Oct. 1, 2017

Committee on the Elimination of Discrimination against Women (CEDAW)
Office of the High Commissioners for Human Rights
Geneva, Switzerland

RE: Supplementary information on Burkina Faso scheduled for review by the CEDAW Committee during its 68th session in October 2017.

Dear Committee Members:

This shadow letter is intended to complement the periodic report submitted by the State of **Burkina Faso** for your consideration during the 68th session of the CEDAW Committee. This letter is intended to provide the Committee with information about Burkina Faso's violations of CEDAW that result from the State's restrictive abortion law.

Articles 383-390 of Burkina Faso's 1996 Penal Code **prohibit abortion except to preserve the life or health of the mother, in case of rape or incest, or if the fetus will have a severe and incurable abnormality, which at least two doctors in a public facility must attest to.** In case of rape or incest, abortion is permitted through 10 weeks of gestation and in cases of rape, the state prosecutor must establish the cause for abortion.[1] A person who carries out an abortion is subject to one to five years' imprisonment and imposition of a fine of 300,000 to 1,500,000 CFA francs if it is performed outside the above grounds. The reproductive health law (Law No. 049-2005/AN) which was passed in 2005 reaffirms the conditions of the penal code under Article 25.

The restrictive law violates **Article 2(f)** of the Convention, which requires State Parties to "take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women." CEDAW **General Recommendation 24** on Women and Health states, "When possible, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion."

Due to the restrictive law, safe abortion is largely inaccessible in Burkina Faso, in violation of **Article 12** of the Convention (the rights of women to health and nondiscrimination) and **Article 16(e)** (the rights of women to decide freely and responsibly on the number and spacing of their children). This Committee has consistently criticized restrictive abortion laws, framing such laws as a violation of the rights to life and health and asking state parties to review legislation making abortion illegal.[2] This Committee has also examined the discriminatory effects of legislation making abortion illegal, noting that "[i]t is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."[3]

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[1]Center for Reproductive Rights (1992-2016). *Burkina Faso's Abortion Provisions*. Retrieved from http://www.reproductiverights.org/world-abortion-laws/burkina-fasos-abortion-provisions

[2] *See, e.g.*, **Bolivia**, 31/05/95, U.N. Doc. A/50/38, par. 393; **Mauritius**, 31/05/95, U.N. Doc. A/50/38, par. 196; **Paraguay**, 09/05/96, U.N. Doc. A/51/38, par. 131.

[3] Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and Health* (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 244, par. 11, U.N. Doc. HRI/GEN/1/Rev.5 (2001).

Women in Burkina Faso already suffer vast discrimination in many areas of their lives, with unequal access to education, health care and employment. Particularly in rural areas, women have little say in domestic decisions and in their own reproductive health choices. **Without access to safe abortion, women in Burkina Faso risk their health and lives every day by resorting to unsafe methods.** In its **General Comment 14**, the CESCR Committee specifies that States must implement measures to "(i)mprove child and maternal health, sexual and reproductive health care services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as resources necessary to act on that information."[4] **In several Concluding Observations, this Committee has expressed deep concern over the relationship between high rates of maternal mortality and illegal, unsafe abortions.**[5] The Committee has made recommendations to States that they increase education on reproductive and sexual health, as well as implement programs to increase access to family planning services and contraception.[6]

Despite various policies and plans to promote family planning, several challenges still stand in the way of progress in Burkina Faso including the prevalence of commodity stock outs and a limited range of available contraceptives, demand creation, especially among rural populations and young people, lack of adequate skilled healthcare personnel and equipment and health financing of health. Though the government has shown some political will towards access to contraception, too little has been done to improve access to post abortion care and comprehensive abortion care, which are an integral part of the sexual and reproductive health needs facing women and young girls in Burkina Faso. **In 2010, the Committee expressed its concern about the lack of available information on the link between the maternal mortality rate and the practice of clandestine abortions, as well as on the effects of criminalization of abortion with regard to the high maternal mortality rate In Burkina Faso.**

We bring the below issues to the attention of the Committee, which present major obstacles to the implementation of the Convention in Burkina Faso**.** Despite significant strides taken to increase contraception access, much remains to be done to address the extremely high levels of maternal deaths linked to unsafe abortion in the country.

- **Criminalization of abortion and the persistence of unsafe abortions**
- **Youth access to reproductive health services and information**
- **Unmet family planning need and maternal health**

[4] Committee on Economic, Social and Cultural Rights (CESCR), *General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12)* (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 90, par. 14, U.N. Doc. HRI/GEN/1/Rev.5 (2001).
[5] *See e.g.*, **Cameroon,** 08/12/99, U.N. Doc. E/C.12/1/Add.40, par. 25; **Mauritius**, 31/05/94, U.N. Doc. E/C.12/1994/8, par. 15; **Mexico,** 08/12/99, U.N. Doc. E/C.12/1/Add.41, par. 29; **Nepal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.66, par. 32.
[6] *See*, *e.g.*, **Bolivia,** 21/05/2001, U.N. Doc. E/C.12/1/Add.60, par. 43; **Mexico,** 08/12/99, U.N. Doc. E/C.12/1/Add.41, par. 43; **Nepal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.66, pars. 33, 55; **Poland,** 16/06/98, U.N. Doc. E/C.12/1/Add.26, par. 12.

1) Criminalization of abortion and the persistence of unsafe abortions

According to the Minister of Health, unsafe abortion accounts for **28.3%** of maternal deaths in Burkina Faso.[7] Not only is this a highly alarming rate, it is one of the highest in the region, and studies are showing that it is on the rise. The most recent of these studies have found that the incidence of abortion is rising, with about 87,000 abortions nationwide in 2008, to 105,000 abortions nationwide in 2012.[8]

Because illegal abortion is a punishable criminal act, the vast majority of women who end their pregnancies in Burkina Faso—whether they could have done so legally or not—do so in secrecy, for fear of prosecution and to avoid the social stigma that surrounds abortion. Most clandestine abortions are often carried out under highly unsafe conditions, which jeopardizes women's health and their lives.[9] Only one-third of Burkinabe women are aware that abortion is legal in some circumstances. The clandestine nature of abortion is compounded by the fact that there is high provider stigma and fear or prosecution, leading women to regularly avoid the formal health system altogether. Regardless of where they live, the vast majority of women decide to terminate a pregnancy for the same reason: they are faced with an unintended and unwanted pregnancy, for health or societal reasons**. An estimated 32% of all pregnancies in Burkina Faso are unintended—meaning they are either mistimed or unwanted altogether—and one-third of these unintended pregnancies end in abortion**.[10]

Research suggests that most abortions are obtained through unskilled practitioners or are self-performed[11] and that approximately 50% of abortions result in complications. Of the women with abortion complications, only 40% receive post abortion care. In 2008, 41% of abortions were carried out by traditional practitioners, 23% by women themselves, while 25 % were performed by midwives and health assistants, and 3% by doctors.[12]

In its report to this Committee, the government if Burkina Faso states that it is considering the removal of procedural obstacles for obtaining an abortion in case of rape or incest. Even if the consent of the prosecutor may now be bypassed, women will still have to obtain an authorization from the gendarmerie or the police. **Unnecessary reporting requirements will only limit access to care, and we urge this Committee to ask the government to remove all reporting requirements for abortion access**.

We urge this Committee to recommend that the government decriminalize abortion in all circumstances, to address the alarming rates of maternal mortality and morbidity due to unsafe abortion.

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[7] Ipas, 2016. Comprehensive abortion care needs and opportunities in francophone West Africa: Situational assessment results, Retrieved at http://www.ipas.org/en/Resources/Ipas%20Publications/Comprehensive-Abortion-Care-Needs-and-Opportunities-in-Francophone-West-Africa.aspx

[8] Sedgh, G., Rossier, C., Kaboré, I., Bankole, A., (2011). Estimating abortion incidence in Burkina Faso using two methodologies. Studies in Family Planning, 42(3), 147-154

[9] Guttmacher Institute. (2014). *Abortion in Burkina Faso*. Retrieved from http://www.guttmacher.org/pubs/FB-Abortion-in-Burkina.html.

[10] *id*

[11] Pathfinder International. (2016) Technical Brief on Advancing Abortion Rights: Cross-country analysis. Retrieved from https://www.pathfinder.org/wp-content/uploads/2016/05/Strategies-to-Advance-Abortion-Access.pdf

[12] Ipas, 2016. Comprehensive abortion care needs and opportunities in francophone West Africa: Situational assessment results, Retrieved at http://www.ipas.org/en/Resources/Ipas%20Publications/Comprehensive-Abortion-Care-Needs-and-Opportunities-in-Francophone-West-Africa.aspx

2) Youth access to reproductive health services and information

Overall, the use of safe abortion methods is very low in Burkina Faso, but it is almost nonexistent among rural women, as 97% of abortions performed in rural areas are unsafe.[13] Women who induce abortion in Burkina Faso tend to be young, unmarried, residing in urban areas, and without other children. Sixty-five percent of women who had abortions in Burka Faso were aged between 15-24 years in 2008.[14]

Poor women are the most exposed to dangerous methods, with approximately 40% of abortions carried out using "potions" composed of things like bleach.[15] A recent ethnographic study on abortion decision making in Ouagadougou found that "the poorest always pay more (cost and consequences), take longer to have an abortion, and have more exposure to the risk of unsafe abortion" compared to their wealthier counterparts. This often extends to fear or disrespect and abuse at the hands of health-care providers.[16] **Efforts must be made to increase awareness of Burkina Faso's abortion law among women, communities and health professionals to ensure that Burkinabe women who are eligible for a legal abortion can access safe services**.

Given that women who have abortions are disproportionately likely to be young and unmarried, special attention should be directed at providing nonjudgmental and accessible family planning services to these groups. A young unmarried woman seeking contraceptives or an abortion may be treated poorly by medical staff, and these judgmental attitudes may hinder her willingness to seek care.

This year, President of Burkina Faso Roch Marc Christian Kaboré demonstrated his interest in health outcomes by ensuring improved access for young people to sexual and reproductive health services**. The government committed to raise the budget for contraceptive commodities for adolescents and young people's sexual and reproductive health from 14% to 30%.** CSOs in Burkina Faso successfully advocated for the inclusion of a stand-alone section on SRH services for adolescents and young people in the new Accelerated Family Planning Action Plan 2017-2020, a significant commitment.

We encourage the Committee to congratulate the government of Burkina Faso on these accomplishments, while urging the State to strengthen these commitments by ensuring comprehensive sexuality education that is accessible for all young people.

3) Unmet family planning need and maternal health

High mortality rates persist in Burkina Faso, disproportionately affecting women, children and infants**. According to the national health development plan 2011-2020, 80% of maternal deaths are due to obstetric causes which are preventable**. Several other factors contribute to maternal mortality and morbidity: namely female genital mutilation, early marriage, early pregnancies, unsafe abortions, poor access to services and socio-cultural constraints.

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[13] Guttmacher Institute. (2014). *Abortion in Burkina Faso*. Retrieved from http://www.guttmacher.org/pubs/FB-Abortion-in-Burkina.html.
[14] Sedgh, G., Rossier, C., Kaboré, I., Bankole, A., & Mikulich, M. (2011). Estimating abortion incidence in Burkina Faso using two methodologies. Studies in Family Planning, 42(3), 147-154.
[15] *Id*
[16] Ouédraogo, R., & Sundby, J. (2014). Social determinants and access to induced abortion in Burkina Faso: from two case studies. Obstetrics and Gynecology International, 2014.

High levels of unintended pregnancies are the result of low levels of contraceptive use. Burkina Faso has an estimated 17.5 million people. The population is growing rapidly due to large families (six children per woman on average) and the proportion of youth in the population (45% of the country's people are under age 15).[17] Nevertheless, many couples are having more children than they would like and many women who do not want a pregnancy do not use contraceptives. About one in four (24%) married women ages 15–49 want to space or limit future births but are not using any method of family planning. Unmet needs for contraception therefore persist at a rate of 27%, with 35.7% for married women overall. The highest unmet need for contraceptive services is among young, unmarried women aged 15-24 years.[18]

Since the early 1990's Burkina Faso has acceded to various regional and international initiatives and strategies that promote the health of mothers and children. Fulfilment of those commitments has included specific measures for maternal and child health (birth-care and emergency obstetric or neonatal care (SONU) subsidization, free preventive care, reduction of the cost of contraceptives, and procurement of contraceptives under the State budget.[19]. A number of other laws,[20] policies, strategies, and plans contribute to the national political-legal environment that supports reproductive health[21]. The passage of the Reproductive Health Law in 2005 ("RH Law") was an important milestone, overturning a 1920 law banning family planning. The RH Law guarantees the right of individuals and couples to reproductive health, equitable access to reproductive health care, and respect for the physical integrity of women and girls. **To date, however, the RH Law has not been fully applied, and many —even healthcare providers—are unaware of its provisions.**

In its report to this Committee, Burkina Faso highlights its aims to reposition Family Planning as a priority.[22] The Ministry of Health, under the leadership of Mr. Nicholas Meda, is working with the support of technical and financial partners to boost the supply of quality services and the public demand for family planning through **"the free provision of services, contraceptive subsidies, community-based distribution of contraceptive products with the support of NGOs and associations, community leaders and weekly surveillance of health products including contraceptives**." In addition, the government has taken steps to strengthen the involvement of men in family planning through the implementation of the "individual, family and community" approach, the "husband's school" strategy.[23] To improve access to FP services for rural populations, it has expanded task shifting to authorize state and patent (IB) nurses, birth attendants (AB), auxiliary birth attendants (AA) and traveling health agents (AIS) to offer long-term methods (implants and IUDs) and community-based health workers (ASBC) to initiate pill supply and administering injectables.[24]

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[17] World Health Organization, World Health Statistics 2015. Retried from WHO Library Cataloguing-in-Publication Data.
[18] Guttmacher Institute. (2014). *Abortion in Burkina Faso*. Retrieved from http://www.guttmacher.org/pubs/FB-Abortion-in-Burkina.html.
[19] The1996 National Pharmaceutical Policy integrated contraceptive purchasing into the broader health commodities system. In 2010, the Strategic Plan to Secure Access to Reproductive Health Commodities (PSSPSR) for 2009–2015 put further emphasis on ensuring a steady and reliable provision of contraceptives.
[20]The Consolidated Action Plan for Family Planning (2013– 2015), highlighted eight priority actions to extend and improve FP services and education.
[21] The Strategic Plan for Health among Youth 2004–2008, National Reproductive Health Policy among Youth and Teenagers, Norms and Standards for Health Services for Youth, a Strategic Plan for RH for Youth, a Strategic Plan to Secure RH Products, the Integrated Communication Plan, the Law on HIV, National Gender Policy, and Framework for Expenditures in the Medium Term.
[22] CEDAW/C/BFA/Q/7/Add.1
[23] *Id*
[24] In February 2011, Burkina Faso hosted an international conference with the theme "Population, Development, and Family Planning: The Urgency to Act where the Technical Group for Reproductive Health prepared the Consolidated Action Plan for Family Planning (2013–2015) in consultation with a broad spectrum of stakeholders. It was also in 2011 that Burkina Faso signed onto the **Ouagadougou Partnership**. At the 2012 London Summit for Family Planning, Burkina committed to increase CPR to 25% by 2015- equaling 400,000 additional women using modern contraceptive methods- in the hope to drastically reduce high maternal and neonatal mortality.

In 2017, the Burkina Faso government further committed to:

- Increase by at least 10% each year the budget line allocated by the State to the purchase of contraceptives from 2017 to 2020.
- By 2020, 50% of local and regional authorities line budget in the municipal budgets for the financing of FP activities from 2018.
- Scale up the delegation of tasks policy for health center agents (registered nurses, auxiliary midwives, pharmacists, pharmacy salespersons) than for community-based health workers (CBAS) by the end of 2018.
- Ensure free family planning
- Establish under the aegis of SEM the Prime Minister, a multisectoral coordinating body for issues related to the Demographic Dividend by the end of 2018[25]

We are pleased to see these commitments by the government of Burkina Faso on addressing access to contraception, and we urge this Committee to encourage the government to follow through on these commitments, as well as promote access to comprehensive sexual and reproductive health care, including safe, legal abortion care.

We urge this Committee to recommend that the government decriminalize abortion in all circumstances in order to address the problem of unsafe abortion.

We further request the Committee to acknowledge that a reformed abortion law should not contain barriers that will hinder access to safe abortion for women in Burkina Faso.

In particular, a reformed law on abortion must not include provisions that limit the type of provider that can legally provide abortion. According to the World Health Organization (WHO), safe abortion can be provided by a range of trained health care professionals, including nurses and midwives.[26] Access to safe abortion services for rural women is particularly compromised by a restrictive law. Burkina Faso increased its health care workforce between 2006 and 2010, but not sufficiently to meet the population's growing needs. Burkina Faso suffers from a severe lack of qualified health workers at all levels including support staff. There is less than 1 (0.45) physician per 10,000 people, 3.57 nurses per 10,000 people, and 2.39 midwives per 10,000[27]. Given this limited supply of doctors in the country, a provision limiting provider type would mean that vulnerable women—in particular young women, poor women and women living in rural areas—are more likely to obtain needed abortion through illegal and unsafe methods.

Provider stigma and fear of prosecution are major barriers for women seeking safe, legal abortion care. Adolescent girls should be able to consent to confidential abortion care in a reformed abortion law, without requirements of parental authorization. Confidential abortion care must be explicit for all women, but particularly for adolescent girls, as they may be more likely to be deterred from seeking safe services if privacy is not guaranteed.

[25] Engagement FP2020, Gouvernement du Burkina Faso. Retrieved from http://www.familyplanning2020.org/entities/91
[26] World Health Organization. 2012. Safe Abortion: Technical and Policy Guidance for Health Systems. Second Edition. Geneva: WHO.
[27] (Burkina Faso Ministry of Health, Statistical Yearbook 2010).

We request that the Committee pose the following questions to the state of Burkina Faso during the 68th Session of the CEDAW Committee:

1. What steps will the State take to ensure that the restrictive abortion law is reformed to address the problem of unsafe abortion, especially amongst poor and rural populations?

2. How will the State ensure that women have access to safe and legal health care services rather than suffering unnecessary and preventable deaths and injuries due to unsafe abortion, in violation of their rights to health and nondiscrimination?

3. What steps will the State take to ensure that comprehensive abortion care, post-abortion and safe abortion care are integrated into the public health care system at all levels, including for poor women and women living in rural areas who may seek such services?

4. How will the State ensure that minors seeking abortion are able to access youth-friendly services they need confidentially?

Restrictions on access to abortion violate a woman's right to health under **Article 12** of the Convention**. In Burkina Faso the restrictive law means that 28% of women who wish to terminate a pregnancy face a threat to their physical, mental, and social well-being**. A woman who turns to an untrained provider or attempts to self-induce can experience devastating life-long effects on her physical health, including infertility, injury, or even death. Abortion restrictions discriminate against women by criminalizing a health care procedure that only women need, and the impact of these restrictions are primarily felt by women who must carry the burden of unwanted pregnancy or else risk her life and health by seeking an unsafe abortion. The government of Burkina Faso should be strongly urged to remove legal restrictions on abortion and ensure that services are safe and accessible to all women who need them, and the government should ensure that this occurs in a timely manner.

We hope that this information will be useful for your review of the State of Burkina Faso's compliance with the CEDAW Convention.

Very Sincerely,

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