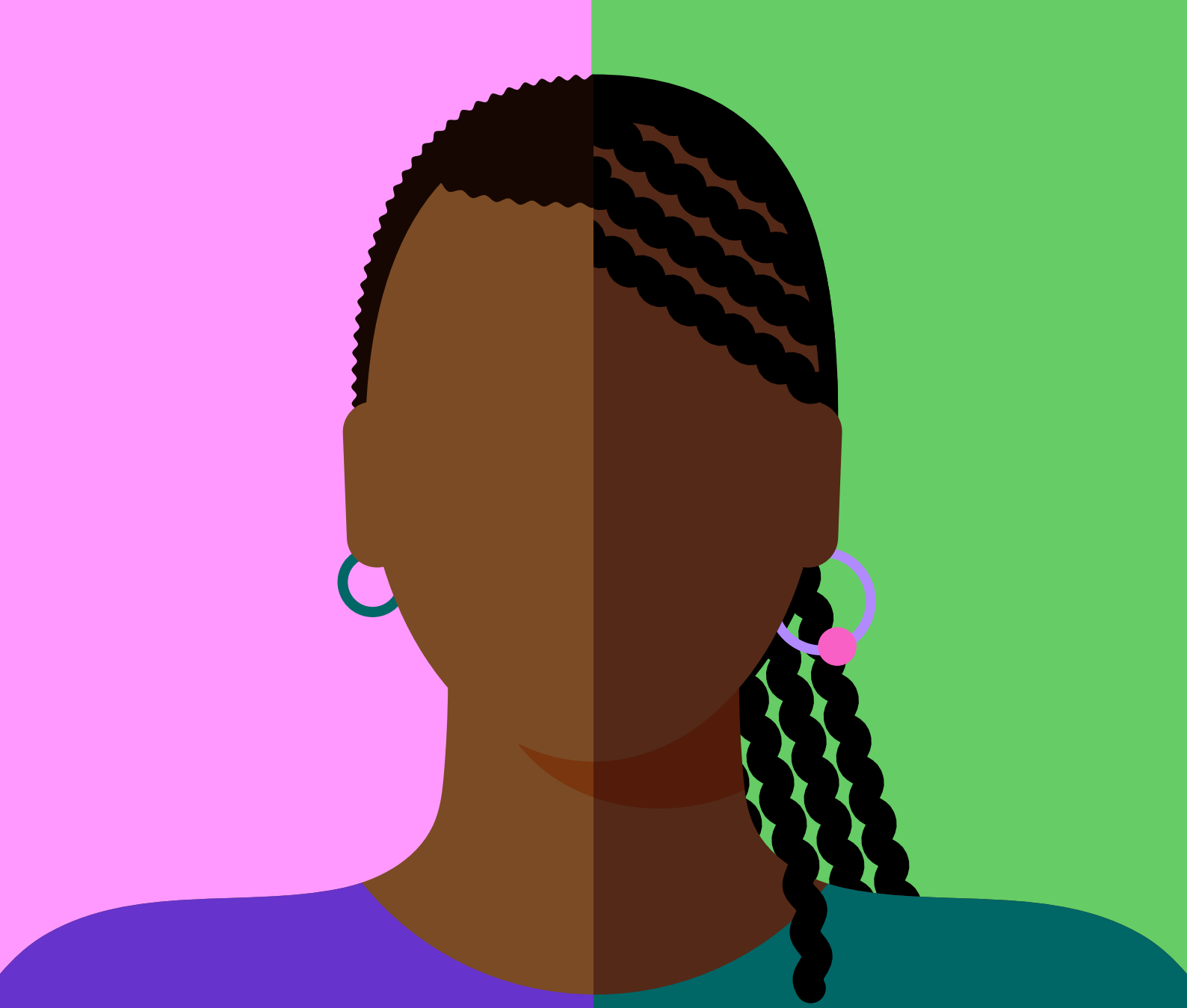

INSIDE THE MAZE WOMEN FACE:
THE REALITY OF UNSAFE ABORTION IN TOGO

A qualitative study in the
Plateaux and Grand Lomé regions

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ATBEF Association Togolaise pour le Bien-Être Familial
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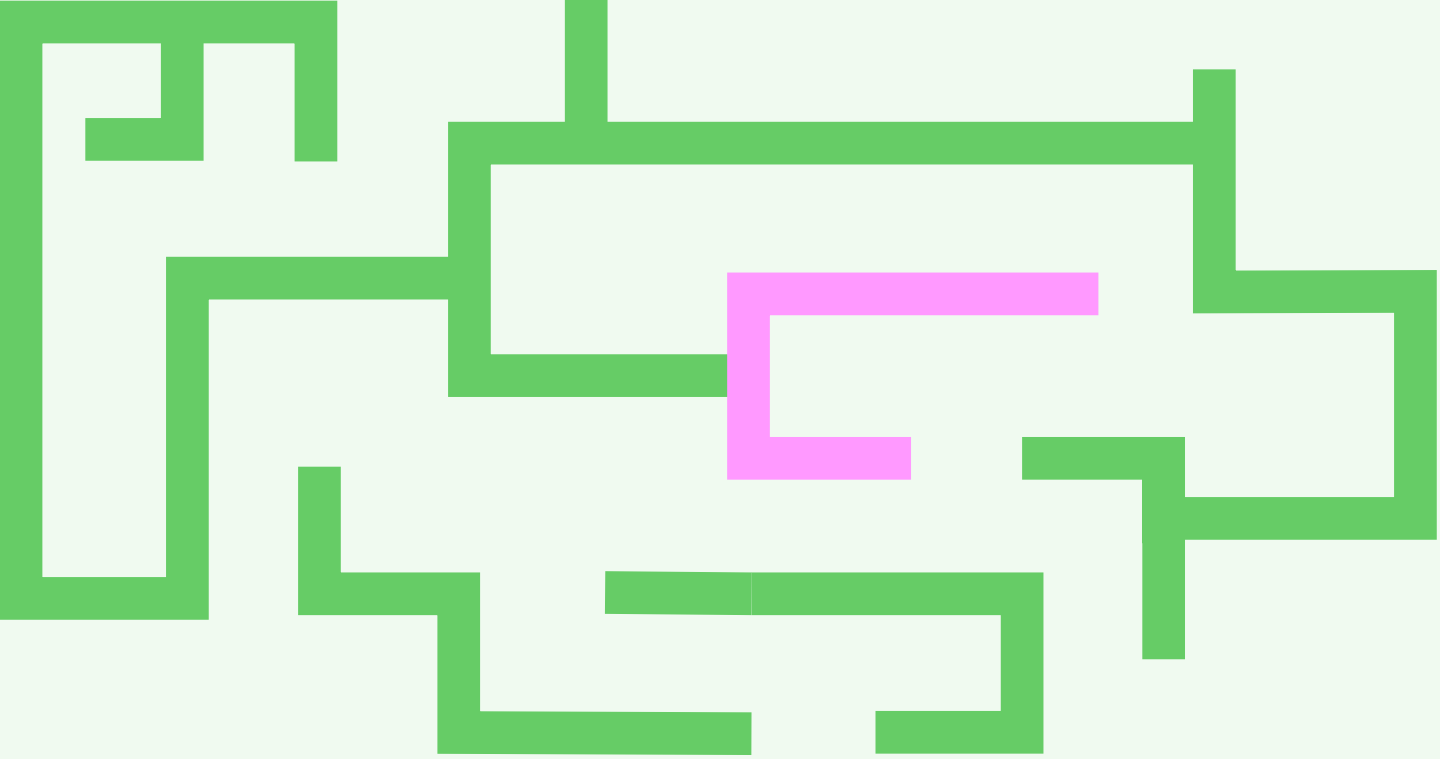

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The report is based on data collected by six dedicated researchers (most of whom are under 35) and two coordinators, over a seven month-period. This research would not have been possible without their commitment and perseverance.

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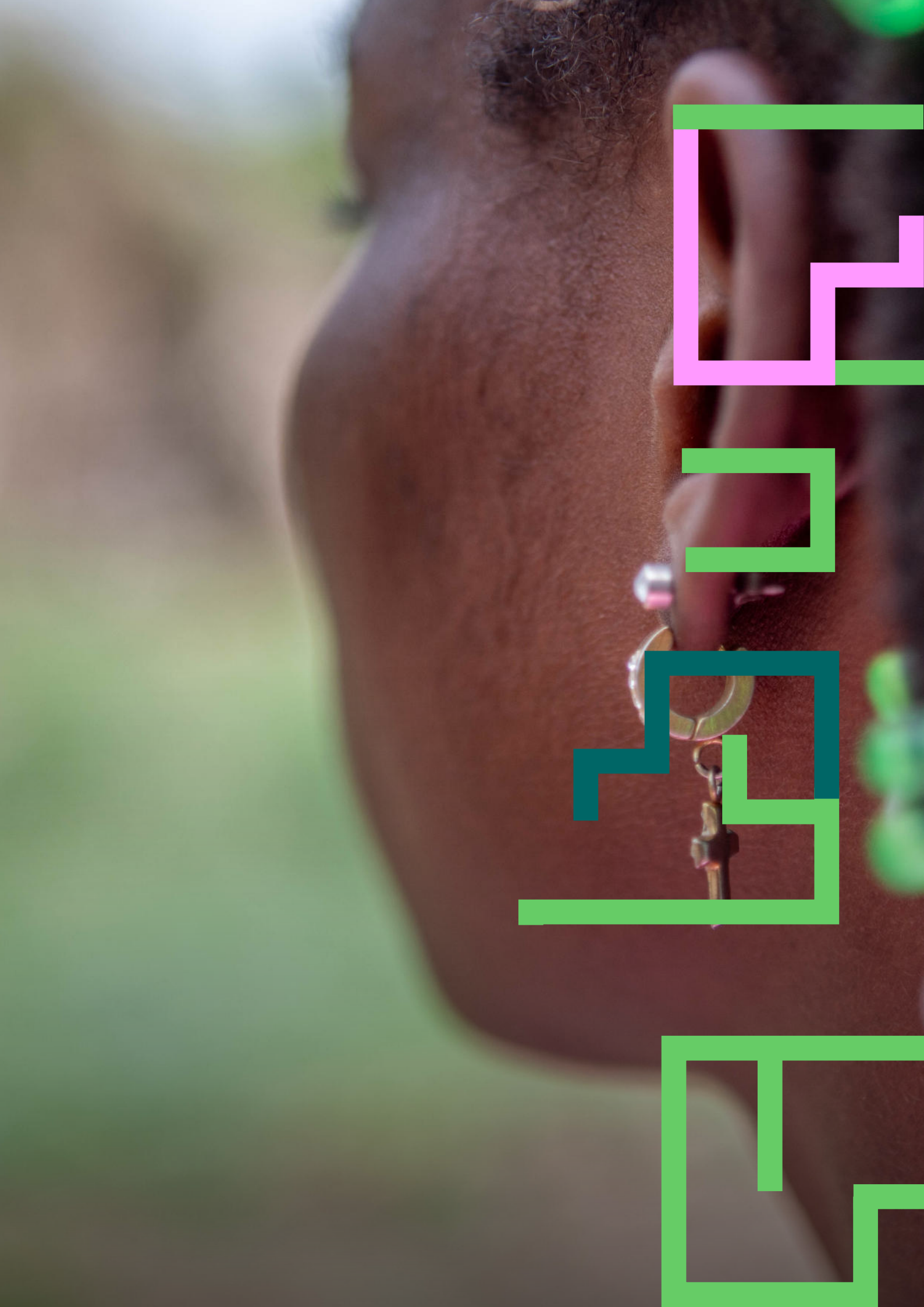


Executive summary

'Inside the Maze Women Face: The reality of unsafe abortion in Togo' examines the lived experiences of adolescent girls and women facing unintended pregnancies they are unable to continue. Drawing on personal testimonies, the report centres the voices of girls and women, exposing the complex maze of stigma, shame, silence, risk and legal restrictions they must navigate. It shows how these forces shape their decisions and experiences.

In doing so, it reveals how restrictive laws, societal pressure and health inequalities limit access to safe abortion and post-abortion care, with adolescent girls and women bearing the brunt of the consequences for their well-being, health and lives.

In Togo, unintended pregnancy remains a major public health issue, despite government efforts. It affects both adolescent girls and women and often results in abortion. Legal abortion is severely restricted.[a] According to estimates by the Guttmacher Institute, however, a total of 60,300 abortions took place in Togo each year between 2015 and 2019.[b] The majority of these abortions take place in unsafe conditions. Unsafe abortions have been identified as the cause of 10 per cent of maternal deaths in one region of Togo.[c]

The research findings provide evidence that, in a context where legal and safe abortion care is virtually inaccessible, adolescent girls and women are forced to take serious risks, including significant health complications and even death. The study uncovers crucial evidence sorely needed to develop solutions for women and girls who undergo unsafe procedures and endure their harmful consequences

a Abortion in Togo is only allowed in three specific circumstances: when the continuation of the pregnancy puts the life or the health of the mother at risk; when there is a high risk of foetal malformation; or when the pregnancy results from rape or incest.

b Togo | Guttmacher Institute These figures and rates of unintended pregnancies and abortions, as well as the proportion of these pregnancies that end in abortion, are derived by the Guttmacher Institute using a statistical model. This model incorporates and draws on all available data concerning pregnancy intentions and abortions among women of reproductive age, collected nationwide, and these figures are considered estimates. Further information is available here: Guttmacher Institute, (2022), Unintended Pregnancy and Abortion Worldwide: Country-Level Estimates Explained [factsheet], New York: Guttmacher Institute.

c Ajavon, D., Edem, L., Yendoube, K., Sibabe, A., et al. (2022). Causes of Maternal Mortality in 2020 in the Kara Region (Togo). Open Journal of Obstetrics and Gynecology, 12, 104-111.

Documenting the lived realities of adolescent girls and women

This ethnographic study was conducted by APHRC, Rutgers, Population Council and ATBEF. It was conducted as part of two programmes: 'She Makes Her Safe Choice', implemented in West and Central Africa with the aim of reducing maternal mortality and morbidity linked to unsafe abortions, and 'Expanding access to quality sexual and reproductive health services in Francophone West Africa'.[d]

The study was conducted in the Grand Lomé and Plateaux regions in Togo, selected for their high rate of unintended pregnancies and abortions. The data consists of participant observation in 12 health facilities and surrounding communities. This included repeated in-depth interviews conducted, with 22 adolescent girls (aged 15-19) and 39 women (61 participants in total) who had undergone abortions. In addition, interviews and focus group discussions were conducted with a wide range of stakeholders. The data collection was largely led by young researchers who spent seven months immersed in the study regions. This allowed them to build the trust needed to carry out this sensitive research.

d The first programme is funded by the Postcode Loterij (Postcode Lottery Netherlands) through Rutgers and the second programme is funded by the William and Flora Hewlett Foundation through Population Council.

The study uncovers crucial evidence needed to develop solutions for women and girls who undergo unsafe abortion procedures and endure their harmful consequences

In Togo,

unintended pregnancy remains a major public health issue and often results in unsafe abortion

Key findings

The study findings show that adolescent girls and women face multiple, interconnected factors that influence the risk of unintended pregnancies[e]. The findings equally highlight the complex decision-making processes around abortion and the difficulties in accessing safe abortion and post-abortion care.

Factors influencing the risk of unintended pregnancies

Interviews with girls, women and key stakeholders identified different factors that increase the risk of unintended pregnancy:

1. **Inadequate sexuality education,** driven by taboos around sexuality, resulting in a lack of accurate information on fertility and contraception.
2. **Fragile family support,** due to parental loss, separation or foster care.
3. **Economic vulnerability,** which can lead to unequal or transactional sexual relationships.
4. **Low use of reliable contraceptive methods,** due to fear of side effects, stigma and lack of support from partners, families and health providers.
5. **Mental health challenges and unmet emotional needs,** linked to social and economic insecurities.
6. **Sexual violence,** compounded by barriers to accessing post-rape care, including emergency contraception.

How decisions about abortions are made

According to prior research, an estimated one third of unintended[f] pregnancies in Togo end in abortion. The present study found that decisions about abortion are rarely made by adolescent girls and women alone. Male partners or relatives are often involved and in some cases make decisions on their behalf without consultation. Social norms strongly shape these decision-making processes.

Common reasons for deciding to have an abortion included:

- Fear of family or community reactions, including social exclusion or loss of support
- Abandonment by, or pressure from, the partner
- Influence from mothers or other relatives
- Inability to continue a pregnancy due to age, education, financial constraints, or unstable living conditions
- Pregnancy resulting from sexual violence
- Pregnancy resulting from a casual relationship

e In this research, 'unintended pregnancies' refer to pregnancies that were unplanned, whereas we use the term 'unwanted pregnancies' is used, once the decision for abortion was made.

f Togo | Guttmacher Institute

> I did not seek care because I was afraid. I could already imagine the blame, the harsh looks, the criticism.

Farida, 35, Plateaux

Navigating access to abortion

- **Fear and misinformation about the law is widespread:** Most adolescent girls and women, including those legally entitled to care, such as victim-survivors of sexual violence, believed abortion was completely prohibited in Togo.
- **Perceived risk versus necessity:** Many associated abortion with serious complications or death, yet felt they had no alternative but to take the risk.
- **Stigma and secrecy:** Fear of social judgement and legal consequences forced girls and women to seek information discretely, mainly through friends, partners, relatives, or social media.
- **Unsafe methods dominate:** Most guidance concerned unsafe methods, including herbs, concoctions, unknown pills, over-the-counter drugs and clandestine clinics.
- **Barriers to safe options.** While some learned about medical abortion pills (such as misoprostol), access was often constrained by cost or refusal from healthcare providers or pharmacists.
- **Decisions shaped by constraint:** Where safe and legal abortion is inaccessible, choices are guided by affordability, discretion, secrecy and recommendations from trusted individuals.
- **Serious health consequences:** Abortion experiences varied widely, often involving severe pain, multiple attempts and limited support. Of the 61 participants, 49 experienced complications that required post-abortion care. These complications included severe bleeding, infection, intense pain and comas.

Experiences of post-abortion care

Key findings show that access to timely and quality post-abortion care was often limited, with serious consequences for adolescent girls and women.

- **Fatal outcomes:** During the study, five young women (aged 19-27) died due to unsafe abortion complications
- **Delays in seeking care:** Fear of disclosure and stigma led some girls and women to delay seeking treatment.
- **Health facility limitations:** Lower-level health facilities often lacked the capacity to manage severe complications, requiring referrals that further delayed critical care.
- **Barriers to quality care included:**
  - Lack of (functioning) equipment and sufficient medication
  - Stigmatisation by health care providers
  - Limited privacy and confidentiality
  - Insufficient pain relief during procedures, such as manual vacuum aspiration
  - Inadequate post-abortion contraception counselling
  - High costs of care

The findings reveal that adolescent girls and women in Togo face a maze of challenges that threaten their well-being, health and lives

Conclusion

This research shows that unintended pregnancies in Togo result from a complex mix of social, economic, cultural and systemic factors. Restrictive laws and social stigma push adolescent girls and women towards unsafe abortion methods, often obtained through informal networks. These practices frequently lead to serious complications or death, five deaths were witnessed during this study.

Fear of stigma also delays care-seeking for complications. While life-saving post-abortion care is available in many health facilities, access remains unequal and the quality of care, preparedness for severe complications, and respect for patients vary widely.

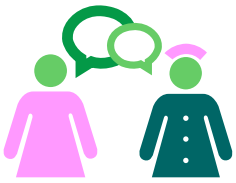
Together, these findings show that adolescent girls and women in Togo navigate a maze of preventable risks that threaten their health and lives.

While the causes of reproductive injustice are complex, they are not insurmountable. This report sets out clear, evidence-based recommendations for action. Developed in collaboration with young people, healthcare professionals and civil society organisations, these recommendations aim to improve access to safe abortion and quality post-abortion care.

Recommendations

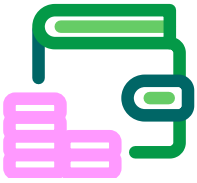
Revise the legal framework on abortion

Reform the legal framework governing safe abortion by amending the 2007 Reproductive Health Act and ensure its implementation in order to reduce maternal mortality and morbidity.



Improve the quality of post-abortion care

Provide training for healthcare providers on comprehensive safe abortion and post-abortion care, including non-judgmental treatment, pain management and contraceptive counselling.



Promote universal access to reproductive health care

Remove financial barriers by making comprehensive safe abortion care, post-abortion care, contraceptives and family planning services free of charge.

Strengthening education on values and sexual health

Provide adolescents with information on relational and sexual wellbeing. Integrate education on values and sexual health into teachers'and social workers' training programmes.

Ensure the availability of medical supplies

Equip all health facilities with the necessary equipment, medications, and contraceptives for comprehensive safe abortion care and post-abortion care.

Conduct a national abortion incidence study

Generate evidence on the magnitude of unsafe abortion complications and abortion-related maternal deaths to inform policies and guide action.

Introduction

This report *'Inside the maze women face: a qualitative study on the reality of unsafe abortions in Togo'* examines the experiences of adolescent girls and women (ages 14-40) in Togo who have experienced an unintended pregnancy.[g] Based on ethnographic research, which centres women's voices, it expands the body of evidence on unsafe abortions in Togo and proposes ways to reduce the harmful – sometimes fatal – health consequences of this often-concealed practice.

g Throughout the report, we use the term 'adolescent girls and women', or in some cases simply 'women', to refer collectively to the 61 females who had experienced an unintended pregnancy who participated in this research, all of whom were aged between 14-40. Young women (aged 18-24) were the largest age group within this sample. The report also notes when findings relate specifically to adolescent girls and young women (aged 14-24).

Due to legal restrictions and prevailing stigma, many adolescent girls and women experience significant risks when faced with an unintended pregnancy.[h] Despite the Togolese government's ongoing efforts to increase the use of contraceptive methods and reduce the number of teenage pregnancies, unintended pregnancies remain a major public health issue. It is estimated by the Guttmacher Institute that 60,300 abortions take place each year between 2015 and 2019.[1] The majority of these abortions occur in unsafe conditions due to restrictive legislation, the stigma surrounding abortion and a lack of access to quality care. The consequences of this can be devastating. Unsafe abortion has been identified as the cause of 10% of maternal deaths in one region of Togo, for example.[2]

For many Togolese adolescent girls and women, the journey to seek abortion care is fraught with obstacles, which can jeopardise their health or even cost them their lives. During the study's data collection period, five women died in health centres included in this research, and many others were hospitalised for complications arising from an unsafe abortion. For these women, access to high-quality post-abortion care, free from stigma, is vital but remains rare.

Based on the study's findings, this report includes concrete recommendations on how to protect adolescent girls and women from the life-threatening risks of unsafe abortion. The recommendations set out avenues for concerted action by public authorities, civil society organisations, health professionals, donors and communities and were developed jointly with stakeholders during a validation workshop in Lomé in October 2025.

This study was led by the African Population and Health Research Centre (APHRC), Rutgers, the Population Council and the Togolese Association for Family Well-being (ATBEF). Data collection was carried out by six young researchers from Togo and two research coordinators in the country.

For many Togolese adolescent girls and women, the journey to seek abortion care is fraught with obstacles, which can jeopardise their health or even cost them their lives

h In this report, we use the term 'unintended pregnancies' to refer to pregnancies that were not anticipated, and we refer to them as 'unwanted pregnancies' once the decision to have an abortion has been made.

The maze women face

Around the world, unintended pregnancy continues to be a major public health issue. According to estimates by the United Nations and the World Health Organization (WHO), millions of unintended pregnancies occur each year, with significant disparities between different world regions.

In Togo, unintended pregnancy particularly affects adolescent girls.[3] Despite ongoing efforts by public authorities to increase the uptake of contraception and to prevent teenage pregnancies and sexual violence, the Ministry of Primary and Secondary Education recorded 2,284 cases of pregnancy in primary and secondary schools at the end of the 2024-2025 school year.[4] It is highly likely that this figure represents only the tip of the iceberg, as many unintended pregnancies end in abortion before they are recorded.[5] According to the Guttmacher Institute's modelling, around 50% of pregnancies in Togo are unintended, of which 32% end in abortion. This amounted to an estimated number of 60,300 abortions each year between 2015 and 2019.[6] The vast majority of of these abortions are unsafe. Using health facility data, the Ministry of Health in Togo estimates that there are approximately 10,000 abortion-related complications each year, a high number, albeit lower than previous estimates. Despite these high figures, voluntary termination of pregnancy is only legal in Togo in three specific cases according to Articles 42–43 of Law No. 2007-005 on reproductive health:[7]

1. The pregnancy poses a risk to the health or life of the pregnant woman.
2. The pregnancy results from rape or incest.
3. There is a serious foetal abnormality.

Togo's 2009 Public Health Code does not mention that abortion is permitted in cases of foetal abnormality. However, regarding the two other legal conditions mentioned above, the code specifies that three doctors must be involved in granting permission for an abortion for it to meet the correct legal threshold.[8]

The true scale of legal abortion access remains unclear

There is very little clarity on how many women access abortion under the conditions provided for by law. A study conducted at ATBEF's main clinic in Togo revealed that 25 medical abortions had taken place over a ten-year period (2012–2021) due to foetal (28%), maternal (20%) and obstetric (52%) causes, which pose a serious risk to the pregnant woman or indicate foetal abnormality.[9]

Research from Rutgers and its partners shows that, for pregnancies resulting from rape or incest, barriers to accessing safe and legal abortion remain particularly high in Togo and other West African countries.[10] Another study conducted in 2016 documented serious obstacles preventing women in Togo from having abortions, even if they are legally entitled.[11] Among these are a lack of awareness of the law and a lack of published implementation guidelines for health providers. This explains why most healthcare professionals are reluctant to perform abortions, even when these are permitted by law.[12]

Legal and political restrictions, combined with the lack of effective enforcement of the law, constitute a structural barrier to accessing safe abortion services.[13] Added to this is the strong social stigma surrounding abortion, driven by religious, social and cultural norms. This stigma hinders the circulation of accurate information on legal provisions and safe abortion methods. This makes it harder for adolescent girls and women to be aware of, and access, safe abortion care if they need it, and it has a detrimental effect on healthcare providers' attitudes and practices.[14] These combined factors particularly affect economically vulnerable adolescent girls and women,[15,16,17] whose unmet need for contraception is particularly high.[18] Without access to modern contraceptive methods, many adolescent girls and women are often forced to resort to unsafe abortions.

Despite a lack of comprehensive and up-to-date statistics, available data suggest that unsafe abortion is a common practice among many Togolese adolescent girls and women. This data is drawn from regional studies, hospital statistics and school surveys. The results of a study carried out in 2002 in Lomé involving 3,230 women of reproductive age (15-49) found that 32% had had an abortion, 25% of whom had experienced more than one abortion.[19] In the Kara region, a study involving adolescent girls found 33% had been pregnant at least once, and 81% had undergone at least one clandestine abortion.[20]

A recent hospital-based study in the Kara region established a link between 10% of maternal deaths and unsafe abortion.[21] In 2024, 1,439 cases of induced abortions requiring hospital care were recorded in Togo, including 225 in Lomé and 336 in the Plateaux region.[22] Although incomplete, these figures nevertheless confirm the high prevalence of abortion, despite it being prohibited outside the relatively rare legal cases mentioned above.

Given the scale of this, more data is needed to better understand the practice of, and experiences with, abortion in Togo. Existing research, while valuable, has often been limited by a narrow geographic or institutional focus and/or outdated data, leaving gaps in understanding current abortion-related dynamics and access to services at community and national levels. Furthermore, the available data provides very little information on the circumstances surrounding unintended pregnancies or on unsafe abortions and related complications. The existing studies often fail to include the perspectives of women, particularly adolescent girls and young women, or their interpretation of the complex dilemmas posed by unintended pregnancy. Filling this knowledge gap is essential to fully understanding the challenges that women in Togo face.

The overall objective of this in-depth, qualitative study is therefore to document the abortion experiences of Togolese adolescent girls and women. It examines the determinants of unintended pregnancies that result in abortion as well as the decision-making processes involved in seeking an abortion. It also analyses the social, gender and health system dynamics surrounding the search for (often unsafe and clandestine) abortion methods, abortion care and post-abortion care.

Methodological approach

This qualitative study took an ethnographic approach to understand the factors that lead to unsafe abortion, and the complexity of abortion pathways in Togo.[i] It drew on participant observation conducted by the research team in 12 health facilities and surrounding communities in various parts of the Plateaux and Grand Lomé regions. It also drew on in-depth and repeated interviews with 61 adolescent girls and women (22 adolescent girls aged 15-19, and 39 women aged 20-40) who had undergone an abortion and the documentation of five deaths linked to unsafe abortion. Interviews were also conducted with others involved in the process of seeking abortion care, namely family members and partners (28 interviews), healthcare providers (40 interviews)[j] key informants (69 interviews), plus 24 focus group discussants.

The study was carried out by the APHRC, Rutgers, the Population Council and the ATBEF. It formed part of two programmes: *Sa Santé, Ses Choix*, implemented across West and Central Africa to reduce maternal mortality and morbidity linked to unsafe abortions,[k] and the Expanding access to quality sexual and reproductive health services in Francophone West Africa' initiative.[l]

The study was carried out in the Grand Lomé and Plateaux regions to observe the dynamics in two different areas. The first region includes the capital, Lomé, which made it possible to capture the specifically urban dynamics surrounding unintended pregnancies and unsafe abortions. The Plateaux region, meanwhile, in addition to having a high rate of unmet family planning needs (around 35% of women of reproductive age have an unmet need for family planning), also has the highest number of hospitalisations due to complications from unsafe abortions.

For the study, a team of six young researchers (five women, one man), and two field coordinators, all with a background in anthropology or sociology, were recruited and trained in ethnographic research methodologies. Particular attention was paid to research ethics when dealing with sensitive topics such as abortion and sexual violence. Ethical approval for this study was granted by the Togolese Bioethics Committee for Health Research (CBRS).[m]

Data collection took place over a seven-month period, from September 2024 to April 2025, with regular discussions and ongoing support from senior researchers. The obstacles encountered and the initial findings were discussed during weekly debriefing sessions, which informed the progress, research and selection of case studies. The main challenges of the fieldwork were gaining the trust of healthcare professionals and adolescent girls and women who had had an abortion and ensuring their continued participation. Some research assistants experienced emotional distress after witnessing serious complications from unsafe abortion, or after seeing some women die from these complications. These difficulties were overcome thanks to the support of the team, senior researchers and a psychologist who was available throughout the project and who provided counselling to one of the research assistants.

The data was subjected to thematic analysis. All interviews and discussions were audio-recorded, transcribed, anonymised and translated. The research team used *Dedoose* software to code the transcripts and field observation notes. The entire team contributed to drafting the report, and the preliminary findings were presented at a validation workshop in Lomé on 2 and 3 October 2025. Workshop participants included the entire research team, research partners, key stakeholders from the Ministry of Health, health professionals, religious and community leaders, representatives of civil society organisations (CSOs) and young

i Further details on the methodology used are set out in Annex 2.
j Key informants included male partners, mothers, relatives, decision-makers and non-regulated abortion providers.
k Funded by the Postcode Loterij (Postcode Lottery Netherlands) via Rutgers.
l Funded by the William and Flora Hewlett Foundation via the Population Council.
m Reference: AVIS N° 033/2024/CBRS 4 July 2024.

people from the research project's youth advisory committee. Recommendations were developed jointly during this workshop. A detailed description of the methodology is provided in Annex 2.

Findings are grounded in participant observation across 12 healthcare facilities and surrounding communities in the Plateaux and Grand Lomé regions

> If my father found out I was pregnant, he'd be furious and might even try to kill me

Research findings

Ingrid's story*

Ingrid, aged 17 and in her final year of secondary school, is an only child. After her parents separated when she was 3, Ingrid was brought up by her father and her paternal grandmother. Ingrid describes a childhood marked by a lack of maternal affection and a feeling of having been abandoned and unwanted by her mother. She did not feel comfortable confiding in her grandmother about personal matters, such as her social life or sexuality.

Deprived of any information about sexuality or reproduction, she had her first sexual experience at the age of 11, with a 13-year-old friend.

> "It happened at his house," says Ingrid. "I didn't know anything about any of that … All I knew was that on the telly, when you saw white people kissing, I'd be told, 'Close your eyes, that's not for children.' I'd pretend to close my eyes, but I'd carry on watching. That was all I knew."

At the age of 16, Ingrid entered a relationship that resulted in an unintended pregnancy. When her classmates began to notice her physical symptoms (weight gain and vomiting) she decided to have an abortion. Her decision was driven by her determination to continue her studies and an absolute fear of her father's reaction. As an only child she was convinced that, if her pregnancy were to be discovered, the consequences would be catastrophic: "I had absolutely no intention of giving birth," Ingrid recalls. "What matters to me right now is my education. If my father found out I was pregnant, he'd be furious and might even try to kill me."

Having decided to terminate the pregnancy, but lacking information on safe methods, Ingrid relied on her partner who took her to an 'underground' (unlicensed) clinic. After an injection, a tablet and a curettage (a scraping of the uterus), Ingrid returned home, thinking she was done.

However, three days later, she developed a high fever, heavy bleeding and severe pelvic pain. Her condition continued to deteriorate and eventually alarmed her grandmother. After a positive test confirmed her pregnancy, Ingrid confirmed the abortion and the complications she had been hiding. Her grandmother took her to a local health centre, but due to the seriousness of her condition, she was immediately transferred to a hospital.

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

The factors contributing to unintended pregnancies

Key findings

Unintended pregnancies in the Grand Lomé and Plateaux regions can be attributed to the following factors, which are often interlinked:

- A lack of relationship and sexuality education for adolescents and young people (whether at home, at school, among peers or on social media, information about sex, relationships and reproduction remains patchy and sometimes inaccurate)
- Weak family ties, particularly in cases of divorce or the death of parents, or when children are placed with foster families
- Economic vulnerability, leading to transactional sex
- Mental health issues
- Low use of contraceptive methods
- Sexual violence

Lack of relationship and sexuality education

Interviews with different types of participants, supplemented by the researchers' observations within the community, have shown that access to information on sexuality and the prevention of unintended pregnancies is a major challenge for adolescents and young people, both male and female. As illustrated by Ingrid's case above, the research highlights a glaring lack of adequate or sufficient relationship and sexuality education for adolescents and young people, both at school and in the family. These shortcomings can be attributed to several factors: the taboo surrounding sexuality, the reluctance of parents and communities to provide sex education to young people and the absence, or inability, of parents to address these issues.

Sexual taboos stop parents providing relationship and sexuality education

Study participants indicated that sexuality is a taboo subject which is rarely discussed with children. Talking about sex openly is often seen as indecent or immoral. This means sex and reproduction are "whispered about" and only discussed when children are not present. One father in Grand Lomé, who participated in a focus group discussion, observed: *"As parents don't like to talk about sexuality with their children, when the children reach puberty, they inevitably run into trouble. Many parents don't talk about sexuality with their daughters either, so many of them end up pregnant when they didn't intend to be."*

It is clear from the data that sex is only addressed when girls start having their periods and boys show signs of puberty. At this stage, the information provided to girls – mainly by their mothers, aunts or grandmothers – was described by participants as limited, superficial and lacking in detail. As a result, girls often have only a vague idea of what sex and reproduction is all about, as illustrated by this fragment from a focus group discussion:

> They say that when you walk past a boy, as *soon as he touches you, you get pregnant.* That seems strange to me: I don't understand how just walking past a boy, if he touches you, you get pregnant … It was at school that we were taught that … when your period ends, there's a time when you're ovulating, and if you go and see a man [if you have sex with him] you get pregnant. That's when I realised you don't get pregnant just because a boy touches you.
>
> **Teenage girl, Grand Lomé**

The findings show that parents provide little information, so as not to encourage teenagers to have sex. One woman explained this reasoning during a group discussion:

> When a girl is 18, you can't directly advise her to protect herself before having sex. If you put ideas like that into a child's head, she'll use them and be inspired by them to do the wrong thing. You must forbid the girl from doing it, whilst telling her that if she wants to get married and for her parents to be proud of her later, she must protect herself; she must practise abstinence.
>
> **Woman, Grand Lomé**

As this account shows, the message about sexuality is often framed around prohibition ('don't look', 'don't go near') to instil fear and deter young people from having sex. But this approach does not stop young people from having sex, as seen in the case of Ingrid and many of the young people interviewed in this study. Instead, it deprives them of the information they need to make fully informed decisions about their sexuality and sexual and reproductive health (SRH) and protect themselves against the associated risks, such as unintended pregnancy and sexually transmitted infections (STIs).

Several participants emphasised the need for parents to establish an early dialogue with their children to provide them with the necessary and appropriate information to help them navigate puberty and make informed decisions about their bodies. This could help to supplement the patchy SRH information, and counteract the misinformation that children and adolescents receive from other sources. While discussing sex is often taboo within the family circle, such discussions frequently take place outside the family, particularly at school, on social media or among peers.

Inadequate relationship and sexuality education in schools

In Togo, relationship and sexuality education is provided in schools, and many teachers regularly receive training in this area. These training courses are mainly organised by non-governmental organisations working to prevent teenage pregnancy, STIs, sexual and gender-based violence SGBV) and unsafe abortions. In practice, however, relationship and sexuality education is rarely treated as a subject in its own right within the school curriculum. Instead, it is delivered in a piecemeal fashion, at the initiative of individual teachers, and incorporated into other subjects, such as life sciences, natural sciences or civic and moral education. This explains why it is often incomplete or superficial. A teacher in the Plateaux region described this situation when they said: *"... Here, sexuality education is virtually non-existent. Very little is said about it in the curricula. I remember the module on human reproduction in natural sciences, but that's not enough."*

This fragmented and superficial approach stems from the lack of institutionalisation of relationship and sexuality education within teacher training programmes. This makes the teaching of the subject informal and at the discretion of teachers and school management. During a group discussion, a teenage girl in Grand Lomé confirmed the superficial nature of the relationship and sexuality education she had received: *"I think we learn more in our day-to-day lives. At school, there are teachers who try to talk about it but without going into detail."*

At school, on the rare occasions when relationship and sexuality education is addressed, it is mainly from the perspective of the risks associated with sex, to the detriment of a comprehensive and positive approach. The absence of a structured educational framework for relationship and sexuality education leads to inconsistent teaching practices, dictated by teachers' personal beliefs, their training and the local socio-cultural context. This disparity raises questions about equal access to information, content consistency and legitimacy. This information gap forces adolescents and young people to rely on their peers or seek information from social media and the internet.

Learning from peers and on social media: advantages and disadvantages

The findings show that peer education fills a major gap for adolescents in learning about relationships and sexuality, particularly when schools fail to provide it or do so inadequately. Peer educators can also reach young people who are not in school. Peer education offers an accessible, informal and youth-friendly approach to sex, which has led some organisations that work on sexual and reproductive health and rights (SRHR) to invest in it to reach both school-going and out-of-school young people.

Outside the formal framework of peer education, friends and peers – much like social media – play an ambivalent dual role in adolescents learning about relationships and sex. Several male and female research participants interviewed on this subject attributed the rise in unintended pregnancies to social media and its use by teenagers. For example, one woman in Grand Lomé said: *"I think social media has played a part in this. I remember that here, at the local school, during break time children log on to WhatsApp on their mobiles to watch pornographic films and images ... So, it's easy for them to learn that sort of thing on their phones."*

Some interviewees remarked that the SRH information shared on social media should be treated with a degree of caution. For instance, one participant in Grand Lomé said: *"In my view, this information isn't reliable. Because I can go straight onto my TikTok account and post a video there. Even if I say silly things and make them public on my*

TikTok account, people will still follow them … You can't trust that sort of information."

This excerpt clearly illustrates the questions people have regarding the content, use, accuracy and reliability of social media platforms when seeking information about relationships and sex. Similar concerns apply to peer networks.

However, some of the adolescents and young people interviewed said the information they found on social media and from their peers was of paramount importance as it enabled them to supplement the patchy information they received from their families or at school. One young person in Grand Lomé commented: *"In particular, I've visited forums on Telegram and elsewhere too, where there's information on sexual health, and that's helped me a lot. I've seen that there are people keen to help young people understand their own bodies and those of their partners better, so you can find that sort of information on social media."*

Young people recognise that certain channels provide useful information which helps them understand their sexuality and other SRHR issues. These are often well-structured and reliable websites or platforms, such as those run by SRHR organisations or networks. Other young people in this study highlighted how, in contrast to these information sources, there are other information sources on social media which promote irresponsible sexual behaviour. Consequently, it is up to young people to find reliable information on SRH topics, such as contraception, on their own. Some described being able to glean useful and credible SRH information through these channels, despite the pervasive amount of misinformation also found on these platforms.

Entrusting children to guardians appears to increase vulnerability to unintended pregnancy

Fragile family ties

The link between fragile family ties and an adolescent girl's risk of unintended pregnancy is clearly evident from the observations and in-depth interviews conducted with adolescent girls and young women in this study. This fragility can arise from divorce, the death of one or both parents or children being placed in the care of relatives or guardians. This can lead adolescent girls to seek emotional connection with adolescent boys or adult men.

Some of the adolescent girls and young women in the study who had experienced unintended pregnancies did not live with both their parents, often due to divorce or separation. Ingrid's story, cited above, shows that parental divorce or separation can lead to family instability and affect a child's social and psychological development.

Ingrid explained researchers: *"I've been living without my mother since I was three. I lack maternal love; I have no little brother or sister, nor any older brother or sister. All of this affects me … Sometimes, the worries at home – as I'm on my own – make me sad. I sometimes cry because of it."*

This loneliness and distress led Ingrid to seek comfort and friendship in relationships with boys who were kind to her:

> I'd told a friend that I was looking for someone to talk to. I tried talking to lots of my female friends, but it didn't work out … She told me to find a male friend. That's what I did, and I realised that this friend – the boy I talk to – has really helped me. He's older than me. He talks to me … We have a good time together. Sometimes, if I fall out with him, he asks me who I'm going to talk to. He treats me like a sister …
>
> **Ingrid, 17, school pupil, Grand Lomé**

Ingrid said it was the need for affection and a confidant that led her to have sex which resulted in an unintended pregnancy.

In other cases, the death of one or both parents increased adolescent girls' vulnerability to unintended pregnancy. Such

a loss, at a young age, tended to break the family structure and deprive children of social guidance and support. The case of Akouvi, a 15-year-old schoolgirl from Grand Lomé who became pregnant at a young age due to the difficulties she faced following her father's death and her mother's remarriage, is a telling example:

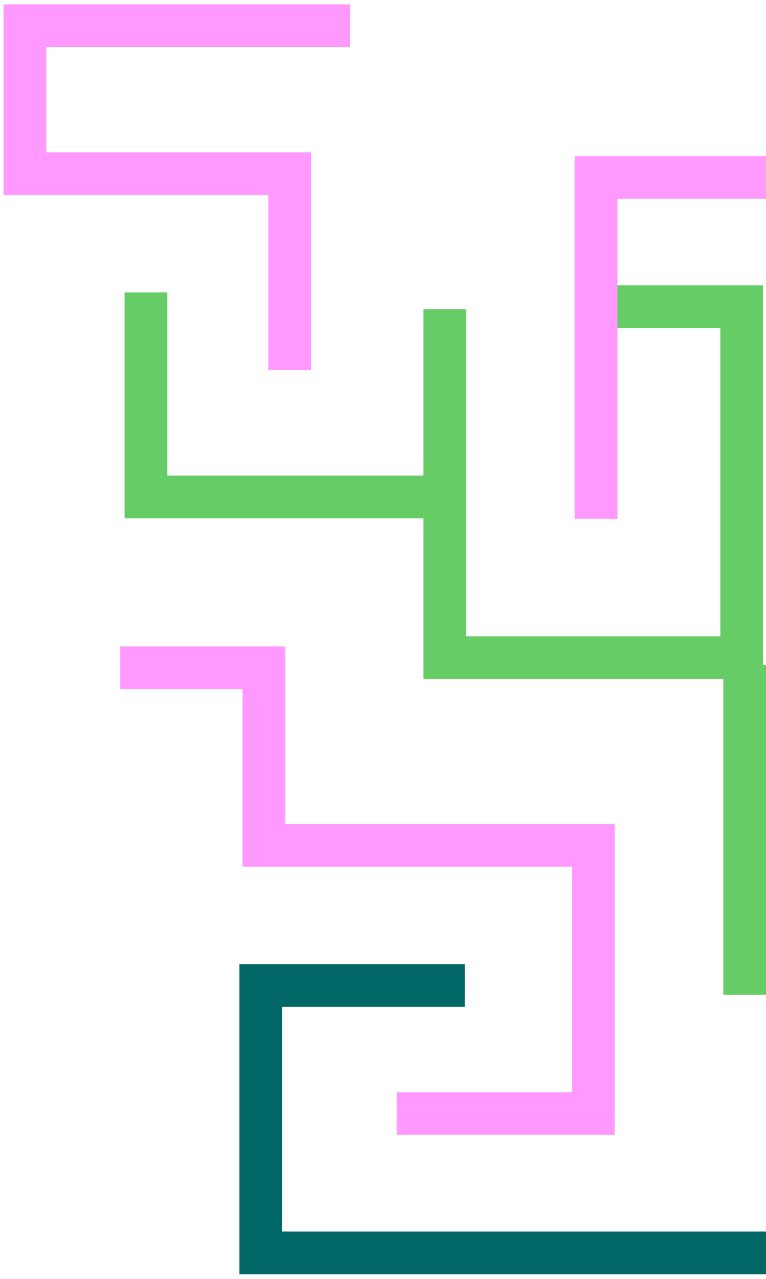
> When my father died, my mother left. I was left with my five younger brothers and sisters, with whom I share the same mother but not the same father. I'm currently living with their father … Men have tried to court me, but I've refused. Kokou is the first person I've ever had a relationship with. I accepted the idea of marriage because of the way my parents treated me here … My [step]father is very mean to me … My mum looks after me. She is the one who gives me my lunch. My [step]father, on the other hand, has never done that. And when my mum doesn't have any money, Kokou sends me some. He helps me a lot and I think of him as my father.
>
> **Akouvi, 15, school pupil, Grand Lomé**

Her stepfather's neglect and abuse led Akouvi to seek paternal love and financial support elsewhere, in the form of a relationship that resulted in an unintended pregnancy.

In some cases, the death or divorce of parents leads to girls being entrusted to other people, often relatives or guardians. This cultural practice aims to fill the gaps in children's socialisation resulting from family breakdown, the absence of a disciplinary framework or financial difficulties. However, it also appears to increase vulnerability to unintended pregnancy.

In the case of Claudine, a 16-year-old schoolgirl, this practice left her vulnerable to sexual violence. No longer able to afford her school fees, Claudine's parents sent her to live with her father's younger sister, and it was there that her cousin Komi raped her. The rape took place while her uncle and aunt were away for two days attending a funeral. After the rape, Komi forbade her from telling anyone about it. Claudine knew nothing about the risks of pregnancy and was unable to recognise the early symptoms that began to appear. It was another cousin, who was responsible for buying her sanitary towels, who eventually realised that Claudine was pregnant and alerted her aunt.

Claudine's story illustrates the impact that foster care can have on an adolescent girl's life. Claudine had received no sexuality education – neither from her parents, nor from her aunt or cousin – and her ambiguous position within her extended family left her vulnerable to sexual violence and an unintended pregnancy. To conceal the rape committed by her son, the aunt decided to ensure Claudine had a clandestine, and therefore unsafe, abortion.



Economic vulnerability and transactional relationships

In addition to fragile social ties, the socio-economic precariousness of women, particularly adolescent girls and young women, appears to be a major determining factor in unintended pregnancy.

Two specific forms of economic vulnerability are addressed here: unemployment or low-paid employment, and a lack of financial support or abandonment by parents or relatives. Both drive adolescent girls and women towards transactional relationships in order to survive financially.

Unemployment or low-paid work

The research shows that many adolescent girls and women who experienced unintended pregnancy were living in precarious economic circumstances. The majority were school pupils, students or apprentices financially dependent on their parents. Others, from families living in rural areas, had barely enough to survive on. This was the case for Maela, aged 27, a mother of six, who worked as a seasonal farm labourer and earned a very low income. She spent her entire wage on feeding her family but was still unable to do so.

With the exception of a few women living in urban areas who held well-paid jobs, the majority of the adolescent girls and women interviewed for this study who lived in urban or suburban areas found themselves in a similar economic situation to those living in rural areas, and worked as street vendors, domestic workers or hairdressers. Others were unable to find any work after graduating and found themselves unemployed. For example, the economic situation of Stella, aged 23 from Lomé, was so precarious that she accepted the advances of a man she considered "strange" due to the financial support he provided. During this relationship, she had unprotected sex which led to an unintended pregnancy.

A lack of support from parents and relatives

While financial support from family – whether from parents or relatives – could protect some adolescent girls and young women, this study shows that many are deprived of such support.

This was the case for Céline, a 22-year-old hairdresser from Grand Lomé. The fourth of twelve children, Céline and her siblings lived with their mother, who was the sole carer for the household. Céline's father, a polygamist, lived elsewhere with one of his wives and did not contribute to the children's upkeep. Céline explained that, despite her mother's efforts, they did not have sufficient resources to meet everyone's needs, which left her in a situation of great insecurity, both emotionally and materially: *"I have younger brothers and sisters who live there, and we have to pay their school fees on top of other family needs. Sometimes she [my mother] tells me there's nothing. So, when I have financial problems, I no longer turn to her … I've had to get a boyfriend who helps me out sometimes …"*

Céline's account highlights the link between economic insecurity and vulnerability to unintended pregnancy. This is a reality shared by many adolescent girls and young women living in similar circumstances. The economic burden of having several children weighs heavily, particularly on single mothers. This creates an environment of chronic vulnerability, in which teenage girls are often the most at risk. With no other recourse, adolescent girls often turn to risky forms of financial support, such as transactional sex.

Transactional sex driven by financial insecurity

As in the cases of Stella and Céline, exchanging sex for money appears to be a common survival strategy to make up for a lack of income. Another participant in the study, Solim, aged 27, an executive assistant in the Grand Lomé region, emphasised this point: *"I've had a few flings, not relationships – I've just gone out with people. It was just for the money … he's generous with his money. When he calls you, you go because you know you'll come back with money."*

Some participants explained that sometimes it is the parents who encourage their daughters to engage in transactional sex. These transactional relationships are built on a profound inequality: the male partner alone decides the timing, the terms and whether or not to use protection during sex. This inequality increases the risk of unintended pregnancy. Such a pregnancy, in turn, would exacerbate the economic insecurity of the young woman, and therefore often end in unsafe abortion.

> **"When I have financial problems, I no longer turn to my mother… I've been forced to have a boyfriend who helps me out sometimes"**
>
> Céline, 22, hairdresser, Grand Lomé

Mental health issues

This study highlights a correlation between mental health issues and unintended pregnancy. This section focuses on the mental health issues experienced by young people, the search for emotional support, and the link to unintended pregnancy.

The mental health issues young people experience

The research found that many adolescent girls and young women who face unintended pregnancy experienced a lack of affection and support due to fragile family ties or their placement in foster care. In Ingrid's case, being separated from her mother at a young age and not having any brothers or sisters caused her significant emotional distress:

Sometimes I'm distant … it's because of my worries. My loneliness at home weighs on me and makes me sad. It makes me cry sometimes. Once I cried until I made myself ill. I cried and refused to eat. For example, at school, I have friends who have sisters in Year 10. Some of them are in Year 13 and I'm in the same class as their younger sisters. So, when I see all that, it affects me. It makes me feel sad. Sometimes, at break time, you'll see sisters or brothers holding hands and having fun. It makes me feel sad …

This extract reveals the significant impact of Ingrid's family situation on her mental health. Like Ingrid, Akouvi also suffered from loneliness during her parents' divorce and her mother's remarriage.

Beyond fragile family ties, the financial insecurity faced by adolescent girls, women and their families also undermines their mental health. The pressure to provide for themselves and their families has caused deep distress for some participants, as in Céline's case described above.

The link between a lack of emotional support and unintended pregnancy

When adolescent girls and young women experience loneliness or emotional deprivation, a lack of communication and connection with their parents or carers can prevent them from seeking help at home and may result in them looking for it elsewhere.

Interviews with adolescent girls and young women suggest that, as a way to seek emotional support, they often form emotional relationships with men – whether teenage boys or adults – which exposes them to a significant risk of unintended pregnancy. Ingrid and other teenage girls interviewed had sought comfort and companionship from boys or adult men. However, these relationships often resulted in unprotected sex and unintended pregnancies.

In conclusion, economic vulnerability and fragile social ties, leading to poor mental health, appear to be major determinants of unintended pregnancies among adolescent girls and young women. This is closely linked to a lack of contraceptive use, for the reasons outlined below.

Low modern contraceptive use

The data collected show that most of the adolescent girls and women who experienced an unintended pregnancy were not using contraception at the time their pregnancy occurred. Participants cited several reasons for this: a lack of information on contraceptive methods, past negative experiences using contraceptives, rumours about contraceptive side effects, and social disapproval of adolescent girls and young women using contraception. In some cases, this was compounded by opposition from a partner, costs or difficulties in accessing healthcare facilities.

A lack of reliable information

Some adolescent girls and women did not use modern contraceptives due to a lack of reliable information, as the following participant explained:

The community lacks information on contraceptive methods, such as injections

> **Even people who know about condoms are reluctant to use them because buying them is still frowned upon**
>
> Young participant, group discussion, Grand Lomé

and implants. Some people believe that once used, they prevent any future pregnancies or cause heavy periods. This lack of information fuels many misconceptions. Even those who are familiar with condoms are reluctant to use them. Buying them is frowned upon. Even married men find it difficult to buy them in pharmacies and lower their voices to ask for them discreetly. This taboo leads young people to prefer *coitus interruptus*. They believe that withdrawing before ejaculation avoids the risks, but this method is unreliable.

Beyond the lack of information, this account also highlights how taboos surrounding sexuality can prevent open and informative discussions about contraception. These taboos act as real barriers that stop both men and women accessing contraception, regardless of their age or marital status. Instead, many turn to traditional practices, such as the rhythm or withdrawal method, without being properly informed of the persistent risk of pregnancy associated with these methods. Indeed, the findings show that some of the female research participants who used the rhythm method were unaware of their menstrual cycle, including their ovulation period.

For example, Cynthia, a 25-year-old student in Grand Lomé, became pregnant after her partner assured her that he could accurately track her ovulation cycle: *"He asked me if I knew my cycle well, and I told him no because I didn't even bother with that sort of thing, as I wasn't having sex. It was only after my abortion that I started learning to track my cycle and understand what it's all about."*

Other young people said that condoms were the main method known to young people, but that they did not always use them correctly.

Concerns about contraceptive side effects

Worries about the side effects of modern contraceptives also emerged as a factor preventing people from using contraception.

A community health worker explained that concerns or misinformation (for example, that contraceptives make users fat or infertile) deter some women from using modern contraception. This was confirmed by women during focus group discussions. One female focus group participant in the Plateaux region

said: *"In my opinion, using condoms, implants or injections isn't a good thing. It's very bad for your health. If only we could rely on our periods. I think it's better to use the rhythm method than contraceptive methods such as injections and implants."*

It is important to note that women's concerns about the side effects of contraceptives often stem from those around them. Their fears are sometimes so strong that they lead participants like Dado, a 23-year-old student from Grand Lomé who has had two unsafe abortions, to continue to oppose contraceptives. She commented: *"Me, using family planning? Never! People often tell me that if I don't want to have children, that's what I should do. But I don't want to put on weight. I have an aunt who had an implant, she became huge, and I don't want that … Even if they gave me millions, I wouldn't do it."*

As this account shows, it is common for adolescent girls and young women to refuse to use contraception for fear of serious side effects which they believe might affect their health and physical appearance. One common concern is that they will not be able to have children in the future if they use contraception. This is greatly feared as a woman's fertility is a source of respect and social status in Togo. This is illustrated by Baméla, a 15-year-old girl, who said: *"People say that the injection carries risks of infertility and incurable diseases. That's why [I don't use it]."*

The spread of this kind of misinformation is fuelled by general condemnation of adolescent girls and young (unmarried) women using contraception, serving to discourage this practice.

The stigma surrounding young people's contraceptive use

The data revealed community leaders also have a negative perception of adolescent girls and young (unmarried) women using contraception. A traditional chief from Grand Lomé was unequivocal, for example: *"Especially a teenage girl who isn't married. Oh no, no, no! As the guardian of customs and traditions, I say that it is not advisable [to use contraceptives]. It is completely unacceptable!"*

The same sentiment was shared by parents and some healthcare providers and community health workers in both regions. The stigma surrounding adolescents' contraceptive use stems from the belief that contraceptives encourage irresponsibility and promiscuity. Like many of the adolescent girls and women in this study, some duty bearers also mistakenly fear that using modern contraceptives leads to infertility.

Partner opposition to contraceptive use

In addition, the findings show that a partner's opposition to contraception is a major barrier. A community health worker from Grand Lomé explained: *"… some [women] who are already married say that their husbands now refuse to allow them to use contraceptives, for fear of being held responsible if anything goes wrong."* This shows that a partner's opposition to contraception often stems from a fear of side effects.

When women do not use contraceptives themselves, they must rely on their partner to prevent unintended pregnancies. Our research found that people do not use condoms consistently. For example, Cynthia, the 25-year-old student mentioned above, described a situation with a partner: *"No, he didn't use protection. He told me that people don't use protection the first few times … I asked him why, but I didn't press the issue. I said, 'OK, no problem."*

In other cases, men persuade their partners that they have the necessary knowledge to practise withdrawal or the rhythm method, whereas in reality, as highlighted earlier, they have limited control over, or knowledge of, these methods.

While some women manage to overcome the barriers described above and use modern contraceptives, they still face difficulties in accessing these methods.

> **As a guardian of customs and traditions, I say it's not advisable to use contraceptives. It's completely unacceptable**
>
> Traditional chief, Grand Lomé

Barriers to accessing contraception

Most of the health centres the researchers visited do not offer services tailored to young people. Participant observation and discussions with family planning service managers found that health centres rarely had youth-friendly SRHR spaces. This gap discourages adolescents and young people from visiting the centres and making use of the family planning services offered there. Furthermore, the stigma surrounding the use of contraception by unmarried young people can result in health centre staff having negative attitudes toward young people who ask for contraception. Élise, a 24-year-old student from the Plateaux region, explained: *"I've heard midwives at the local hospital express surprise that female students come in to get implants and contraceptives. Comments like these discourage young people from adopting these methods, when in reality, those who take this initiative have understood the importance of contraception."*

Reported behaviours include healthcare providers shouting and being dismissive or patronising. Sometimes, healthcare providers discouraged young single people from using long-acting contraceptive methods by citing fertility risks. These attitudes create barriers for young people who wish to access family planning services. The fear of being judged may deter young people from visiting health facilities in the first place or cause them to leave without getting the contraceptive of their choice.

Sexual violence

Among the adolescent girls and young women who participated in this study, some became pregnant because of sexual abuse or rape. Two experiences are shared below.

A first case study is that of Claudine, aged 16, mentioned above, who became pregnant after being raped by her cousin when being fostered by her extended family. At her attacker's insistence, she did not tell anyone about the rape she had suffered. When her aunt and another cousin later discovered she was pregnant, they arranged for her to have a clandestine abortion, without acknowledging the sexual violence she had suffered or holding the perpetrator accountable for his actions.

A second case study concerns Akouvi, aged 15, who met her boyfriend Kokou, a local boy, while visiting her grandfather's village. One evening, Akouvi and Kokou, along with Landry (Kokou's friend) and his girlfriend, were kissing on a playground. When Kokou tried to have sex with Akouvi and she refused several times, Landry helped him by holding Akouvi down so that Kokou could have sex with her against her will. Akouvi said: *"I bit his friend's hand, so he'd let me go. I pushed Kokou, he fell over, and I ran, but he caught up with me."* Kokou eventually raped her. She became pregnant, after which Kokou helped her to obtain an illegal abortion. Akouvi's story illustrates how sexual coercion by a boyfriend can escalate into rape and lead to an unintended pregnancy.

These cases share a common feature: the silence that often surrounds the sexual violence adolescent girls experience. During her interview Akouvi did not strongly condemn her boyfriend's behaviour, which raises questions about how consent is interpreted, particularly among couples or people who are dating. This research also highlights how the behaviour of young men who commit sexual violence is not necessarily condemned, as when Claudine's aunt quickly arranged an abortion to prevent her son from being identified as a rapist.

The findings reveal that many adolescent girls have been victims of sexual assault and have been unable to access post-rape healthcare to treat their injuries, prevent STIs and unintended pregnancies. Nor have they been able to access legal services to hold the perpetrators accountable for their actions.

There is also a lack of awareness that rape and incest constitute grounds for accessing a legal and safe abortion in Togo, which contributes to victim-survivors being exposed to clandestine and unsafe abortion practices.

In conclusion, this section highlights several factors associated with unintended pregnancies among study participants. These include, but are not limited to, inadequate relationship and sexuality education, barriers to contraceptive use, economic insecurity, fragile social ties, sexual violence and mental health issues. Often, several of these factors combine to exacerbate vulnerability and distress. Once pregnant, the adolescent girls and women who took part in this study had to make the difficult decision to either continue with an unintended pregnancy or terminate it.

"I've heard midwives express surprise that female students come for implants and contraceptives"

Élise, 24, student, Plateaux

Silence often surrounds the sexual violence adolescent girls experience

Ama's story

Ama, 17, from Grand Lomé, had left school and worked sporadically at a roadside restaurant. She'd recently moved to the city with her boyfriend Koffi, despite her mother's opposition, in search of work.

Koffi, 21, had dropped out of university and worked days in a poorly paid factory job and nights as a DJ. Ama had initially resisted his advances, fearing pregnancy, but eventually agreed to have sex, reassured by his knowledge of contraception.

Koffi encouraged Ama to use injectable contraception, but she refused, fearing side effects, a mistrust rooted in her sister's repeated miscarriages, which she blamed on contraceptive use. Koffi disliked condoms, so the couple relied on the rhythm method, which failed, and Ama became pregnant.

When Koffi learned of the pregnancy, he said they lacked the financial resources for a child and approached midwives at a nearby health centre about abortion care. "We could have sorted it out quietly at home, but I knew that method is very risky. At least at the hospital, the procedure would be safer," he says. The midwives advised against abortion, and the couple initially agreed to continue the pregnancy.

As the pregnancy progressed, Ama says the couple began arguing and that Koffi physically assaulted her, demanding she abort. Koffi denies this, saying their conflict was over her refusal to attend antenatal appointments. Ama eventually decided to terminate the pregnancy without telling Koffi. Too ashamed to request the medication herself at a pharmacy, she asked a stranger to buy it for her. The woman didn't explain how to use it, and Ama swallowed all five tablets at once, with no effect.

Weeks later, she tried a method suggested by friends: an energy drink mixed with paracetamol. She began bleeding heavily, and Koffi took her to the health centre.

Despite significant blood loss, Ama waited a long time before being seen. A midwife then spoke harshly to her, accusing her of inducing an abortion. "I was insulted, called a witch and accused of being stubborn," she recalls. "They look after patients well, but because of what I did, I was treated really badly." No painkillers were given while the remaining pregnancy tissue was removed. Ama described the pain as unbearable: "It hurt a lot … the sort of pain that could kill a human being."

The abortion decision-making process

Key findings

It is rare for adolescent girls or women to make the decision to have an abortion on their own. Often their partner or parents are involved, and sometimes their choice prevails without the girl or woman's consultation. Social norms weigh heavily on this decision-making process.

Common reasons for deciding to have an abortion include:

- fear of negative reactions from family or the community, including social exclusion or loss of support
- Abandonment or pressure by the partner
- influence from the mother or other relatives
- inability to carry the pregnancy to term, due to age, studies, financial difficulties or unstable living conditions
- the pregnancy is a result of sexual violence
- the pregnancy is a result of a casual relationship

Often, a combination of these factors contributes to the decision-making process.

The findings confirm that, in the context of an unintended pregnancy, the decision-making process is both complex and non-linear and involves a mix of individual, social, economic, legal, cultural, religious and medical factors.

Several of the adolescent girls and women interviewed for this study carried their unintended pregnancies to term. They did so out of fear of complications or due to social or religious stigma associated with abortion. In some cases, attempts to terminate the pregnancy failed. In others, family members or their partner prevented them from having an abortion. Sometimes, a healthcare provider convinced them of the (supposed) risks of having an abortion, implying that even a safe, facility-based abortion procedure contained risks. They would then emphasize the "importance" of carrying the pregnancy to term.

Other adolescent girls and women chose to have an abortion, and the remainder of this report focuses on their experiences. The following section details the complexity of decision-making regarding abortion: the emotions involved, the interrelated reasons for terminating an unintended pregnancy, and the participants.

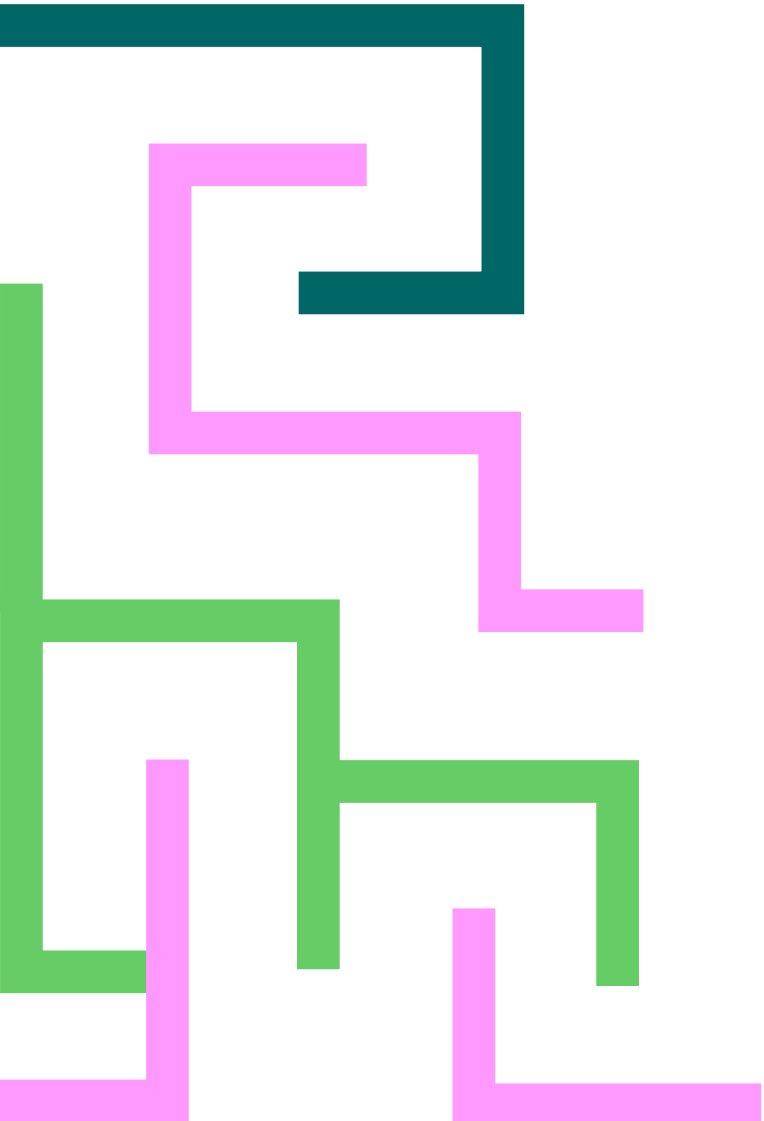
Discovering an unintended pregnancy: emotions and seeking support

When a woman discovers she is unintentionally pregnant, this often marks a juncture pivotal that begins the process of deciding whether to continue the pregnancy. However, the findings show that this discovery can come late.

This is particularly true for the adolescent girls in the study who had received only limited education about SRH, including their menstrual cycle. They were often unaware that their actions could lead to pregnancy or failed to recognise the early signs.

Akoko, aged 19, initially put her missed period down to an irregular cycle. The continued absence of her period prompted her to take a pregnancy test, and it was then that she learnt she was pregnant. While she had estimated herself to be two-months pregnant, the healthcare professional who eventually provided post-abortion care estimated she

For many adolescent girls and young women, unintended pregnancy was seen as a threat to their family relationships, education and social standing



had been four months pregnant, based on the size of the placenta that was removed. For some of the adolescent research participants, it was an older woman in their social circle (e.g., mother, sister, aunt or grandmother) who first noticed the pregnancy and then confronted them about it.

The discovery of an unintended pregnancy triggered a range of emotions among participants. Many reported feeling overwhelming, negative emotions, such as shock, panic and despair, even if they had already suspected they were pregnant. This was the case for Céline, aged 22, who said: *"I started crying and shaking. I didn't know what to do."* These reactions were linked to the potential impact the pregnancy might have on their lives. Indeed, the adolescent girls and young women in this study often viewed the pregnancy as an immediate threat to their family relations, studies and social status. This fear stemmed from the (violent) reaction many expected to get from their parents or partner, from social stigma (particularly for teenage girls still at school or in apprenticeships, or for unmarried women) and from uncertainties about the future. The social norms they had internalised made them feel guilty, as pregnancy before marriage is seen as a disgrace to the family and a personal failing.

While some adolescent girls and young women chose to hide their pregnancy from those around them to avoid any stigma, others sought to confide in someone. The first person they dared to speak to was often a confidante, someone who would not judge them. For instance, Reine, a 23-year-old student from Grand Lomé, said: *"I spoke to my best friend first. She listened to me without criticising me. She told me we'd find a solution together."* By confiding in her friend in this way, Reine was able to find both comfort and support.

Other women and teenage girls turned to a family member. This is what Mawussé, an 18-year-old student from the Plateaux region, did when she confided in her cousin. She expected to find understanding and support from her, as her cousin had acted as a mediator in her relationship with her boyfriend, giving her the confidence she needed to talk to him. However, her cousin reacted violently to the news and reportedly warned her: *"You'll be in big trouble with your mum!"* Instead of receiving the help

she had hoped for, her cousin's reaction only intensified Mawussé's feelings of loneliness, shame, guilt and anxiety.

Other women chose to tell their partners to find out whether they would take their share of responsibility for the pregnancy or choose to distance themselves. Élyse, a 33-year-old housewife from the Plateaux region, recounted: *"When I told him, he was silent at first, then he asked me if I was sure. He looked panicked, but he didn't run away."* Although Élyse's partner felt overwhelmed, he decided to support her. Other participants said their partners reacted harshly and violently, notably by denying any responsibility. This is what happened to Ama, aged 17, who said: *"He wasn't happy. When I told him the news, he frowned and told me he couldn't afford to cover the costs of a pregnancy until the baby was born. He told me not to keep it."*

Sometimes, after much hesitation and fear, some of the adolescent girls in this study asked their mother for help. Reactions varied from one mother to another. Akouvi, aged 15 from Grand Lomé, explained: *"I was afraid to tell her, and when I finally found the courage to do so, she remained calm and started to cry …"* Others reported that their mothers had become angry, beaten them or thrown them out of the house. This was the case of Benjamine, a 16-year-old schoolgirl from the Plateaux region, who said: *"She hit me with a stick. After hitting me, she went and told my boyfriend's mother."*

Confiding in someone – whether that person's reaction was supportive or judgemental – meant that the adolescent girls and young women in this study no longer had to bear the burden of an unintended pregnancy alone. Along with their confidantes they now had to decide whether to carry the pregnancy to term or terminate it. Fear, shame, uncertainty and the need to find a solution weighed heavily on their choices.

The reasons behind the decision to have an abortion

This section focuses on the motivations that led women who experienced an unintended pregnancy to seek an abortion. These reasons are often interrelated and may overlap.

Fear of parental and social disapproval

Adira, a 25-year-old student from Grand Lomé, dreaded the reactions her friends and neighbours would have when they found out she was pregnant. She imagined the stares, the rumours and the criticism. She also feared her parents' reaction and the impact the pregnancy would have on her studies. It is common for parents to pay school fees, sometimes at the expense of other siblings' education. Adolescent girls and young women fear that a pregnancy outside marriage might jeopardise this financial support and any future education or training.

Adolescent boys shared similar fears regarding their parents' reactions, as well as fear of their wider social circle;

> People start insulting you, telling you, 'You're not old enough to have a child! You've got a woman pregnant, but what do you actually have? … You don't even have a plot of land to feed your wife and child, and you've got her pregnant. What are you going to do to provide for them? You can't even support yourself: your father is the one supporting you, and now you've got a girl pregnant'… That's how people react.
>
> **A young man, Plateaux**

Fear of such family or social condemnation drives adolescent boys to deny responsibility for a pregnancy or to pressure their partner into having an abortion. Some adolescent girls have ended up deciding to have an abortion to avoid the shame, ridicule or exclusion that comes with being pregnant outside of marriage.

Partner abandonment or pressure

Some participants resorted to having an abortion after being abandoned by their partner or coming under pressure from them to terminate the pregnancy. Ama, the 17-year-old mentioned previously who worked in a small restaurant in Grand Lomé described such an experience: "At the slightest provocation, he would hit me and demand that I have an abortion." Experiencing constant pressure and violence, Ama opted for an abortion.

The research findings revealed that, in some cases, such as Ama's, the partner's reaction to the news of a pregnancy strongly influenced the decision to have an abortion. In Ama's case, her partner pressured her to have an abortion because he could not afford to provide for a child. In other cases, the partner feared the reactions of his parents or those around him. This is what often prompts men to dispute paternity as a way to distance themselves from an unintended pregnancy. Such behaviour leads to conflict, mistrust, accusations and even abandonment.

This is what Marlène, a 25-year-old seamstress from Grand Lomé, experienced. She recalled: *"... at a certain point, he changed completely and people started telling him that it would all end in tears and that he wasn't responsible for the pregnancy, as several men were making advances towards me."* Faced with the rumours, Marlène's partner denied being responsible for the pregnancy and distanced himself from her. Anxious and feeling abandoned, Marlène saw an unsafe abortion as the only solution. A partner's refusal to accept or acknowledge the pregnancy often deprives the pregnant woman of the social, financial and emotional support they need to carry the pregnancy to term.

The influence of mothers and other close relatives

The data show that male partners are not the only ones to pressure adolescent girls and young women into having an abortion. Sometimes, it is the mother or other close relatives who decide that an abortion is the only 'solution' to an unintended pregnancy, without necessarily consulting the adolescent girl or young woman who is pregnant. This was the experience of Benjamine, a 20-year-old apprentice from the Plateaux region. It was her mother, fearing her husband's reaction, who made the decision that her daughter should have an abortion. The mother was afraid the father might become violent or even kick their daughter out of the house. Although her boyfriend was against the abortion and wanted to leave with Benjamine so that she could carry the pregnancy to term, Benjamine chose to go along with her mother's wishes, fully aware that she depended on her the most.

Similarly, Georgette, aged 29, from the Plateaux region, had an abortion while she was still a student. At the time, she was living with her aunt and seeing a young man. Her aunt was furious when she found out about the pregnancy. Not only did she fear that Georgette's parents would blame her for the situation, but she also reminded Georgette that she had a strained relationship with the young man's family. She gave Georgette an ultimatum: either claim the pregnancy was by another man or have an abortion. Georgette could not attribute the pregnancy to anyone else. Instead, she tried to seek support from her biological parents to carry the pregnancy to term. However, they sided with her aunt's position and ordered her to have an abortion. Georgette felt she had no choice but to comply with their wishes.

These examples illustrate the significant influence mothers and other close relatives can have on adolescent girls' and young women's decision to have an abortion. Their decision, or their coercion, was often motivated by a desire to avoid bringing shame and dishonour upon the family and to safeguard their daughter's future. Young women often have little say in the decision.

Decisions based on age, educational prospects, financial difficulties or unstable living conditions

The majority of the adolescent girls and young women interviewed for this study stated that they did not feel ready to cope with an unintended pregnancy. This sense of unpreparedness most often stemmed from the precarious nature of their financial situation, the need to continue their education or the feeling that they lacked maturity. In one case, health problems were cited as the main reason.

For many women in this study, unemployment and financial insecurity made continuing a pregnancy difficult

Many participants were still young (some were minors) and felt they lacked the necessary life experience to look after a child. For teenage girls still at school, in training or preparing for a qualification, an unintended pregnancy posed a major obstacle to their prospects. Several feared they would have to give up their studies or abandon their career plans, and the desire to succeed in their studies or careers was a factor in their decision to have an abortion. Adira, a 25-year-old student, said: *"I was still at school; I couldn't afford to get pregnant at that time. I was afraid of falling behind in my studies."*

Continuing with a pregnancy requires sufficient financial resources, yet many of the women in this study were unemployed or lacked financial support. This includes Ahoefa, aged 39, from Grand Lomé, who was 19 when she became unintentionally pregnant and had her first abortion. She recalled: "I didn't have a job, I had nothing, not even enough to buy food. Sometimes it's hard! How could I possibly manage with a child?" The young age or unemployment of their partner, or being abandoned by them, only heightened women's fear regarding their financial inability to provide for a pregnancy and a child. Céline, mentioned previously, explained:

Sometimes family networks were an important source of support, but many were constrained by their own economic vulnerability

> As he [my partner] couldn't afford it and, above all, didn't have a job … we were already struggling to put food on the table. Sometimes he'd go to his mums to bring back a bit of food. It was hard for both of us to make ends meet. In those circumstances, I carried the pregnancy for a month or two, but I knew it would be difficult for us to cope with what came next, with the antenatal appointments and everything else. It was me who suggested having an abortion because we couldn't manage financially.
>
> **Céline, 22, hair braider, Grand Lomé**

This account illustrates the precarious situation in which many women and their partners find themselves: a lack of employment, stable housing and sufficient food. While several participants turned to their parents and relatives for support, many of these families were themselves in a situation of great economic vulnerability and would have been unable to support them in the long term had the pregnancy continued. Faced with this material insecurity and other challenges, these women came to regard an abortion as the only viable option.

Pregnancy resulting from sexual violence

The data from this research show that some teenage girls and young women became pregnant because of forced sexual intercourse. Five reported having become pregnant following sexual violence, which led them to undergo an unsafe abortion, despite being legally eligible for safe abortion care. In the case of Akouvi, who was raped by her partner, the couple chose to stay together, while deciding not to continue with the pregnancy. Bamela, another young research participant, received support from her mother, who helped her find a way to obtain an abortion. In Claudine's case it was the aunt herself who took the initiative to force her to have an abortion. The motivations varied depending on the situation, but in the cases of Claudine and Bamela, it was women within their immediate family circle (in this instance, the aunt and the mother) who chose to keep the sexual violence the young women had suffered a secret. Often, being a survivor of sexual violence is seen as

shameful: the victim is blamed, stigmatised and left to fend for herself. In such cases, abortion is not merely intended to end an unintended pregnancy, it also serves to conceal sexual violence and to avoid the shame and stigma associated with it.

Pregnancy resulting from a casual relationship

Several of the women interviewed became unintentionally pregnant following a casual or short-term relationship and felt the relationship was too uncertain or not serious enough to continue the pregnancy. Solim, 27, an executive assistant in Grand Lomé, described being in such a situation: *"To be honest, he wasn't someone I planned to spend my life with. It was just a bit of a fling. I couldn't see myself getting pregnant by him."* She therefore did not want a child from this relationship and chose to terminate the pregnancy.

In conclusion, the findings show that the decision to have an abortion is influenced by a complex set of personal, social, economic and cultural factors. In some cases, it was the fear of family or community stigma that led women to conceal their pregnancy and view abortion as their only possible way out. For others, their choice was dictated by financial insecurity or economic dependence: they felt they could not afford to provide for a child or feared that the pregnancy would jeopardise their studies and their future. Others, were in an unstable relationship, lacked support from their partner, or their pregnancy was the result of sexual violence or a temporary relationship.

The people involved in the abortion decision-making process

As noted above, the decision to have an abortion is not always solely made by the woman who is pregnant. It may involve several people, whose roles and influences vary and sometimes complement one another. This section examines both situations; namely, where the decision is made exclusively by the woman herself, and situations where it is influenced by other people.

Dealing with an unintended pregnancy alone

Although decision-making regarding abortion often involves various people and dynamics, some interviewees revealed situations where women chose to act alone. This decision to act independently was most often driven by a woman's need to preserve their independence, avoid tension or protect themselves from anticipated disapproving reactions. This choice to remain silent was particularly evident among participants who knew that their partner or those around them would try to persuade them – or even force them – to continue with the pregnancy.

Others began by confiding in their partner in the hope of receiving emotional support for their decision to have an abortion. But this confidence soon turned to conflict when their partner opposed the idea. In such cases, the woman would often go ahead with the decision alone and in secret. This is what happened to Anita, a 22-year-old housewife from the Plateaux region, who recalled: *"No, I didn't tell him anything. I knew he wanted to keep the baby and that he wasn't prepared to consider any other option."*

This fear of male opposition reflects a context in which women are afraid to discuss their reproductive choices freely. In some situations, when women needed financial support to terminate the pregnancy, they sought to obtain it indirectly, sometimes even from their partner, without revealing the real reason. The case of Véronique, a 21-year-old nurse, illustrates this situation well: *"I didn't want to explain to him why I wanted those drinks. I was afraid he'd work out what I was up to and try to persuade me not to have an abortion. So, I just asked him to buy them, and he did so without asking any questions."* Through this silence, Véronique sought to retain complete control over her decision not to continue with the pregnancy, aware that any explanation might lead her partner to pressure her to continue with an unintended pregnancy against her wishes.

Between support and coercion: the role of a partner and loved ones

Several adolescent girls and women who participated in this study made the decision to have an abortion on their own. Others did so with the agreement of their partner and/or

their family, particularly their mother. Others did not want to abort but were forced into it.

Many participants' partners played an important role in the decision-making process. As noted above, many women informed their partner of their unintended pregnancy. This news led to three distinct scenarios: in the first, a mutual agreement was made to terminate the pregnancy; in the second, the woman wanted to continue the pregnancy, but her partner did not, and in the third, the woman wanted to terminate the pregnancy, but the partner did not.

Where there was mutual agreement to have an abortion, partner support took various forms, ranging from emotional to financial. Lisa, a trainee in Grand Lomé who is married and the mother of three children, recalled:

> At the time, we were going through a difficult financial situation, and that's when I told my husband that we couldn't keep the baby. What's more, I have fragile health: when I get pregnant, my cervix doesn't hold. And to top it all off, it coincided with my work placement, so if there was any way to do it, we had to terminate the pregnancy. My husband wasn't surprised. We discussed it and together we decided to have an abortion.
>
> **Lisa, 34, trainee, Grand Lomé**

Due to this mutual agreement, Lisa was able to exercise her reproductive choice in a supportive environment. Her husband then found her a qualified provider, enabling her to receive safe abortion care at a registered clinic – one of the few such cases documented in this study.

Several women reported having been forced to terminate their pregnancies. In these cases, it was the woman's partner or their mother who forced them to have an abortion. This was the case for Béné, a 25-year-old reprographer from the Plateaux region, whose partner forced her to have an abortion because he was already married and the father of two children. She recalled: *"He didn't agree; he wanted me to have an abortion. He kept pressuring me to have an abortion. At first, I refused, but I eventually gave in… Yes, I was afraid of having an abortion because it was my first time and I didn't know how painful it would be."*

Often, the participant's mother or other relatives intervened as soon as they found out about the pregnancy, deciding on the termination without really taking their daughter's views into account (as in the cases of Benjamine and Georgette, both teenagers). Once the decision had been made, the next step was to work out how to proceed, as discreetly as possible, as the following section shows.

He wanted me to have an abortion. He kept pressuring me to have an abortion. At first, I refused, but I eventually gave in…

Béné, 25, reprographer, Plateaux

Ayoefa's story

When 19-year-old Ayoefa became unintentionally pregnant, she told her boyfriend Thomas, and together they decided to terminate the pregnancy. The couple were fearful of Ayoefa's father's reaction as he was authoritarian and often cruel. Thomas sought help from his older sister, who prepared a concoction intended to induce an abortion. But when offered the concoction Ayoefa refused to drink it. *"My older sister gave me something to drink in a cup. It was black, like tar,"* she recalls.

Ayoefa's refusal was driven by fear of the consequences: her doubts about the mixture and her uncertainty about what to do next. Although she did not wish to carry the pregnancy to term, she did not feel ready to resort to such a risky method.

After Ayoefa refused the drink, Thomas turned to a man in their neighbourhood known for offering "private" abortion services. It was not clear whether he was a doctor or a qualified nurse, but he regularly performed abortions. After speaking to Thomas, the man agreed to carry out the procedure. When Thomas returned, this time accompanied by Ayoefa, she was surprised to find herself in an underground clinic, as Thomas had told her the procedure would take place in a hospital. With no alternatives and no one else to support or advise her, she said nothing.

The man asked her to go into a room so that he could begin the procedure. He did not ask her how far along she was in her pregnancy, did not carry out any examination, and did not prescribe any medication to relieve her pain or anxiety. Ayoefa says the experience was frightening and extremely painful: 'I was thinking of my mother *and I was in a lot of pain. And when the man took a long instrument to insert into my private parts, I thought to myself: 'If I die here, who will know?' And I cried."*

After the procedure, the practitioner told her she would bleed for a few days and that everything would be fine. "He prescribed us some medication, which we went to collect from the chemists, but without any advice on follow-up medical care," she recalls.

Relieved to think they'd resolved a difficult situation, Ayoefa and Thomas went home, unaware that this marked the start of a long period of health complications for her.

> **I was thinking: 'if I die here, who will know?' And I cried**
>
> Ayoefa, 19-year-old, Grand Lomé

Abortion experiences in Togo

Key findings

This research identified a wide range of pathways through which women in Togo accessed an abortion. Most of these pathways were shaped by obstacles, such as stigma, fear, a lack of information, and legal and financial constraints. It is these obstacles that explain why women resort to unsafe abortion methods, which often resulted in serious health consequences.

- **Fear and misinformation regarding Togo's abortion law is widespread.** Most of the adolescent girls and women interviewed, including those legally eligible for safe abortion care (such as victim-survivors of sexual violence), believed that abortion was completely banned in Togo.
- **Perceived risk versus necessity.** Many women in this study associated abortion with serious complications, or even death, but felt they had no choice but to take that risk.
- **Stigma and secrecy.** Driven by fear of social judgement and legal sanctions, women discreetly seek information about abortion from friends, partners, parents or on social media.
- **The prevalence of unsafe abortion methods.** The advice women received mainly concerned unsafe methods, such as taking medicinal herbs, home-made concoctions, tablets of unknown origin or over-the-counter medicines or visiting clandestine clinics.
- **Barriers to safe options.** Although some participants had heard of safe medical abortion pills (such as misoprostol), they had been put off by their high cost or by healthcare providers or pharmacists refusing to supply them.

This chapter outlines the various resources available as well as the abortion pathways open to adolescent girls and women in Togo. First, it examines access to information about key issues such as safe and unsafe abortion methods and associated risks and Togo's abortion law, before exploring the countless complex pathways that women take to have an abortion.

Access to information

Access to information on different abortion methods and on Togo's abortion law is essential for women to access safe abortion care. This section examines the types of information and the means of access which play key role in the pathways to abortion adolescent girls and women in Togo experience.

Understanding the legal framework

In Togo, the law permits abortion only in exceptional circumstances, namely when the pregnancy results from rape or incest, when the mother's life is at risk, or in case of foetal abnormalities. However, most of the adolescent girls, women and their families interviewed were unaware that this law even existed. Many believed that abortion is completely banned in Togo, as was evident during a focus group discussion with young women held in the Plateaux region. Typifying this view, one young woman said: *"What I know about Togolese law is that abortion is not permitted on Togolese territory."*

Conversely most participants were aware that imprisonment is the punishment for having or assisting an illegal abortion.[n] The fact that most abortions are illegal, and the severe penalties associated with having an illegal abortion, forces women and their loved ones to resort to clandestine means, using unsafe methods and dangerous practices.

During the discussions, it became clear that, even when the circumstances of an unintended pregnancy fall within the legal framework for abortion, women often face obstacles. For instance, when a pregnancy is the result of rape, women are required to

Restrictive abortion laws and fear of penalties push women and their families towards clandestine and unsafe practices

n Between six months and two years under Article 830 of the Criminal Code.

present a medical certificate or proof of rape which many find difficult to obtain. These formalities act as a significant deterrent to accessing safe abortion care. As one woman recalled: *"They asked me for a document to prove the rape, but as I didn't have one, they refused to help me."* Another woman in a group discussion said she struggled to get access to safe abortion care even though she knew she was legally entitled to it: *"The law says that abortion is permitted in certain cases. That's what I'd been told, but once you get to the hospital, there's no one there to help you. They look at you as if you'd committed a crime. That's why many prefer to go underground, even though it's risky."*

This research shows that, as Togo's abortion law is little known and poorly enforced, it exacerbates stigma, isolates women and prevents them from seeking help from professionals, even if their circumstances meet the criteria for accessing safe abortion care.

Awareness of the option to visit Benin for safe abortion care

In 2021, Benin's law on reproductive health was amended to allow women who are up to 12 weeks pregnant to access safe abortion care at approved health centres in cases of educational, professional, economic or moral distress. In theory, this means Togolese women who meet these criteria can cross the border into Benin to have a legal and safe abortion. However, the Togolese participants in this research were unaware of the reform of Benin's abortion law, and none had made use of this option.

Information on the consequences of unsafe abortion

Participants in both regions, particularly adolescent girls and women, associated abortion with a risk of infertility and death. For example, a participant in a focus group in Grand Lomé observed: *"An abortion can lead to a series of subsequent abortions … someone who has one repeatedly is then at risk of having miscarriages."* During the same focus group, another woman said: *"Some abortions go very badly and cause severe blood loss. And sometimes teenage girls die as a result of these procedures, after suffering greatly."*

The continued pursuit of unsafe methods to terminate unintended pregnancies by adolescent girls and women, and by those around them, despite awareness of the serious health consequences, reflects the depth of their distress.

Sources of information on abortion

Although legal restrictions and social stigma severely limit access to reliable information on safe abortion methods, all manner of messages continue to circulate about safe and unsafe methods within informal community networks. Adolescent girls and women mainly obtain information about abortion from their peers, their relatives and, occasionally, social media, radio or television. This information is generally fragmentary and incomplete.

Research participants reported that they had gleaned information about unsafe ways to have an abortion by talking to their peers at school or university, or by overhearing conversations between women. For example, Rose, a 35-year-old sales assistant in Grand Lomé, told us that information on abortion methods circulates through everyday conversations between women: *"You tell your friend that you have malaria. She replies that she's heard that a certain herbal concoction [normally taken for malaria] can also induce an abortion. She'll then say to you: 'Are you sure it's really malaria you've got?' That's more or less how the discussions start."*

Marlène, 25, a seamstress in Grand Lomé, echoed this observation. She said that teenage girls can easily gather information about abortion methods by talking amongst themselves at school, even though she herself had serious doubts about the safety of the methods that were being discussed.

Some participants demonstrated more in-depth knowledge of safe abortion methods and practices. Their main sources of information were traditional media (radio and television), social media and personal contacts with people who had paramedical or medical training. For example, Dado, a 23-year-old student from Grand Lomé, said: *"I already knew that there were medicines because … well, I actually have lots of friends who are nurses. I can contact them and ask them to give me the name of a medicine."*

Some of the adolescent girls who participated in this study reported that, before becoming pregnant, they had only a very limited understanding of abortion: they were familiar with the term without really understanding what it meant.

Known and used abortion methods

Participants cited a wide range of abortion methods, including herbal teas, over-the-counter medicines mixed with energy drinks or alcohol, herbal remedies, injections and tablets. They also mentioned visits to clandestine or private clinics. Table 1 below, while not exhaustive, illustrates the wide variety of methods which information is circulated about. Most of these methods are unsafe, yet easy to obtain and inexpensive.

Table 1: Knowledge on abortion methods

Age of woman	Place of residence	Prior knowledge of abortion methods	Sources of information
17	Peri-urban area	Rush (caffeine-based energy drink) + paracetamol	Friends
17	Rural area	Kpatima water (African hyssop) + Rush	Friends
19	Rural area	Lemon + sugar, warm Guinness, misoprostol	Friends at school, the internet
23	Urban area	Medication or clinic consultation	Friends
25	Urban area	Red potash Drinking warm beer	At school

> **When you see a girl and a boy going to his house, you can be sure it's for an abortion**
>
> Adolescent girl, Grand Lomé

> **There are girls who take black-market medicines or deadly concoctions, such as potash mixed with water. It's suicidal**
>
> Young man, Grand Lomé

Other participants sought help from people close to them (friends, siblings or family members), who put them in touch with medicine sellers – whether official or clandestine – to obtain abortion-inducing drugs. Abortion medication such as misoprostol can be obtained through a prescription provided by a doctor, but healthcare providers are generally reluctant to supply it due to legal bans on abortion. Some women have nevertheless managed to obtain misoprostol through informal channels, the nature of which remains unclear. Others have consulted traditional healers, who prepare concoctions made from plants and herbs. This research also suggests some healthcare providers offer clandestine abortions, as one adolescent girl explained during a focus group discussion in Grand Lomé: *"In our neighbourhood, there's a doctor who performs abortions. When you're at home and you see a girl and a boy going to his house, you can be sure it's for an abortion … People say he uses a device, but I don't know what it is."*

Information also circulates about other alternative methods, such as consuming foods believed to cause miscarriage (eggs, parsley, pineapple and bananas), or using local tobacco or potash (a particularly dangerous traditional bicarbonate). As one young man who took part in a focus group discussion in Grand Lomé explained: *"There are girls who take black-market medicines or deadly concoctions, such as potash mixed with water. It's suicidal."*

The research revealed significant inequalities in access to reliable information on safe abortion methods. While a minority of young women obtain reliable information from the media and from healthcare professionals in their social circle, the predominant sources focus on so-called 'natural' or 'neo-traditional' methods, which carry serious health risks, including potentially fatal complications.

Perceived danger

Knowledge of an abortion method does not necessarily lead to its adoption. This was evident in Ayoefa's case, mentioned above. Ayoefa refused to drink the first concoction she was offered, judging it to be dangerous. Aware of the potentially fatal consequences of an unsafe abortion, adolescent girls and women in this study – even those with

little information – sought to minimise the risks. Another example is that of Marlène, a 25-year-old seamstress from Grand Lomé, who considered ingesting red potash – a method mentioned by her schoolmates, too risky. She preferred to attempt an abortion using warm beer. Ayoefa and Marlène's cases illustrate how the stigma and secrecy surrounding abortion prevent women who are unintentionally pregnant, or sometimes their partners or loved ones, from conducting thorough research and fully assessing the available options. Instead, they try to avoid methods they perceive as too risky but still opt for unsafe methods.

Access to abortion methods and care

Actors involved in the abortion process

The consequences of having an unsafe abortion were starkly illustrated during this study. Amélie, aged 23, an apprentice from the Plateaux region, died because of an unsafe abortion performed in secret by a traditional healer. She sought to have an abortion without anyone's knowledge to avoid having to face pressure from her partner or same parents, as did other adolescent girls and women in this study,

Others, such as 19-year-old Ayoefa, sought help from someone else to access an abortion. Who they confided in varied. It might have been their partner, a friend, their mother, a traditional healer or an unlicensed practitioner. Very often, women seeking an abortion, or their partners, confided in someone they trusted for advice, asking them to keep it secret. If that person did not have the necessary information about how to terminate a pregnancy without visiting a health clinic, they were usually able to refer them to someone else or ask on their behalf. This is what happened in the case of Rose, the 35-year-old sales assistant mentioned above. She said: *"I asked my friend to help me, and she said she would find out. The next day, as I hadn't heard from her, I rang her and she said she'd come round and brought me the medicine. She showed me how to take it, and that was it."*

Others turned to relatives who had previously had an abortion. For example, Dado explained that she was certain her friend would keep her secret, as she herself had had several abortions. Her friend took her to a healthcare professional who carried out the procedure in an informal setting, outside their clinic, using the manual vacuum aspiration (MVA) method.[o]

The data reveal that 'traditional', unsafe methods, such as taking a home-made concoction, were used more frequently when only women were involved in the process. When male partners supported their partner's search for an abortion, they were more likely to help their partner obtain tablets, most commonly misoprostol. It was not always clear how these were obtained. When male partners were involved, referrals to abortion clinics (whether private or clandestine) were also more common.

Healthcare professionals were also approached directly by adolescent girls and young women seeking an abortion. In most cases, these contacts were family members, parents, friends or acquaintances. Lisa, aged 34, recounted: *"One of my partner's brothers runs the health centre here, so we went to see him. We explained the problem to him, and he referred us to someone."* Similarly, Sabine, a 22-year-old student in Grand Lomé, explained that her partner, after giving her a tablet (misoprostol), *"put me in touch with a nurse in his family. She looked after me right through to the end to make sure everything went well."*

The findings show that women seeking an abortion generally relied on trusted, informal networks to access an abortion, including informal services provided by both licensed and unlicensed healthcare professionals.

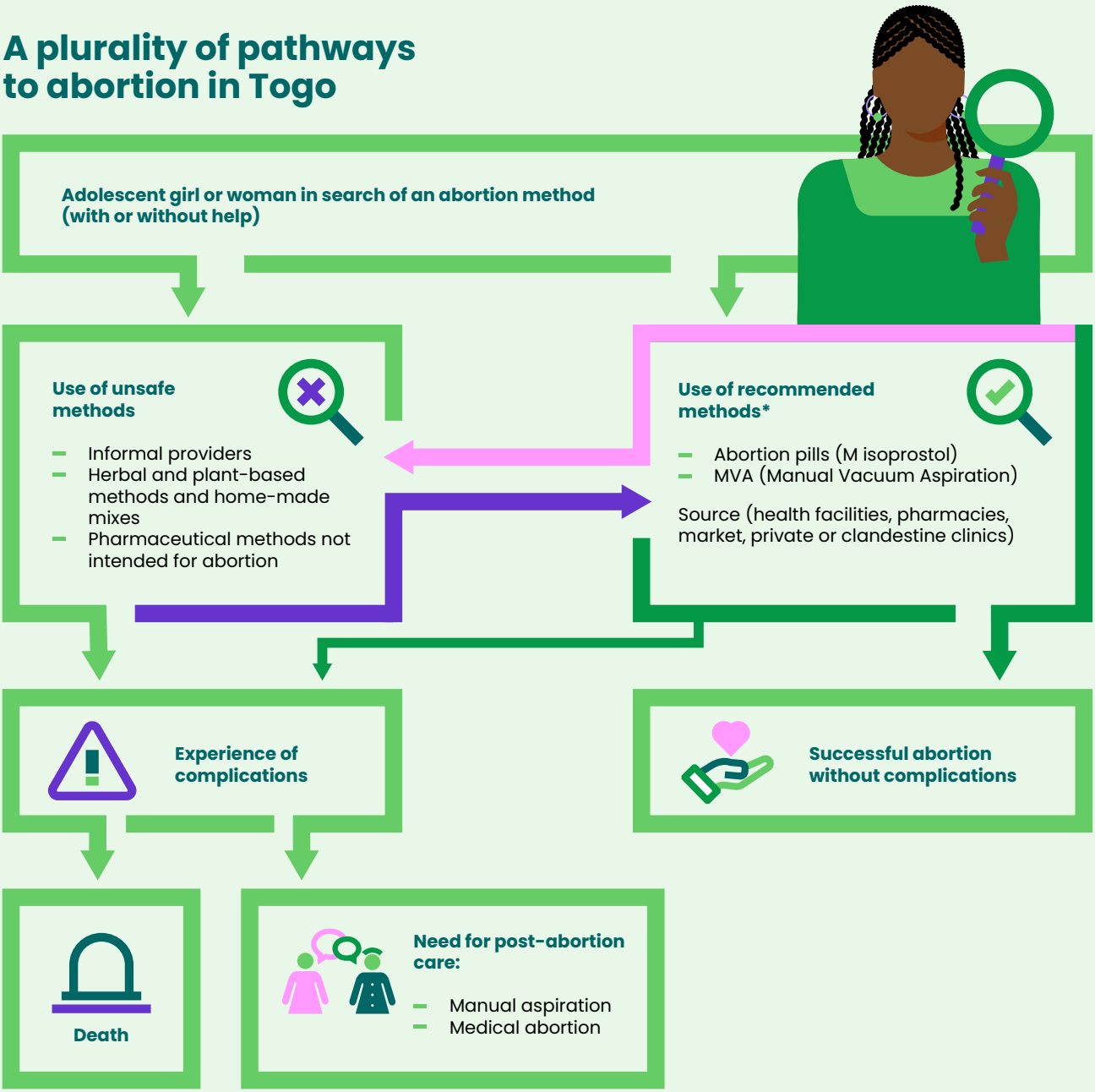
o Although medical abortion is recommended by the WHO and considered safe when performed by a qualified practitioner in accordance with minimum medical standards, Dado suffered from fairly serious complications, which were ultimately resolved by the same provider. These complications lead us to conclude that the provider failed to comply with the relevant standards.

Abortion journeys in Togo

The experiences of abortion among adolescent girls and women in Togo reveal a wide range of pathways, illustrated in the model below:

Figure 1

A plurality of pathways to abortion in Togo



*These methods are considered safe, provided they are used in accordance with the WHO guidelines. In this study, however, they were sometimes used in a way that does not comply with WHO guidelines and could therefore not always be qualified as safe. For example when an MVA was provided in a clandestine clinic in inappropriate conditions, this would lead to complications, whereas some women used a low dosage of Misoprostol, which proved ineffective, leading them to look for another, sometimes unsafe, method, explaining the pink arrow.

The model shows that some women used so-called 'recommended' methods (such as misoprostol or medical abortion). However, as not all the conditions necessary to ensure the safety of these methods were met, these methods could still lead to complications. This could happen, for example, when misoprostol tablets were not taken exactly as recommended or the conditions under which a manual vacuum aspiration was conducted were unhygienic. In other situations, a 'recommended method', such as taking misoprostol, had no effect (presumably because it was taken incorrectly or it was counterfeit medication), and women then sought another method, whether recommended or not. In many other cases, unrecommended and unsafe methods were used, leading to complications and, in five cases, death.

Repeated attempts at abortion

The data show that several adolescent girls and young women made multiple attempts to have an abortion before a pregnancy was terminated. This was the case for Ingrid, the 17-year-old from Grand Lomé previously mentioned, who shared:

> I took alcohol [she had drunk an 18% alcoholic beverage] mixed with a high-caffeine energy drink and some Sedaspir tablets,[p] but without success. My partner took me to a practitioner. He gave me the tablets, gave me an injection in my bum and I started bleeding. Then he inserted something into my vagina, sucked it out and said: 'It's over.'
>
> **Ingrid, 17, schoolgirl, Grand Lomé**

Despite these multiple attempts, Ingrid's abortion was incomplete. A few days later, she was once again writhing in pain and bleeding continuously. Following a consultation, she was admitted to a referral hospital, where she received post-abortion care and pain relief.

Table 2 below lists initial failures and the methods subsequently attempted by some study participants.

Table 2: Initial failures and the methods subsequently attempted

Age	Background	Method
16	Urban area	First attempt: Batchana + Rush + Sedaspir Second attempt: MVA by an unlicensed practitioner
17	Suburban area	First attempt: Pharmacy (five tablets) Second attempt: Rush + paracetamol
19	Rural area	First attempt: Lemon + sugar Second attempt: Hot Guinness Third attempt: Misoprostol
22	Peri-urban area	First attempt: Herbal teas Second attempt: Medical abortion at an unlicensed clinic
34	Urban area	Several unsuccessful attempts using a combination of lemon juice, papaya leaves, anti-malarial leaves and Sedaspir. The woman stopped her attempts in the seventh or eighth month of pregnancy and eventually gave birth.

p Sedaspir is a painkiller available without a prescription and can be bought in pharmacies or from street vendors. Some participants in the study used it as a method of contraception, taking it just before or after sexual intercourse, while others used it to induce an abortion. (Sedaspir is not a recommended form of contraception, nor is it a safe abortion method.)

Age	Background	Method
27	Urban area	First attempt: injection administered by an clandestine abortion practitioner Second attempt: second injection by the same clandestine abortion practitioner Third attempt: Curettage at an illegal clinic

Repeated attempts using unsafe, non-recommended methods or going to clandestine abortion providers, without seeking formal healthcare, can delay access to appropriate care for complications and increase the severity of complications women experience.

Experiences of abortion

The study participants described a wide variety of abortion experiences. For some, the process was relatively quick and painless. Others, particularly those who underwent an MVA at a clandestine illegal or private clinic, reported extreme pain. Still others had to make several attempts before succeeding.

This was the case for Solim, a 27-year-old executive assistant from Grand Lomé, who, upon learning she was unintentionally pregnant, turned to a friend for help. Accompanied by this friend, she first consulted a clandestine provider who offered her abortion injections. After two failed attempts, her friend referred her to another clandestine clinic: *"That's where I was able to have a curettage. Under general anaesthetic, everything went well. No bleeding, nothing … Immediately afterwards, I felt a very slight pain in my lower abdomen, which quickly disappeared."*

Benjamine, a 20-year-old apprentice in the Plateaux region, needed only one attempt to provoke an abortion, but she described the experience as deeply traumatic. Fearing Benjamine's father's reaction, her mother forced her daughter and her partner to seek an abortion. Benjamine's partner raised the sum of 40,000 West African CFA francs (61 euros),[q] which he paid to a traditional healer in a remote location but did not accompany Benjamine to the procedure. This practitioner, whom Benjamine described as dirty and unkempt, admitted to her that some clients had lost their lives there and demanded absolute secrecy regarding his abortion services. Despite Benjamine's anxiety, her mother told her that if she did not have an abortion, her father would throw her out of the house. The procedure involved an injection followed by an extremely painful MVA. When Benjamine began screaming in pain, the man ordered her to be quiet so as not to alert passers-by, threatening to stop the procedure if she did not comply. Three days later, severe pain and complications led to her being admitted to hospital for post-abortion care. Benjamine's account is not unique. It is common for women who visit clandestine clinics to be ordered to stifle their cries of pain while being denied adequate pain relief.

A few participants described less painful, experiences, as illustrated by Adira's account. Adira, a 25-year-old student from Grand Lomé, confided in a friend who had previously successfully terminated a pregnancy using tablets. Her friend gave her precise instructions on the dosage and expected effects, then went to buy the medication for her. The next day, Adira experienced abdominal pain and vaginal bleeding. Although her parents were at home, she was able to conceal her symptoms by attributing them to her period. Her periods resumed normally one month after the procedure. Although anxious, Adira managed the process on her own, reassured by her friend's clear explanations.

q All currency conversions were carried out on 4 February 2026 using the Oanda Currency Converter, available at www.oanda.com/currency-converter.

These data reveal the wide variety of abortion experiences, depending on the method chosen, the level of trust in the provider or support person, the quality of communication (particularly clarity regarding the expected effects) and how someone is treated. They also show the variety of methods used by many participants: some have had to make multiple attempts at having a clandestine abortion, which increase costs and health risks, while others used only one method with which they were able to induce an abortion.

Disparities in the costs of abortions

While many of the unsafe methods that women were familiar with prior to their abortion were affordable, other methods were expensive. Ama, mentioned above, bought paracetamol for 100 West African CFA francs (0.15 euros), which she took with an energy drink costing 250 West African CFA francs (0.35 euros). Despite her extremely limited means, she was able to cover these costs on her own. In contrast, Dado, a 23-year-old student, was charged 20,000 West African CFA francs (30 euros) for her treatment at a clandestine clinic, plus 5,000 West African CFA francs (7.6 euros) for medication – equivalent to almost a month's rent for herself, her mother and her two brothers (30,000 West African CFA francs /45 euros). Dado's entrepreneurial activities enabled her to raise this sum.

Ama's cost represents 1.5% of Dado's, which highlights the disparity in the abortion methods available depending on one's means. Risky traditional methods and home-made concoctions are more affordable than those offered in clinics, whether clandestine or private. Somewhere in between lies misoprostol, the abortion pill used by a considerable number of participants in this study, which is often obtained by male partners through informal or opaque channels. As such, the reported costs of an abortion range from 350 West African CFA francs (0.5 euros) to 65,000 West African CFA francs (99 euros).

Repeated attempts to abort a pregnancy require greater financial resources. For example, Solim paid 65,000 West African CFA francs (99 euros) for three separate attempts. In many cases, such as those of Ama and Dado, the women ultimately had to incur additional costs to treat complications resulting from their unsafe abortions, a topic that will be discussed below.

The practitioner admitted that some clients had died there and demanded absolute secrecy about his abortion services

Akouvi's story

To end an unintended pregnancy, 15-year-old Akouvi took tablets of unknown origin which Kokou, her boyfriend, gave her. A few days later, Akouvi felt dizzy and fainted while on her way to his house. When she came round, she found herself in a stranger's house, drenched in sweat and still bleeding. The man helped her contact her mother, who arrived about 50 minutes later.

Akouvi recalls how her mother:

> *"I screamed and collapsed, crying. Afterwards, she got up, helped me walk and took me to hospital."*

At the first health centre, the staff were unable to provide Akouvi with emergency care and referred her to a better-equipped facility. Akouvi explains:

> *"We were simply told to go to another health centre, as they couldn't treat me there, so we left."*

It was late at night and, not knowing whether the referral hospital was accepting patients at that hour, Akouvi's mother suggested they go home and return the following morning. Akouvi spent the night in excruciating pain and bleeding heavily.

Early the next morning, after struggling to find transport, they arrived at the hospital. Akouvi recounts:

> *"We went straight to the maternity ward. I sat on the terrace whilst my mother went to knock on the door."*

Akouvi was admitted straight away, and the midwives quickly understood her situation: *"They didn't say a word to me. They just asked me to lie down on the mattress, which I did. One of the ladies came to look after me"*

After the treatment, a midwife asked Akouvi what she had taken to induce the bleeding. Akouvi denied having taken anything and claimed she had simply fallen over. The midwife did not believe her but decided not to ask any further questions. Akouvi was discharged from hospital a few days later and recovered at home.

Experiences and practices in post-abortion care

Key findings

Access to prompt, high-quality post-abortion care is limited in Togo. This has serious consequences for adolescent girls and women. The following findings regarding post-abortion care in Togo stand out:

- **Serious health consequences** Experiences of unsafe abortion varied widely, often characterised by severe pain, repeated attempts and a lack of support. Of the 61 participants in the study, 49 experienced complications (including heavy bleeding, infections, severe pain and coma) requiring post-abortion care.
- **Delays in seeking care** Fear of disclosing an illegal abortion and stigmatisation led many adolescent girls and women to delay seeking post-abortion care.
- **Fatal outcomes** During the study, five young women (aged between 19 and 27) died because of complications linked to an unsafe abortion.
- **Limited resources in healthcare facilities** Primary healthcare facilities often lack the capacity to treat serious complications following an unsafe abortion, necessitating referrals that further delay critical care.
- **Barriers to quality post-abortion care:**
  - A lack of (functional) equipment and medicine
  - Stigmatisation by healthcare providers
  - Lack of respect for privacy and confidentiality
  - Inadequate pain management during procedures, such as MVA
  - Inadequate counselling on post-abortion contraception
  - High cost of care

This chapter will focus on the key stages of the post-abortion care pathway following an unsafe abortion, including the decision to seek care, the people involved in the decision-making process and access to post-abortion care in healthcare facilities.

Abortion-related complications and seeking post-abortion care

As seen in the previous chapter, most of the participants in this study resorted to unsafe methods to terminate their pregnancies. Consequently, of the 61 women who had or attempted an abortion, 49 experienced complications.

Symptoms and warning signs

Observations and interviews with adolescent girls and women, their relatives and healthcare providers, show that many experienced a range of complications, the most common of which were heavy bleeding and severe pain. Because many women knew, or had been told, that bleeding and pain were part of the abortion process, they were not initially concerned by these symptoms. Concern arose when the bleeding became heavier, when painkillers stopped working or when the symptoms persisted for longer than expected. A 28-year-old saleswoman from the Plateaux region described her experience, which echoed many others: *"The pain lasted all night and I couldn't sleep. It felt as though something was tearing inside me. I was also losing a lot of blood."*

The inability to endure severe symptoms, to stand upright or tremors and shivering were warning signs of an abnormal condition requiring medical intervention. Véronique, a 21-year-old nurse from the Plateaux region, recalled: *"I was already in pain, and I knew I had to make a decision quickly."* While some participants decided to seek care at this point, others delayed doing so, for various reasons.

Fear of disclosure and power dynamics delay women's access to post-abortion care

When women face complications due to an unsafe abortion, delays in care seeking are mainly due to the fear of revealing their abortion to their families or healthcare providers. This was the case for Farida, a 35-year-old shop assistant from the Plateaux region:

> The second day was awful. I couldn't even leave the room. I couldn't sit up … every minute was pure torture. I cried all on my own … but I didn't seek care because I was afraid. I was afraid that people would find out I'd tried to have an abortion. I could already picture the reproaches, the scornful looks, the criticism.
>
> **Farida, 35, shop assistant, Plateaux**

Like Farida, many women feared being ostracised. For some, simply going to the health centre in their neighbourhood or village posed an unacceptable risk of exposure and unwanted questions. Some participants feared not only being recognised by their relatives and neighbours but also being judged by healthcare providers and reported to the police.

Sometimes, these deliberations and the resulting decisions to delay seeking post-abortion care were made alone. This was often the case when the people close to the woman were not involved in the abortion process (as in the cases of Farida and Véronique). In other cases, the decision to delay care seeking was made by family members or a partner instead of the woman herself, or in consultation with them.

Some women only confided in their loved ones when they could no longer hide their symptoms after an unsafe abortion and they feared for their lives. This is what happened to Ingrid, who waited until she was writhing in pain before alerting her grandmother:

> It was when the side effects started to kick in that I had to tell Granny the truth. She told me that at the stage I was at, it was no longer a matter of discussion, but that my life was at stake. She asked me to go to hospital … to do whatever was necessary to keep me alive, so that my mum wouldn't come and kill her.
>
> **Ingrid, 17, schoolgirl, Grand Lomé**

In some cases, family members only became aware of the unsafe abortion and its complications after a woman fainted, requiring them to be rushed to a healthcare facility, as Armandine described:

> The bleeding started with pain in my lower abdomen. I told myself it was a good sign. The bleeding carried on like that for two days and the pain eased off. On the third day, I was lying in my bedroom and needed to go to the toilet. I got up to go to the loo and, on my way back, I collapsed as I passed my flatmate's room. I rang … [my] aunt … and when she arrived, we were taken to hospital.
>
> **Armandine, 32, intern, Grand Lomé**

In these cases, it was relatives or neighbours who decided to seek immediate medical care, for fear of more serious consequences. Sometimes also out of fear that for which they might be held responsible if something terrible happens, as Ingrid's grandmother suggested. In other cases, relatives or partners contributed to further delaying the search for medical care. Some relatives or partners were afraid that the abortion would become public knowledge and that they would be implicated, and consequently encouraged the women to endure the pain, as a 23-year-old participant from the Plateaux region described: *"My mother refused [to go to the health centre] because there are a lot of people we know there."*

Given the power dynamics at play, particularly the control exercised by family members and partners over the financial and material resources needed to access post-abortion care, many women had little choice but to accept these decisions. In other cases, care was delayed while family members or partners sought the money needed for treatment.

> **The pain lasted all night and I couldn't sleep. It felt as though something was tearing inside me. I was also losing a lot of blood**
>
> Woman, Plateaux

Due to delays in seeking care, some teenage girls and women arrived at healthcare facilities in a critical condition

Due to these delays in seeking post-abortion care, some women arrived at health facilities in a critical condition. This led some women to die shortly after admission. In one of the fatal cases observed in the Plateaux region, the midwife who admitted her explained:

> "The young woman had locked herself in her bedroom, probably out of fear or shame. It was her flatmates, alerted by her screams, who forced the door open to come to her aid. When they finally managed to get in, they were horrified to find her lying in a pool of blood. The scene was shocking and immediately triggered an emergency response. They straight away alerted the flat's landlady, who decided to take her to hospital."
>
> **Midwife, referral health centre, Plateaux region**

Despite the swift intervention of her flat mates and the landlady, healthcare providers were unable to save the young woman's life due to the delay and the complications that had set in following an unsafe abortion.

Barriers to the availability, access and provision of post-abortion care

The healthcare providers and stakeholders interviewed described post-abortion care as "essential" and "lifesaving". However, observations and conversations with participants revealed that primary healthcare centres often lack the resources needed to provide this care, such as MVA kits, medication supplies and qualified staff. Providers explained that, although they often provide initial care, they are frequently forced to refer patients to higher-level facilities, particularly those admitted with serious complications. At primary health centre-level, managing post-abortion complications mainly involves stabilising the patient. A midwife at a referral facility in the Plateaux region explained: *"We do what we can … Some arrive very weak, with infections. We start by giving them antibiotics, then we have to refer them to another facility."*

Some health centre staff attempted to treat patients before referring them to higher-level facilities, while others referred them immediately upon admission without any prior treatment, as seen in the case of Akouvi, mentioned above. In her case, the healthcare providers on duty during the night shift examined Akouvi briefly, then told her mother that her condition was beyond their capabilities and referred them to a higher-level healthcare facility. However, this led to a delay in Akouvi accessing urgent medical care. Although her case should have been treated as an emergency, Akouvi and her mother returned home and waited until the following morning before going to the referral centre.

In other cases, the delay in receiving post-abortion care was due to families having to raise the necessary funds, as they anticipated that treatment at a referral health facility would be expensive. Some participants also reported difficulties in finding transport,

Although providers often deliver initial care, many patients with serious complications must be referred to higher-level facilities

Referrals not only further delay access to urgent care but also result in additional costs for patients and their families

as most of these facilities do not have ambulances to transport patients. Some participants living in rural areas had to travel long distances to reach referral hospitals, which were often located in towns. Béné, a 25-year-old reprographer from the Plateaux region, recalled: *"We went to the nearest health centre when I started experiencing lower abdominal pain a few days after attempting an abortion. I was feeling weaker and weaker, but the nurses told me they weren't able to treat me and that I had to go to the big hospital in the city."* Referrals not only further delay access to urgent care but also result in additional costs for patients and their families.

The study's findings show that, although referral facilities receive the majority of post-abortion care patients, they also face numerous obstacles in delivering this care. The healthcare providers interviewed reported having to cope with an excessive workload, combined with a staff shortage and a lack of training in the management of post-abortion complications, as well as persistent stigma surrounding post-abortion care. A medical assistant at a referral health centre in the Plateaux region stated: *"Even here we are not always prepared. We're learning on the job. And sometimes, colleagues judge us. It's not easy."*

Only certain members of staff in health centres, notably a few midwives, are authorised to provide post-abortion care. Uterine evacuation, for example, whether carried out with misoprostol or by intrauterine aspiration, requires specific technical skills and a sound grasp of protocols. Training is therefore essential to ensure that providers have the necessary knowledge and skills. However, the lack of such training, as well as trained staff being transferred to other facilities, significantly reduces the number of people able to carry out these procedures. Beyond the lack of training, the findings highlight how some staff members either have a lack of interest or feel uncomfortable about providing post-abortion care. Some healthcare providers interviewed described how some colleagues would refuse to provide post-abortion care on religious grounds and would refer their patients to other members of the team.

The data also highlighted how some referral health facilities lack the adequate equipment to provide post-abortion care, as one midwife explained:

> Our problem here is that the equipment passes through many hands. In fact, trainees, teachers – everyone uses it. This means the equipment doesn't last. And when the equipment breaks down, it's difficult for them [the administration] to replace it, because they say it was given to us less than three months ago and it's already damaged ... We have a problem with the equipment. The equipment isn't always in good enough condition to be used.
>
> **Midwife, referral health facility, Grand Lomé**

Equipment, such as medical abortion kits, deteriorates rapidly due to intensive use, but replacing it remains difficult. Ultimately, these capacity constraints, both in primary care facilities and in referral centres, have a direct impact on the quality of post-abortion care available and on patient health.

"The equipment isn't always in good enough condition to be used"

Patient and provider perspectives on the quality of post-abortion care

While most adolescent girls and women in this study who needed post-abortion care eventually received it and were able to recover from post-abortion complications, this research also revealed shortcomings with the quality of the care provided.

Waiting times

The time between a woman's admission and the provision of post-abortion care varied depending on the type of facility, the woman's condition and the ratio of healthcare providers to patients. This delay ranged from a few minutes to more than five hours. Some women reported being attended to immediately upon arrival, particularly those admitted in a serious condition or when patient numbers were low. A 25-year-old woman from the Plateaux region reported: *"When I arrived, the nurse immediately sat me down and said, 'Don't worry, we'll take care of you.' That really reassured me."*

> **When I arrived, the nurse immediately sat me down and said, *'Don't worry, we'll take care of you.'* That really reassured me**

However, many women reported experiencing long waiting times for post-abortion care. Flore, a 22-year-old trainee hairdresser in Grand Lomé, said: *"I stood there for nearly an hour. Nobody spoke to me. I didn't even know if I was in the right place."*

In some cases, the treatment process was initiated by healthcare providers who then left the women waiting. This was the case for Laure, a 21-year-old waitress in the Grand Lomé region, who was forced to wait for hours, worrying about her condition as the pain returned and she continued to bleed heavily. She told us: *"I was left to suffer until 2am, with nothing being done. It was only then that I was finally prescribed medication and injections, which my family had to go and buy themselves."*

The study highlights how healthcare facilities are often overburdened and understaffed,

as described by a midwife at a referral centre in Grand Lomé: *"When a birth is in progress or a life-threatening situation arises, other patients must wait. It's not for lack of willingness, but because we simply cannot do everything."*

Some women concealed the fact that they were experiencing complications from an unsafe abortion and were therefore not treated as a priority, except for those admitted with heavy bleeding, acute pain or loss of consciousness. In some cases, delays in treatment were due to the absence or unavailability of qualified staff (particularly during night shifts or at weekends). Further delays occurred when healthcare providers discovered that the complications were linked to an induced abortion. In these situations, providers displayed detachment, judgement (implicit or explicit) or delayed providing assistance.

Interactions between healthcare providers and women seeking post-abortion care

Based on observations and interviews, a mix of interactions between adolescent girls or women seeking post-abortion care and healthcare providers could be identified. Some were difficult interactions, due to the providers' workload and their values. Other participants received respectful and attentive care.

Healthcare providers also reported instances where they had to protect a patient's confidentiality while managing the pressure – sometimes unconscious – exerted by that woman's family members or partner. For example, a midwife at a referral centre in the Plateaux region said: *"Sometimes we must ask those accompanying the patient to step outside. Not to exclude them, but so that the patient can speak without fear."* Notes from one of the research assistants working in the same region corroborated these observations: *"You can sense that some teenage girls are under pressure. They look at their parents before answering."*

Women experiencing complications after an unsafe abortion often experience additional emotional distress due to the stress and isolation in their abortion journey. It became clear from the data that, in addition to medical care, patients needed emotional support, but this was rarely provided. Emotional support varied considerably, depending on the number of patients and healthcare providers' values. In some situations, simple gestures and a few kind words were greatly appreciated, as a 23-year-old woman from the Plateaux region described: *"After the procedure, the assistant stayed with me for a while. He said to me, 'You were scared, weren't you? Don't worry any more, you're safe now."* This participant, who had expected to be judged or told off, was so relieved and moved by the assistant's kindness that she began to cry.

Such support, combined with a genuine concern for confidentiality, respect for privacy and empathy, was observed when healthcare providers had sufficient time to talk with patients. The same quality of care was noted in cases of apparent miscarriages, where responsibility for the loss of the pregnancy was not questioned. In contrast to the women who received support, other women received very little or no support during their post-abortion care. This was the case with a 23-year-old woman from the Plateaux region who narrated: *"They carried out the suction and that was it. Not a single word. I was alone, I felt ashamed, and I didn't even know if it was over."* This young woman remained in a state of uncertainty throughout the procedure and only realised afterwards that the procedure had finished. Some participants told in the interviews that they had wanted to ask healthcare staff questions but did not do so because they were afraid of negative reactions.

As well as delays in post-abortion care and a lack of empathy, some women, particularly adolescent girls and young women, faced stigmatisation and verbal abuse from healthcare providers. In several health facilities, the research team observed instances where healthcare staff had a sudden change in attitude as soon as they discovered that their patient was experiencing complications related to an induced abortion. They became distant, expressed implicit or explicit disapproval, or delayed treatment. This is what a 15-year-old girl from the Plateaux region experienced;

"When I said it was after an abortion, their faces changed. They left me in the corridor, without a word, for hours." Another participant, aged 26, from the Grand Lomé region, recounted how she was left to bleed for over two hours, which she perceived as a form of punishment. Others were disrespected, as this participant described: *"The midwives really insulted me. They told me: 'Your boyfriend hasn't found a better girl to go out with yet?' That made me very sad."*

> **When I said it was after an abortion, their faces changed. They left me in the corridor, without a word, for hours**

Some women treated for post-abortion complications were stigmatised by healthcare providers' indirect or non-verbal behaviour. These healthcare providers avoided making eye contact with their patient, refused to answer their questions, shouted their name while addressing others more politely and spoke about them loudly with their colleagues. Béné, aged 25, from the Plateaux region, recalled: *"I was standing in the queue; they were talking amongst themselves and saying out loud: 'There are still girls coming here for that [abortion]; they're not ashamed.' They knew I could hear them."* These healthcare providers used indirect verbal abuse to express their disapproval without addressing Béné directly.

A lack of respect for privacy and confidentiality was also experienced by women being treated for post-abortion complications in healthcare facilities. Often, there were no suitable spaces for confidential discussions between healthcare providers and patients. Conversations on sensitive topics such as abortion were often held in open spaces, such as corridors or waiting rooms. When these conversations took place in consultation or delivery rooms, they occurred in the presence of other patients or staff members not involved in the care process. The following observation notes from a referral hospital in Grand Lomé clearly illustrate this type of interaction:

A midwife entered accompanied by a patient admitted for post-abortion care. She sat her down in a room already occupied by other patients and midwives. She did not really explain why she was there; she simply said: *'Sit here, we'll come and look after you in a moment.'* The patient looked a bit lost; she kept her head down and didn't speak. You could tell she felt uncomfortable. The other women in the room were glancing at her, and several were whispering amongst themselves. The midwife left without further explanation, and the patient remained there, alone, waiting. There was no real privacy; everyone could hear everything that was being said. It was embarrassing, especially for her.

Observation notes, referral hospital, Grand Lomé

Research participants who experienced such confidentiality breaches said they made them feel uncomfortable and exposed them to further stigmatisation, particularly when some of those present were from their own community.

According to the participants, the combination of stigma, discrimination and inadequate confidentiality measures, coupled with limited opportunities to express emotions such as pain or fear, reinforced their sense of isolation. Furthermore, the poor quality of care had a psychological and physical impact on the adolescent girls and women: several participants reported being made to wait, despite their condition requiring urgent treatment. As one participant concluded: *"I wasn't asking to be loved. Just to be treated like everyone else."* Consequently, some patients, such as Nabila, a 23 -year-old secretary from the Plateaux region, said: *"I was in pain afterwards, but I didn't dare go back to hospital. I was too scared of going through that again."*

Some of the healthcare providers interviewed acknowledged the lack of emotional support and the stigma experienced by certain patients, which they attributed to a lack of time or training.

Pain management

As highlighted in the previous chapter, the abortion process itself was often experienced as painful. Complications contributed to increased pain, sometimes to the point of the pain becoming unbearable. As these observation notes show, screams of pain were common amongst those admitted for post-abortion care:

We made our way to the delivery room where she was lying, screaming in pain. Her heart-rending cries echoed throughout the room: *'I'm in so much pain, help me, I'm in so much pain.'* The distress in her voice was palpable, and every word expressed intolerable suffering.

Observation notes, referral hospital, Plateaux

Women who experienced such pain often had to undergo intrauterine aspiration, which only made their discomfort and pain worse. Although this pain required immediate attention, observations of post-abortion care procedures and participant interviews revealed disparities in the application of pain management protocols across health facilities. Almost all MVA procedures were carried out without analgesics. The observation notes below highlight an example:

Subsequently, the nurse came to insert an intravenous drip, then the assistant arrived with his kit ... He inserted a speculum into the vagina to reach the cervix ... He then told me to put on gloves and fetch him a slightly larger speculum. I hand it to him ... then he removes the first speculum to insert the second. The woman screams out in pain again, and the assistant asks her what's wrong. She replies that it hurts, and the assistant tells her that everything will be fine ... He then takes a small cannula and inserts it. As soon as he inserts the cannula, she screams and starts crying. The assistant connects the suction syringe and begins to move it back and forth, from left to right, as if twirling it, then pulls on the syringe to suck out whatever is in the cannula ... Throughout this time, the woman has not stopped screaming and crying and writhing in pain.

Observation notes, referral facility, Plateaux

Various explanations have been put forward to justify the lack of pain management

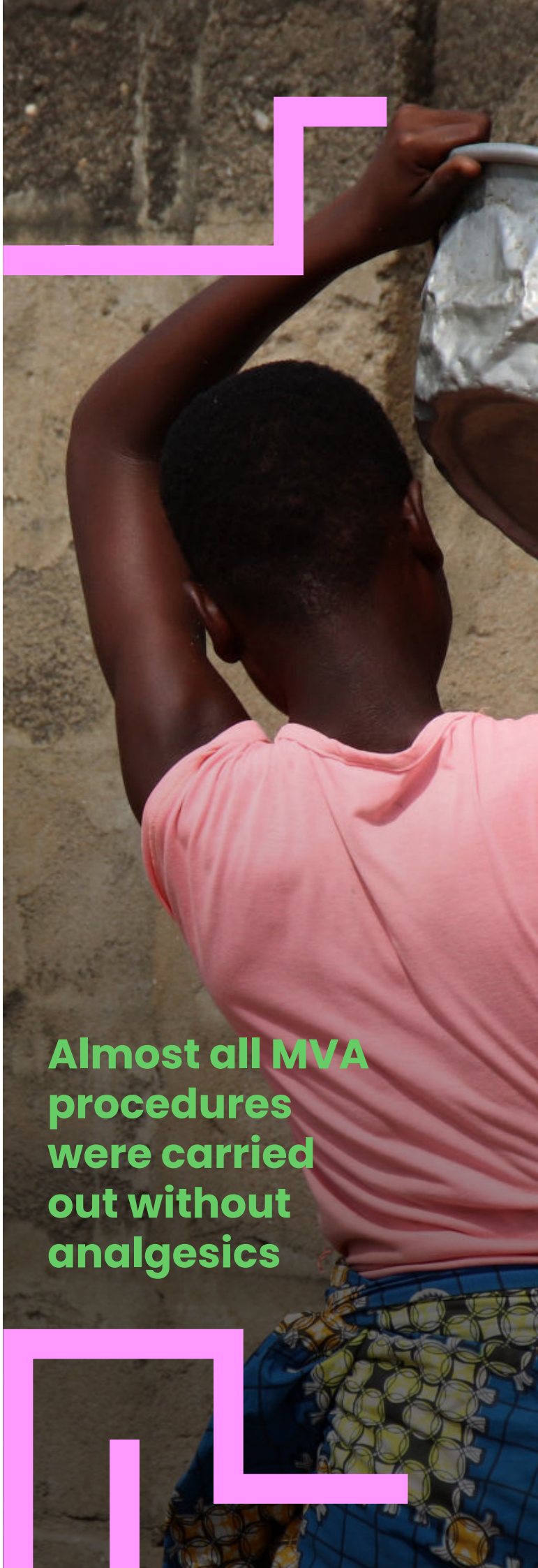
during medical abortion procedures, such as a lack of competence or confidence in administering local anaesthesia (known as paracervical block), or a fear of complications. A midwife stated:

> We administer painkillers according to the level of pain the person can tolerate. Otherwise, normally, to perform a medical abortion, you need to administer anaesthesia – local anaesthesia. But sometimes, local anaesthesia can lead to other complications. If you don't know how to do it, you could perforate the uterus or cause other damage.
>
> **A midwife, private clinic, Grand Lomé**

In one of the rare instances where the research team observed a paracervical block being administered, the healthcare provider struggled to perform it. One of her colleagues even asked her if she knew how to do it.
To avoid such difficulties, according to the findings, the paracervical block was rarely used during post-abortion care, even though it is one of the most effective pain management procedures recommended. Instead, healthcare providers were selective in administering analgesics, generally reserving them only for patients deemed unable to tolerate the pain. However, this assessment of a patient's pain is subjective and sometimes far removed from reality. It is possible that some patients experienced severe pain but concealed it so as not to attract attention and avoid shame.

In the absence of effective pain-management procedures, healthcare providers reported adopting approaches such as 'verbal anaesthesia', which involves talking to the patient during the post-abortion procedure to distract her. They also reported administering injections of analgesics that were not necessarily effective:

> So, I explain to her that, yes, it's going to hurt, and that she should expect it. I give her some paracetamol, sometimes an injection or a mild painkiller. Seeing that she's been given something, she thinks to herself: '*That's it, it won't hurt anymore.*' Psychologically, she believes it will reduce her pain, so she tries to cope with it.
>
> **A midwife, private clinic, Grand Lomé**



Almost all MVA procedures were carried out without analgesics

Due to these approaches, adolescent girls and women in this study were subjected to traumatic pain, which made medical abortion procedures lengthy and sometimes difficult to carry out:

> She would sometimes kick out, and as she writhed in pain, she slid right to the edge of the bed, so that the assistant could no longer continue with the suction. He paused for a moment, asked her to move back onto the bed, spread her legs and lie still. She continued to cry and replied that she was in pain. The assistant replied that he himself had a backache and that the longer she stayed still, the quicker it would be over.
>
> **Observation notes, primary facility, Plateaux**

Some providers lacked empathy, threatening to stop the procedure when the patient was screaming in pain

Some providers lacked empathy, threatening to stop the procedure when the patient was screaming in pain.

A lack of post-abortion contraceptive advice and low uptake of contraception

Echoing the findings on the administration of analgesics, the facilities observed did not systematically offer counselling on post-abortion contraception. Although healthcare providers understand that contraception counselling is a component of post-abortion care – recognising its rationale (to help patients avoid further unintended pregnancies) – and strive to provide it, they reported occasional 'missed opportunities' to advise patients on contraception. A midwife at a referral facility in the Plateaux region commented: *"... I have to be honest: this counselling isn't provided systematically for all patients, especially in emergency cases where we have to act very quickly. Also, due to staff shortages and time constraints, counselling is sometimes limited or rushed, which isn't ideal."*

These missed opportunities include situations where individuals do not receive advice and are instead prescribed or offered contraceptive methods without adequate explanation. This was the case for a 28-year-old woman from the Plateaux region who recalled: *"They gave me a tablet and told me to wait. I wasn't told what it was or what it was for."* She later

realised that these tablets were contraceptive pills. Adolescent girls and women often refused contraceptives, considering them unsuitable for their bodies, due to the lack of information they had been given.

Both healthcare providers and patients attributed the absence, or inadequacy, of counselling to excessive workloads and staff shortages, which prevented healthcare workers from devoting sufficient time to discussions about contraception. Anita, a 22-year-old housewife from the Plateaux region, recounted: *"The nurse told me she had too many people to speak to and that I should come back if I had any questions."* Some healthcare providers planned to offer contraception counselling at follow-up appointment, but women often did not attend. Some women explained that they had not received information on contraception because they had a strained relationship with healthcare staff. For example, when asked whether the health centre had given her any information on family planning, a 19-year-old girl from the Plateaux region replied: *"I told you that the people at the centre ignore us."* This teenager and other participants who had undergone an unsafe abortion told us they had not had any discussions about family planning with the healthcare providers, who appeared not to care about their well-being and instead adopted a judgemental attitude towards them.

Among those adolescent girls and women in our study who received post-abortion counselling about contraception, some explained that without hesitation they had agreed to use a contraceptive method so as not to have to "go through the same thing" again. In these cases, their experience of unsafe abortion (particularly the physical pain and psychological burden) outweighed any fears or concerns they had about contraceptives. As well as preventing similar experiences, some wanted to safeguard their career prospects or their studies. A 19-year-old student from the Plateaux region explained: *"I left school because of my pregnancy. Now that I'm free, I don't want any more problems. I absolutely must continue my studies."*

Conversely, some participants chose not to use contraception after leaving a health centre following post-abortion care due to a lack of confidence in modern contraceptives. One participant, Anita, explained: *"I'd rather be careful myself for the time being; I don't want to put anything into my body."* Like others, Anita feared the side effects of contraceptives,

Among adolescent girls and women receiving post-abortion contraceptive counselling, some agreed without hesitation to use contraception to avoid a repeat experience

> When I was about to go home, the midwife decided I had to go to the family planning clinic. I went there, but it was expensive; I thought it was free. I told them I'd come back

which high-quality counselling could have addressed.

The need to get permission from a husband, partner or parent also prevented some adolescent girls and women from leaving a health centre with a contraceptive method after receiving post-abortion care. These women asked for time to consult their partner and never returned. Some individuals also declined the contraceptives offered to them due to their personal or religious beliefs.

Another significant factor hindering the uptake of contraception was the cost of services, as recounted by this 22-year-old saleswoman from the Plateaux region: *"When I was about to go home, the midwife decided I had to go to the family planning clinic. I went there, but it was expensive; I thought it was free. I told them I'd come back."* This young woman told us she did not return to the clinic as she was unable to raise the necessary funds.

The costs of post-abortion care

Post-abortion care often involves significant costs, including consultations, ultrasound scans, blood tests (to check blood group and complete blood count), uterine evacuation procedures and medication (painkillers, antibiotics). A midwife explained:

> When the woman arrives, she pays for the admission pack, which costs 3,500 [West African CFA francs]. The blood group test costs 2,000, the complete blood count 5,000, so admission costs 10,500. Then there's the procedure pack, which costs 15,000. And the oral medication we prescribe here costs around 5,000. That's about 5,000, bringing the total to around 30,000. Yes, it's more than 30,000 … And if there are complications, then …
>
> **A midwife, 37, referral hospital, Grand Lomé**

The total cost of post-abortion care ranged from 15,000 (23 euros) to 120,000 West African CFA francs (183 euros), depending on the severity of complications. Women with a negative blood group had to bear additional costs associated with the injection of anti-D serum. Added to this were other expenses,

such as additional laboratory tests, transport to the hospital, supplementary medication, examinations conducted outside the facility, and unregulated payments made directly to service providers.

In many cases, women and their families had to pay part of these costs before receiving treatment. However, many found this difficult due to financial constraints. Some women, their relatives or partners had to dip into their savings or borrow money. Grace, a 22-year-old student from the Plateaux region, recalled: *"I had to borrow money from my neighbour to get to hospital. I didn't even have enough to pay for transport."* Others arrived with no money at all and had to urgently contact their partner or relatives who were slow to respond, thereby complicating the continuity of care. Some women were even kept in hospital for several days while they waited to settle their bills. Blewussi, aged 23, from the Plateaux region, was presented with a bill for 70,000 West African CFA francs (107 euros), which she could not afford to pay. With help from her family and friends, she managed to raise part of the sum, but she was kept in hospital for a whole day until her boyfriend sent her the rest of the money to cover her medical costs and transport.

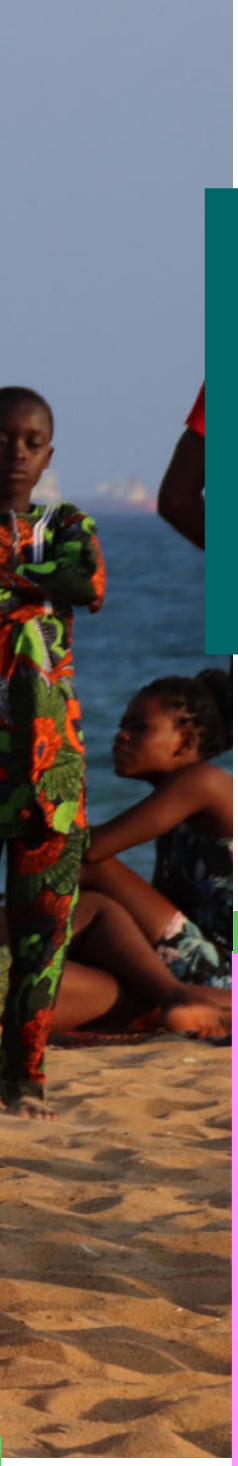
Some women tried to negotiate with healthcare providers to obtain a waiver or a reduction in costs (e.g., only buying the medication they considered essential). Some healthcare providers helped them by drawing on their own stocks, prescribing cheaper alternatives or opting for less expensive procedures. Akofa, a midwife from the Plateaux region, was one of those compassionate healthcare providers who worked tirelessly to help patients and their families. She explained that when she sees women with limited financial resources, she chooses to perform a digital curettage rather than a MVA. While this method reduces costs, it contravenes standard protocols for treating an incomplete abortion and significantly increases the risk of severe pain.

Unlike Akofa, some providers expressed irritation towards resource-poor patients and subjected them to humiliating treatment. While some of these women begged for mercy, healthcare providers retorted with comments such as: *"Haven't you paid for your medicines? So you want us to treat you for free?"* or *"Here are the girls who're going to get themselves pregnant and who've come to bother us."* Such remarks provoke feelings of shame and despair among the women they are aimed at.

The study data showed that the cost of post-abortion care had mental, economic and physical repercussions for women, their families and their partners. Some repercussions are so severe they end in women losing their lives and their loved ones being traumatised. This is what happened to Amélie. Amélie's boyfriend Franck, a 20-year-old farmer and occasional courier from the Plateaux region, accompanied Amélie to hospital after she had secretly consumed a concoction to terminate their pregnancy. Franck spent all his savings on her treatment, then left the hospital in search of further funds. While he was away, he received a call from Amélie's mother informing him of his girlfriend's death. He recalls: *"I didn't know what to do. I was screaming at the top of my voice and crying like a baby. 'I'll never see you again' I kept saying. I was at my wits' end and didn't know whether to go back to the hospital, stay in my village or go to Amélie's village, which was 5km from her training centre."* As well as mourning the loss of his partner and bearing the financial burden of her care, Franck had to cope with pressure from his girlfriend's parents, who accused him of being responsible for her death and demanded that he pay for the funeral costs.

The total cost of post-abortion care ranged from 15,000 (23 euros) to 120,000 (183 euros) West African CFA francs, depending on the severity of complications

Discussion



This study was conducted to collect data to fill a significant gap in the literature on unsafe abortions in Togo. It specifically documents the experiences of under-reported unsafe abortions among adolescent girls and women. Using an ethnographic approach combining participant observation and in-depth interviews, the study reveals the labyrinthine challenges women face in accessing abortion and post-abortion care.

The interlinked factors driving unintended pregnancies

In sub-Saharan Africa, unintended pregnancies are associated with unsafe abortions and maternal deaths.[23,24] This report shows that vulnerability to unintended pregnancy is caused by a variety of factors, which are often intertwined, including low use of modern contraceptives, fragile family ties, economic insecurity and sexual violence. Other studies have confirmed unmet contraceptive needs among young Togolese women, particularly in the 'poor' or 'middle' wealth quintiles.[25] The study reveals that negative perceptions of contraceptives are widespread among adolescent girls, women, their partners and the community. Regardless of age or level of education, these perceptions contribute to a heavy reliance on natural or ineffective contraceptive methods. The fear of infertility, particularly among adolescent girls and young women, is a major factor in the rejection of modern contraception. For others, religious belief plays an important role.

This research shows that the economic insecurity of adolescent girls and their families is also a contributing factor to transactional and early sexual relations, sometimes encouraged by parents. Furthermore, this study provides unique insights into the relationship between adolescent girls' mental health and their vulnerability to unintended pregnancies. Indeed, the results show that mental health issues – linked to fragile social bonds, such as a lack of family affection, or depression caused by financial insecurity – lead some teenage girls to seek emotional support through early intimate relationships. This leaves them vulnerable to unintended pregnancies.

Sexual violence is another key factor in unintended pregnancy, as confirmed by other studies.[26] A recent survey of 461 secondary school pupils in Lomé, aged between 15 and 23, found that 27.5% had their first sexual experience under duress.[27] Another study found that 11% of Togolese women (aged 15+) had experienced sexual violence within a relationship.[28] Although women who become pregnant due to sexual violence theoretically have access to legal and safe abortion in Togo, a recent study shows that multiple barriers prevent them from accessing it in practice.[29]

The lack of adequate relationship and sexuality education at home and at school, due to cultural taboos,[30] is another major contributing factor to unintended pregnancy in Togo.

Fear of infertility and religious beliefs are major factors in the rejection of modern contraception

There is an urgent need to invest in gender-transformative relationship and sexuality education in the country, and to support parents in breaking this taboo by discussing sexuality openly with their children in order to better prepare them for adolescence and adult life.[31,32,33]

Varying degrees of autonomy in abortion decision-making

In Togo, one third of unintended pregnancies are estimated to result in an abortion.[34] The study's findings confirm that the decision-making process regarding abortion is both complex and non-linear, influenced simultaneously by individual, social, economic, legal, cultural, religious and medical factors.[35] The main factors cited include fear of how the family and community will react to the pregnancy, abandonment or pressure from the partner, and the influence of the mother and other close relatives.

These relational dimensions of decision-making regarding abortion – which feminist academics have termed 'relational autonomy' in reproductive choices – are intrinsically intertwined with kinship networks, social cohesion and strategies for social survival, rather than isolated individual will.[36,37]

The study also highlights the issue of reproductive coercion. This encompasses behaviours through which individuals exercise control over their partner's reproductive autonomy by various means, including forced abortion. This form of intimate partner violence undermines women's free will in reproductive decision-making and constitutes a major public health issue. This remains understudied and calls for further research.[38,39]

The study shows how parents and close relatives can be agents of reproductive coercion, just as partners can be. Findings highlight the pressure that mothers and other family members (e.g., sisters, aunts, grandmothers) can exert on adolescent girls to persuade them to have an abortion. While this behaviour may be explained by a desire to preserve family cohesion, to protect their daughters or to conform to prevailing social expectations, it nevertheless significantly

restricts the reproductive autonomy of the adolescents concerned. The clear involvement of other actors in decision-making and in seeking out clandestine methods of abortion (see below) shows that the stigma attached to abortion continues to weigh primarily on the pregnant woman, despite many people being involved behind the scenes. To combat reproductive coercion, it is essential to ensure adolescent girls and women have access to legal abortion care and appropriate abortion counselling services, which should include clear protocols that enable healthcare providers to identify situations of coercion.

Abortion experiences in Togo

Our findings show that, in the majority of cases, adolescent girls and women, along with their partners and family members, resort to unsafe abortion methods, despite being aware of the risks involved. Several factors explain the use of unsafe methods, including a restrictive legal framework which limits access to safe options, as noted in other studies.[40] Although the law recognises the right of Togolese girls and women, under certain circumstances, to a safe and legal abortion, the study shows this law remains largely unknown to the general public. In contrast, the penalties for abortion, as set out in the Penal Code, are very well known. The majority of participants were convinced that all abortions were illegal, which led them to seek solutions on the black market. The fact that the existing law has not been widely publicised or effectively enforced contributes to the stigma surrounding abortion, both among healthcare professionals and within society as a whole.[41]

The stigma surrounding abortion operates at the individual, community, institutional and structural levels and contributes to creating a challenging environment for both research into, and the provision of, abortion and post-abortion care in Togo. The study found that this stigma, combined with the restrictive legal framework, makes it difficult for adolescent girls and women to find reliable information about abortion and access safe methods.

Conversely, the restrictive legal framework encourages the development of an informal sector offering a multitude of unsafe methods, towards which adolescent girls and women are directed by trusted individuals,

This study provides unique insights into the relation between adolescent girls' mental health and their vulnerability to unintended pregnancies

such as their partners or relatives. This exposes women to serious risks, as they may resort to a range of dangerous and inadvisable methods. As other studies conducted in similar legal contexts have shown, women prioritise social safety and their privacy at the expense of medical safety.[42] This often leads to unsafe abortions which have severe complications that affect the health and lives of many adolescent girls and women. The study documented five deaths caused by unsafe abortions and numerous cases of serious abortion-related complications, including heavy bleeding, infections, acute pain and comas.

Post-abortion care

The study clearly highlights that women seeking post-abortion care due to complications experience frequent delays. As other studies have shown,[43] these delays are due to women's fear that their abortion will be disclosed and that they will suffer stigma as a result. When they do seek care, the lack of capacity in primary-level facilities to provide adequate post-abortion care often leads to individuals being referred to higher-level facilities. This delays access to care, particularly for those with limited financial resources. Women and their partners and families must raise the necessary funds before they can access care and transport. This causes significant delays in accessing urgent medical treatment.

The study also finds major concerns regarding the quality of interactions between healthcare providers and women during post-abortion care. These problems are often attributed to providers' workloads and personal values.[44,45] While some women received respectful and empathetic care, emotional support was often lacking. The level of emotional support available varied widely and was dependent on patient volume, healthcare providers' values and the socio-demographic characteristics of the women seeking post-abortion care, including their age, socio-economic status and the severity of their complications.

Common negative experiences among those suffering from abortion-related complications include neglect, stigmatisation and verbal abuse. The lack of robust protocols guaranteeing confidentiality and respect for privacy further exacerbates women's distress. Pain management often remains inadequate. In some cases, the administration of analgesics is deliberately withheld by healthcare providers as a punishment for behaviour deemed transgressive.[46] Healthcare providers have acknowledged these difficulties, attributing them primarily to a lack of time and insufficient training in comprehensive post-abortion care. This poor quality of care not only causes psychological distress for women but also has physical consequences. Women are often reluctant to seek follow-up care for fear of being mistreated again. These difficulties could be overcome if healthcare providers received training on post-abortion care services tailored to adolescent girls or women which systematically incorporated values clarification.[47]

The pressures of conflicting social norms

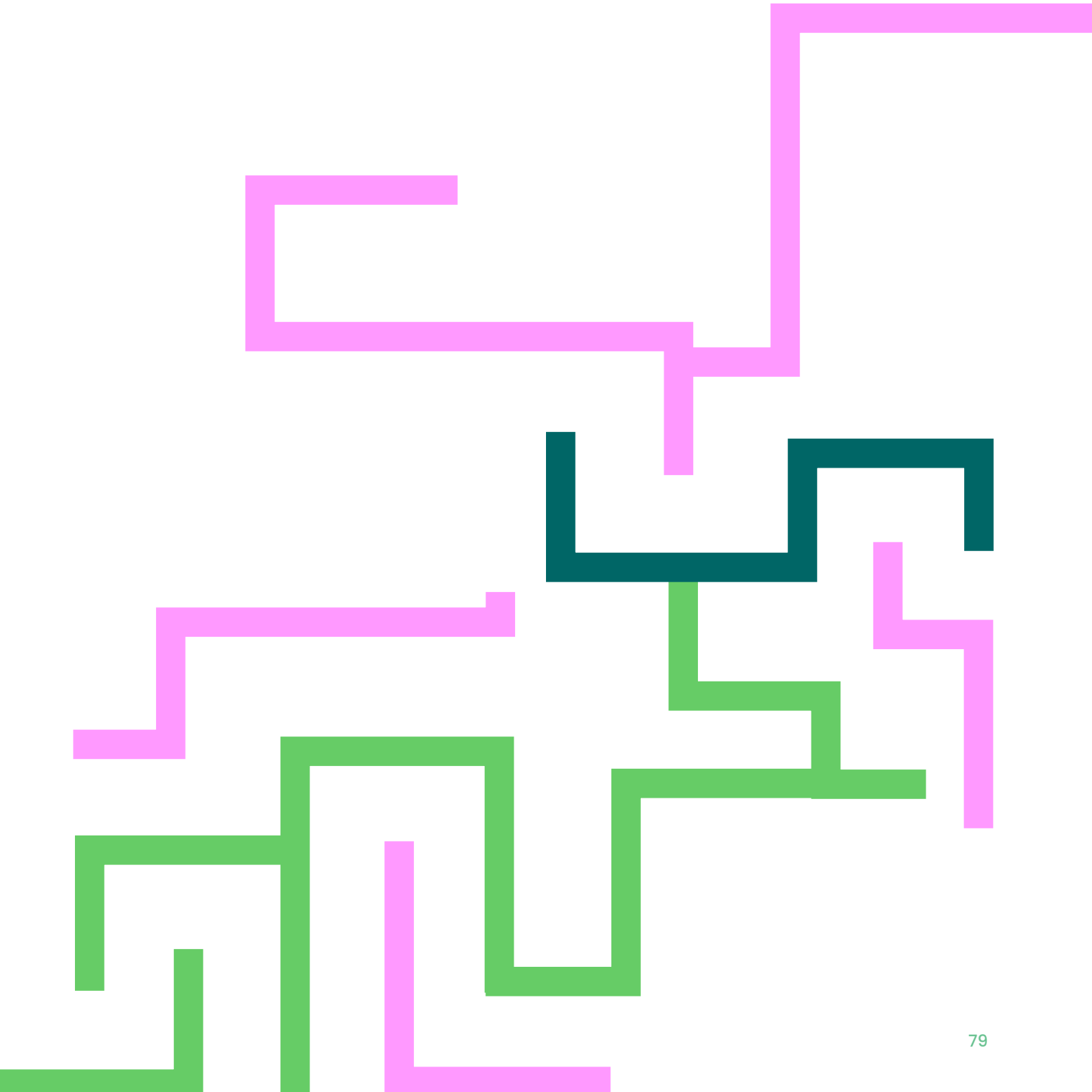
Overall, this research shows that, like those in neighbouring countries, Togolese adolescent girls and women are forced to navigate contradictory social norms, bearing a triple normative burden. These norms prevent adolescents receiving adequate relationship and sexuality education, yet stigmatise early and extramarital pregnancies, and strongly condemn and stigmatise abortion.[48] These norms force adolescent girls and women experiencing an unintended pregnancy to resort to unsafe abortion methods. This reality shows that addressing unsafe abortion goes far beyond the legal or medical dimensions. Rather, the structural factors and root causes of unintended pregnancy identified in this study must be addressed. To do so, it is essential to invest in transforming harmful gender norms, promoting gender equality and reducing the stigma surrounding abortion.

Obstetric violence

Other authors have highlighted the forms of violence inherent in the model of post-abortion care present in Togo and other countries. Although originally conceived as a measure to save lives, restricting legal access to abortion in Togo to emergency situations (such as post-abortion complications) paradoxically obscures the need for comprehensive, legal, safe and accessible abortion services.[49] The level of obstetric violence (the mistreatment, disrespect or abuse of pregnant women) observed

during post-abortion care is also significant. These practices are due to the restrictive legal framework, the high level of stigma surrounding abortion, a lack of resources within the health system, healthcare providers' excessive workloads and the persistence of discriminatory personal values. In its current form, post-abortion care in Togo is jeopardising the health, safety and dignity of adolescent girls and women.[50]

Togolese girls and women are forced to navigate contradictory social norms



Conclusion: dismantling the maze women face

This report reveals common, albeit hidden, experiences in the lives of Togolese adolescent girls and women. It highlights the root causes of unintended pregnancies, as well as the many challenges adolescent girls and women who experience them face. This includes the complexity of the pathways leading to abortion and the management of its complications.

While abortion is often perceived as an issue that concerns only adolescent girls and women, the findings show that adolescent boys and men, as well as mothers, aunts and fathers, play an important role. These individuals influence the factors that increase vulnerability to unintended pregnancy, as well as shaping decision-making processes relating to abortion and affecting access to clandestine abortion methods, which are largely unsafe.

Aided by harmful social norms and a restrictive legal framework, providers of clandestine abortions influence and exploit an ecosystem of unsafe abortion, a confusing maze which forces women who are unintentionally pregnant to resort to unsafe methods. Although many people are involved, it is adolescent girls and women who bear the heaviest burden: they are forced to put themselves at risk by resorting to unsafe abortion before they can access legal medical care in the strong likelihood that they experience complications.

The findings challenge the perception of abortion as solely a women's issue, highlighting the role of families and partners

Seeking post-abortion care often exposes women to a new form of harm: obstetric violence. This violence stems both from healthcare providers' personal values and from a health system that is ill-equipped to provide high-quality care, free from moral judgement. The restrictive legal framework, the fear it instils, social stigma and the chronic underfunding of health systems make it difficult for women, particularly adolescent girls and young women, to access prompt, adequate and respectful care. The maze of accessing healthcare becomes life-threatening when a shortage of resources combines with the fear of stigma, preventing adolescent girls and women from seeking and receiving care in a timely manner. More empirical data is needed to understand the scale of complications and deaths linked to unsafe abortions in Togo as well as the underlying factors that cause them.

It is important to build on the lessons from this study and the findings of previous research to advance the rights of adolescent girls and women to health, education, autonomy and bodily integrity. These findings should also be used to address the multiple forms of violence women experience. While the root causes of reproductive injustice identified in this report are numerous, they are not insurmountable. A key first step is to strengthen access to relationship and sexuality education to enable young people to make informed choices, which can help them prevent unintended pregnancies.

Interventions are needed to combat harmful gender norms which expose adolescent girls and women to sexual violence, such as rape and sexual abuse. It is equally important to destigmatise the use of modern contraceptive methods among young people and to ensure they have access to appropriate SRH services. These actions must be accompanied by adequate funding for Togo's health system to provide high-quality care for all.

Parents, adolescent boys, men and healthcare providers must have access to information on safe abortion methods, autonomy and consent, so they can become true allies in efforts to prevent unintended pregnancies and unsafe abortions in Togo.

Finally, the legal framework governing abortion must be revised to expand access to safe abortion care which prioritises the

health, lives and well-being of adolescent girls and women and reflect their realities and needs. This reform must be accompanied by robust accountability mechanisms to ensure the effective implementation and dissemination of the new legal framework.

Only through such actions can the appalling maze that traps adolescent girls and women be dismantled, paving the way for a dignified and healthy future for all women and their families.

When resource shortages and stigma combine, barriers to healthcare can become life-threatening

Reforming the legal framework is essential to expand access to safe abortion and protect the health and wellbeing of adolescent girls and women

Recommendations

1 Reform the legal framework for reproductive health

Reforming the legal framework will guarantee that adolescent girls and women facing an unintended pregnancy have access to safe and legal abortion, and will prevent them from putting their lives at risk by resorting to unsafe methods. To achieve this, the following sub-recommendations are relevant:

- Revise the 2007 Reproductive Health Act to broaden the legal grounds for access to safe abortion and ensure its effective implementation to reduce maternal mortality and morbidity.
- Draft and publish the implementing regulations for the revised Act to facilitate its practical implementation.
- Widely disseminate these implementing regulations among service providers in the health, social, judicial and security sectors.
- Increase the number of healthcare providers providing comprehensive safe abortion care, and improve their training.
- Ensure the monitoring and effective implementation of the revised Act on reproductive health.
- Inform the public about the content of the new revised Act on reproductive health.

2 Improve the quality of post-abortion care

Through targeted training for healthcare providers on the management of abortions and post-abortion care. This care must be provided without judgement, include adequate pain management and be systematically accompanied by advice on contraception. To achieve this, the following sub-recommendations are relevant:

- Train healthcare providers in comprehensive abortion care and post-abortion care in accordance with the law (continuing professional development), with a focus on: raising awareness of the Reproductive Health Act; comprehensive abortion care; post-abortion care including pain management, empathetic listening and post-abortion contraceptive counselling; youth-friendly reproductive health rights and services; and values clarification to reduce stigma and opposition to the provision of safe abortion and post-abortion care services.
- Expand the initial training programme for healthcare professionals on comprehensive abortion care and post-abortion care in accordance with the law, with a focus on: raising awareness of the Reproductive Health Act; comprehensive abortion care; post-abortion care including pain management, empathetic listening and post-abortion contraceptive counselling; youth-friendly reproductive health rights and services; and values clarification to reduce stigma and opposition to the provision of safe abortion and post-abortion care services.
- Ensure that post-abortion care is provided to the highest quality standard, free from stigma and with respect for privacy, and includes adequate pain management, and high-quality contraceptive advice to prevent further unintended pregnancies.
- Ensure standardised practices in the provision of high-quality safe abortion care by implementing a national protocol or guideline aligned with the latest WHO recommendations and evidence-based guidelines and disseminate this to all healthcare professionals in Togo.

3 Ensure the availability of medical supplies

Ensure availability to prevent any delays in the provision of safe abortion care in accordance with the legal framework, including post-abortion care, and to guarantee high-quality care. To achieve this, the following sub-recommendations are relevant:

- Ensure that every health centre and hospital has access to high-quality equipment, medicines and contraceptives to provide high-quality care, manage complications arising from unsafe abortions, effectively manage pain during procedures and provide appropriate advice on contraception.

4 Promote universal and equitable access to reproductive health services

Financial barriers must be removed by ensuring comprehensive care relating to safe abortion care, post-abortion care and contraception is provided free of charge through universal health coverage. To achieve this, the following sub-recommendations are relevant:

- Make comprehensive safe abortion care and post-abortion care free of charge
- Make access to modern contraceptive methods free of charge for young people and women
- Establish more youth-friendly SRH services
- Raise public awareness to address the concerns that stop people using contraception

5 Strengthen relationship and sexuality education

Young people must have access to reliable information on emotional and sexual life to prevent unintended pregnancies, sexual violence and unsafe abortions. Relationship and sexuality education must be integrated into the initial training programmes for teachers and social workers.

6

Promote positive masculinity and challenge harmful norms

To tackle both the causes and consequences of unintended pregnancies, it is essential to promote positive masculinity and challenge harmful norms that perpetuate sexual and gender-based violence, discourage girls and young women from using contraceptives and stigmatise abortion.

Conduct a study on the prevalence of abortion in Togo

7

To accurately measure the prevalence of unsafe abortions, their complications and associated maternal deaths, a national incidence study is essential.

Annexes

Annex 1

Research objectives

Overall objective

The general objective of this in-depth qualitative study is to address the knowledge gap regarding the determinants of unintended pregnancies resulting in abortions, decision-making processes related to abortion, and the social, gender and health system dynamics that influence the search for abortion methods and post-abortion care.

Specific objectives

1. To explore the dynamics surrounding unintended pregnancies and decision-making processes regarding abortion, according to women's economic, cultural and social backgrounds.
2. To examine the pathways to seeking and accessing abortion care in a context where such access is legally restricted.
3. To understand public knowledge of the legal framework governing abortion, attitudes towards abortion, and how these influence abortion decision-making and pathways to seeking care.
4. To understand which factors (including partner support, access to information, place of residence and financial and social resources) influence adolescent girls' and women's access to safe or unsafe methods of abortion.
5. To understand the experiences of adolescent girls, women and healthcare providers in Togo regarding the provision of, and access to, post-abortion care.

Annex 2

Methodology

Study design

To understand the factors leading to unsafe abortions and the complexities of abortion pathways in Togo, this study adopted an ethnographic approach. This is a qualitative method of data collection, commonly used in the social and behavioural sciences to make sense of complex social phenomena. It relies, among other things, on detailed (participant) observations in specific contexts and in-depth interviews with study participants.[51] Ethnography is particularly well suited to the study of sensitive social phenomena and their underlying factors[52] which are often hidden due to the stigma associated with them or their illegal nature), as it requires prolonged immersion within the population groups being studied in order to gain their trust and understand them fully.

This study combines an ethnographic approach with a youth-centred approach, by training and engaging young researchers from Togo to be at the forefront of data collection, interpretation and analysis. This youth-centred approach has enabled young people's genuine and inclusive participation in producing evidence on unsafe abortions in Togo. This has not only generated high-quality data and a deep contextual understanding of young people's behaviours and concerns, it has also ensured young people's right to participate in matters that affect them.[53] This approach has helped to build the capacity of young Togolese researchers to conduct qualitative research on sensitive issues relating to SRHR.

Rationale for the selection of study sites

This research was carried out by the APHRC, Rutgers, the Population Council and the ATBEF. It formed part of two programmes: *Sa Santé, Ses Choix* (Her Health, Her Choices), implemented in West and Central Africa to reduce maternal mortality and morbidity linked to unsafe abortions,[q] and expanding access to quality sexual and reproductive health services in French-speaking West Africa.[s] A preliminary literature review revealed a glaring lack of empirical data on abortion in Togo compared with other countries in the region. The national partner, ATBEF, confirmed this gap and guided the research objectives accordingly.

Several indicators justified the choice of the two study sites, namely the Grand Lomé and Plateaux regions. Grand Lomé, home to the capital Lomé, was chosen due to its status as the country's administrative and metropolitan hub. This enabled an examination of the urban and contemporary factors associated with unintended pregnancy, including sexual violence, economic insecurity, transactional sex for daily survival and postponement of marriages that may influence premarital sex. Available reproductive health data reveals a high rate (of unmet family planning needs in Lomé (34.4%).[54] Grand Lomé has also been identified as a region with numerous clandestine abortion clinics offering access to a wide range of informal, unsafe methods. The Plateaux region, in addition to having a high rate of unmet family planning needs (34.7%)[55], recorded the highest number of unsafe abortions requiring post-abortion care in health facilities in 2023.

Health facilities were selected based on the high number of post-abortion care cases treated and their location (ensuring a balanced distribution by location; specifically, two in rural areas, two in urban areas and two in peri-urban areas). Information on the number of post-abortion care cases was obtained from the Health Management Information System via the SRHR coordinators in each region.

Study population and sampling

The main target population for this study consisted of adolescent girls and women who had undergone an abortion in the two years prior to the start of the research. In-depth, repeated interviews were conducted with 61 participants (28 women from Grand Lomé and 33 from the Plateaux region). Five deaths linked to unsafe abortions (all occurring in the Plateaux region) were documented through observations in health facilities, interviews with healthcare providers and, where possible,

r Funded by Postcode Loterij (Postcode Lottery Netherlands) via Rutgers
s Funded by the William and Flora Hewlett Foundation via the Population Council.

with partners or relatives. The 61 participants were identified in healthcare facilities and neighbouring communities, with the support of healthcare providers and community health workers, as well as through snowball sampling. In all cases, healthcare providers or other key informants first approached the participants on behalf of the researchers to invite them to take part in the study before introducing them to the research assistants. All participants gave their informed consent before taking part in the study.

This work also involved relatives of the adolescent girls and women in this study who had undergone an abortion, with the women's consent. Similarly, where possible, the spouses or partners of the adolescent girls or women were approached: twelve partners plus sixteen family members were interviewed across the two regions.

Community members (consisting of adult men and women, adolescents and young people) took part in 24 focus group discussions (12 per region) on general SRHR topics. This approach was designed to preserve the confidentiality of the study's main themes and to protect the anonymity of the individual participants with whom the research assistants were in contact. The groups were formed in a homogeneous manner (by gender, age and role within the community) to minimise power imbalances that might inhibit participation.

In addition, 40 healthcare providers from public, private and community-based facilities were interviewed across both regions.

Interviews were also conducted with medicine vendors, pharmacists, traditional healers, religious leaders and representatives of public and private institutions and CSOs (38 in the Plateaux region and 33 in the Grand Lomé region).

The data from the interviews and focus group discussions was supplemented by a substantial amount of observational data collected in health facilities and within communities.

Table 1: Summary of study participants by category

Participants	Number	Total
In-depth interviews with adolescent girls and women who have had an abortion	61	**61**
Interviews with healthcare providers	40	**40**
Interviews with relatives and partners	12 partners 16 family members	**28**
Focus group discussions with community members	8 with young women and men, aged between 18 and 24 8 with the mothers of adolescent girls and young women 8 with the fathers of adolescent girls and young women	**24**
Key informants		**69**

Data collection

Data was collected over a seven-month period, between September 2024 and April 2025, using the following techniques and methods.

Participant observation in healthcare facilities and communities

In the selected healthcare facilities, research assistants identified all points of post-abortion care provision. Where relevant and where access had been granted, participant observation was carried out, particularly in A&E departments, maternity wards (delivery rooms) and gynaecology and obstetrics departments. These observations focused on the overall quality of care, the capacity of the health system, the behaviours, beliefs and practices of healthcare providers, as well as the abortion-related complications faced by women and the type of care they received. In reception areas and waiting rooms, observations focused on interactions between women seeking post-abortion care and healthcare providers, and between women seeking post-abortion care and the people accompanying them. For women receiving post-abortion care (identified with the help of healthcare providers), the process was tracked from initial contact through to discharge. In addition, research assistants observed training sessions for healthcare providers and information sessions on SRH, as well as community engagement activities on SRH during the data collection period.

During observations and informal discussions, research assistants and healthcare providers identified adolescent girls and women who agreed, on the basis of informed consent, to participate in this study and with whom they established relationships of trust outside healthcare facilities. Upon their discharge, a new consent form was obtained to continue the observations and interviews.

At community level, research assistants undertook 'study walks', which involved visiting various neighbourhoods and engaging in informal discussions and activities with community members. These exchanges enabled the collection of contextual information and perceptions regarding relevant issues such as SRH, teenage pregnancy, abortion practices and knowledge of the abortion law. They also helped to identify other adolescent girls and women who had undergone an abortion.

In-depth and repeat interviews with adolescent girls and women who had undergone an abortion

Once the participants had been identified and their consent obtained, in-depth interviews were conducted in confidential settings with 61 adolescent girls and women. The table below summarises the characteristics of the women interviewed.

Table 2: Socio-demographic characteristics of the adolescent girls and women interviewed

Characteristic		Frequency (n=61)
Age	15 -17	**14**
	18- 24	**26**
	25 - 30	**16**
	31 - 40	**5**
Marital status	Married	**11**
	Divorced	**0**
	Single	**47**
	Living with a partner	**3**
Level of education	No education	**4**
	Primary	**12**
	Secondary	**37**
	University	**8**
Place of residence	Urban	**35**
	Suburban	**10**
	Rural	**16**
Occupation	Student (primary or secondary education)	**13**
	Student (higher education)	**3**
	Housewife	**2**
	Trainee	**2**
	Informal sector worker	**41**

In-depth interviews with spouses/partners and relatives of women who had undergone an abortion

During informal discussions with young women who had undergone an abortion, the possibility of interviewing their partners or relatives was assessed, with their prior consent. In total, twelve partners and sixteen relatives were interviewed, including mothers, guardians, brothers, grandmothers and cousins.

In-depth interviews with healthcare providers

Individual interviews were conducted with 40 healthcare providers, selected from the facilities participating in the study. They were selected on the basis of their direct involvement in the provision of post-abortion care. In total, 19 interviews were conducted in the Grand Lomé region and 21 in the Plateaux region.

Table 3: Profiles of the healthcare workers interviewed

Characteristic		Frequency (n=61)
Age	20 to 30 years	**6**
	31 to 40 years	**16**
	41 to 50 years	**18**
Level of education	CEPD	**1**
	A-level	**4**
	Bachelor's degree	**27**
	DES	**2**
	PhD	**6**
Place of residence	Urban area	**19**
	Peri-urban area	**11**
	Rural area	**10**
Occupation	Midwife	**23**
	Gynaecologist	**6**
	Registered nurse	**3**
	Medical assistant	**2**
	Gynaecology assistant	**2**
	Midwife	**4**

As shown in the table, the study included all categories of healthcare providers working in the maternity ward.

Interviews with key informants

The interviews with key informants focused primarily on informal abortion service providers, community health workers, medicine sellers and pharmacists, as well as traditional healers, religious leaders and custodians of community customs and traditions. They were identified using a snowball sampling approach. The interviews sought to gather their perspectives and understand their roles in the provision of abortion services. A total of 69 key informants were interviewed: 33 in the Grand Lomé region and 36 in the Plateaux region.

Table 4 : Characteristics of key informants

Characteristics of key informants	Frequency (n=69)
CSO staff, social services	**10**
Community leaders (community health workers, members of neighbourhood development committees, traditional and neighbourhood leaders)	**17**
Peer educators/advocacy officers from the MAJ (Youth Action Movement)	**5**
Religious leaders (priests, imams, pastors, traditional chiefs)	**9**
Representative from the Ministry of Health (Department of Maternal and Child Health)	**1**
Lawyer	**1**
Education professionals (teacher, headteacher)	**6**
Pharmacists/informal sellers of medicines	**8**
Representatives of organisations for people with disabilities	**2**
(Non-medical) staff at healthcare facilities	**10**

Focus group discussions

Focus group discussions were held with adolescents, young people and adults (male and female) from the target communities. These discussions aimed to document the broader social, cultural and religious norms within which the adolescent girls and women participating in the study lived. They brought together community members, regardless of any personal experience of abortion. A total of 24 focus groups were facilitated across the two regions.

Data management and analysis

The audio files were transcribed in full after each interview and then translated from the local languages (Éwé, Kabiyé, Kotokoli) into French where necessary. The names of participants and health centres were pseudonymised to ensure their anonymity. All digital files (notes, transcripts, recordings) were stored on a secure drive, accessible only to the research team.

Thematic analysis served as the main analytical framework. The development of the coding scheme and subsequent analyses were both theoretical (based on the research protocol) and data-driven, reflecting additional themes emerging from the data. Weekly calls and online communications were used to discuss and resolve challenges encountered during coding. Dedoose software was used for coding.

Emerging themes relating to factors contributing to the vulnerability of adolescent girls and women to abortion, the decision-making process, the abortion journey and post-abortion care were extracted and analysed in greater detail for this report. The findings, drawn from observations and interviews, are presented in the form of verbatim transcripts and case studies, with pseudonyms used to preserve participants' anonymity.

The research team and its positionality

This research was designed and carried out by researchers from APHRC, Rutgers, ATBEF and the Population Council, and subsequently validated by a youth advisory committee from Togo. The organisations and individuals involved in this research represent institutions committed to SRH, rights and justice. The study adopts an approach centred on amplifying marginalised voices, critically analysing power relations and advocating for justice and systemic reform.

The research was conducted by six researchers – most of whom are young people – and two national coordinators from Togo, who were directly involved in data collection. The project also benefited from the support of four senior researchers based in Togo, Senegal, Kenya and the Netherlands, as well as four other research coordinators from Senegal, Togo and Benin. The majority of the researchers have a background in anthropology or related social science disciplines. One of the senior researchers, who is from Togo, is a gynaecologist. During the data collection period, all team members took part in weekly two-hour online debriefing sessions to discuss the practical difficulties encountered and the ethical dilemmas raised during data collection. All remained available to provide support throughout the data collection period, should the need arise.

This report was drafted collaboratively by the entire team and an external consultant, with the exception of a young researcher who left the project. A preliminary set of findings was presented at a validation workshop held in Lomé on 2 and 3 October 2025. This workshop brought together the research team, research partners, key representatives from the Ministry of Health, health professionals, religious and community leaders, representatives of civil society organisations, and the study's youth advisory committee. Workshop participants jointly formulated the recommendations presented in this report and developed a strategy for disseminating and ensuring ownership of the research findings.

Limitations

More than seven months were spent conducting fieldwork in twelve selected health facilities and communities in the Grand Lomé and Plateaux regions of Togo to gain an in-depth understanding of unsafe abortions and post-abortion care in these settings. However, the findings presented cannot be generalised to other regions of the country, due to the cultural, religious and socio-economic diversity specific to each region.

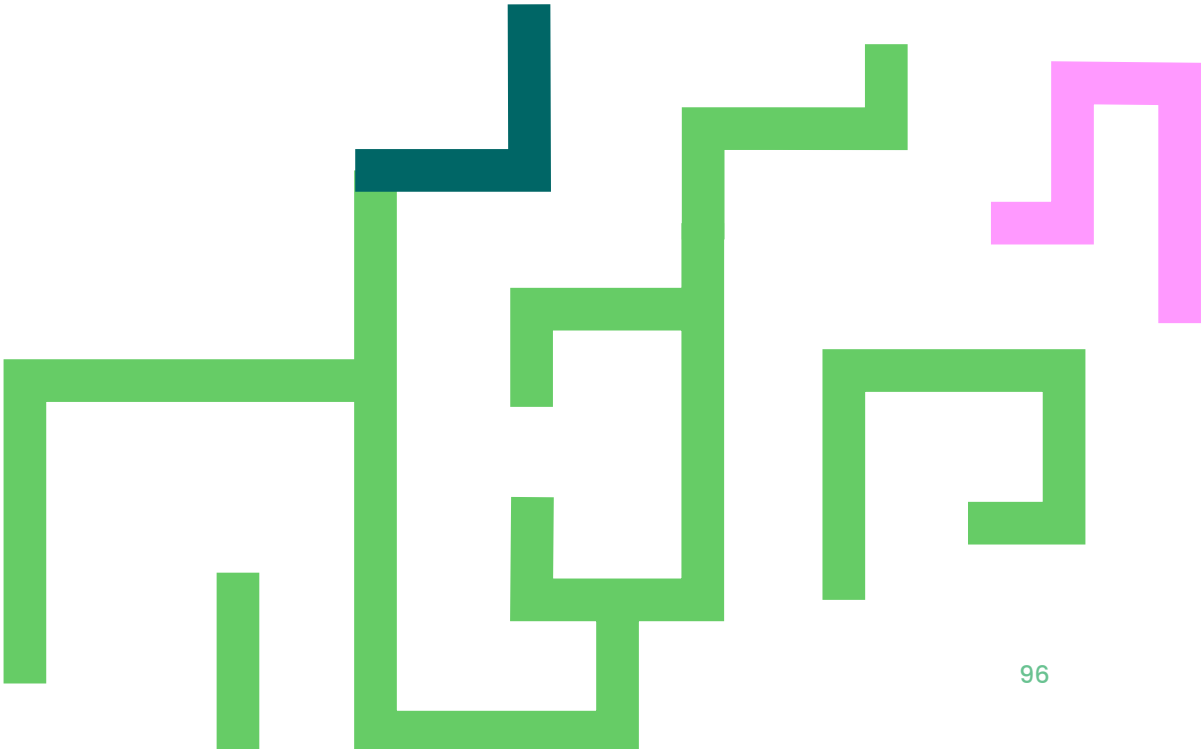
Furthermore, the social taboo and legal restrictions surrounding the issue of abortion in Togo posed obstacles to data collection. Despite an extended presence at the study sites aimed at building trust, several factors may have influenced what participants chose to share — or not to share — as well as the way in which their comments were phrased. These factors included fear of stigmatisation, legal repercussions and moral judgement. At the start of the research, the team encountered mistrust from some healthcare providers, which significantly hampered access to certain relevant healthcare settings. Repeated intervention by senior researchers gradually helped to overcome these reservations.

It proved difficult to contact some adolescent girls and women for follow-up interviews, as they feared their abortion might be revealed. In other cases, they wished to move on from their experience of abortion and not relive it. Participants' decisions to withdraw from the study were always fully respected, in accordance with the consent protocol.

Data collection focused primarily on adolescent girls and women who had an abortion following an unintended pregnancy. Although information was also collected from women who carried an unintended pregnancy to term, this group remains under-represented in the sample. Further research could deepen our understanding of the experiences and perspectives of this important group of adolescent girls and women.

The findings presented in this report have been shaped by the researchers' analyses and interpretations, which are themselves influenced by their worldviews, positionality and religious or cultural beliefs. These factors may have influenced the way in which data was collected, interpreted and presented. To enhance reflexivity and minimise potential biases, this research report was developed and co-authored by the entire multidisciplinary research team, including ten Togolese researchers, to ensure a diversity of perspectives and analyses. The findings have also been validated by a wide range of stakeholders, ensuring that they accurately reflect the realities in Togo.

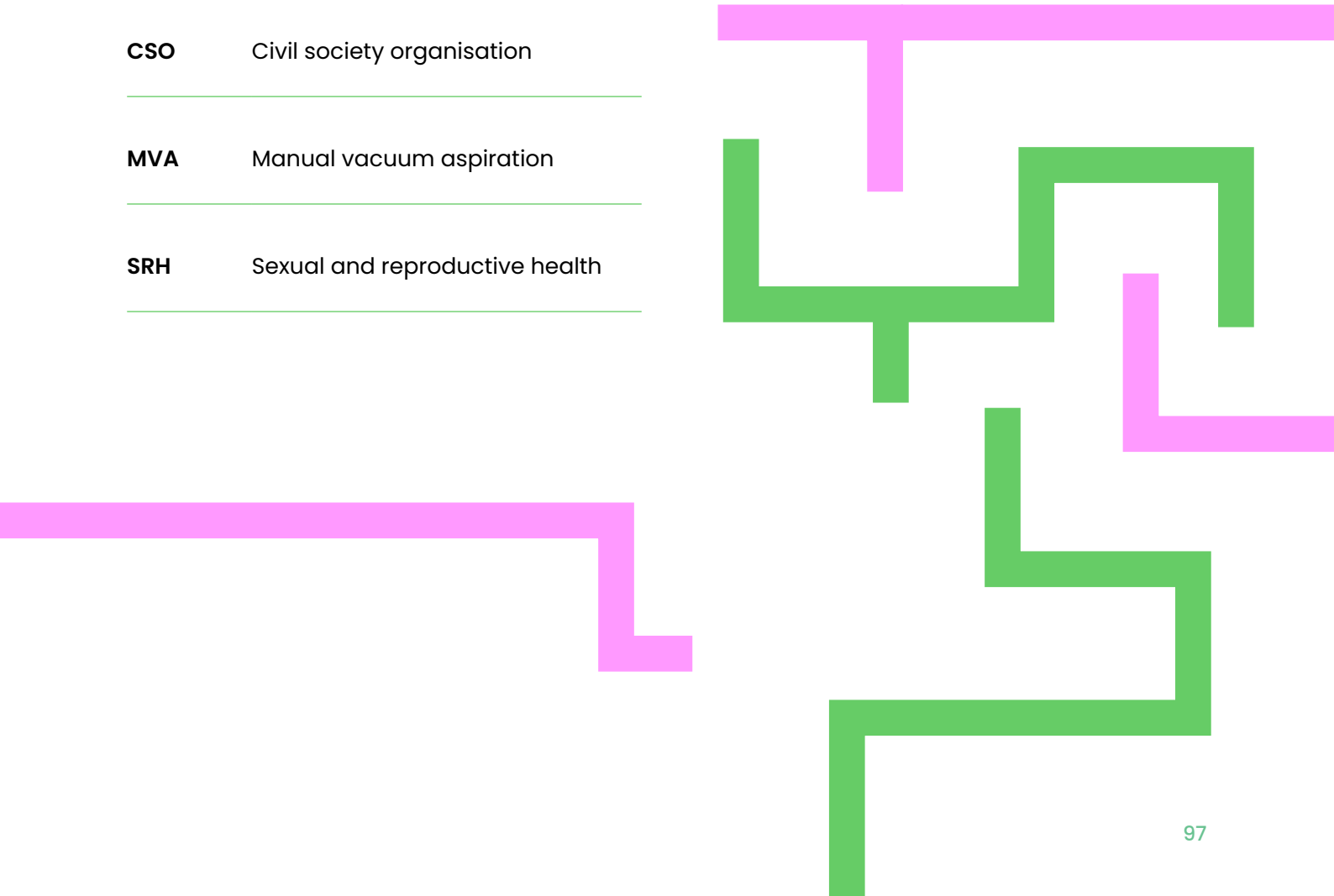
Despite these limitations, the study provides valuable new insights that are likely to inform future research, public policy and programmes in Togo (and beyond), where available data on this subject is limited.



Annex 3

Abbreviations and acronyms

APHRC	Africa Population and Health Research Centre
ATBEF	Togolese Association for Family Wellbeing
CBRS	Togolese Bioethics Committee for Health Research
CFA	African Financial Community
CSO	Civil society organisation
MVA	Manual vacuum aspiration
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STIs	Sexually transmitted infections
WHO	World Health Organization



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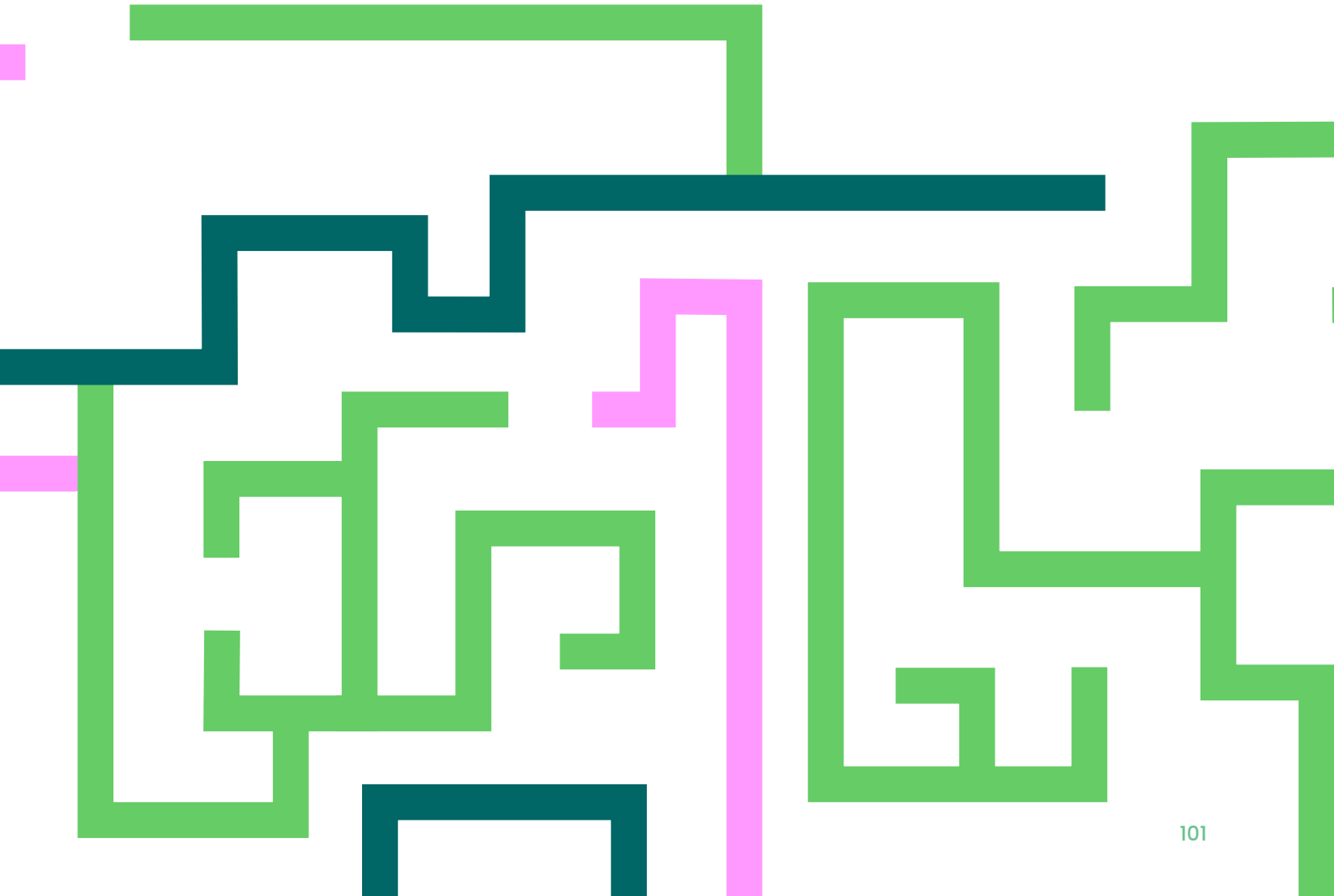
Behind the report

This report was made possible thanks to the dedication and creativity of many talented partners and collaborators. Together, their collective efforts have transformed the research into a living story, which we hope will inform, inspire and spur action.

A huge thank you to the people and communities featured in the photographs. Your openness and courage bring this report to life and remind us why this work is important.

Design: Rewire Design

Photography: Yanick Folly



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