GUTTMACHER INSTITUTE

Fact Sheet

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Abortion in Burkina Faso

• In Burkina Faso, abortion is legally permitted to save the life and protect the health of a pregnant woman, as well as in cases of rape, incest or severe fetal impairment.

• Knowledge of the legal status of abortion is low: Only about one-third of Burkinabe women are aware that abortion is legal in some cases. Because illegal abortion is a punishable criminal act, the vast majority of women who end their pregnancies—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 carried out under unsafe conditions, jeopardizing women's health and sometimes their lives.

ABORTION INCIDENCE

• In 2012, approximately 105,000 abortions occurred in Burkina Faso; the national abortion rate was 25 pregnancy terminations for every 1,000 women aged 15–49.

• In rural areas the abortion rate was slightly lower (22 per 1,000 women), but it was significantly higher in urban areas other than the capital of Ouagadougou (42 per 1,000); in the capital, the rate was 28 per 1,000 women.

CHARACTERISTICS OF WOMEN HAVING AN ABORTION

• Burkinabe women who have abortions are not typical of all women of childbearing age. They tend to be younger, better educated, more likely to live in urban areas, unmarried and without children.

• In 2008, 65% of women who had had an abortion in the past two years were between the ages of 15 and 24, and the same proportion had no children. Among all women aged 15–49, just 24% were childless.

• Abortion occurs disproportionately among unmarried women: Six in 10 women who had an abortion were unmarried, though only two in 10 of all women of childbearing age were unmarried in 2008.

ABORTION PROVIDERS AND METHODS

In 2008, the most commonly used abortion providers were traditional practitioners, and they performed 41% of all abortions in Burkina Faso. In 23% of all abortion cases, women terminated the pregnancy themselves.

• Abortions were also performed by midwives and trained male birth attendants (*maïeuticiens*, 13%), and by health assistants (12%). These assistants may have received basic training in primary health care, but not necessarily in safe abortion techniques.

• Only 3% of women were believed to have obtained their abortions from doctors. The remaining 7% used other providers or means.

• Both social and economic status are related to significant differences in the safety of abortions. Poor women in rural areas typically experience the greatest risk, with seven in 10 using traditional practitioners or ending their pregnancies themselves.

• In contrast, three-quarters of nonpoor urban women use trained medical professionals, with about a quarter each using doctors, midwives or maïeuticiens, or other trained health assistants.

• Among women who have an abortion, four in five of those with no schooling turn to traditional practitioners or self-abort, whereas only half of those with at least a secondary education do so.

• Abortion is highly stigmatized in Burkina Faso. Even though the most educated women may have access to better services, many still rely on traditional practitioners, who are perceived to be discreet, or they self-induce, a reflection of the strong desire to keep the procedure secret.

• About four in 10 of all women who had abortions used potions, high doses of drugs or caustic products, such as bleach or laundry soap.

• 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.

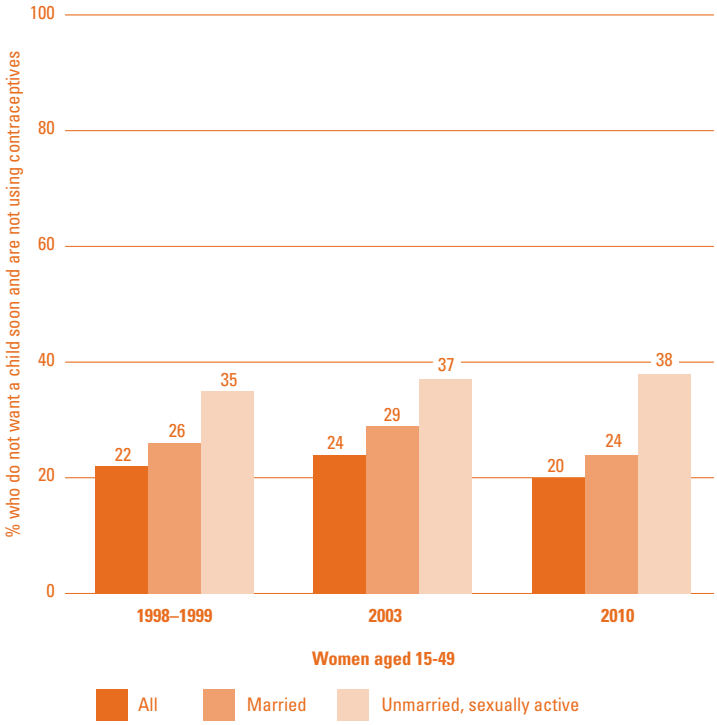
• The cost of abortion procedures varies greatly, with estimated fees paid to private or clinic-based doctors being much higher than those charged by traditional providers.

CONSEQUENCES OF UNSAFE ABORTION

• Approximately 23,000 women in Burkina Faso were treated for abortion-related complications in 2008. An estimated

Unmet Need for Contraception

Unmet need remains high in both married and unmarried women



15,000 suffered serious complications but did not receive the care they needed.

• Almost six in 10 women who go to traditional practitioners and half of those who induce their own abortions are estimated to experience complications, compared with about two in 10 women who go to midwives, maïeuticiens or other medical workers, and with one in 10 who use a doctor's services.

• Nationally, almost four in 10 women who experience abortion-related complications do not receive the medical care they need. This is most likely among poor women living in rural areas and least likely among better-off women living in urban areas, reflecting that postabortion care services are more accessible in urban settings as long as women can afford to pay for them.

• The proportion of maternal deaths in Burkina Faso resulting from unsafe abortion has not been assessed. However, about one in seven maternal deaths in Sub-Saharan Africa are due to unsafe abortion.

HIGH UNMET NEED FOR FAMILY PLANNING PERSISTS

• Each year, one-third of all pregnancies in Burkina Faso are unintended—either mistimed or unwanted altogether—and one-third of unintended pregnancies end in abortion.

• Many women are at risk for an unintended pregnancy: In 2010, one in five Burkinabe women of childbearing age had an unmet need for contraception, meaning they wanted to avoid pregnancy but were not using any modern or traditional method.

• Married women have a high level of unmet need: One-quarter of them do not want a child soon or want no more children, but are not using any contraceptive method. This proportion has changed little since 1999.

• Among unmarried, sexually active women, unmet need is even higher—it was 37% in 2003 and 38% in 2010.

• Very low use of contraception contributes to the level of unmet need: In 2010, only 16% of married women of childbearing age were using any contraceptive method.

• In 2010, the prevalence of modern or traditional contraceptive use among married urban women was three times as high as that among married rural women (34% vs. 11%). Among women with seven or more years of schooling, prevalence was nearly four times as high as that among women with lower levels of education (50% vs. 13%).

• These stark disparities in contraceptive use suggest that poverty, low education and poor access to services in rural areas may play a role in hampering a woman's ability to learn about and obtain family planning services.

POLICY IMPLICATIONS

• Family planning programs should be expanded and promoted throughout the country's primary health services and the provision of family planning counseling and methods should be made a routine part of postabortion care. Lowering the cost of services would likely result in increased contraceptive use.

• 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.

• To reduce the incidence of severe illness and death from abortion-related complications, access to high-quality postabortion care services needs to be improved, and subsidized services should be more comprehensive to ensure that poor women can obtain the care they need.

• Coordinated efforts from the government and nonprofit organizations will be necessary to increase public awareness of the country's abortion law and to ensure that Burkinabe women are able to access safe and legal abortion services within the confines of the existing law.

The data in this fact sheet are drawn from Bankole A et al., Grossesse non désirée et avortement provoqué au Burkina Faso: causes et conséquences, *New York: Guttmacher Institute, 2013, and based on research conducted by the Guttmacher Institute and the Institut Supérieur des Sciences de la Population (ISSP) of the University of Ouagadougou. Support for this fact sheet and the monograph on which it is based was provided by the Dutch Ministry of Foreign Affairs and The William and Flora Hewlett Foundation.*

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