total
Benin	24	3	9	36
Burkina Faso	19	2	6	27
Côte d'Ivoire	36	3	4	43
Cameroon	17	3	9	29
Togo	35	3	7	45
Total	131	14	35	180

A thematic saturation assessment was carried out iteratively during data collection. For each category of informants, preliminary analysis of interviews through memos and debriefing meetings identified the point at which new data no longer provided significantly new elements to the emerging themes. This assessment, carried out through triangulation between national teams, guided decisions on whether to stop or continue data collection depending on the context. Saturation was reached more quickly for some categories (health professionals) than for others (institutional stakeholders), explaining the variations in sample sizes between countries.

The variations in access to survivors reflect the accessibility challenges associated with the sensitivity of the subject in different socio-cultural contexts. The rich and in-depth information obtained in the 35 (as opposed to 50) unique interviews with victim-survivors or their relatives/ friends nevertheless form an extremely important and informative base to the analysis. The overachievement of interviews with institutional and civil society actors (131 compared to 100 planned) can be explained by the fact that some participants were more available than expected.

Data collection

The data collection combined three complementary methodological approaches that allowed for the triangulation of information: document analysis, semi-structured individual interviews and group discussions. This strategy aims to capture the dynamics of access to safe abortion through the diversity of perspectives of the participants and the wealth of available sources of information.

Documentary analysis

Documentary analysis provides an in-depth understanding of the legal and political context of access to safe abortion in each country, allowing the testimonies collected to be contextualised and gaps between normative frameworks and practical application to be identified.

The strategy combines a systematic approach using official national legal databases, the institutional websites of ministries of health and justice, and targeted research using specialised databases (The Global Abortion Policies Database, WHO

Legal Atlas) and reports from international organisations (WHO, Guttmacher Institute, Center for Reproductive Rights).

A standardised extraction grid facilitates comparative analysis, structured around five dimensions: legal conditions of access (permitted grounds, gestational limits), authorised providers (professionals, structures), provisions relating to providers (conscientious objection, professional protections), sanctions and restrictions, and historical developments in reforms. Cross-validation was carried out by triangulating official sources with analyses by legal experts in the region and verification with national research teams, ensuring the accuracy of legal information and its appropriate contextual interpretation.

Individual interviews

Individual interviews are the main method of data collection, providing in-depth information on the realities of access to safe abortion from a diversity of stakeholders that play a role in the abortion ecosystem.

The interviews targeted different categories:

- For institutional and civil society actors: The interviews targeted 13 categories of information sources – health professionals, representatives of the ministries of health and justice, members of NGOs working on SRHR and/or GBV, members of professional associations, representatives of the judiciary and law enforcement agencies, social service professionals, community and religious authorities, specialised journalists, and young activists. This diversity aims to capture all perspectives influencing access to services, from policy makers to practitioners in the field.
- For survivors and relatives: The interviews targeted women of reproductive age who had experienced sexual violence (rape or incest) as well as their relatives, representing diverse socio-economic backgrounds and geographical areas. Allowing for an exploration of their experiences with seeking care and justice including safe and legal abortion services where desired, the obstacles encountered and the long-term impacts.

Tailored interview guides were developed for each category of informant, with a particular focus on barriers to accessing safe abortion after rape or incest. The interviews, lasting between 45 and 90 minutes, were conducted in French or local languages (vernacular) depending on the context (e.g. Mooré in Burkina Faso).

The interviews were conducted by young researchers (one per country) trained in interview techniques, including interviewing on sensitive topics, and research ethics.

All interviews were recorded when consent was provided by the participants. In case the consent to recording the interview was not given, detailed note taking during the interview and a quick working out of notes immediately after the interview were employed to remain as close as possible to participants answers.

Focus groups

Focus groups complemented the document analysis and individual interviews by exploring the social norms, attitudes and collective perceptions that influence access to safe abortion in each national context. This approach provides insight into the community dynamics and social representations that shape the conditions for the acceptability of services.

Focus groups primarily targeted community and religious leaders, with a deliberate emphasis on female representation. With at least one focus group per country with female leaders. This approach aimed to give prominence to the voices of women in leadership positions, who are often less heard in public debates on abortion.

Each focus group included 6 to 8 participants representing different religious denominations, ethnic groups and geographical areas to ensure diverse representation. The discussions, lasting 90 to 120 minutes, addressed community perceptions of GBV, early pregnancy, ways of handling unintended pregnancies, religious and cultural interpretations of abortion, understanding of current laws, attitudes towards abortion in cases of rape or incest, and the role of authorities in accessing services.

Data analysis approach

Iterative collaborative qualitative analysis strategy

The data analysis was based on a four-phase iterative collaborative qualitative analysis approach, specifically designed to optimise analytical quality in a transnational research context with progressive data availability.

This approach is based on the principle of systematic triangulation of data sources and cross-validation of interpretations.

Phase 1: Real-time analytical capitalisation

From the start of each national data collection, the coordination team organised daily debriefing sessions to immediately capture the analytical knowledge acquired while the contextual expertise of the field teams was at its peak. These debriefings constituted the first level of qualitative analysis, enabling the identification of emerging patterns and progressive thematic saturation.

The use of a structured collaborative framework on the MURAL platform, organised according to specific research questions, ensured the systematic nature of the analytical collection and the traceability of the knowledge acquired by country and dimension. This phase generated analytical hypotheses that were submitted for validation in subsequent phases.

Phase 2: Consolidation through structured analysis matrices

Each national team developed consolidated analysis matrices structured according to the key dimensions of the study: legal framework, survivors' experiences, access to services, sociocultural factors, and coordination between stakeholders. These matrices, informed by debriefings and were populated with data from the first available transcripts, including illustrative quotes and included

specific focus on explicitly identifying areas of uncertainty requiring confirmation.

The coordination team reviewed these matrices using a standardised validation grid to identify transnational convergences, contextual specificities, and assumptions requiring further exploration. This phase produced a structured preliminary analysis.

Phase 3: Intensive joint analysis workshop

A three-day co-analysis workshop brought together all national teams and coordination staff in Cotonou for an in-depth collective validation of the preliminary analyses. The coordination team provided facilitated further collaborative analysis according to the conceptual frameworks used.

The group work systematically analysed country data and focussed on identifying robust cross-cutting patterns. This phase generated consolidated preliminary conclusions and identified areas requiring further confirmation and validation.

Phase 4: Confirmation and adjustment

The gradual integration of full interview transcripts as they became available enabled the final adjustments and validation of the consolidated analyses.

The confirmation process followed a systematic approach: confirmed elements were marked as validated, contradictory elements were subject to in-depth reanalysis, and new elements were integrated according to the same collaborative validation standards.

Ethical approvals and protection policies

The research team obtained the required ethical approvals in each country. The research protocol has been submitted to and approved by the national ethics committees of the five participating countries:

- Local Ethics Committee for Biomedical Research (CLERB-UP) in Benin (Ref: 820/2024/CLERB-UP/P/SP/R/SA, 21 November 2024)
- Ethics Committee for Health Research (CERS) in Burkina Faso (Deliberation No. 2024-11-353, 6 November 2024)
- National Ethics Committee for Research in Human Health (CNERSH) in Cameroon (No. 2025/02/1374/CE/CNERSH/SP, 6 March 2025)
- National Ethics Committee for Life Sciences and Health (CNESVS) in Côte d'Ivoire (Ref: 000273, 16 December 2024)
- Bioethics Committee for Health Research (CBRS) in Togo (Opinion No. 0458/2024/CBRS, 5 December 2024)

A specific protocol has been developed for the protection of personal data and the security of testimonies, which are particularly sensitive in contexts where abortion remains partially criminalised.

Interviews were conducted in local languages where necessary. Transcripts were anonymised and data stored securely in accordance with the requirements of the General Data Protection Regulation (GDPR).

Preventing harm

In order to access victim-survivors that were willing to share their stories the in-country research teams were helped by shelters, local organisations and partner organisations that supported victim-survivors. These actors identified girls and women who could be able to participate in an interview and they were able to provide referral where needed. After this pre-selection, women and girls were only enrolled on the basis of informed consent or assent.

Discussing experiences related to SGBV and abortion can be emotionally distressing for victim-survivors. To mitigate the risk or psychological distress occurring because of the interview, the interview guides for survivors were designed so that those conducting the interviews emphasised and repeated, as part of the informed consent process and during the interview, that survivors were free to stop the interview at any time without any repercussions. The interview questions were also carefully crafted, starting with more general, community-focused questions before moving to personal questions, with instructions for the interviewer to check in with the participant several times to ensure they were comfortable in answering. Interviewers were trained to recognise signs of distress and to interrupt or redirect the interview if necessary, following the distress protocol. The protocol included instructions for referral to designated medical or psychological care providers if needed.

The risk of social stigma was also important to consider. In many contexts, abortion remains a taboo subject, and simply participating in a study on this topic could expose participants to negative judgements from their community. This could lead to social exclusion, family conflicts, or even professional repercussions for some participants, such as healthcare providers. To reduce this risk, the researchers paid particular attention to confidentiality and anonymity. Interviews were conducted in neutral and discreet locations, chosen in consultation with the participants. Finally, for healthcare professionals and representatives of local or national institutions, there was a risk of professional repercussions if they spoke openly about the subject. The researchers therefore always checked their preference for the interview location, assuming that the workplace was the most obvious but not always the best place.

To avoid the risk of the young researchers involved in the study being traumatised by interaction with traumatic stories (or potentially triggering own negative experiences), they were trained in recognising and acting upon stress symptoms. Collective debriefs were organised daily during data collection to permit immediate sharing of difficult situations, problems and dilemmas encountered. Opportunities for individual debriefing were regularly offered to the team

including the possibility of online counselling, provided by an experienced psychologist in Cameroon who had also trained the full team on recognising distress and establishing interview readiness of survivors.

Limitations

This study is exploratory in nature and provides rich, contextualised insights into the lived experiences of victim-survivors of sexual violence in seeking safe abortion care. The small sample size however limits the generalisability of the findings. While qualitative research prioritises depth and richness over generalisability, the sample size means that the findings may not fully represent the diversity of experiences present among victim-survivors, especially given the cultural, religious and socio-economic diversity within the studied countries.

The use of purposive sampling, based on the areas of intervention of the Ado Avance Ensemble programme, may introduce biases related to the specific network of partners and stakeholders involved, potentially affecting the representativeness of the data. Additionally, given the sensitivity of the topic, participants may have been reluctant to disclose certain details.

Furthermore, the findings are shaped by the researchers' analyses and interpretations, as well as by their world views, positionalities and assumptions, which can influence how data is collected, interpreted and presented. Steps were taken to enhance reflexivity and reduce potential bias, such as working with a multidisciplinary, multi-country research team and systematic triangulation and cross-validation of interpretations.

Despite these limitations, the study offers valuable perspectives that can inform future research, policy and programmes, particularly in West and Central Africa where limited data exist.

Annex 2

Legal and policy frameworks documented in the five countries

Benin

Category	Text	Date	Key content
Legislation	Law No. 2003-04	03/03/2003	The law on sexual and reproductive health authorises voluntary termination of pregnancy under three conditions.
International	Maputo Protocol	30/09/2005	Benin ratifies the Maputo Protocol on the rights of women in Africa, including Article 14(2)(c) on abortion.
Legislation	Law No. 2011-26 on the prevention and punishment of violence against women	09/01/2012	This law establishes a comprehensive framework for preventing and punishing violence against women. The law does not refer to the right to voluntary termination of pregnancy after sexual violence.
Legislation	Penal Code	2018	The new Penal Code incorporates provisions on abortion (Articles 513-518), rape and sexual assault (Articles 553 to 557).

Category	Text	Date	Key content
Legislation	Law No. 2021-12 amending and supplementing Law No. 2003-04 of 3 March 2003 on sexual and reproductive health.	20/12/2021	This law amends the 2003 legislation by authorising voluntary termination of pregnancy in four distinct situations, including, as a fourth condition, material, educational, professional or moral distress. Article 19-I explains that offering services to perform voluntary termination of pregnancy, in public, at meetings or through the dissemination of written material, is punishable under Article 519 of the Criminal Code. It also stipulates that the same penalties apply to persons who promote means, objects and processes relating to voluntary termination of pregnancy.
Operational	Decree No. 054/MS/DC/SGM/C/SA of 23 June 2022: establishing the package of services relating to sexual and reproductive health.	22/06/2022	The decree explicitly includes "safe abortion services" in the range of standardised SRH services
Operational	Standard Operating Procedures (SOPs) for the prevention of and response to gender-based violence	February 2023	This protocol standardises procedures for responding to gender-based violence (updated since 2014). Despite referring to the 2021 law on reproductive health, it does not mention access to voluntary termination of pregnancy for victim-survivors of sexual violence, which is a major gap in intersectoral coordination.
Operational	Decree No. 2023-151 establishing the conditions for voluntary termination of pregnancy	19/04/2023	This decree establishes the conditions for voluntary termination of pregnancy with operational definitions, including conscientious objection for health professionals.

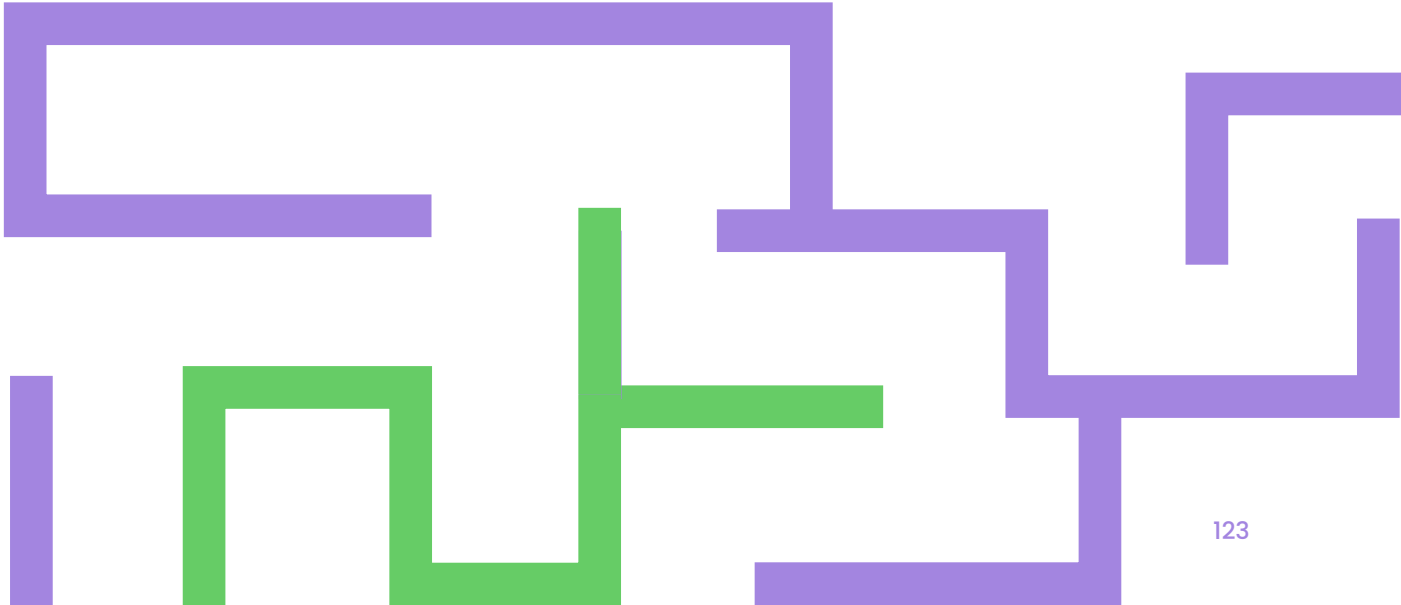
Source: Field data, November 2024 – June 2025

Burkina Faso

Category	Text	Date	Key content
Legislation	Public Health Code	13/05/1994	Article 89 prohibits advertising, sales and information relating to abortion products, as well as incitement to abortion in public places. This ban on promotion often leads to confusion and a mistaken belief that information on legal abortion is prohibited. The document also explains the conditions under which pharmacists may sell abortion products and the instruments necessary to perform an abortion.
Legislation	Penal Code	13/11/1996	This revision introduces the first extensions of authorisation for rape and incest with a 10-week time limit and for congenital malformations (previous provisions limited abortion solely to saving the mother's life).
Legislation	Law No. 049-2005/ AN of 22 December 2005 on Reproductive Health	22/12/2005	This law establishes the general framework for reproductive health in Burkina Faso.
International	Maputo Protocol	09/06/2006	Burkina Faso ratifies the Maputo Protocol on the rights of women in Africa, including Article 14(2)(c) on abortion.
Operational	Reproductive health policies and standards	May 2010	This document sets out broad guidelines on reproductive health. It confirms existing laws (3 conditions) and emphasises the prevention of clandestine abortions among young people and the importance of post-abortion care for the reproductive health of women and young people.
Legislation	Decree No. 2014-048/ PRES/PM/MS on the code of ethics	07/02/2014	Article 117 sets out the conditions under which practitioners may perform therapeutic abortions, as well as the procedures for exercising medical conscientious objection.

Category	Text	Date	Key content
Legislation	Law No. 061-2015/CNT on the prevention, punishment and redress of violence against women and girls and care for victims	06/09/2015	The law recognises and criminalises violence against women and girls, including cultural, economic, moral, psychological, patrimonial, physical and sexual violence. The law does not refer to the right to voluntary termination of pregnancy for victim-survivors of sexual violence who subsequently become pregnant.
Legislation	Penal Code	31/05/2018	Articles 513-13 and 513-14 authorise safe termination of pregnancy in three specific circumstances; Article 513-15 criminalises incitement to abortion by any means of distribution or publicity.
Operational	Manual on Post-Abortion Care and Care for the Safe Termination of Pregnancy Authorised by Law (Reference Manual)	August 2021	This technical manual guides providers on post-abortion care and safe legal termination of pregnancy. It specifically details the procedures in cases of rape or incest: filing a complaint, obtaining a favourable opinion from a prosecutor certifying the materiality of distress, and then referring the patient to a practitioner within 14 weeks.

Source: Field data, November 2024 – June 2025



Cameroon

Category	Text	Date	Key content
Legislation	Decree No. 83-166 establishing the code of ethics for doctors	12/04/1983	This decree prohibits all abortion practices.
Legislation	Law No. 90-035 on the practice and organisation of the profession of pharmacist	10/08/1990	Article 75 prohibits any person from engaging in acts likely to cause or promote abortion, including through the sale or distribution of abortive products, speeches in public places and written documents.
International	Maputo Protocol	13/09/2012	Cameroon ratifies the Maputo Protocol on the Rights of Women in Africa, including Article 14(2) (c) on abortion with reservations. (The reservations including that 'The acceptance of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in African should in no way be construed as endorsement, encouragement or promotion of [...] abortion (except therapeutic abortion)')
Operational	Strategic Plan for Reproductive Health (2014-2020) Strategic Plan for Adolescent Health (2015-2019) National Multisectoral Programme to Reduce Maternal Mortality (2014-2020)	2014	Various national plans relating to reproductive health have been put in place, with gender-based violence a recurring theme, but no document explicitly refers to therapeutic abortion services.

Category	Text	Date	Key content
Operational	National Protocol on Gender-Based Violence	Oct. 2015	This protocol, which is not publicly available but is mentioned in field data, organises care for victim-survivors of gender-based violence. It is not clear whether this protocol explicitly refers to legal abortion services in cases of rape or incest.
Legislation	Revised Penal Code	12/07/2016	Article 339 authorises therapeutic abortion under two strict conditions: to save the mother from serious danger to her health (if the facts are confirmed by a qualified person and justified by necessity), or if the pregnancy is the result of rape (after certification by the Ministry of the Republic of the materiality of the facts).
Operational	Norms and standards on reproductive health and family planning	March 2018	This document defines standards for reproductive health and family planning. It also mentions severe embryonic and foetal malformations due to serious psychological consequences for the mother's health as a third condition. The document describes the essential steps to be taken prior to therapeutic abortion for health reasons (concerning the mother, embryo or foetus) but does not specify the steps to be taken for victims of rape.
Operational	SOGOC guidelines	-	SOGOC is developing a set of reference services to guide victim-survivors.
Operational	National Reproductive Health Strategic Plan (2024-2030)	13/03/2025	This plan not yet available at the time of this study.

Category	Text	Date	Key content
Event	Plenary session on the domestication of Article 14 of the Maputo Protocol	27/03/2025	Among the key measures adopted are the drafting of a specific law on reproductive health to implement the Maputo Protocol and the revision of the penal code concerning medical abortion.

Source: Field data, November 2024 – May 2025

Côte d'Ivoire

Category	Text	Date	Key content
Legislation	Penal Code	31/07/1981	Abortion is completely prohibited and punishable in Côte d'Ivoire under Article 366; this law introduces the first criminalisation of rape in Ivorian law.
International	Maputo Protocol	27/02/2004	The country signs the Maputo Protocol on the Rights of Women in Africa, including Article 14(2)(c) on abortion.
Operational	Gender-Based Violence Information Management System (GBVIMS)	April 2010	Introduction of a system for collecting, storing and analysing data on gender-based violence with the primary objective of providing a continuous supply of reliable data.
International	Maputo Protocol	05/10/2011	The country ratifies the Maputo Protocol.
Operational	National Strategy on Gender-Based Violence	2014	This strategy organises public intervention on the issue of gender-based violence according to five areas of intervention.

Category	Text	Date	Key content
Operational	Circular No. 005 on the reception of complaints from victim-survivors of physical assault by the Judicial Police	18/03/2015	This circular facilitates the initial reporting of gender-based violence.
Operational	Circular No. 15/MJ/CAB on the receipt of rape complaints.	13/07/2016	This circular specifies the constituent elements of rape and reminds judicial police officers of their obligation to receive complaints from victim-survivors with or without a medical certificate.
Operational	Interministerial circular No. 016/MJ/MEMIS/MPRD on receiving complaints of gender-based violence	04/08/2016	This circular recognises that a medical certificate is not relevant when receiving complaints in cases of gender-based violence.
Legislation	Penal Code	10/07/2019	This code establishes an initial restrictive framework for abortion, authorising abortion under two conditions: to save the mother's life and in cases of rape (but not incest). With the warning that persons belonging to the medical profession or a profession related to public health who indicate, promote or personally carry out the means of performing an abortion (under conditions not provided for by law) shall be punished.
Legislation	Law 2021-893 amending the Criminal Code	2021	This law broadens the definition of rape and the penalties.
Legislation	Law 2021-894 on measures to protect victim-survivors of domestic violence, rape and sexual violence other than domestic violence.	2021	This law strengthens the legal arsenal to better protect victim-survivors and punish those responsible for such violence.

Category	Text	Date	Key content
Legislation	Law No. 2024-358	11/06/2024	This law modifies the Penal Code. Article 427 introduces a major reform extending the conditions for access to abortion in three circumstances: rape and incest, the mental and physical health of the mother, and where the mother's life is in danger.

Source: Field data, November 2024 – June 2025

Togo

Category	Text	Date	Key content
Legislation	Penal Code	1980	No reference to abortion. Until 2006, the French law of 1920, which restricted abortion to cases where the woman's life was in danger, was in force.
International	CEDAW	1983	The country ratifies the Convention on the Elimination of All Forms of Discrimination Against Women.
Legislation	Law No. 84-14 on the protection of learners	1984	This law condemns anyone who contributes to the pregnancy or abortion of a girl enrolled in a school or vocational training centre.
International	Maputo Protocol	30/12/2003-12/10/2005	Togo signed the Maputo Protocol in 2003 and ratified it without reservation in October 2005.

Category	Text	Date	Key content
Legislation	Law No. 2007-005 on reproductive health	10/01/2007	This law authorises voluntary termination of pregnancy on prescription by a medical practitioner, and in cases of pregnancy resulting from rape or incest, where the life and health of the woman are at risk, or where there is a high risk of serious harm to the unborn child. This law on reproductive health has remained without implementing regulations for 20 years.
Legislation	Public Health Code	2009	Article 107 prohibits the sale or distribution of methods or materials necessary for the performance of an abortion. Article 108 specifies the conditions under which termination of pregnancy is authorised, in particular (1) to save the life of a mother threatened by the continuation of pregnancy (certification by three practitioners required) (2) after proof of incest or rape (certification by three practitioners required).
Operational	National Policy for Gender Equity and Equality (PNEEG)	January 2011	Adoption of national policy for gender equality.
Operational	National Strategy to Combat Gender-Based Violence	June 2012	This strategy aims to reduce socio-cultural and economic inequalities within families and society and to establish a legal and institutional environment conducive to non-violence.

Category	Text	Date	Key content
Legislation	Medical code of ethics	2013	Article 22 governs conscientious objection by health professionals and specifies that a practitioner may only perform a voluntary termination of pregnancy under the conditions provided for by law, when the continuation of the pregnancy poses a threat to the health or life of the mother or child. (Rape and incest are not mentioned.)
Legislation	New Penal Code	2015	Article 829 reaffirms the legal conditions for access to voluntary termination of pregnancy. The new Code devotes several articles to the prohibition of violence against women, including domestic violence and sexual assault.
Legislation	Law No. 2022-020 on the protection of learners against sexual violence in Togo	02/12/2022	This law strengthens the 1984 law on the protection of apprentices and broadens the scope of protection to cover all forms of sexual violence. It also emphasises support for victim-survivors and provides for the establishment of a national observatory to monitor and evaluate sexual violence in places of learning. On voluntary termination of pregnancy, it states: "Voluntary termination of pregnancy as a result of sexual violence is lawful."
Operational	National protocol for the care of victims of gender-based violence	Sept. 2023	This protocol aims to harmonise procedures and guarantee victim-survivors access to a range of integrated, high-quality services; the protocol does not mention legal abortion in cases of sexual violence.

Source: Field data Togo research team, November 2024 – June 2025

Annex 3

Study objectives

This research aims to document and analyse, in a comparative manner, access to legal and safe abortion for victim-survivors of sexual violence in five countries in West and Central Africa – Benin, Burkina Faso, Côte d'Ivoire, Togo and Cameroon – with contrasting legal trajectories.

The study examines the legal and policy frameworks in place, identifies barriers to effective access, analyses the influence of social and cultural factors, assesses inequalities in access according to the characteristics of vulnerable populations, and identifies organisational innovations that could improve care for these particularly exposed populations.

Understanding the obstacles to the implementation of existing laws through in-depth research is essential to inform policymakers and other key stakeholders to develop effective strategies that ensure victim-survivors of sexual violence receive the care they are entitled to.

Overall objective

To analyse the conditions of access to safe and legal abortion care and the obstacles encountered by victim-survivors of sexual violence in West Africa (Benin, Burkina Faso, Côte d'Ivoire, Togo) and Central Africa (Cameroon), with a view to formulating recommendations for improving access to reproductive health and rights.

Specific objectives

1. Document the legal and policy frameworks governing access to safe and legal abortion care in the five target countries (Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Togo), examining their compliance with the Maputo Protocol;
2. Identify legal, political and operational barriers that hinder access to legal and safe abortion for victim-survivors of rape or incest, analysing the gaps

- between stated policy intentions and implementation realities;
3. Examine the social, cultural, economic, geographical and health system factors that prevent victim-survivors of sexual violence from effectively accessing legal and safe abortion, analysing their interactions and their differentiated impacts according to national contexts;
 4. Assess inequalities in access to safe and legal abortion by analysing how victim-survivors belonging to marginalised or vulnerable groups may face additional barriers;
 5. Formulate recommendations for different stakeholders to improve effective access to safe and legal abortion for victim-survivors of sexual violence in West and Central Africa.

Annex 4

Abbreviations and acronyms

ABBEF	Burkina Faso Association for Family Welfare
ABPF	Beninese Association for the Promotion of the Family
AIBEF	Ivorian Association for Family Welfare
APHRC	African Population and Health Research Center
ATBEF	Togolese Association for Family Welfare
CAMNAFAW	Cameroon National Association for Family Welfare
GBV	Gender-based violence
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CNGOB	National College of Gynaecologists and Obstetricians of Benin
CFA	Communauté financière africaine or African Financial Community
CSO	Civil Society Organisation

IPPF	International Planned Parenthood Federation
NGO	Non-governmental organisation
SGBV	Sexual and gender-based violence
SOGOC	Society of Gynaecology and Obstetrics of Cameroon
SRH	Sexual and reproductive health
STIs	Sexually transmitted infections
SRHR	Sexual and reproductive health and rights
UNFPA	United Nations Population Fund
WHO	World Health Organization

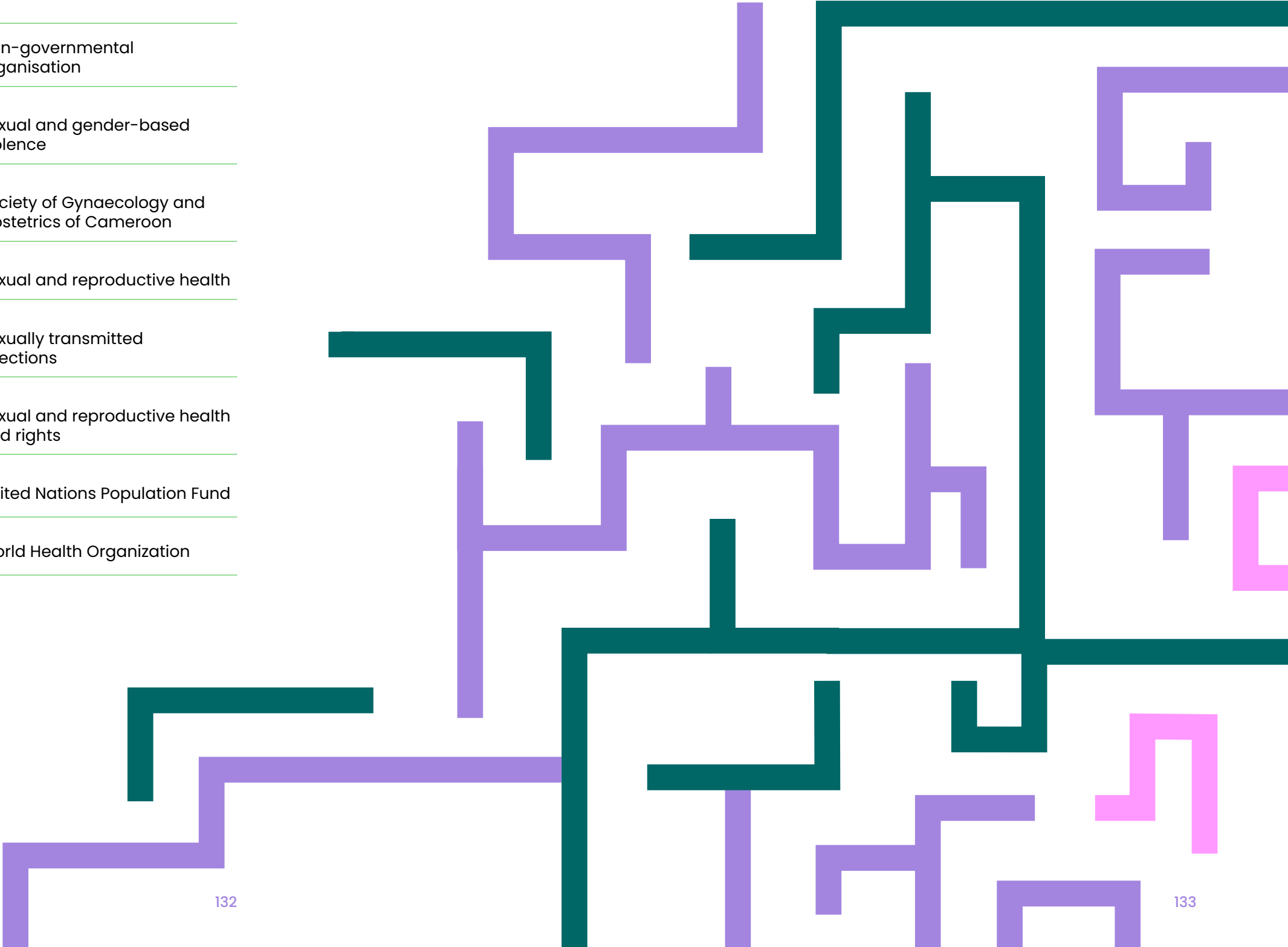
List of tables

Table 1: Geographical distribution of study areas by country

Table 2: Breakdown of interviews conducted by country

List of figures

Figure 1: Berman’s policy implementation analysis framework adapted by Dossou et al. (2022)



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Behind the report

This report was made possible through the dedication and creativity of many talented partners and collaborators. Together, this collective effort transformed research into a living story — one that we hope will inform, inspire and drive action.

A heartfelt thank-you to the individuals and communities featured in the photographs. Your openness and courage bring this report to life and remind us why this work matters.

Design: Rewire Design

Photography: Yannick Folley, Eva Blue and Pexels.

Campaign lead: Jo Atkins-Potts

Rutgers is the Dutch centre of knowledge and expertise on sexual health, safety and well-being. We provide reliable information and resources. In collaboration with partners and experts in education, healthcare and well-being, we support young people to grow up healthy, safe and happy. Our work spans the Netherlands, Europe and beyond.

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Every woman and girl should have the right to make decisions about her own body and health. Yet millions are denied this right, often forced to seek unsafe abortion care. The consequences are devastating: maternal mortality, preventable injuries and countless futures cut short. This study uncovers the barriers women face, amplifies victim-survivors' voices and provides evidence to inform policies and interventions that make safe, accessible care a reality.

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