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The politics of unsafe abortion in Burkina Faso: The interface of local norms and global public health practice

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In Burkina Faso, abortion is legally restricted and socially stigmatised, but also frequent. Unsafe abortions represent a significant public health challenge, contributing to the country's very high maternal mortality ratio. Inspired by an internationally disseminated public health framing of unsafe abortion, the country's main policy response has been to provide post-abortion care (PAC) to avert deaths from abortion complications. Drawing on ethnographic research, this article describes how Burkina Faso's PAC policy emerged at the interface of political and moral negotiations between public health professionals, national bureaucrats and international agencies and NGOs. Burkinabè decision-makers and doctors, who are often hostile to induced abortion, have been convinced that PAC is 'life-saving care' which should be delivered for ethical medical reasons. Moreover, by supporting PAC they not only demonstrate compliance with international standards but also, importantly, do not have to contend with any change in abortion legislation, which they oppose. Rights-based international NGOs, in turn, tactically focus on PAC as a 'first step' towards their broader institutional objective to secure safe abortion and abortion rights. Such negotiations between national and international actors result in widespread support for PAC but stifled debate about further legalisation of abortion.

Keywords: abortion; politics; Burkina Faso; global/local; ethnography

Introduction

In Burkina Faso, an impoverished country in West Africa, induced abortion is legally restricted, but frequent and often unsafe. The law prohibits abortion except when the mother's life or health is endangered, in cases of severe foetal malformation, or when the pregnancy results from rape or incest. Yet, it is estimated that 105,000 abortions occurred in Burkina Faso in 2012, the vast majority of which were clandestine procedures performed under unsafe conditions (Bankole et al., 2014). Moreover, 43% of women who had an unsafe abortion experienced complications serious enough to require treatment, although many women did not receive the medical care they needed (Bankole et al., 2014), contributing to the country's very high level of maternal mortality.¹ This problem of frequent clandestine and unsafe abortions is publicly acknowledged in Burkina Faso. Yet, there has been little effort to challenge the legal and social barriers to safe abortion. Instead,

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the main policy response has been to implement a public health programme to treat complications resulting from unsafe abortion as part of the country's broader effort to reduce maternal mortality.

In this respect, Burkina Faso is typical of countries in which abortion is legally restricted, many of which have implemented post-abortion care (PAC) programmes in recent years. PAC is a public health response to tackling the consequences of unsafe abortion but does not address the legality or safety of abortion *per se* (Rasch, 2011). The PAC concept derives from a public health framing of abortion that has been disseminated internationally for the past two decades, since the UN-sponsored International Conference on Population and Development (ICPD) put the issue of unsafe abortion on the international agenda in 1994. Abortion was then, as now, a highly controversial issue. In order to broaden potential support, ICPD pro-choice groups, led by UN officials, fell short of demanding legalised abortion in favour of urging governments and the international community to make abortion safe where legal, and, in all cases, to make treatment for abortion complications accessible (DeJong, 2000; Lopreite, 2012). In the decades since, many countries have implemented public health measures to address the consequences of unsafe abortion, but relatively few have enacted legal reform; 40% of the world's women still live in countries with laws that prohibit abortion or only allow abortion to protect a woman's life or her physical or mental health (Rasch, 2011). In the African region, action to address unsafe abortion has only rarely included legal reform and has focused instead on new service-delivery guidelines and regulations, strengthened training programmes and expanded community outreach programmes, often focused on family planning and PAC (Hessini, Brookman-Amisshah, & Crane, 2006).

In this article, we describe how Burkina Faso's PAC policy emerged at the interface of political and moral negotiations between public health professionals, national bureaucrats and international agencies and NGOs. By privileging policy actors' accounts and practices, we contribute an ethnographic perspective to an emerging literature on domestic abortion politics in low- and middle-income countries (Ashenafi, 2004; Hessini et al., 2006; Kumar, 2012; Lopreite, 2012; Oye-Adeniran, Long, & Adewole, 2004; Shephard, 2006). Focused on Latin America and Asian countries, this literature emphasises the important influence of international actors and policy ideas on domestic policy responses to abortion. Our analysis seeks to elucidate the conditions under which international ideas 'penetrate domestic discourses' and influence policy reform (Lopreite, 2012), while also delineating the role of personal histories, ideologies, moral convictions and interests in shaping policy (Okonofua et al., 2009).

We show that encounters between national policy-makers and public health officials and their counterparts in international NGOs pose a dilemma for both parties. Burkinabè decision-makers, who are often hostile to induced abortion, have been convinced that PAC is 'life-saving care' which should be delivered for ethical medical reasons. By supporting PAC, they not only demonstrate compliance with international standards but also, importantly, do not have to contend with any change in abortion legislation, which they oppose. Rights-based international NGOs have, in turn, tactically focused on PAC as a 'first step' towards their broader institutional objectives. They accept a narrow focus on PAC – rather than the broader politics of abortion rights these actors often engage with at the international level – as part of a strategic modification necessary to successfully negotiate their relationship with their domestic counterparts. The result of these negotiations is widespread, though ambiguous, support for PAC but stifled debate about further legalisation of abortion.

Methods

This is the first study of the history and politics of abortion in Burkina Faso, conducted as part of an interdisciplinary study of unsafe abortion that combines perspectives from anthropology, health economics, medicine and health services analysis (Drabo, 2013; Iboudo, Greco, Sundby, & Torsvik, 2014; Lichtwarck, 2013; Ouattara & Storeng, *in press*; Ouédraogo & Sundby, 2014). The Oslo Regional Committee for Medical and Health Research Committee, Norway, and the Burkinabè Ministry of Health's Ethics Committee for Health Research approved the study.

Both authors conducted the ethnographic fieldwork and analysis upon which this article draws. Between 2010 and 2013, we observed national and international abortion-related debates articulated in scientific publications, national and international policy documents, conferences and articles in the Burkinabè press. We also conducted open-ended in-depth interviews with 40 professionals who had been involved in formulating or implementing PAC policy. To identify them, we first constructed an initial list of individuals from relevant government departments, hospitals and national and international NGOs, which was modified with help from the Director of the Ministry of Health and the consultant gynaecologist at Ouagadougou's university hospital, whom we knew from previous research, as well as through snowball sampling. At the international level, we identified informants from the most prominent reproductive health NGOs. All the individual informants we contacted accepted an interview, except the Ministry for the Promotion of Women which did not respond to our request. One person did not want the interview to be recorded. None of the interviewees wanted to be interviewed outside of their formal place of work, which may have biased the responses in favour of formal positions.

In Burkina Faso, we conducted 28 interviews with officials in the Ministry of Health (4) and other ministries (social action, human rights, justice) (3), public health specialists (4) and representatives of international agencies and NGOs (17). In the UK and USA, we interviewed seven representatives of international or global non-governmental reproductive health organisations, several of whom had responsibility for programme activities in Burkina Faso. The majority of Burkinabè informants were Catholic, while four were Muslim. Only eight of the informants in Burkina Faso were women, while all but one of the international-level informants was female. Interviews were conducted in French (28) or English (7) and were recorded with the informants' consent and transcribed verbatim. Because abortion policy is a highly sensitive issue, individuals' statements have been anonymised.

We analysed interview transcripts and other materials individually and together during analysis workshops in Ouagadougou and Oslo. We conducted a thematic, critical analysis of the data. Our analysis is also informed by observations collected over nearly a decade of collaborative ethnographic research on maternal health in Burkina Faso (Ouattara & Storeng, 2008; Storeng, Murray, Akoum, Ouattara, & Filippi, 2010). Below, we first describe the legal and social status of abortion in Burkina Faso, before discussing the development of its PAC policy and how an ambiguous consensus has been achieved on this policy between national decision-makers and global NGOs, despite their divergent positions on the question of abortion.

Abortion in Burkina Faso

Burkina Faso's abortion law, inherited from its French coloniser, has not changed fundamentally since the country's independence in 1960. The penal code prohibits induced

abortion, although following an amendment adopted in 1996, it is authorised at all stages of pregnancy when the mother's life or health is endangered and in cases of severe foetal malformation, and during the first 10 weeks of pregnancy in cases of rape or incest. However, the procedures involved in compiling medical and legal evidence of rape and incest are cumbersome and nearly impossible to complete in time to obtain a legal 'therapeutic' abortion.

Despite the restrictive law, induced abortions are, as mentioned, frequent and often unsafe (Bankole et al., 2014; Sedgh, Rossier, Kabore, Bankole, & Mikulich, 2011). Women of lower socio-economic status are at highest risk. Most (72%) of poor rural women who have an abortion go to traditional practitioners with no medical training or attempt to end their pregnancy themselves using dangerous methods such as potions, high doses of drugs or products including bleach and laundry soap, while most (74%) better-off urban women use trained medical professionals (Bankole et al., 2014). Better-off women can also access the drug misoprostol through prescriptions or on the black market to induce abortions at home (Ouédraogo & Sundby, 2014).² Women presenting for PAC after clandestine abortions often claim to have had a miscarriage, while health care providers rarely report illegal abortions to the police. The fact that women and providers are rarely, if ever, prosecuted for illegal abortions reflects that abortion is associated with so-called 'clandestine' strategies of subterfuge (Guillaume, 2009), and also that there is a certain level of tacit acceptance of the practice.

Nevertheless, as in nearly all societies, abortion is the 'object of condemnation' (Boltanski, 2004, p. 30). The practice requires discretion on the part of everyone involved (women, providers, policy-makers, etc.) and involves furtive strategies shrouded in secrecy (Guillaume, 2009). This reflects that abortion is a subject on which there is no social consensus, alongside extramarital sexual activity, contraceptive use by young people and out-of-wedlock pregnancies (Rossier, 2007). This is the case across Burkina Faso's multiple ethnic and religious communities, which are divided between Islam, Christianity (mostly Catholicism and Pentecostalism) and animism. One recent survey of Burkinabès' opinions listed abortion, prostitution and homosexuality as the most widely censured social phenomena (Centre for democratic governance, Burkina Faso [CGD], 2010). Newspaper articles on abortion emphasise its frequency and the prohibition and secrecy surrounding it, as highlighted by titles such as 'the silent drama'.

Popular discourse portrays abortion as the consequence of young girls' improper upbringing and stresses the need to 'sensitise' young girls about sexuality to avoid 'unwanted' pregnancies. Policy actors have appropriated the medicalised discourse on abortion diffused by global public health actors. They portray abortion as a consequence of women's 'unmet need' for contraceptive methods and emphasise the need to 'create demand' for family planning by educating women. In clinical practice, health care providers routinely stigmatise women presenting for PAC by delaying their care, demanding informal payments and, sometimes, refusing to provide treatment (Drabo, 2013). Receiving medical treatment for abortion complications – whether the abortion was induced or spontaneous – thus leaves women vulnerable to being suspected of a clandestine abortion. Due to the difficult procedures involved in obtaining abortions for legal indications, individual doctors often arbitrate over women's access to 'therapeutic' abortion, often without consulting the legal system or medical colleagues. This is in order to avoid being accused of colluding with women, who are often suspected of lying about sexual assault to justify their abortion requests. Moral values thus clearly intrude into health care settings but also, as we discuss below, into technical policy responses to abortion.

PAC policy and the politics of abortion

Popular and professional resistance to address the social and legal politics of abortion help to explain why Burkina Faso's primary response to the widely recognised problem of unsafe abortion has been a public health harm-reduction approach focused on PAC.

In Burkina Faso, medical doctors rather than women's rights activists shaped the official response to unsafe abortion (cf. Ouattara & Storeng, *in press*). In the mid-1990s, a small group of public health clinicians working in and around the capital Ouagadougou's university teaching hospital started to formulate what was to become the national PAC policy, influenced by the public health framing of unsafe abortion coming out of the ICPD. Though many of them were personally opposed to induced abortion, they were motivated by a medical ethical imperative to prevent the abortion-related deaths and illness they had observed in their clinical practice. Moreover, they were appalled by a local study revealing that abortion complications accounted for nearly a quarter of all maternal deaths in their hospital (Ky, 1998). At the time, abortion complications were treated sporadically and patients were frequently stigmatised. Incomplete abortion was usually treated with curettage, which required surgical facilities that were only available in the obstetric services of the two national university hospitals.

Supported by a small group of sympathetic partners from the Ministry of Health and from international reproductive health NGOs, these clinicians formed the Reproductive Health Research Cell (CRESAR). CRESAR managed to convince the Ministry of Health to develop a national PAC programme to be rolled out in public health services. In interviews, original CRESAR members recalled that this had been a delicate process requiring them to continually reassure the Ministry of Health and religious leaders that their policy recommendations were not veiled calls for liberalised abortion practices. Caution was required to 'not upset the Ministry of Health,' as one of the gynaecologists involved in these negotiations recalled. CRESAR's claims for a PAC programme not only drew legitimacy from the international public health framing of unsafe abortion but also generated support by appealing to the government's perceived need to demonstrate its commitments to reproductive health as a signatory to the ICPD Programme of Action. Starting in 1997, PAC gradually became incorporated into the national health programme. The Family Health Department, the core technical department of the Ministry of Health, initially took on the task of coordinating PAC training for health care providers, supported by the American NGO Population Council, while the American NGO Ipas supplied manual vacuum aspiration (MVA) equipment to be used in the treatment of incomplete abortion. The Ministry subsequently pushed for the decentralisation of PAC services in health districts and incorporated PAC within the Emergency Obstetric and Neonatal Care component of the Safe Motherhood programme. The Department of Adolescent, Child and Senior Health was given responsibility for creating awareness among young people and for ensuring their access to services, as well as informing providers working with these groups.

In keeping with international guidelines (e.g. WHO, 1992, 2003), PAC formally included dimensions such as building trust with the patient and links with other reproductive health services. It was to encompass all services provided to women who arrive at a health care facility in situations of incomplete abortion (induced or not), as well as prevention of unsafe abortions through family planning, and public dissemination of policies and laws on abortion and reproductive health. In its implementation, however, PAC quickly became reduced to its curative dimension, the medical treatment of incomplete abortion and other abortion complications, preferably with MVA (Lichtwarck,

2013). The fact that care providers today often use the terms MVA and PAC interchangeably highlights just how short the PAC programme has fallen of the comprehensive vision outlined in formal policy documents.

An ambiguous consensus

Despite the contested status of abortion in Burkina Faso, an ambiguous consensus has been reached on introducing PAC in health programmes and health facilities as part of safe motherhood services. How can this be accounted for?

First, national decision-makers, doctors and nurses, most of whom are hostile to induced abortion in the name of ethical religious values, have been convinced that PAC is 'lifesaving care' which should be delivered for medical ethical reasons. This framing enables health care providers to reconcile tensions between personal and religious attitudes and the professional imperative to save lives. As a senior gynaecologist and one of the early proponents of the PAC policy explained to us, 'as a service provider, professionally ... I'm compelled to provide care when the client asks me ... but in my religious faith, I'm Catholic, and I know abortion is forbidden!' She explained how she strategically opts to confess to a priest known to be sympathetic to her position to avoid religious condemnation after performing clinical acts that conflict with her religious convictions: 'if I have to perform this act, I'll go to confession; but I won't go to just any priest, because I know I'll run into resistance'.

For some doctors who were personally opposed to abortion, medical ethical and health systems considerations combined to justify the need for a more liberal abortion law. As one male hospital-based gynaecologist explained:

If you take me ... an ordinary citizen belonging to the Catholic religion, what do I think about abortion? I would tell you, it's not right! I would never do it, because my religion, which I believe and to which I belong, forbids it ... But if you ask me the question ... [as a] gynaecologist and obstetrician, responsible for the reproductive health of thousands of people ... I would tell you that I am in favour of some opening for legalised, medicalised abortion ... because it's the only path that will enable us to avoid the complications that burden our services needlessly ... and end up making victims of women.

More commonly, however, PAC was supported precisely because it does not imply any change in abortion legislation, an important point for national decision-makers who, on the whole, are resistant to legal reform. We were often told that the Burkinabè society is 'not ready' – on both a moral and practical level – for such change. Any legal reform would be accompanied by an unwelcome liberalisation of attitudes and a run on services that the health system would be unable to support, predicted one Ministry of Health official:

I think we're not ready to move towards legalising abortion. Legalisation ... implies, after all, [that we need] well-equipped services, services that are fully accessible ... and competencies ... it's a major undertaking, involving ... the woman herself, involving her family ... personally, I don't think that at this current stage, of our values, of our religious beliefs, that we could really put in place that whole process ... personally, it's my opinion.

For the Ministry of Health, supporting the PAC policy is a way to demonstrate compliance with international frameworks on unsafe abortion, including the ICPD and also various guidelines and recommendations issued by the WHO. Given the country's dependence on external financial and technical support, its leaders not surprisingly seek

to adopt policy positions that resonate with or are ‘in line with’ with international policy trends. As another Ministry of Health official put it:

At the central level here ... we work with ... the United Nations – UNICEF, UNFPA, WHO – and we take into account ... commitments that the country’s authorities ... at the highest level have made at conferences and meetings, whether international or inter-African or sub-regional ... It’s on the basis of all that, that we actually adopt different concepts to develop our own policy ... So that the national policy is in line with ... global policies on health.

Accordingly, PAC is increasingly framed as part of the national effort to reduce the maternal mortality ratio (MMR) and achieve the UN Millennium Development Goal on maternal health (MDG 5). Through this focus on the ‘lifesaving’ dimension of PAC, the national authorities demonstrate responsiveness to the problem of unsafe abortion that conveniently helps push the issue of its legal status and social causes to the periphery of public debate.

The effort to evade public debate on abortion became especially evident in the controversy that was ongoing within professional medical and health policy communities during our fieldwork about whether to register misoprostol for use in the national PAC programme. Despite its medical indication for the treatment of abortion complications, its registration for this purpose in Burkina Faso had, at the time, been blocked by a senior female Ministry of Health official known to strongly oppose induced abortion. She allegedly feared that registering the drug would encourage its use to induce abortions illegally. While many decision-makers publicly shared this concern, others, including senior figures within the Ministry of Health, privately admitted that they favoured registration from a pragmatic perspective, arguing that it would simplify PAC procedures and also make clandestine abortions safer. At the same time, both parties sought to contain any outward sign of negotiation on this subject to avoid sparking an unwanted public debate on the legal status of abortion. The treatment of abortion as a public policy question thus continues to be compromised by the difficult tension between what abortion represents in terms of local evaluative moral standards that relate to the individual level and commitment to a cause in the name of public interest.

Working within the system

International or ‘global’ reproductive health NGOs have been instrumental in supporting the national consensus on PAC. These NGOs are largely headquartered in the UK and the USA and have set up offices in many low- and middle-income countries, including, since the early 1990s, in Burkina Faso. They include Ipas and Population Council, which, as mentioned above, were important in implementing the national PAC policy in the late 1990s. They have since been joined by organisations including the International Planned Parenthood Federation (IPPF), JHIEPEGO and Family Care International and, most recently, Marie Stopes International (MSI).

These NGOs are part of a broader global reproductive health advocacy coalition that has taken an active stance in favour of abortion rights. For instance, Ipas describes itself as ‘a global non-profit that works to increase women’s ability to exercise their sexual and reproductive rights’ (<http://www.ipas.org/>, accessed 24 March 2014), while IPPF and MSI are both known as among the world’s largest abortion providers. However, at the national level, these international NGOs have positioned themselves differently; they have decided to work ‘within the system’ for tactical reasons and not to open public debate about induced abortion. Accordingly, they support the national PAC policy in a

variety of ways, ranging from providing material support for PAC services, training public sector health workers in clinical PAC skills, operating private clinics to supplement public services or supporting locally owned non-governmental organisations.

The decision to 'take a back seat' on advocacy, as one of our informants put it, has been arrived at over time. International NGO actors explained that they had come to Burkina Faso intending to advocate for legal reform, but that they modified their stance once they realised that the policy environment was 'unreceptive,' and that there were no domestic pro-choice activist groups with whom to ally. 'We told ourselves it was doomed to fail ... people's mentalities really weren't yet ready' recalled one NGO representative, echoing the national actors cited above.

In contrast to their international stance, these NGOs often avoid the word 'abortion' entirely in national-level public profiling of their work in order to not antagonise the government, whose support they need to be able to operate. 'It's about finding the right message, and using that in the right context,' explained one senior NGO representative. 'Even though we work for an organisation that provides abortion [in other countries], we don't always want to shout it from the roof tops. So in terms of advocacy, we are "maternal health"'. Others also stressed the importance of taking a self-protective, non-confrontational approach. For instance, the country-based representative of another international NGO explained: 'We've got to be so careful that the association is not seen [as promoting abortion] ... we [therefore] position ourselves as a family planning provider and PAC can be provided [under that rubric]'.

Avoiding rhetoric that jars with local cultural and religious norms was an explicit priority for these actors. For instance, a senior international NGO policy director with decades of abortion-related experience from Africa had concluded that framing abortion as a right is often counter-productive:

The issue of rights is actually a hindrance because many ... as soon as you mention a woman's rights they become completely closed up and they don't want to have anything to do with it. But when you present it in terms of a public health issue, it's far more difficult for officials to ignore it.

Others claimed that arguments about rights tend to be dismissed as Western, whereas 'if you talk to them about a woman dying, that is not a Western concept'.

NGO actors were, on the whole, pragmatic about the need to modify their ideological stance to accommodate contextual constraints. During what they often referred to as 'the Dark Period' of the Global Gag Rule, when the US Government withdrew funding to any NGO working on abortion under the Mexico City Policy (Bendavid, Avila, & Miller, 2011), a focus on PAC became a way for many American NGOs to get around the Gag Rule restrictions. They saw their PAC work in Burkina Faso in similar terms, as a 'first step' in a two-pronged approach with a long-term objective of advocating legal reform and an interim focus on 'harm reduction' through PAC.

This compromise position was tenable to them because participating in implementation of the national PAC programme offered them a certain room for manoeuvre to work on abortion beyond simply the treatment of abortion complications. For instance, public sector PAC training fed into their longer-term strategy of building up a cadre of health workers able to provide safe abortion care should the law be liberalised, since the clinical skills required for PAC and inducing abortions are essentially the same. Moreover, explained one NGO representative, PAC training offers valuable opportunities to conduct so-called 'value clarification,' activities designed to challenge providers' reluctance to work on abortion and

to expand provision of services as widely as possible within the current legal context. This can involve clarifying the conditions under which ‘therapeutic’ abortions can be legally provided, by ‘broadening’ the interpretation of health to justify – whether legally or from a medical ethical perspective – abortion in cases where continuing the pregnancy would threaten not only women’s physical health but also on their psychological health. A senior international NGO representative claimed that value clarification has been highly successful in shifting both attitudes and clinical practices:

At the beginning we had reluctance. What we observed in Burkina Faso was that they were all ... extremely sympathetic to the idea that we needed to find measures to reduce unsafe abortion. [But] they lacked the capacity to offer abortion services, and they lacked the confidence that they could do so without being arrested, or threatened by the law or the community. With the reassurance that they were working within a broad legal framework, with the increased [knowledge] that what they were doing was well received by the government, and with the support from the senior management to do their work, and also through training to increase their competence, the capacity to provide those services, we’ve just seen a radical change.

Other NGO representatives similarly claimed that ‘value clarification’ has helped providers to recognise the value of their own professional contribution and improve their attitudes towards PAC patients:

I don’t think we have managed to get rid of all stigma. But I think we have certainly helped them to distinguish their professional obligations from their personal views, and also to open their minds and to expand their personal views and to see that actually what I am doing is important to the community. It is now to the point where some of them have given their mobile number to the clients so that they can be on call whenever clients come. So they are able really to, and willing, to work beyond the call of duty.

The importance of a non-confrontational approach was said to be particularly important because, as one senior NGO representative claimed, the Ministry of Health is actually quite acquiescent towards NGOs’ work even if the government is ‘quite reluctant to change the status quo’. One sign of the Ministry’s openness, we were told, was that it had granted an NGO licence to import misoprostol for use in PAC services in its clinic, despite the exclusion of the drug from public sector PAC protocols and despite lacking oversight over whether the NGO would use the drug only for PAC or also to induce abortions. A UK-based NGO policy adviser with extensive experience from African countries interpreted such flexibility as a sign of the ministry’s recognition that NGOs actually help them address unsafe abortion without drawing too much attention to their own position, a strategy she had also observed elsewhere: ‘In many African countries the government is not keen on rocking the boat by changing the law, but they are happy to work around it. And they are happy to work with others to do what they can’t necessarily do themselves’.

Maintaining this precarious balance depends on collaboration between all the international NGOs present in the country. At the time of our fieldwork, this balance had been threatened by the recent arrival of an international organisation that was perceived – both by national and international actors – to have pushed the boundaries too far. As one of the most established NGO partners explained:

Those people, they wanted to go a little bit further. They said ... they would come in and do abortions ... [but] I said ‘we need to respect the law’ ... they were hot-headed, they said, ‘no,

we need to fight for making abortions legal'. I said, 'we need to proceed carefully, not to make any missteps'.

More established partners thus ensure that newcomers 'toe the line' to avoid antagonising the government and thereby compromising the international NGOs' collective position. The research director of one NGO explained the rationale behind this strategy:

I think sometimes it's better to keep your mouth shut and provide services to the full extent of the current law. And just have a broad interpretation of that current law and do services. And sometimes the time is right to be vocally aggressive and get in there and change the law. And I think that, at the national level people probably have a better sense of that than anyone else does.

Despite widespread support for this perspective, international NGO representatives were also candid about the limitations of their approach. Because they tend to be personally committed to abortion as a human right *and* public health issue, a focus on harm reduction alone can be a 'very good entry point', as one NGO adviser put it, but it can never be a *sufficient* response.

In fact, many NGO representatives were clearly frustrated that they were participating in what one of them referred to as 'the domino effect of avoiding the issue'. Another described the PAC work as part of a broader strategy of separating unsafe abortion as a public health challenge from the political struggle for reproductive rights by framing it instead as a maternal health issue in order to, as she explained, benefit from the 'relative lack of controversy' in the maternal health area. While PAC undoubtedly helps to save lives and improve maternal health indicators, NGO actors were clear that its limitations include that it does not address women's right to choose whether or not to have children, nor deal with the safety of abortion, or address many of the barriers to safe abortion, including restrictive abortion legislation, poor health care infrastructure and, not least, stigma (cf. Kumar, 2002). As long as there are conditions imposed on when women can have safe abortions, 'it puts the decision out of the hands of the women and into the hands of the doctor, to basically decide if this woman is worthy', said an American NGO adviser. Crucially, she insisted, it is difficult to tackle stigma while abortion is still criminalised. Nevertheless, policy experts in international NGOs were adamant that liberalisation of abortion law should not necessarily be seen as a panacea, since even where abortion law has been liberalised, there are many other challenges to access to safe abortion (cf. Beck, Berry, & Chojjil, 2013).

Discussion

This paper has shown how an ambiguous consensus has been reached on introducing PAC in health programmes and health facilities in Burkina Faso as a part of safe motherhood services. We have argued that PAC has emerged as a strategic political response precisely because it enables productive exchange between international and national actors, while avoiding the sticky politics of abortion, which the national authorities admit they are not 'ready' to confront.

On the one hand, a focus on PAC enables national actors (many of whom are doctors) to resolve the impasse between local social and religious norms, the medical imperative to save lives and the institutional pressure to comply with international agreements on reproductive health. At the same time, they use PAC to restrain public debate about legalisation of abortion. On the other hand, PAC also allows international actors to advance their institutional objectives while being non-committal about broader social and

political change. PAC has thus become a common denominator upon which national and international actors can agree and collaborate, without having to address explicitly their divergent positions on the legal status of abortion.

While the ideas formulated at the ICPD have clearly influenced this policy response, national politics, moral concerns, personal agendas and the complex interactions between national policy actors and international partners are equally important, as evidenced by the constant manoeuvring to render practices acceptable within local moral and cultural frames. The interactions among those acting on behalf of the State and those acting on behalf of international institutions and NGOs give rise to a 'negotiated order' (Strauss, 1992) around moral values – local codes of social conduct for the former and universal moral values for the latter. National policy actors use condemnatory rhetoric on the one hand, while exercising, on the other hand, a certain tolerance for abortion, as long as it is practiced discreetly. They exercise harm reduction (Erdman, 2012) in as much as they pragmatically accept that women will induce abortions (regardless of its legal status) and treat its consequences, but do not accept legal reform as a necessary consequence to a harm-reduction approach.

The tactics we have described are part of a long history of 'skirting the issue' of women's health at both national and international levels (Birn, 1999). The ICPD programme of Action, for instance, represented a compromise between feminists seeking women's right to abortion on demand and socially conservative governments who were vehemently opposed to the expansion of abortion rights (McIntosh & Finkle, 1995). As mentioned above, it was to broaden the range of potential support that the ICPD pro-choice groups framed abortion as a health problem and drew attention to unsafe abortions as a cause of maternal mortality, with less emphasis on women's privacy rights (Lopreite, 2012). Similarly, the international safe motherhood advocacy coalition has 'sacrificed' the issue of abortion for the sake of protecting political support for the expansion of life-saving maternal health services, while more recently allying itself with the child and neonatal health field to distance *maternal* health from *reproductive* health to avoid being implicated in the controversy associated with the latter (Storeng, 2010; Storeng & Béhague, 2013).

At the national level, similar strategies abound, although they have rarely been documented. Exceptions include Shephard (2006), who discusses how a 'double discourse' persists in Latin America with regards to the high political cost of action on abortion. Privileged individuals do not publicly question conservative policy, but benefit from 'escape valves' such as private clinics offering clandestine abortions, to which the poor have no access. Suh (2014) describes the complex 'boundary work' – or strategies deployed by professionals to define and defend jurisdictional authority – that goes on in PAC in Senegal. In a context where abortion is legally restricted, health care providers obscure induced abortion in medical documents to circumvent police involvement, a strategy that also contributes to abortion stigma by reinforcing the notion that women who have induced abortions are deviant (Suh, 2014).

International actors campaigning for women's right to abortion on demand have considered PAC as a meaningful commitment in some countries, signalling readiness among the national leaders to consider the question of abortion from a wider, rights-based perspective. And in some countries, like Nepal, the implementation of PAC has contributed to a move towards safe abortion by facilitating the successful scaling-up of abortion services, once legalised (Samandari, Wolf, Basnett, Hyman, & Andersen, 2012). In Burkina Faso, international actors seem to be driven by a hopeful expectation that their PAC work will contribute to incremental policy change in favour of abortion on demand.

Yet, although they support the PAC policy, Burkinabè policy actors remain profoundly apprehensive about enlarging it, fearing that doing so will lead to more permissive abortion practices. By committing to PAC, national policy-makers claim compliance with international commitments to safe abortion as part of broader health system efforts to improve maternal health, but in doing so they are also circumventing public debate about abortion per se and failing to address the unspoken social, moral and legal politics that make abortions unsafe in the first place.

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Notes

1. According to the WHO, Burkina Faso's MMR was 300 per 100,000 live births in 2010, although the numbers are highly uncertain (WHO, 2012). By comparison, the MMR in developing countries is 240 versus 16 in developed countries (WHO, 2012). The Ministry of Health estimates that 10% of maternal deaths result from abortion complications (Ministère de la santé, 2011). Globally, 21.6 million unsafe abortions are performed each year, accounting for an estimated 13% of all maternal deaths worldwide, almost all occurring in developing countries (WHO, 2011).
2. Misoprostol, a drug indicated for labour induction, management of miscarriage and post-partum haemorrhage, is increasingly being used worldwide to induce abortion and treat abortion complications (Kulczycki, 2011). It is not registered for induced abortion in Burkina Faso.

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