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# Unintended Pregnancy and Induced Abortion In Burkina Faso: Causes and Consequences

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English translation of *Grossesse non désirée et avortement provoqué au Burkina Faso: causes et conséquences,* 2013

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The report draws on data from three surveys conducted in 2009: the Health Facilities Survey (HFS), the Community-Based Survey (CBS) and the Health Professionals Survey (HPS). Idrissa Kaboré, Clémentine Rossier Rossier, Gilda Sedgh and Akinrinola Bankole were the co-investigators for these surveys and were responsible for their overall design and implementation; they were also responsible for data analysis, for which they received valuable support from Rubina Hussain and Suzette Audam. Romaric Aristide Bado, Sylvie D. Marie-Jeanne Goumbre and Abella Kaboré provided support in training interviewers and Blandine Thiéba/Bonané provided advisory support. Idrissa Kaboré, Salamata Ouédraogo and Sié Néha supervised fieldwork for the HFS; Arsène Sanou, Soumaila Coulibaly, Zakaria Gansané, Nazaire Franck Garanet, Tiéba Millogo, Solange Kontogom and Dénis Kontogom served as HFS interviewers. Fieldwork for the CBS was supervised by Pascaline P. Yaméogo/Ouédraogo, Flora Kalmogo, Fatima Sawadogo, Habibou Meda, Maria G Kantiono, Armelle P. Coulidiaty, Fatimata Sanogo, Assata Belem/Diabaté; the survey was fielded by Safiatou Sonde, Safiatou Boly, Rosine G. Coulidiaty, Mamounata Ouédraogo, Marie-Jeanne Sawadogo, Nadège Compaoré, Annabelle A.

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## Executive Summary

Induced abortion is permitted in Burkina Faso only to save the life and protect the health of a pregnant woman, or in cases of rape, incest, and severe fetal impairment. As a result, the vast majority of women who end unintended pregnancies do so in secrecy, out of fear of prosecution and to avoid the social stigma that surrounds this practice. Most clandestine abortions are carried out in unsafe conditions that jeopardize women's health and sometimes their lives. This report presents estimates of the number and rate of induced abortions that occurred in Burkina Faso in 2008 and 2012; reports levels of unintended pregnancy (the major reason that women seek abortions in the first place); and describes some of the adverse consequences of unsafe abortion for women, their families and society.

### The incidence of abortion

• Using findings from three national surveys, we can now estimate the level of induced abortion in Burkina Faso. In 2008, the rate was 25 pregnancy terminations for every 1,000 women aged 15–49. The rate was 23 per 1,000 in rural areas and 28 per 1,000 in Ouagadougou, but it was highest—42 per 1,000—in urban areas other than Ouagadougou.

• The large differences between the country's urban and rural areas in levels of unintended pregnancy and induced abortion are the result of cultural, ethnic, religious and demographic factors that influence sexual and reproductive behavior and attitudes in the two regions. The importance that couples and social groups place on having large families in an especially important factor. The average desired family size, for example, is 5.9 children in rural areas, compared with 2.8 in Ouagadougou.

• One-third of all pregnancies each year in Burkina Faso are unintended, and one-third of unintended pregnancies are ended by abortion.

• Women who have induced abortions are not typical of all women of childbearing age. They tend to be younger and better educated than other women, and are more likely than other women to live in urban areas, to be unmarried and to not have any children.

**The conditions and consequences of unsafe abortion**

• Between one-half and two-thirds of all women who have abortions go to traditional providers with no special skills or training, or end their own pregnancies, often using dangerous methods. Only about one in seven abortions are carried out by doctors (3%) or trained health assistants (12%); these safe procedures are most frequently obtained by better-off women who live in urban areas. While one-fourth of abortions obtained by these women are performed by a doctor and another one-fourth by a trained health assistant, doctor-assisted pregnancy terminations are almost non-existent among poor rural women, and only one in 11 of their abortions are performed by a trained health assistant.

• Four in 10 women who have unsafe abortions are estimated to experience complications that can threaten their health and even their life. While this proportion is lower for better-off urban women (one in four), nearly half of poor rural women who have abortions experience health-related complications.

• 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 one in five women who go to midwives, trained male birth attendants or other medical workers, and with only one in 10 women who use a doctor's services.

• Some women who experience complications do not get the postabortion care they need. Nationally, almost four in 10 women with abortion-related complications receive no care; this proportion is highest for poor women living in rural areas and lowest for better-off women living in urban areas, reflecting that postabortion care services are more accessible in urban than in rural areas (as long as women can afford to pay for them).

• Half of women receiving postabortion care for complications from unsafe abortions are treated in primary health care facilities. Another one-quarter receive care from a centre médical avec antenne chirurgicale or from an even more basic centre médical.

**Unintended pregnancy**

• Average family size in Burkina Faso is high, although it has declined from 6.9 children per woman in 1993 to 6.0 in 2010. However, average family size in 2010 was smaller in Ouagadougou (3.4 children) than in other urban areas (4.4) or in rural areas (6.7).

• The conditions that would allow most women to avoid unintended pregnancies do not currently exist in Burkina Faso. Contraceptive use is very low: In 2010, only 16% of married women of childbearing age were using a contraceptive method. The overall level of contraceptive use has doubled since 1993, when it was 8%, and the use of modern methods tripled during that period. Nevertheless, the low level of contraceptive use in is the main reason for Burkina Faso's high rate of unintended pregnancy.

•Unmet need for contraception is high in Burkina Faso and has been for the past 10 decade. In 1998-1999, 26% of married women aged 15–49 did not want a child soon or ever but were not using any contraceptive method. In 2010, this proportion was virtually unchanged (24%).

• Among single but sexually active women in this age group, unmet need is even higher—it was 35% in 1998-1999 and 38% in 2010.

**Policy implications of the findings**

• Contraceptive use must increase if more women in Burkina Faso are to be able to avoid becoming pregnant when they do not wish to. A reduction in the level of unintended pregnancy is the major solution to bringing down the country's current level of unsafe abortion.

• Possible strategies to facilitate the wider adoption of modern contraceptive methods in Burkina Faso include the expansion and promotion of family planning programs through the country's primary health services, and the provision of family planning methods as an essential part of postabortion care.

• Policymakers in Burkina Faso should consider lowering the obstacle of high cost that appears to prevent many poor women from obtaining family planning services. In public health clinics, women are charged—albeit at a subsidized price—for contraceptive supplies.

• In light of the finding that women who have abortions are disproportionately likely to be young and unmarried, special attention should be given to providing nonjudgmental and accessible family planning services to these groups.

• Seven in 10 women of childbearing age in Burkina Faso have had no schooling. It is unlikely that contraceptive use levels will rise substantially in the absence of a concerted national effort to improve educational levels among women.

• To reduce levels of severe morbidity and death associated with abortion-related complications, access to high quality postabortion care services needs to be improved. Efforts should be made to subsidize the cost of postabortion care for all complications, irrespective of types of treatment received. Postabortion services should include contraceptive counseling and supplies to help women prevent future unwanted pregnancies.

• Because abortion is legal in Burkina Faso under certain circumstances, efforts should be made to ensure that eligible women have access to safe legal abortions within the limits of the law. All medical students, and all medical practitioners (including midlevel staff) working in hospitals, should be trained to meet this need through the correct use of manual vacuum aspiration—a technique with a very low risk of complications when properly used.

## Chapter 1. Introduction

Burkina Faso, a predominantly rural country whose population of about 17 million inhabitants is growing at a rate of 3.1% a year,[1,2] is located in the Sahelian region of Sub-Saharan Africa. In 2006, it had one of the world's lowest per capita incomes.[A] The social fabric of the country is grounded in community, ethnic group, lineage and the extended family. In this context, women's role in childbearing, which ensures continuation of the family and social group, is a particularly important aspect of life.[3] However, the centrality of family and a woman's fecundity coexists with the fact that almost eight in 10 women of childbearing age want to postpone their next birth or stop childbearing altogether (Appendix Table 1), and that one in three pregnancies is unintended (i.e., the woman did not want to be pregnant at all or would have preferred to be pregnant at a different time).

On average, women in Burkina Faso are having 6.0 children, but they say they want only 5.2 (Appendix Table 2), indicating that many women are having more children than they desire. The major reason for the high level of unintended pregnancy in Burkina Faso is that the vast majority of women do not use contraceptives—only 15% of married women of childbearing age (15–49) use a modern method.[4] Moreover, 24% of married women aged 15–49, and 40% of sexually active unmarried women aged 15–24, do not currently want to get pregnant but are not using any method. For some of these women, particularly those who are unmarried,[5,6] induced abortion may play an important (but dangerous) role in their efforts to avoid an unwanted birth.

In fact, three in 10 unintended pregnancies in Burkina Faso end in abortion.[7] Most of these abortions are performed in secret by traditional or unskilled providers using unsafe methods, because the procedure is legally permitted only on narrow grounds—to save a woman's life, to protect her physical health, or in cases of rape, incest or severe fetal impairment[8]—and because the legal requirements for abortion are so cumbersome that few, if any, women are able to meet them.[9] Clandestine abortions carried out in unsanitary conditions or by unskilled providers often

[A] In 2011, Burkina Faso was ranked 181st out of 187 countries in Human Development Index scores (source: United Nations Development Program, *Human Development Report,* New York: Palgrave Macmillan, 2011, Table 1).

lead to severe health complications, such as infection and bleeding; in some cases, they result in maternal death.[B,10,11]

Although the level of maternal mortality in Burkina Faso has fallen considerably during the past two decades, it remains high. According to Demographic and Health Survey data, the maternal mortality ratio has declined from 566 maternal deaths per 100,000 live births in 1993[12] to 484 per 100,000 in 1998–1999[13] and 341 per 100,000 in 2010.4 The government has made the reduction of maternal mortality a major policy focus: It has increased the number of health facilities capable of providing emergency obstetric care, and removed the prohibitively high hospital fees formerly charged to women seeking safe deliveries. However, many women, especially those in rural areas, still lack access to safe maternity care.9 In 2008, one in four health facilities lacked the health personnel needed to provide internationally recommended levels of obstetric services.[14]

Although we do not know the precise contribution of unsafe abortion to overall maternal mortality in Burkina Faso, we do know that about one in seven maternal deaths in Sub-Saharan Africa as a whole are from this cause, and that the proportion has not declined in the last two decades, even though the maternal mortality ratio itself fell slightly (from 370 to 300 maternal deaths per 100,000 live births) between 2005 and 2010.[15,16]

**Living conditions are difficult for most of the population in Burkina Faso**

Social and economic conditions are extremely difficult for a large proportion of the population in Burkina Faso, particularly in rural areas. Forty-six percent of the population (52% in rural areas and 20% in urban areas) was living below the poverty level in 2008;[14] per capita income was just US$379 in 2007.[17] Educational levels are very low, especially for women; in 2010, only 12% of women of childbearing age (and just 4% of those in rural areas) had continued their education beyond primary school (Appendix Table 1), and 74% had received no schooling at all.4 Many

[B] Because Burkina Faso permits pregnancy termination only on narrow grounds, and because very few legal abortions are performed, we assumed that all induced abortions mentioned in the surveys cited in this report were illegal and therefore clandestine. However, not all clandestine procedures are carried out in unsafe conditions; those performed by skilled providers in hygienic settings may be safe, even though they are clandestine.

rural communities are unconnected by paved roads,[9] and the country has very few doctors[C] or high-level hospitals.[14] Many women lack access to reproductive health care and do not have the knowledge or money to obtain contraceptives—a safe means of achieving their fertility goals. In addition, some younger people, particularly in urban areas, engage in premarital sex (Appendix Table 2) but lack access to sex education and reproductive health services.[18]

**Reliable information about unsafe abortion is urgently needed**

Measuring and understanding the prevalence of induced abortion in Burkina Faso is extremely difficult. Two major aspects of abortion practice impede accurate assessment of its frequency: The procedure, as noted above, is permitted only on very limited grounds8 that do not apply to most women with an unintended pregnancy; and ending a pregnancy is highly stigmatized in this deeply religious and pronatalist country.[19,20] For these reasons, most women who have an abortion do so secretly, as they fear discovery or feel a sense of shame; many women turn to unsafe providers and unsafe methods, and most are reluctant to reveal that they have ended a pregnancy.[21]

Lack of well-documented evidence about the harmful impact of unintended pregnancy and unsafe abortion on many women's lives reduces the likelihood that improvements can occur. Reliable estimates of the number of women who have unsafe abortions, the costs of these dangerous procedures, and unsafe abortion's effects on women and their reproductive health, are fundamental to the ability of health planners and women's health advocates to address the larger problem of unintended pregnancy and its adverse consequences for women, their families and the country as a whole.

**New sources of information about induced abortion are now available**

This report brings together for the first time information about induced abortion in Burkina Faso

[C] According to the World Bank, Burkina Faso had 0.1 doctors per 1,000 population in 2008 (source: World Bank, Physicians (per 1,000 population), no date, <http://data.worldbank.org/indicator/sh.med.phys.zs>, accessed May 12, 2012).

obtained from four data sources. For more detail on these research initiatives, see the Data Sources box on page 14. The four sources are:

- The 2009 Health Facilities Survey, which used a nationally representative sample of public and private health care facilities in Burkina Faso to estimate the number of women hospitalized for the treatment of abortion-related health complications.

- The 2009 Health Professionals Survey, a purposive survey of health professionals familiar with the conditions in which women are having abortions in Burkina Faso, the health consequences of these largely unsafe procedures, and whether women with abortion-related complications are receiving the treatment they need.

- The 2009 Community-Based Survey, a nationally representative survey of women of childbearing age that investigated attitudes toward abortion and asked women whether their closest friends, neighbors and family members of childbearing age had confided in them that they had ended a pregnancy (and, if so, the measures they had taken and the consequences of their actions). This survey also inquired about women's attitudes to abortion.

- Demographic and Health Surveys carried out in Burkina Faso between 1993 and 2010 that provide information about levels, trends, and patterns of unintended births, contraceptive use and unmet need for family planning among nationally representative samples of women of childbearing age.

This report also draws on published and unpublished data concerning reproductive health, family planning and government health policy in Burkina Faso. By weaving together salient findings from a range of sources, it is possible to create a coherent picture of the causes, estimated levels and impact of unintended pregnancy and unsafe abortion in Burkina Faso, as well as a better understanding of the aspects of the country's current family planning programs that are lacking and the specific groups they may be failing to serve. However, it should be emphasized that because of the difficulty of directly measuring a clandestine behavior such as abortion in countries where it is legally and/or socially restricted, the abortion rates and patterns presented in this report were obtained through indirect methods (see the Methodology box on page 22) which

involve a degree of uncertainty

**How the report is organized**

Chapter 2 provides an estimate of the number of women in Burkina Faso who have an abortion, presents national and regional estimates of the annual abortion rate and outlines a profile of the women most likely to have had an abortion in the recent past. It also discusses women's attitudes toward abortion and their understanding of its legal status. Chapter 3 focuses on the providers women turn to if they want to end a pregnancy, the kinds of methods they are likely to use and how much they pay for an abortion. Chapter 4 presents estimates of the proportion of women who experience health complications from unsafe abortion, and the proportion who are able to obtain emergency medical care if they do experience complications. It also describes the types of health care facilities from which women receive care. Chapter 5, which looks at the antecedents of abortion, presents information on the incidence of unintended pregnancy, rates of contraceptive use and levels of unmet need. It also examines the reasons why many women who want to avoid becoming pregnant do not use contraceptives. The chapter ends with a review of the costs, as well as the health and financial benefits, of meeting unmet need for family planning in Burkina Faso.[22] Chapter 6 summarizes the report's major findings and makes policy and program recommendations about ways to reduce the toll of both unintended pregnancy and unsafe abortion in Burkina Faso.

Through documentation of the serious health consequences and high costs of unsafe abortion, we intend to bring this issue to the attention of policymakers, program planners, women's health advocates and the national and international media. Easy-to-read charts and tables highlight findings that can be used to increase understanding of the causes, scale and damaging impact of unintended pregnancy and unsafe abortion in the lives of women and their families.

**BOX**

**Data Sources**

This report is largely based on data from four sources in Burkina Faso. Three are surveys that were conducted in 2009 by the Guttmacher Institute and its partner organization in Burkina Faso, Institut Supérieur des Sciences de la Population. Two of these surveys—one of which interviewed health professionals, and the other senior staff at health facilities that treated postabortion complications—were used to generate estimates of the magnitude of the practice of induced abortion in Burkina Faso. The third was a nationally representative, community-based survey that collected information about women's experiences with abortion. Data from Burkina Faso Demographic and Health Surveys conducted from 1993 to 2010 were also used in this report.

**Health Facilities Survey**

From March to July 2009, researchers surveyed a nationally representative sample of facilities within Burkina Faso's formal health care system that treat women with abortion-related complications. These facilities included three levels of public providers—centres de santé et de promotion sociale (CSPS), centres medicaux (CMA) and centres hospitaliers régionaux (CHR)—as well as private-sector facilities staffed with doctors. The study sampled 42% of the private facilities, 10% of the CSPS facilities and all of the CMA and CHR facilities that treated postabortion complications, for a total of nearly 300 facilities. At each selected facility, a senior staff member who was knowledgeable about the facility's provision of postabortion care was asked to participate in the survey. In hospitals, this person was typically the chief or another senior member of the obstetrics and gynecology department; in smaller facilities, it was generally the director, a midwife or a nurse. From the resulting information, the research team obtained estimates of the number of women who received postabortion care at each facility, and the numbers were weighted to provide national, urban and rural estimates.

**Health Professionals Survey**

From March to June 2009, the research team conducted in-depth interviews with a purposive sample of 82 health professionals who had experience in the field of reproductive health and

were knowledgeable about abortion provision and postabortion care in Burkina Faso. This group included medical doctors, midwives, researchers, policymakers, family planning administrators and women's rights activists. The survey asked respondents about their perceptions of various aspects of induced abortion in Burkina Faso, including the provider types and methods used by poor and nonpoor women in both rural and urban areas, the proportion of abortion patients who experience complications (according to provider type), and the proportion of women with complications who are likely to obtain care from a health facility.

**Community-Based Survey**

From February to April 2009, the research team conducted a nationally representative, household-based survey of reproductive-aged women in Burkina Faso. In this cross-sectional dsurvey, 4,206 women from all of the country's 13 regions were interviewed about their own abortion experiences as well as those of close friends, family members and neighbors. The rationale behind this approach is that women may be more likely to talk about the abortion experiences of women close to them than about their own experiences with abortion. The survey asked respondents to list women of reproductive age who were in their social network or family and who confide in them; overall, respondents listed more than 7,000 confidants. Women were then asked whether each confidant they listed had had an abortion; for each one who had, they were asked a detailed series of questions about the confidant's abortion experiences. In addition to providing information about women's abortion experiences, this methodological approach also permits application of an indirect estimation technique, the Anonymous Third Party Reporting Method.[23]

**Demographic and Health Surveys**

This report also used data from Burkina Faso Demographic and Health Surveys conducted in 1993, 1998–1999, 2003 and 2010. These are nationally representative surveys that interview women of reproductive age about topics such as childbearing, fertility preferences, contraceptive use, marital and sexual behavior, and social and demographic characteristics.

**Data Limitations**

The Health Facilities Survey obtained an approximate count of the number of postabortion patients treated at each sampled facility. The survey was retrospective and asked respondents about the number of patients in the past month and an average month, but it did not collect data prospectively from patients or their medical records.

The Community-Based Survey asked women about the abortion experiences of their close confidants. Respondents may have received incomplete or inaccurate information about their confidants' abortions, and they may not have reported all of the abortions they were told about. Moreover, some confidants may not have told respondents about their abortions.

The Health Professionals Survey solicited the perceptions and opinions of a cross-section of knowledgeable health professionals regarding the conditions of clandestine abortion service provision, the probability that women experience complications and the likelihood that they receive any needed treatment, all according to women's poverty status and residence. The sample was small and not nationally representative, and only 14 (17%) of the respondents were working primarily in rural areas. The probabilities and estimates offered by knowledgeable health professionals are not based on empirical data from women who have had an abortion.

Despite these limitations, the information from these sources offers an approximate picture of the circumstances and conditions surrounding abortion in Burkina Faso, and it allows us to make a reasonable estimate of the incidence of abortion. Such indirect estimates, based on a number of assumptions, are necessary given that national statistics on abortion and abortion-related complications do not exist.

## Chapter 2. Prevalence and Patterns of Induced Abortion

Recent studies confirm that many women in Burkina Faso end unintended pregnancies by abortion. Data collected through the Health Facilities Survey indicate that in 2008, almost 23,000 women were hospitalized for the treatment of complications from unsafe abortions.[24,25] When this number is combined with estimates of the much larger number of women who had unsafe abortions but either did not have complications or had complications but did not receive care in health facilities,[26] the result is that an estimated 87,200 women in Burkina Faso took clandestine measures to end a pregnancy in 2008.[D] This number translates to an estimated annual abortion rate of 25 per 1,000 women aged 15–49,[E] a moderate rate that is comparable to the level observed in 2008 for the West Africa subregion (28 per 1,000 women aged 15–44).[10] It is the same as the rate estimated for Nigeria in 1996, and slightly higher than the rate for Ghana in 2007 (21 per 1,000).[27,28] These rates fall between the 2008 rates in Eastern Africa (38 per 1000) and Southern Africa (15 per 1,000).[29]

The estimated abortion rate is 28 per 1,000 in Ouagadougou, Burkina Faso's capital city, but it is higher—42 per 1,000—in the country's other urban regions, which include the second largest city, Bobo-Dioulasso (Figure 2.1). The rate is lower—22 per 1,000—in rural areas, which is where 75% of the population lives.4

If we assume that abortion rates remained the same between 2008 and 2012, but adjust our estimate of the number of abortions by taking into account population growth and the increase in the number of women of childbearing age during that time,[F] then we estimate that approximately 105,000 abortions occurred in Burkina Faso in 2012 (Table 2.1).

[D] The results of the Health Professionals Survey suggest that for every woman who received treatment for abortion complications, an additional 2.8 women either did not have complications or had complications but did not receive care.
[E] The national rate is derived by applying a multiplier of 3.8 (calculated from Health Professionals Survey data) to findings from the Health Facilities Survey.
[F] Population data are based on United Nations estimates.

The breakdown by region in Table 2.1 indicates that although Burkina Faso's estimated abortion rate is higher in urban than rural areas (Figure 2.1), two-thirds of all clandestine abortions are estimated to occur among rural women.

The major factors that contribute to regional differences in the estimated abortion rate undoubtedly include differences in levels of unintended pregnancy, in women's motivation to end unintended pregnancies, in the types of providers available to women seeking clandestine abortions, and in women's own characteristics, particularly their social and economic status. However, until these factors—and their interactions—are better understood, the role each plays in contributing to the variations in the abortion rate, especially between rural and urban areas, cannot be clearly understood.

**Secrecy and underreporting result in varying estimates of abortion incidence**

Because illegal abortion is a punishable criminal act in Burkina Faso, most women who end a pregnancy keep their abortion secret. This high degree of secrecy makes it difficult to know how prevalent the practice is, or to identify the characteristics of women who have abortions. However, in many cultures, women who secretly try to end an unintended pregnancy often confide in somebody close to them.

From the information women give to trusted friends and family members, one can estimate that in 2009, 3.2% of women aged 15–49 in Burkina Faso had had an abortion in the past two years.[30] The women most likely to have recently ended a pregnancy were those between the ages of 15 and 24, 5.7% of whom had told a close friend or family member that they had had an abortion; the proportions were much smaller among women aged 25–34 (2.1%) and those 35 or older (1.4%). Differentials were also wide between urban and rural women—6% of women living in urban areas other than Ouagadougou had had an abortion in the past two years, compared with 3.8% of residents of the capital city and 2.6% of women living in rural areas. Another large difference is by education level: Among women with at least a secondary education, 6.9% were estimated to have had a recent abortion, compared with 5.4% of women with only a primary education and 2.2% of those who had never been to school.[30] Because

education increases the opportunity cost of childbearing and childrearing, better-educated women are probably more motivated than their less-educated counterparts to have an abortion if they become pregnant unintentionally.[31,32]

In countries where abortions laws are restrictive and there is a strong stigma attached to abortion, it is likely that some women do not reveal their abortion experiences, even to their friends. However, although estimates of abortion incidence that are based on the private confidences of women are likely to be underestimates to some extent, the results can be used to draw a general picture of the groups of women who are most likely to have an abortion.

The data from the Community-Based Survey suggest that 1.7% of women of childbearing age in Burkina Faso end a pregnancy each year.[30] This rate is one-third lower than the annual estimate of 2.5%, or 25 per 1,000, derived by applying the indirect estimation methodology to the abortion-related hospitalization data (see Methodology box on p. 23).[25] The fact that the two approaches yield different annual estimates attests to the difficulty of determining the actual level of abortion in settings where no empirical data exist. Nevertheless, even these estimates (both of which are probably underestimates) are informative and highly useful in understanding general levels and group differences.

**Abortion is especially common among young, single and more educated women**

Women who had told a close family member, friend or neighbor that they had recently had an abortion differed in a number of ways from the general population of women of childbearing age (Figure 2.2). Two-thirds (65%) of women who had had an abortion were between the ages of 15 and 24, compared with 41% of all women aged 15–49. Twenty-seven percent of abortion recipients had at least a secondary education, compared with only 9% of all women of childbearing age. And 36% of women who had ended a pregnancy recently were living in an urban area, compared with 22% of all women of childbearing age. Perhaps the most striking feature distinguishing women who had had an abortion from their peers is that 65% were childless, a much higher proportion than the 24% of all women aged 15–49 who had not had a

child.[30] Six in 10 women who had had an abortion were unmarried at the time,[33] compared with slightly more than two in 10 of all women aged 15–49.4

The elevated likelihood of induced abortion among younger women was also revealed in a 2004 national survey, which found that 18% of female adolescents reported having one or more friends who had attempted to interrupt a pregnancy, as did 16% of male adolescents.[18]

In summary, women are most likely to have had an abortion if they are younger, have completed secondary school (or beyond), live in urban areas, do not have children and are unmarried. Because Burkina Faso is still a largely rural society in which many women receive no schooling (74% of women of reproductive age have had no formal instruction4) and early marriage is common (the median age at first marriage among 20–24 year old women is 17.9 years—Appendix Table 2), women with recent experience of abortion appear to come disproportionately from the relatively small segment of the female population who live in more modernized urban areas of the country, remain unmarried and childless until their 20s, and pursue at least a secondary education. These are precisely the kinds of women who have difficulty obtaining contraceptives,[34] would have a strong reason to not want to be identified as sexually active and would not want their education interrupted by an unplanned pregnancy.[20,21]

**Women's attitudes toward the legality and acceptability of abortion are fluid**

There is often dissonance between a woman's expressed attitude toward the practice of induced abortion and what she herself does if faced with an unintended pregnancy. Moreover, those who declare themselves to be tolerant of pregnancy terminations undertaken for certain reasons—such as to avoid the difficulties a woman with an unwanted pregnancy might face if she carries the pregnancy to term—may nonetheless offer a blanket condemnation of induced abortion. When women are asked whether they consider abortion acceptable (or somewhat acceptable) under various circumstances, the only reason that is supported by a majority of respondents is to save a woman's life (61%; Figure 2.3). About four in 10 women find abortion acceptable if the woman's health is threatened. Support for abortion if the pregnancy is the result of rape is very

weak (only one in four women consider this reason at least somewhat acceptable), even though the law allows abortion in this situation.[30] However, knowledge of the legal status of abortion of abortion in Burkina Faso is low; in fact, in the Community-Based Survey, only 37% of women of childbearing age said they knew that such a law exists.

That many women disapprove of abortion even to save a woman's life—and that a substantial majority disapprove of the procedure under other circumstances—might seem surprising given the widespread occurrence of abortion in the country. Similar contradictions between attitudes and behavior are probably common in many countries, especially those where, in the face of true hardship, abstract principles come into conflict with the realities of daily life. It is easy to imagine how negative attitudes can prevail even though abortions are commonplace, considering that most abortions in Burkina Faso are clandestine and that even a woman who publicly condemns the procedure may herself have obtained one secretly.

Attitudes toward abortion are undoubtedly shaped by the strong religious beliefs of people in Burkina Faso. Overall, three-fifths (62%) of the population is Muslim, almost one in three (30%) is Catholic or Protestant and about one in fifteen (7%) is an animist.4 The prevalence of these affiliations varies by region; the dominance of the Muslim and Christian faiths in urban areas might help explain why the disapproval of abortion appears stronger in cities than in rural areas, where animism is relatively common.[19]

**BOX**

**Methodology for estimating abortion incidence**

The Abortion Incidence Complication Method[35] was used to calculate estimates for Burkina Faso of the annual number of abortions per 1,000 women (abortion rate) and the annual number of postabortion complications treated in health facilities per 1,000 women (treatment rate) in 2008. Using these estimates, as well as pregnancy estimates and official population data, we also estimated rates of unintended pregnancy and the distribution of pregnancies according to outcome (planned births, unplanned births, abortions and miscarriages).

To use the Abortion Incidence Complications Method, two essential pieces of data were needed: the number of women treated at health facilities for complications of induced abortion over a one-year period, and the proportion of women having an induced abortion who are treated for complications at a health facility.

The first measure—the number of women treated for complications of induced abortion—was estimated using data from the Health Facilities Survey.[24] Informants from a nationally representative sample of health facilities were asked about the characteristics of their facility, the services the facility provided (including postabortion care), the procedures used at the facility to treat abortion complications and the estimated number of women treated for complications of induced abortion and spontaneous abortion (miscarriage).

To account for the likelihood that postabortion caseloads fluctuate during the year, informants were asked to provide estimates of the number of women treated for complications during two reference periods: the past month and a typical month. By averaging these two estimates and multiplying by 12, we arrived at an estimate of the total number of postabortion patients in a full year. To avoid double-counting, before averaging we subtracted the number of women who had been referred to another (likely higher-level) facility, on the assumption that these women had obtained care elsewhere and, thus, would be included in that facility's count.

As noted above, the Health Facilities Survey asked for estimates of the number of women treated for complications of either spontaneous abortion or induced abortion. Respondents were asked about both because clinicians often have difficulty distinguishing complications of induced abortion from those of miscarriage, and because the stigma attached to induced abortion may discourage women from admitting the cause of their complications. However, to obtain an estimate of the number of induced abortions, we needed to estimate the number of spontaneous abortions and subtract this number from the total. Data from clinical studies—the only ones available with the detailed information we need—were used to estimate the number of pregnant women likely to have experienced a miscarriage at 13–21 weeks' gestation[36,37] ; we used this range because only women miscarrying during this stage of pregnancy would likely need care in a hospital or health facility. We estimated that the number of late miscarriages equaled 3.41% of all reported live births.[35]

Because not all women who need facility-based treatment for a late miscarriage succeed in obtaining it, a further adjustment was needed to account for untreated women. We assumed that the proportion of women with late miscarriages who received care was the same as the proportion of deliveries that take place in a health facility. We estimated the proportion of deliveries in 2008 that occurred in a facility by interpolating between the values obtained in the 2006 and 2009 Ministry of Health surveys.[38,39] Thus, for 2008, we estimated that 70% of deliveries in Burkina Faso occurred in health facilities. However, the proportion varied across areas, ranging from 51% to 79% in predominantly rural areas and from 82% to 94% in the regions containing the country's two largest cities (Ouagadougou and Bobo Dioulasso). After using these proportions to make the appropriate adjustments and subtracting the number of women treated for late complications of miscarriage from the total number of postabortion cases, we estimate that of the 38,396 women treated in Burkina Faso in 2008 for complications from pregnancy losses, 15,448 were treated for late miscarriage complications and 22,948 for induced abortion complications.

In addition to calculating estimates of the number of women treated for complication of induced abortion in the country as a whole, we also calculated estimates for Ouagadougou, for other urban areas and for rural regions. The estimates by rural and urban residence reflect where

women were treated, not necessarily where they lived. If women travel from one area to another to obtain medical care, residence-based estimates would be undercounts for sending areas and overcounts for receiving areas.

The second measure needed to estimate the number of abortions—the estimated proportion of all women having an induced abortion who are treated at a facility for complications—comes from the Health Professionals Survey.[26] Responses from interviews with 82 knowledgeable informants was used to calculate a multiplier—or adjustment factor—to account for women who have an abortion but do not receive facility-based treatment for complications. These women either do not develop complications severe enough to require treatment, obtain care at an informal facility, do not obtain needed care or die before obtaining care. By multiplying the number of women treated for complications of induced abortion by the adjustment factor, we were able to estimate the total number of induced abortions.

The multiplier also accounts for differences in the likelihood of complications according to the woman's socioeconomic status and area of residence—whether she is poor or nonpoor and whether she lives in an urban or rural area. These characteristics are important because they influence whether a woman seeking an abortion is able to obtain a relatively safe procedure or whether she must rely on a untrained provider. No specific definitions of poor and nonpoor were used in the survey; the term "poor" was intended to capture the experiences of women with lower than average levels of income and/or education. The assessment might also refer to women who live in slums, women who are day laborers or married to day laborers, and those who are migrants (especially migrant laborers). Survey respondents were allowed to determine, based on their own understanding of the terms poor and nonpoor, the types of women they classified into each category. The resulting data were used to create weights to account for the differing proportion of women in each of four subgroups—poor rural, nonpoor rural, poor urban and nonpoor urban—nationally and in each province. On the basis of responses from the Health Professionals Survey, we estimated that 27% of women who had an induced abortion in 2008 received treatment at a health facility. The national-level multiplier is the inverse of this proportion—100/27, or 3.7. We also calculated multipliers for Burkina Faso's urban and rural areas (3.8 and 3.7, respectively).

**Limitations**

The methodological approach and the data both have some limitations. The calculation of the number of women in Burkina Faso treated for late miscarriages in health facilities was based on assumptions from clinical studies conducted in the developed world. Data specific to the developing world, and to Burkina Faso in particular, are unavailable. Moreover, these clinical studies date from the 1980s. Although miscarriage rates are relatively stable, they may be somewhat different in Burkina Faso than in developed countries and may have changed over the past 25 years.

Given the lack of empirical data on the conditions of abortion provision in Burkina Faso, the proportions of women needing facility-based postabortion care and the probability that these women obtain such care, we relied on the perceptions of key informants participating in the Health Professionals Survey. Similarly, the facility-based hospitalization data have a margin of error, because they rely on estimates and are based on a sample survey.

Additionally, the abortion rates calculated for urban and rural areas reflect where women obtain abortions, but not necessarily where they reside. Abortion rates in the urban areas of Ouagadougou and Bobo Dioulasso may include women who traveled from rural areas seeking abortion services or postabortion care, as well as confidentiality.

## Chapter 3. The Practice of Induced Abortion

In countries where induced abortion is permitted only on narrow grounds, the skills and training of providers who terminate unwanted pregnancies, and the types of methods they use, vary widely. According to health professionals familiar with conditions in Burkina Faso,[G] the providers who typically perform abortions include doctors, midwives, male trained birth attendants (maïeuticiens), medical paraprofessionals (e.g., trained health assistants) and traditional health practitioners; moreover, women often terminate pregnancies themselves.[26] The most commonly used providers are traditional practitioners, whom experts estimate perform 41% of all abortions (Figure 3.1); in another 23% of cases, women terminate the pregnancy themselves. Less often, abortions are performed by midwives or male trained birth attendants (13%), or by trained health assistants (12%), who may have received basic training in primary health care but not necessarily in safe abortion techniques.[26] Only 3% of women are thought to obtain their abortions from doctors. The remaining 7% appear to go to other, unknown types of providers.

The estimates of health professionals are very similar to those from the Community-Based Survey. The women in whom friends, neighbors and family members had confided about their abortions reported that roughly four in 10 women had used traditional providers, three in 10 had ended their own pregnancy and three in 10 had used the services of trained health professionals.[30]

### Poor women are the most likely to turn to unskilled providers

Because women's economic status and place of residence are likely to influence the types of providers they use, participants in the Health Professionals Survey were asked to provide estimates concerning the abortions obtained by four different population groups—poor urban

[G] In this and the following chapter, the information on where women go to end a pregnancy, the types of methods they use and the health impact of unsafe abortions comes from two sources: knowledgeable health professionals and women themselves. See the Data Sources box on p. 00 for more information.

women, poor rural women, nonpoor urban women and nonpoor rural women.[H] Poor women living in rural areas were judged to use the riskiest sources for an abortion. Seven in 10 go to traditional practitioners or end their pregnancies themselves, and only one in five uses the services of providers with formal medical training—either doctors (1%), trained health assistants (9%) or midwives or other trained birth attendants (11%) (Figure 3.1). In contrast, three-quarters of nonpoor urban women are believed to use the services of trained medical professionals, including doctors (26%), trained health workers (25%) and midwives and other trained birth attendants (23%). The patterns of abortion provision for poor urban women and nonpoor rural women are broadly similar to each other; in terms of safety, both fall between the patterns for poor rural women and nonpoor urban women, as half of women in each group are thought to either self-induce or go to traditional practitioners.[26]

Nonpoor urban women's choices reflect both the greater availability of trained health providers in towns and cities and the ability of more affluent women to find and afford the services of these providers. Conversely, the unsafe choices made by poor rural women probably reflect the lack of trained health workers in rural areas and these women's inability to find or afford such providers.

Findings from the Community-Based Survey confirm that a woman's place of residence is an important factor in the type of provider she uses, but they also suggest that her level of education is another strong determinant. A substantial proportion of women in Burkina Faso have never gone to school; 82% of these women turn to traditional practitioners or self-abort if they want to end an unwanted pregnancy, compared with 53% of women who have at least a secondary education.[30] The link between education and provider type undoubtedly also reflects that the ability to pay for professional services is closely related to a woman's level of schooling.

The more children a woman has had, the more likely she is to have used a skilled provider, which suggests that women who have given birth are more likely than other women to be

[H] The survey did not define "poor" and "nonpoor." The term poor was intended to capture the experiences of women with lower than average levels of income or education; the assessment might also refer to women who live in slums, women who are day laborers or married to day laborers, and those who are migrants (especially migrant laborers). Respondents were allowed to determine, based on their own understanding, the types of women classified into each category.

familiar with the modern health resources available in the community. On the other hand, a woman's choice of provider does not seem to be strongly linked to her age or marital status. Similar proportions of younger women and older women use traditional providers, as do similar proportions of unmarried women and married women (data not shown).[30]

Nevertheless, it is striking that even among the most educated women who have an abortion, more than half turn to a traditional practitioner or end their own pregnancies.[30] Presumably, many do this because their desire to keep the procedure a secret is just as strong as that of their less educated peers. Women from all backgrounds may tend to believe that their privacy is best protected if they use traditional practitioners, who can be visited incognito and at night, reducing the likelihood that they will meet someone they know. In addition, traditional providers do not keep written records, which provides a further element of confidentiality. It is also possible that when seeking to terminate a pregnancy, even women with knowledge and resources are hard-pressed to find a trained provider.

**Most women who have clandestine abortions rely on unsafe methods**

The safety of an induced abortion depends not only on who performs it, but also on the technique employed and the location of the procedure. In many countries where abortion is outlawed, women who can afford the fees often obtain abortions from trained health professionals (doctors or nurses) who can perform a safe procedure using modern techniques—dilation and curettage (D&C) or vacuum aspiration—performed in hygienic settings.[40] In contrast, poor women and those living in rural areas generally have to rely on traditional, often dangerous techniques performed in unsanitary conditions.

In Burkina Faso, according to the friends, neighbors and relatives of women who have had an abortion, about four in 10 abortions are carried out by the use of potions, high doses of drugs, or caustic products, such as bleach or laundry soap (Figure 3.2). The next most commonly used methods are injection of hormonal drugs (one in seven abortions), presumably to bring on miscarriage, and the use of unspecified traditional methods that women use themselves (one in seven). In contrast, the use of safe methods—D&C and vacuum aspiration—is very low; these

methods are used by about one in 16 women. Other infrequently used methods include the insertion of catheters, sticks or sharp objects into the vagina, and the consumption or vaginal application of cola, beer or coffee.[30] Many of these methods, except for D&C and vacuum aspiration procedures performed by a trained health professional, can lead to serious health risks, particularly when they result in physical trauma or incomplete abortions that lead to infection or heavy bleeding.[30]

The use of safe methods is very low for Burkina Faso as a whole, but it is almost nonexistent among rural women. According to the Community–Based Survey, only 3% of abortions obtained in rural areas are done safely (Figure 3.2); the rest are performed using one of the many nonsurgical methods, including suppositories, catheters and caustic products. The proportion of abortions carried out using potions, high doses of drugs or caustic products is much greater among rural women (about half) than among women in urban areas (slightly more than two in 10), although urban women are slightly more likely than rural residents to use high doses of drugs rather than potions. On the other hand, urban women are much more likely than rural women to terminate their pregnancy by injection (24% vs. 8%), D&C or vacuum aspiration (13% vs. 3%) or the insertion of a catheter (18% vs. 1%).

Misoprostol, an effective and safe drug that can terminate pregnancies if used correctly under the supervision of properly trained health workers, is banned in Burkina Faso as an abortifacient, as it is in most countries in the Sub-Saharan region. Nevertheless, in many of these countries it is often widely available on the black market. An ongoing study reveals that this drug is being used in Ouagadougou.[41] However, its use was not reported in the Community Based Survey.

**The high cost of a safe abortion is a barrier for most women**

Health professionals knowledgeable about the conditions in which clandestine abortions are carried out in Burkina Faso have estimated the probable cost to women of each of the procedures used to end a pregnancy. As might be expected, women in rural areas are believed to pay less than those in urban areas; moreover, the less skilled the provider is, the less expensive the procedure (Table 3.1).

While the costs shown in Table 3.1 might appear small, they represent a great deal of money in a country where the per capita income is very low. The huge difference in the estimated fees paid to private or clinic-based doctors and those paid to traditional providers goes a long way in explaining why so few women in Burkina Faso obtain abortions from trained health professionals. In Burkina Faso, as in every country where unsafe abortion is virtually the only possible way to terminate a pregnancy in the face of restrictive abortion laws, it is largely poor women who use the least costly and least safe methods and providers, and it is poor women who ultimately pay the greatest price for their actions—damage to their reproductive health and, sometimes, loss of their life.

## Chapter 4. The Consequences of Unsafe Abortion

As we saw in Chapter 3, poor women and rural women—who, together, account for almost nine in 10 women of childbearing age in Burkina Faso[26]—are the ones most likely to use the least safe abortion methods and to turn to the least reliable providers. On the other hand, some urban women, as well as those who are better educated, are able to obtain clandestine abortions from health workers who have been trained to observe the basic rules of hygiene and safety. Similar disparities exist in most countries where access to safe, affordable abortion is restricted: Many women with financial resources (mainly those living in urban areas) can obtain safe pregnancy terminations, while most poor women and those living in rural areas use dangerous and sometimes ineffective methods and providers (including themselves), often ending up with incomplete abortions and related health complications.[42,43] In Burkina Faso, this situation is exacerbated by the fact that even some women who are not poor resort to unsafe measures to terminate their pregnancies.[26]

### Complication rates are highest for women using unskilled traditional providers

Knowledgeable health professionals estimate that four in 10 women (43%) who have an abortion in Burkina Faso end up with some kind of health complication (Figure 4.1).[26] An estimate based on responses by women themselves suggests that 49% of abortions result in complications.[30]

Health professionals judged the risk of serious medical consequences to be greatest among poor women living in rural areas (46%) and lowest among nonpoor women in urban areas (23%).[26] This difference can be attributed to differences in the ways the two groups end their pregnancies, including the types of providers from whom women obtain their abortions. The proportion of abortions resulting in complications is thought to be highest among women who go to traditional practitioners (57%; Figure 4.1). The next most dangerous strategy is for women to end their pregnancies by themselves; half of these women (51%) are estimated to experience complications. Even among women who rely on nonphysician medical workers, one in five are believed to end up with health complications (21–23%). Only among women who go to doctors is the risk of complications lower than one in 10 (8%).

**Four in 10 women with abortion complications do not receive treatment**

The health professionals were also asked whether they thought it likely that women who experience complications—an incomplete abortion, bleeding, infection or some lesser problem—obtain treatment. Of the estimated 43% of all women having abortions who are believed to experience complications, fewer than three-fifths (56%, or 27% of all women who have an abortion) obtain the care they need, while more than two-fifths (44%, or 17% of women who have an abortion) do not get care (Figure 4.2). However, treatment rates vary widely according to women's social and demographic characteristics. Only 2% of nonpoor urban women who obtain an abortion have complications but do not receive the care they need, compared with 19% of poor rural women and 12% of poor urban women.

Although only about six in 10 women in Burkina Faso with abortion-related complications are able to obtain the postabortion care they need, almost nine in 10 nonpoor urban women are able to do so.[26] This high proportion suggests that in urban areas, many women and their families recognize that vaginal bleeding and high fevers from infection are serious symptoms that require immediate professional treatment, and that they know where to go for care and have the means to pay for it. This awareness and ability to pay are all the more likely given that urban women who have abortions tend be better educated than the average woman of childbearing age. Moreover, a woman's level of schooling is related not only to her income level, but perhaps also to how well she understands any information and instructions she receives about the signs of complications, and about when and where to seek medical treatment for complications.

Women's generally high level of awareness of the need for postabortion care might also be attributable to a vigorous government program, introduced in 2006, to reduce maternal mortality by offering women improved and heavily subsidized delivery and emergency obstetric care.[44,45] It is notable, for instance, that between 2003 and 2010, the proportion of births occurring in a health facility increased from 39% to 66%.[4,7]

According to health professionals, although an estimated six in 10 women with abortion-related complications receive the treatment they need (the comparable estimate from women themselves

is 56%[30]), about four in 10 do not (Figure 4.3). These are largely poor women living in rural areas. Several factors may contribute to their lack of care: They may not recognize that they are in danger; the type of health facility they need may be unavailable in their area; they may not know that the appropriate facility exists; they may not think they can afford hospital charges; or they may have no means of transportation or be unable to afford the travel costs.

Data from the Health Facilities Survey indicate that almost 23,000 women in Burkina Faso were treated for abortion-related complications in 2008.[24] If we apply this number to the health professionals' estimates of the proportions of women with complications who do not receive care, we can conclude that nearly 15,000 additional women with serious complications should have obtained postabortion care but did not. The majority of these women were almost certainly poor.

Although urban women represent only one in four women of childbearing age, they accounted for one-third of those receiving treatment for abortion-related complications in 2008, an indication that emergency health services are more easily available to urban than rural women. The overrepresentation of urban women is also partially due to their greater likelihood in the first place of terminating an unintended pregnancy.

**Women obtain postabortion services from both hospitals and local clinics**

The health system in Burkina Faso is organized into three levels. The first level is the health district, which is represented by two types of clinics:

- The first type is the centre de santé et de promotion sociale (CSPS). In these facilities there is a dispensary, a maternity clinic and a depot selling essential generic drugs.

- The second type of health district facility is the centre médical avec antenne chirurgical (CMA), or medical center equipped to perform basic kinds of surgery. Cases from the CSPS are referred to a CMA. The CSPS and the CMA are the backbone of health care services available at the district level.

The second level of health care, the regional level, is represented by a Centre Hospitalier Régional (CHR). Each of the country's 13 health regions is organized to operate such a hospital, even though currently only nine do. These are the health facilities to which patients unable to be treated in a CMA are referred.

Tertiary-level health facilities are represented by the country's two major teaching hospitals, one in Ouagadougou and the other in Bobo-Dioulasso. [46]

In addition, an estimated 320 private health facilities are based in Ouagadougou and Bobo-Dioulasso.

The important role that primary-care health clinics play in postabortion care can be seen in Figure 4.3. Health professionals estimate that half of women who obtain treatment for abortion complications receive this care from a CSPS, compared with 25% who go to a CMA or CM. Although regional hospitals (CHRs) and the university hospital in Ouagadougou are probably the facilities best equipped to treat serious abortion-related complications, they are believed to be the source of care for only 18% of women with complications; their relatively small role may be related to the high likelihood that transportation to such centers is poor in many rural areas. Moreover, although women who are so ill that they cannot be treated at a local health center may be referred and perhaps transported to tertiary-level hospitals, the number of such cases is small.

**Little is known about the severity of abortion complications in Burkina Faso**

The severity of abortion-related complications is, of course, important in determining the gravity of the health consequences of unsafe abortion. Our data do not allow us to assess this aspect of the problem. However, the fact that locally-grown plants are the basis for many of the traditional methods used to end pregnancy is a cause for concern. An ethnological study conducted in northern Burkina Faso found that although the leaves of a bush often used to induce abortion contain contraction-inducing ergot alkaloids, (which would, in theory, help end a pregnancy), they also contain toxic, strychnine-like substances that can cause heavy vaginal bleeding, abdominal pain, diarrhea, vomiting and even death.[20]

There has been no national assessment of the contribution of unsafe abortion to Burkina Faso's high level of maternal mortality. Moreover, it is unknown how many women with abortion-related complications have died or suffered long-term health consequences (such as infertility) as a result of not receiving care.

## Chapter 5. Unintended Pregnancy: The Underlying Cause of Unsafe Abortion

As is true of women the world over,[40] women in Burkina Faso do not risk the often-dangerous consequences of unsafe abortion for trivial reasons. They do so largely out of desperation to end a pregnancy that they had not planned or hoped for—an unintended pregnancy. Very few women anywhere in the world end a pregnancy for any reason other than that it is unintended (that is, mistimed or unwanted altogether), even though the specific motivations for their decisions vary widely.[I, 46,47]

In 2008, an estimated 32% of all pregnancies in Burkina Faso among women aged 15–49 were unintended (Figure 5.1).[J] One-third of these unintended pregnancies (and thus one in 10 of all pregnancies) were resolved by abortion.[25] The women having them probably felt that these pregnancies, if continued, would have led to especially difficult problems (having to end their education, being unable to raise a child alone) or brought shame upon them or their family.

The ideal of a large family is still strong in Burkina Faso, and probably few women feel comfortable admitting that any child is unwanted. However, ambivalence might figure in some younger women's decision making about an unintended pregnancy. A qualitative study in Ouagadougou found that young unmarried women who are under pressure from their families to marry sometimes become pregnant intentionally to encourage their boyfriend to marry them. But if the boyfriend is disinclined to marry, or if the relationship deteriorates or is broken off, the young women subsequently decide that the pregnancy is unwanted and seek a clandestine abortion.[41]

Ambivalence about fertility preferences, and consequently about pregnancy prevention, is found even among women who say they want to delay or stop childbearing. In a 2006 study, among

[I] In every part of the world, the proportions of abortions that are performed to end pregnancies that resulted from rape or incest, that resulted in a nonviable fetus or that endangered the woman's health or life are very small.
[J] Although most of the demographic indicators published in this report are from the 2010 Demographic and Health Survey (DHS), the estimates of unintended pregnancies are based, in part, on the proportion of births that were unplanned as reported by women in the 2003 DHS. We used the findings from the 2003 survey because estimates from the 2010 survey were not consistent with those from earlier surveys or with related indicators. We believe that changes in the wording of the survey questions on the planning status of pregnancies that resulted in births may have resulted in significant underestimation of the proportion of births that were unplanned in 2010.

women who reported that they wanted to delay having another child, about a third of both contraceptive users (36%) and nonusers (32%) said it would be only a small problem, or even no problem, if they were to become pregnant in the next few weeks.[48] Even among those who said they wanted to stop having children altogether, about one in five (19%) said it would be only a small problem, or no problem, if they were to become pregnant in the next few weeks. Women who are ambivalent about their fertility desires are also likely to have ambivalent views about contraception, even if they are already using a method), leaving them at high risk for unintended pregnancy.

**Women in rural areas have, and say they want, large families**

Average family size in Burkina Faso is among the highest recorded in the Sub-Saharan Africa.[49] As of 2010, women were having an average of six children, down from 6.9 in 1993 (Figure 5.2). Urban women were having far fewer children than those living in rural areas (3.9 vs. 6.7, on average, in 2010; Appendix Table 2). What is more, women who lived in the capital city of Ouagadougou were having one child fewer, on average, than those in other urban areas (3.4 vs. 4.4). The main explanation for the urban-rural differential is the difference in overall economic development that characterizes the two regions.[K],4 However, because Burkina Faso is a predominantly rural country, declines in family size in the cities do not greatly reduce the overall average, which remains very high.

Average family size has declined slightly in all areas of the country, but the decrease between 1993 and 2010 was larger among women living in Ouagadougou (28%) and in other urban areas (20%) than among rural women (8%). This suggests that women in the country's urban areas not only want much smaller families than do their rural counterparts, but also are adopting the ideal of smaller families more rapidly.

[K] In 2010, desired family size was 2.8 children among married women aged 15–49 who had at least a secondary education, compared with 5.8 children among those with no schooling; the prevalence of effective contraceptive use was 44% among the former group, compared with 11% among the latter.

**Many women want fewer children than they are having**

Although large families are still considered desirable in Burkina Faso, especially in rural areas, some women would actually prefer to have fewer children than they have. In 1993, when the average family size among all women of childbearing age was 6.9, the average woman's preference was to have only six children, indicating that the typical woman had nearly one child more than she wanted (Figure 5.2). By 2010, the gap between actual and wanted family size had barely changed—it was 0.8, on average.

Traditional values favoring large families still prevail in less-developed, largely agricultural settings, whereas in cities most couples feel economic pressure to have fewer children so that they can afford to educate them in preparation for finding the types of jobs available in the modern world. In rural areas, male children without much schooling can still work in agriculture, and uneducated girls can help with burdensome, time-consuming fieldwork and with household and child care chores. This may particularly be the case in Burkina Faso, which is predominantly rural, and where roughly half of males (56%) and females (47%) aged 15–19 reported in 2010 that they had never attended school.4

Although the reasons behind the large differential in average family size between rural and urban areas are both economic and social, they also stem from the fact that rural women lack the health education and services that would enable them to regulate their childbearing through the use of family planning methods.

We see, then, that despite the broad picture of high fertility in Burkina Faso, average family size is slowly declining and, in fact, many women would prefer to have still smaller families. However, are women adopting contraceptive use at a sufficiently high rate to allow them to achieve this goal?

**Contraceptive use is very low among married women in Burkina Faso**

A number of factors contribute to unintended pregnancy in Burkina Faso. But the root cause is the low level of contraceptive use, which leaves many women who do not want to become pregnant unable to avoid it. In 2010, only 16% of married women aged 15–49 were using a contraceptive method. This is two percentage points higher than the level seven years earlier (14%) and double that seen in 1993 (8%; Figure 5.3). In 2010, the prevalence of contraceptive use among urban women was three times that among rural women (34% vs. 11%); among women with seven or more years of schooling, it was nearly four times that of women with lower levels of education (50% vs. 13%).4 The differential between the wealthiest quintile of women and the poorest quintile (37% vs. 7%) was also stark. These findings suggest that poverty, high levels of illiteracy and poor access to services in rural areas are all major factors hampering a woman's ability to learn about and obtain family planning services.

Although the rate of contraceptive use doubled between 1993 and 2010, the proportion of women using a modern method more than tripled during that period, from 4% to 15% (Appendix Table 1). This indicates that at least some women are becoming more knowledgeable about modern contraceptives and are determined to use methods that have lower failure rates.

Overall, the fact that contraceptive use rates are highest among more educated and urban married women both helps explain their lower fertility relative to rural women and indicates their stronger motivation to achieve the small families these women want (2.8–3.8 children in 2010).4

**Many women who do not want a pregnancy do not use contraceptives**

When women who would prefer to postpone or completely avoid becoming pregnant are not using contraceptives, they are considered to have an unmet need for family planning. That is, they are sexually active, fertile and do not want a pregnancy (soon or ever), but are not using a contraceptive method. In 2010, one in five women of childbearing age in Burkina Faso (20%) had an unmet need for contraception (Figure 5.4). About one in four married women (24%) had an unmet need for contraceptive protection in 2010; the level was even higher (38%) among

sexually active unmarried women (who account for a much smaller proportion of women aged 15–49). The reason that unmet need is greater among sexually active single women than among married women—despite the former's higher rates of contraceptive use—is that single women are far more likely than their married counterparts to not want to become pregnant.

Premarital sexual activity is a contributing factor to the high level of unintended pregnancy in Burkina Faso. In most developing regions of the world, prevailing social taboos against premarital and nonmarital sexual activity are gradually weakening as economies modernize, as higher proportions of girls stay in secondary school and as traditional community controls over young women's sexual behavior are loosened. In Burkina Faso, one in six unmarried women aged 15–24 (17%) were involved in a sexual relationship of some kind in 2010.[4] Sexual activity outside of marriage was especially evident in urban areas, where the proportion of unmarried young women who were sexually active was higher than in rural areas (24% vs. 11%) in 2010.

Premarital and nonmarital relationships create an even greater need for women to have contraceptive protection. Few unmarried but sexually active women from any background want to have a child (and thereby incur even greater social disapproval). In addition, the more educated young women are, the more they have to lose by becoming pregnant, which often leads to their having to leave school. Moreover, very few young unmarried women—even those who live in urban areas and might have paid work—are in a position to raise and care for a child born out of wedlock. Given these compelling reasons to avoid becoming an unmarried mother, one would expect to see greater use of contraceptives among single women than among their married counterparts.

This is, in fact, the case in Burkina Faso, where 54% of sexually active unmarried women aged 15–24 were using contraceptives in 2010 (Appendix Table 1). Sixty-two percent of those living in urban areas were using a method, as were 67% of those with at least seven years of schooling (data not shown).4 These levels are much higher than the level among married women aged 15–24 (13%).

**Young single women are rarely given sexual and reproductive health information**

In Burkina Faso, as in many countries in Sub-Saharan Africa, most young women have not attended school, and those who engage in premarital sexual activity face strong societal disapproval. As a result, these women typically have poor or even no access to adequate sexuality education and contraceptive services. A national survey of adolescents conducted in 2004 found that only about one in eight young women aged 12–19 had received any sex education in school, that slightly more than half did not know where they could obtain contraceptives and that the most important barriers to accessing contraceptive services were fear and embarrassment.[18] Most adolescents had never talked with their parents or guardians about sex-related matters, or ever received information about contraceptive methods.[50] And fewer than one in 10 girls aged 12–14 had received specific information about how pregnancy happens, how to prevent pregnancy and how to say no to sex; the proportion who had received information about sexually transmitted infections was similarly small.[51]

**What prevents women who do not want to get pregnant from using contraceptives?**

Demographic and Health Surveys often ask women who have an unmet need for family planning why they are not using a contraceptive method. In Burkina Faso, the typical responses that married women with unmet need give are that they have intercourse only infrequently (almost one-quarter cite this reason); another one in four say that they have recently given birth or are breastfeeding; and 11–17% report that their partner is opposed to contraceptive use, that they fear side effects or that contraceptives are too expensive.4

Clearly, many women are misinformed about their risk of pregnancy; infrequent sex is no guarantee that a pregnancy will not occur, and lactational or postpartum amenorrhea protects against pregnancy for only a short period following a birth. (Some women may overestimate lactional amenorrhea's effectiveness because this approach is part of Burkina Faso's official family planning program.[52])

However, women are correct about the high cost of contraceptives. A recent study found that although prices are kept relatively low through government subsidies, the cost of contraceptives

in Burkina Faso is high in relation to people's incomes.9 At family planning clinics, a woman may have to pay not only for the contraceptives themselves, but also (especially if she is a new client) for the consultation, the provider's gloves, a disposable speculum and a pregnancy test (if she is amenorrheic).[53] These costs can be a substantial burden, particularly given that many women have no independent income of their own.

In 1999, nearly one in five women in Burkina Faso (19%) said that they did not use contraceptives because they did not know of any methods to prevent pregnancy.[13] By 2010, this proportion had dropped to 3%; 4 this decline suggests that in the intervening years, awareness of the availability and efficacy of contraceptives expanded substantially, whether through organized information and education campaigns or by word of mouth. Nevertheless, awareness of contraceptives does not guarantee their use, as other barriers, whether supply-related or cultural, may impede women from practicing family planning. Moreover, a 2004 study found that only 9% of 15–19 year-old females in Burkina Faso had in-depth knowledge of contraception.[54]

Some evidence indicates that judgmental attitudes on the part of health care providers who disapprove of premarital sex may deter unmarried but sexually active young women from seeking contraceptive protection. A qualitative study conducted in Ouagadougou, where 19% of single women aged 15–24 were sexually active in 2010 (Appendix Table 2), found that "young people are reluctant to reveal their sexual activity by visiting family planning services to get medical contraception."[19]

## Chapter 6. Conclusions and Recommendations

Despite the fact that women in Burkina Faso still want and have many children, three in 10 pregnancies are unintended and one in three unintended pregnancies are ended through abortion. Because most women who terminate unintended pregnancies do so in secrecy, out of fear of prosecution and to avoid the social stigma that surrounds the practice, accurate estimation of the incidence of abortion is very difficult. However, a number of recent national surveys have made it possible to use indirect research methods to examine the clandestine practice of abortion in Burkina Faso. The resulting findings give us a better grasp of abortion's prevalence, the characteristics of women who have abortions, the conditions under which women have them (including the types of providers and methods used) and the magnitude of the complications associated with clandestine procedures. They also show that unintended pregnancy—the root cause of induced abortion—occurs because many women are not using, or are not able to obtain, the contraceptive services and methods that would help them to avoid becoming pregnant when they do not want to. What, then, are some of the health policy and program implications of these findings?

### Contraceptive use need to be increased to reduce the need for abortion

The introduction of health programs designed to meet the high level of unmet need for contraception among women in Burkina Faso would result in fewer unintended pregnancies and fewer abortions. We offer a number of recommendations in various program areas:

*Expand and promote family planning services.* New policy, program and public education initiatives are necessary to promote the concept of family planning and to broaden knowledge of its health and societal benefits. The absence of health facilities offering contraceptives and the high cost of contraceptive services are common reasons why women with unmet need do not practice contraception. Government planners and outside donors should endeavor, therefore, to improve access to family planning services, especially in rural areas. This could be achieved by equipping public health facilities with the resources needed to offer a wide range of contraceptive services, providing women with accurate information about medical methods (to

help dispel myths) and ensuring a constant supply of contraceptive commodities. Collaborations between the government and the private sector that pool resources to ensure continuity of services should be promoted. Similarly, stakeholders should find ways to make contraceptive services affordable to women. Poor women and adolescents, in particular, should have access to free contraceptive services; current government policy is still to charge women a subsidized price for supplies.9

*Offer contraceptive counseling and a wide array of methods.* Women's needs are best met by providing access to a variety of contraceptive methods. For example, a coital-dependent method, such as condoms, may be the best choice for adolescents, who may have sporadic, short-term relationships. Women living in areas where the prevalence of HIV is high may also need to learn about condoms and be able to obtain them and use them correctly. Young, sexually active women who do not want to start childbearing until they are married or better established might best be served by such methods as the implant or the injectable. For married women who want to delay pregnancy for two or more years, the IUD or the pill might be an appropriate choice. Residents of remote rural areas with no health infrastructure might find the injectable a convenient method, and women who have had all the children they want might consider sterilization. Finally, counseling and services should be designed to provide women who have sex sporadically or infrequently with the methods that suit them best.

*Explain to women the high risk of unprotected sex.* Many women who do not want a pregnancy but are not using contraceptives say that they are not using a method primarily because they have intercourse only infrequently. Sources of reproductive health information in Burkina Faso, including both school-based and out-of-school information programs, should be available to help women understand that just one sexual act can result in an unintended pregnancy. Health professionals who counsel women about contraceptives should emphasize the long-term safety of modern methods.

*Introduce community-based distribution services.* Program planners should design community-based programs to educate women about the wide range of contraceptive methods that exist, help

them decide which would be best for them and then set up the services and supply systems necessary to make each method consistently available.

*Pay particular attention to the needs of adolescents and unmarried women.* In Burkina Faso, women who have abortions are more likely than the typical woman of childbearing age to be young and unmarried. Improving their agency (sense of being able to act effectively) and their access to contraceptive services often requires strategies that differ from those for other women. A young unmarried woman seeking contraceptives or an abortion may be treated with disdain by receptionists, nurses or other medical staff, and these judgmental attitudes may greatly hinder the woman's willingness to seek care. Because of young and unmarried women's high risk of unintended pregnancy and their stronger motivation to terminate such pregnancies through unsafe abortion, it is vital that efforts be mounted to reduce levels of unprotected sex among these women through formal and informal educational channels, including classroom teaching and peer education, and to remove barriers to contraceptive use.

*Improve women's educational levels.* The fact that seven in 10 women have had no schooling is surely an important factor in the low prevalence of contraceptive use in Burkina Faso. Compared with women without schooling, better-educated women marry at an older age, and they tend to have greater knowledge of contraception, more autonomy to make decisions regarding contraceptive use, better access to services and greater motivation to prevent unintended pregnancies (because of the higher opportunity costs of unintended childbearing).[55,56] In a recent analysis that examined the links between education and fertility in 30 African countries, the researcher pointed to the beneficial "impact on reproductive behavior that can be expected from raising educational levels among women."[57] In the section of the 2006 Burkina Faso census report pertaining to fertility, the authors reaffirm this connection; they suggest that measures to strengthen the country's population policies and programs focus not only on expanding the availability of contraceptive services, but also on educating girls and improving female literacy.[58]

*Improve postabortion services*. Even when most couples are using modern contraceptives, the need for abortion does not entirely disappear. Contraceptives used incorrectly or irregularly often fail, resulting in unintended pregnancies that may be ended through unsafe abortion. For some years now, postabortion care in Burkina Faso has been provided as part of a national maternal

health care program. Although postabortion services are supposed to be offered at low cost, only the fees charged for manual vacuum aspiration (MVA) are currently subsidized.[59] Many complications, such as hemorrhage, sepsis (infection), anemia, and uterine laceration or perforation, may require other forms of treatment that are not subsidized. Furthermore, women who suffer these complications often have to stay in the hospital longer, thus incurring additional costs. Efforts should be made to equip all qualified health facilities with modern, efficient equipment for treating complications of unsafe abortion, and to extend subsidies for postabortion care to services other than MVA. Moreover, national policies should be established and enforced to ensure that all postabortion services include mandatory contraceptive counseling to educate women on how to prevent future unwanted pregnancies. The counseling should be private, emphasize the relative safety of modern contraceptives, provide information about possible side effects and conclude with the provision of a method to women who want one.

The World Health Organization recommends that all health facilities that provide care for incomplete abortions have the equipment and the trained staff needed to ensure that MVA is consistently used when medically appropriate, and that MVA be provided at a cost that is not prohibitive for poor women.[60]

Medical care for women suffering from complications of unsafe abortion drains already scarce health resources (beds, equipment, skilled staff, blood supplies, drugs) away from safe obstetric care.[61],[62] This is regrettable because larger investments in maternal health care are needed if overall maternal mortality is to be reduced in Burkina Faso.9

*Make abortion care better and safer.* A study conducted in 1996–1998 in two large hospitals in Ouagadougou and Bobo-Dioulasso found that the upgrading of postabortion care is beneficial for both patients and providers.[63] The pilot study, which involved training doctors, nurses and midwives to provide postabortion services (including MVA, family planning and infection prevention), resulted in substantially improved care. For example, staff time for emergency treatment, estimated to be 73 minutes before the training, was reduced to just 23 minutes; the average hospital stay decreased from 36 hours to 19 hours; the mean cost of treatment to patients was reduced from $34 to $15; and the proportion of postabortion patients who initiated

contraception increased from 57% to 83%. Although these findings are important, similar efforts are needed throughout the country, as patients are still experiencing delays in treatment, long hospital stays, high treatment costs and judgmental attitudes from providers.

Although abortion is legally restricted in Burkina Faso, the grounds for legal abortion are not as restrictive as many people, including health care providers, think. Public health standards require provision of medically appropriate care to women who are treated for complications of pregnancy loss and legal abortion. All medical students and medical practitioners (including midlevel staff) working in hospitals should be trained to meet this need through the correct use of MVA—a technique with a very low risk of complications when properly used. In addition, because MVA is the best method to use in treating first-trimester pregnancy losses—not only from unsafe abortion, but also from miscarriage—helping practitioners become skilled in this technique would be of double public health value.

*Educate the public about the provision of legal abortion.* Given that lack of understanding of existing abortion laws is a major impediment to their implementation,[64] a nongovernmental organization should consider disseminating information about the precise conditions under which abortion is considered legal in Burkina Faso, along with clear guidelines as to how an eligible woman might obtain one.

This study has revealed that women's attitudes toward abortion appear to be more conservative than the abortion law itself. The majority of women approve of abortion only if the woman's life will be endangered by continuing the pregnancy. Although this view may largely reflect women's moral beliefs, in many cases it may also be related to beliefs about the legal status of abortion. Only 37% of women of childbearing age knew of the law's existence, and many of those who were aware of the law did not know its provisions. In fact, the legal grounds for abortion are broader in Burkina Faso than in many other Sub-Saharan African countries. Educating the general public about the provisions of the abortion law can help change people's attitudes toward abortion, reduce the stigma around the procedure and give women the courage to obtain a legal abortion safely by going to trained providers who use safe methods.

**Meeting women's unmet need could save both lives and money**

Unintended childbearing and unsafe abortion have potentially serious consequences for both families and the economy as a whole: Parents' ability to send their children to school is hindered when they have many children; unwanted pregnancy can lead to the premature end of schooling for some young women; and the lasting health effects of an unsafe abortion can limit a woman's subsequent productive capacity. A recent analysis of the potential costs of unplanned pregnancy to women's health and survival, as well as to the country's reproductive health care budget, demonstrates the substantial benefits to be derived from helping women to have only the children they want, when they want them. The study estimated that if half of women in Burkina Faso with an unmet need for family planning were to use effective contraceptive methods, there would be 116,000 fewer unintended pregnancies, 37,000 fewer unsafe abortions and 400 fewer maternal deaths each year. It would also save US$18 million in health outlays annually.[22]

**A national campaign is needed to reduce unintended pregnancy and unsafe abortion**

Policies and programs to improve access to contraceptive services, reduce levels of unplanned pregnancy and unsafe abortion, and provide greater access to safe abortion under the law would help protect the health and save the lives of women. Such initiatives would also bring significant social and economic benefits for women and families, by enabling young women to complete their education and women of all ages to avoid having children for whom they cannot adequately provide. Any national effort to reach these goals requires the participation of experts engaged in a wide range of activities, including creation of informed public policy, strong public advocacy, capacity building, provision of high-quality medical care and public education. Thousands of capable and responsible Burkina Faso professionals—community leaders, politicians, teachers, doctors, medical school professors, researchers, journalists, advocates, community and religious leaders, and members of women's groups—can and should be enlisted in fighting for this important and worthy goal. High-level members of the government, local officials and even pop stars could be enlisted to state publicly, loudly and often that the use of contraceptives to prevent unwanted pregnancy is good—for women, children, families and society. Example and leadership are crucial in any campaign to persuade couples of the huge benefits of family planning.

**BOX**

**More Research Is Needed to Fill the Gaps in our Knowledge**

Although recent research has yielded valuable information about abortion in Burkina Faso, many gaps in knowledge need to be filled. Further research is therefore needed to shed light on those areas where evidence is still lacking. Future research should examine issues related to the methods women are using to obtain abortions. In current research, use of potions and women's own methods are frequently mentioned approaches to ending pregnancies. What, exactly, are these potions and methods? How unsafe are they? And is misoprostol being introduced into Burkina Faso?

Although reliable evidence on the level of complications from induced abortion is now available, information is lacking about the severity of these complications. Future research should be directed at understanding the seriousness of complications that women experience from having unsafe abortions.

Another topic that warrants further study is postabortion care services. What is the quality of this care, and what challenges are providers encountering? Where in Burkina Faso are postabortion care services available, and where are they needed? Are women stigmatized if they go for postabortion care? What is the cost of these services to the health system? Finally, what are the short- and long-term health, financial and social consequences of unsafe abortion and related hospitalization to women and their households?

Another important issue about which little is known is the role that men play in discussions about ending unwanted pregnancies, in helping women obtain abortions and in paying for the services. In the same vein, we need more information on women's abortion-seeking behavior, including the process by which they arrive at the decision to end a pregnancy. Who is involved in such decisions? How do women know where to go for treatment, how do they get to a facility and what kind of delays do they experience? Finally, we need more information about the characteristics of women who have abortions. Does the profile that emerges from this study—that abortion recipients are disproportionately single, urban residents, educated and childless—

take adequate account of the rural women, most of them illiterate, who are also ending their pregnancies? Information on these issues can be obtained via qualitative or community-based surveys that focus on women's own abortion experiences, as well as health facility–based surveys of women admitted for the treatment of abortion-related complications.

**APPENDIX TABLE 1** **Selected measures of women's social and demographic characteristics, fertility contraceptive use and other reproductive health outcomes, by region, Burkina Faso, 2010**

| | Total | Boucle de Mouhoun | Cascades | Centre | Centre-Est |
|---|---|---|---|---|---|
| **SOCIAL AND DEMOGRAPHIC** | | | | | |
| *Women aged 15*49* | | | | | |
| % living in rural areas | 73 | 91 | 70 | 12 | 82 |
| % with secondary education or higher | 12 | 6 | 10 | 37 | 8 |
| % living in poverty | 22 | 16 | 9 | 2 | 18 |
| **FERTILITY** | | | | | |
| Total fertility rate (lifetime births per woman) | 6.0 | 6.8 | 6.0 | 3.7 | 6.3 |
| Wanted total fertility rate (lifetime births per woman) | 5.2 | 5.6 | 4.9 | 3.0 | 5.7 |
| **PLANNING STATUS OF BIRTHS*†** | | | | | |
| % unplanned | 8 | 11 | 14 | 17 | 2 |
| % mistimed | 6 | 9 | 12 | 13 | 1 |
| % unwanted | 2 | 3 | 2 | 4 | 0 |
| **PRENATAL AND DELIVERY CARE‡** | | | | | |
| % of women receiving prenatal care from a health professional | 94 | 93 | 94 | 98 | 98 |
| % of deliveries occuring in a health facility | 66 | 64 | 77 | 97 | 84 |
| **CONTRACEPTION/UNMET NEED** | | | | | |
| *Married women aged 15-49* | | | | | |
| % who want to delay or stop childbearing | 77 | 80 | 76 | 76 | 78 |
| % using any contraceptive method | 16 | 12 | 19 | 36 | 9 |
| % using a modern method | 15 | 11 | 18 | 31 | 9 |
| % with unmet need for contraception | 24 | 32 | 22 | 22 | 26 |
| % with unmet need for spacing births | 17 | 22 | 17 | 14 | 21 |
| % with unmet need for limiting births | 7 | 9 | 5 | 7 | 6 |
| *Unmarried, sexually active women aged 15-24* | | | | | |
| % using any contraceptive method | 54 | 31 | 60 | 58 | § |
| % using a modern method | 52 | 31 | 55 | 56 | § |
| % with unmet need for contraception | 40 | 66 | 37 | 31 | § |
| **OUTCOMES AMONG YOUNG WOMEN** | | | | | |
| *Unmarried women aged 15-24* | | | | | |
| % who are sexually active | 17 | 18 | 31 | 18 | 2 |
| *Women aged 15-19* | | | | | |
| % who are mothers or are currently pregnant | 24 | 32 | 28 | 8 | 19 |
| *Women aged 15-24* | | | | | |
| % of births that were unplanned*† | 8 | 9 | 15 | 17 | 2 |
| *Women aged 20-24* | | | | | |
| Median age at first sex | 18 | 18 | 17 | 20 | 18 |
| Median age at first marriage | 18 | 18 | 18 | 20** | 18 |
| Median age at first birth | 20 | 19 | 19 | 22** | 19 |

*Among births in the past five years. †The wording of the questions in the 2010 Demographic and Health Survey regarding the planning status of births was not consistent with that of earlier surveys and may have caused significant underestimation of the proportion of births that were unplanned. ‡ Restricted to pregnancies ending in birth. § Percentage not calculated because of small number of cases (<20). **Among women aged 25-29. *Source* : Reference 4.

| Centre-Nord | Centre-Ouest | Centre-Sud | Est | Hauts Bassins | Nord | Plateau Central | Sahel | Sud-Ouest |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| 92 | 84 | 89 | 93 | 56 | 87 | 91 | 94 | 86 |
| 5 | 10 | 10 | 5 | 15 | 6 | 8 | 2 | 7 |
| 26 | 23 | 22 | 44 | 11 | 19 | 18 | 50 | 46 |
| | | | | | | | | |
| 6.7 | 6.4 | 5.6 | 7.5 | 5.2 | 6.2 | 5.8 | 7.5 | 6.4 |
| 6.1 | 5.4 | 5.3 | 6.4 | 4.4 | 5.8 | 5.2 | 7.1 | 5.9 |
| | | | | | | | | |
| 2 | 10 | 12 | 4 | 14 | 6 | 4 | 2 | 5 |
| 2 | 9 | 10 | 4 | 10 | 5 | 3 | 2 | 4 |
| 0 | 1 | 2 | 0 | 3 | 1 | 2 | 0 | 1 |
| | | | | | | | | |
| 96 | 95 | 97 | 92 | 96 | 95 | 98 | 86 | 90 |
| 68 | 60 | 85 | 51 | 75 | 62 | 82 | 35 | 43 |
| | | | | | | | | |
| 79 | 77 | 80 | 84 | 81 | 78 | 75 | 69 | 65 |
| 10 | 11 | 17 | 11 | 28 | 11 | 16 | 7 | 10 |
| 9 | 10 | 16 | 11 | 27 | 10 | 14 | 7 | 10 |
| 23 | 26 | 28 | 25 | 22 | 24 | 21 | 19 | 15 |
| 16 | 20 | 19 | 20 | 14 | 18 | 14 | 15 | 11 |
| 6 | 6 | 9 | 5 | 8 | 6 | 7 | 4 | 4 |
| § | 54 | § | § | 70 | 38 | § | § | § |
| § | 52 | § | § | 70 | 38 | § | § | § |
| § | 31 | § | § | 29 | 62 | § | § | § |
| | | | | | | | | |
| 6 | 20 | 19 | 15 | 25 | 16 | 13 | 9 | 23 |
| 29 | 20 | 24 | 37 | 21 | 26 | 11 | 39 | 34 |
| 1 | 11 | 15 | 4 | 14 | 6 | 4 | 2 | 7 |
| 18 | 18 | 18 | 17 | 17 | 17 | 18 | 16 | 17 |
| 18 | 18 | 18 | 17 | 18 | 18 | 18 | 16 | 18 |
| 19 | 20 | 20 | 18 | 20 | 20 | 20 | 18 | 19 |

**APPENDIX TABLE 2** **Selected measures of women's social and demographic characteristics, fertility, contraceptive use and other reproductive health outcomes, Burkina Faso, 1993-2010**

| | Year | Total | Ouagadougou | Other urban areas | Total urban | Rural areas |
|---|---|---|---|---|---|---|
| **SOCIAL AND DEMOGRAPHIC CHARACTERISTICS** | | | | | | |
| *Women aged 15–49* | | | | | | |
| **% who live in rural areas** | 1993 | 80 | 0 | na | na | na |
| | 1999 | 83 | 0 | na | na | na |
| | 2003 | 78 | 0 | na | na | na |
| | 2010 | 73 | 0 | na | na | na |
| **% with secondary education or higher** | 1993 | 6 | 30 | 18 | 25 | 2 |
| | 1999 | 6 | 35 | 27 | 31 | 1 |
| | 2003 | 9 | 39 | 28 | 34 | 2 |
| | 2010 | 12 | 41 | 29 | 35 | 4 |
| **FÉCONDITÉ** | | | | | | |
| **Total fertility rate (lifetime births per woman)** | 1993 | 6.9 | 4.7 | 5.5 | 5.0 | 7.3 |
| | 1999 | 6.8 | 4.1 | na | 4.1 | 7.3 |
| | 2003 | 6.2 | 3.1 | 4.4 | 3.7 | 6.9 |
| | 2010 | 6.0 | 3.4 | 4.4 | 3.9 | 6.7 |
| **Wanted fertility rate (lifetime births per woman)** | 1993 | 6.0 | 3.6 | 4.4 | 3.9 | 6.5 |
| | 1999 | 6.0 | 3.4 | na | 3.4 | 6.5 |
| | 2003 | 5.4 | 2.8 | 3.7 | 3.2 | 6.0 |
| | 2010 | 5.2 | 2.8 | 3.8 | 3.3 | 5.9 |
| **PLANNING STATUS OF BIRTHS*** | | | | | | |
| **% unplanned** | 1993 | 24 | 35 | 34 | 35 | 23 |
| | 1999 | 22 | 31 | 24 | 27 | 22 |
| | 2003 | 23 | 22 | 27 | 24 | 22 |
| | 2010† | 8 | 17 | 12 | 14 | 7 |
| **% mistimed** | 1993 | 21 | 28 | 28 | 0 | 20 |
| | 1999 | 19 | 26 | 19 | 23 | 18 |
| | 2003 | 20 | 17 | 22 | 20 | 20 |
| | 2010† | 6 | 13 | 10 | 11 | 5 |
| **% unwanted** | 1993 | 3 | 7 | 6 | 7 | 3 |
| | 1999 | 4 | 5 | 4 | 5 | 4 |
| | 2003 | 3 | 5 | 5 | 5 | 3 |
| | 2010† | 2 | 4 | 2 | 3 | 1 |
| **PRENATAL AND DELIVERY CARE‡** | | | | | | |
| **% of women receiving prenatal care from a health professional** | 1993 | 37 | 97 | 89 | 93 | 27 |
| | 1999 | 61 | 98 | 93 | 96 | 57 |
| | 2003 | 73 | 99 | 95 | 97 | 70 |
| | 2010 | 94 | 98 | 98 | 98 | 94 |
| **% of deliveries occuring in a health facility** | 1993 | 43 | 93 | 87 | 88 | 35 |
| | 1999 | 32 | 99 | 58 | 90 | 26 |
| | 2003 | 39 | 95 | 81 | 87 | 31 |
| | 2010 | 66 | 97 | 92 | 94 | 61 |

**Appendix Table 2, continued**

| | Year | Total | Ouagadougou | Other urban areas | Total urban | Rural areas |
|---|---|---|---|---|---|---|
| **CONTRACEPTION/UNMET NEED** | | | | | | |
| *Married women aged 15–49* | | | | | | |
| **% who want to delay or stop childbearing** | 1993 | 71 | 75 | 71 | 73 | 71 |
| | 1999 | 76 | 77 | 73 | 75 | 76 |
| | 2003 | 76 | 70 | 77 | 74 | 77 |
| | 2010 | 77 | 76 | 78 | 77 | 78 |
| **% using any contraceptive method** | 1993 | 8 | 31 | 19 | 26 | 4 |
| | 1999 | 12 | 32 | 27 | 29 | 9 |
| | 2003 | 14 | 37 | 32 | 34 | 10 |
| | 2010 | 16 | 38 | 31 | 34 | 11 |
| **% using a modern method** | 1993 | 4 | 20 | 13 | 17 | 1 |
| | 1999 | 5 | 22 | 17 | 20 | 3 |
| | 2003 | 9 | 29 | 27 | 28 | 5 |
| | 2010 | 15 | 32 | 29 | 31 | 11 |
| **% with an unmet need for contraception** | 1993 | 24 | 28 | 31 | 29 | 23 |
| | 1999 | 26 | 25 | 23 | 24 | 26 |
| | 2003 | 29 | 20 | 26 | 23 | 30 |
| | 2010 | 24 | 21 | 21 | 21 | 25 |
| **% with unmet need for spacing births** | 2010 | 17 | 14 | 15 | 15 | 18 |
| **% with unmet need for limiting births** | 2010 | 7 | 7 | 7 | 7 | 6 |
| *Unmarried, sexually active women aged 15–24* | | | | | | |
| **% using any contraceptive method** | 1993 | 28 | 10 | 30‡ | 36 | 22 |
| | 1999 | 48 | 68 | 54 | 61 | 37 |
| | 2003 | 52 | 63 | 67 | 65 | 35 |
| | 2010 | 54 | 58 | 65 | 62 | 37 |
| **% using a modern method** | 1993 | 11 | 14 | 17‡ | 16 | 8 |
| | 1999 | 41 | 60 | 50 | 55 | 31 |
| | 2003 | 49 | 60 | 62 | 61 | 33 |
| | 2010 | 52 | 56 | 64 | 61 | 36 |
| **% with an unmet need for contraception** | 1993 | nd | nd | nd | nd | nd |
| | 1999 | 38 | 22 | 42 | 32 | 42 |
| | 2003 | 38 | 29 | 29 | 29 | 52 |
| | 2010 | 40 | 31 | 33 | 32 | 55 |
| **OUTCOMES AMONG YOUNG WOMEN** | | | | | | |
| *Unmarried women aged 15–24* | | | | | | |
| **% who are sexually active** | 1993 | 15 | 18 | 20 | 19 | 13 |
| | 1999 | 21 | 29 | 27 | 28 | 18 |
| | 2003 | 21 | 26 | 29 | 27 | 16 |
| | 2010 | 17 | 19 | 28 | 24 | 11 |
| *Women aged 15–19* | | | | | | |
| **% who are mothers or currently pregnant** | 1993 | 31 | 15 | 25 | 19 | 35 |
| | 1999 | 25 | 17 | 12 | 15 | 28 |
| | 2003 | 23 | 6 | 17 | 11 | 28 |
| | 2010 | 24 | 8 | 17 | 13 | 29 |

**Appendix Table 2, continued**

| | Year | Total | Ouagadougou | Other urban areas | Total urban | Rural areas |
|---|---|---|---|---|---|---|
| *Women aged 15–24* | | | | | | |
| **% of births that were unplanned*** | 1993 | 22 | 33 | 34 | 33 | 20 |
| | 1999 | 15 | 27 | 17 | 22 | 14 |
| | 2003 | 20 | 32 | 24 | 27 | 19 |
| | 2010† | 8 | 18 | 19 | 19 | 6 |
| **OUTCOMES AMONG YOUNG WOMEN** | | | | | | |
| *Women aged 20–24* | | | | | | |
| **Median age at first sex** | 1993 | 17.2 | 17.9 | 17.4 | 17.7 | 17.1 |
| | 1999 | 17.3 | 18.9 | 17.2 | 18.2 | 17.2 |
| | 2003 | 17.5 | 18.7 | 17.9 | 18.4 | 17.3 |
| | 2010 | 17.5 | 18.7 | 18.1 | 18.4 | 17.2 |
| **Median age at first marriage** | 1993 | 17.3 | 17.5 | 17.2 | 17.4 | 17.3 |
| | 1999 | 17.6 | 20.1§ | 18.9§ | 19.6§ | 17.4 |
| | 2003 | 17.9 | 20.5§ | 18.8§ | 19.8§ | 17.6 |
| | 2010 | 17.9 | 20.6§ | 19.0§ | 19.8§ | 17.4 |
| **Median age at first birth** | 1993 | 19.1 | 20.6 | 19.9 | 20.4 | 18.9 |
| | 1999 | 19.1 | 20.7§ | 19.3§ | 20.2§ | 18.8 |
| | 2003 | 19.5 | 21.7§ | 20.8§ | 20.8§ | 19.0 |
| | 2010 | 19.5 | 22.7§ | 20.4§ | 21.5§ | 18.8 |

**Among births in the past five years. †The wording of questions in the 2010 Demographic and Health Survey regarding the planning status of births was not consistent with that of earlier surveys and may have caused significant underestimation of the proportion of births that were unplanned. ‡Restricted to pregnancies ending in birth. §Among women aged 25–29.
**Sources**: References 4, 7, 12 and 13.

**TABLE 2.1**

## Number of estimated unsafe abortions in Burkina Faso, by residence, 2012

| Residence | Number of abortions |
|---|---|
| **Urban areas (total)** | 37,900 |
| Ouagadougou | 17,300 |
| Other urban areas | 20,600 |
| **Rural areas** | 67,100 |
| **Total** | **105,000** |

**Sources** References 23 and 25.

**TABLE 2.2**

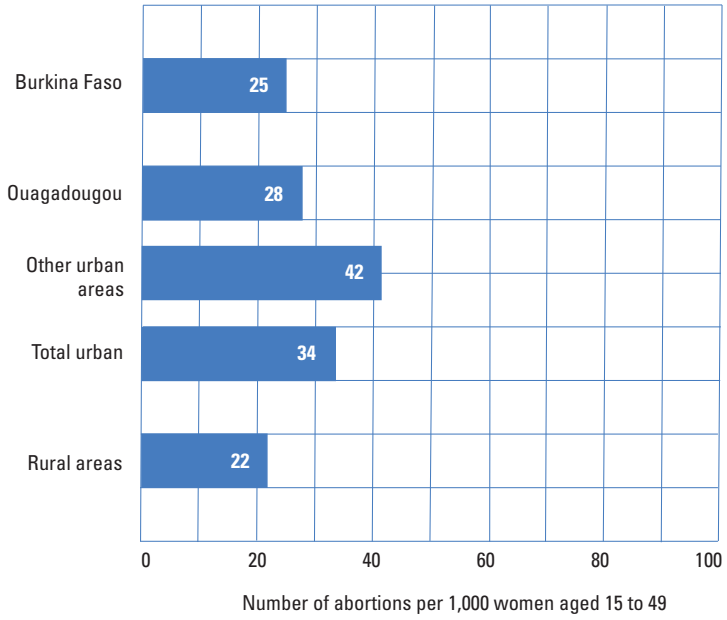
**Women who have had an abortion in the past two years are younger, much more likely to be childless, more educated and more likely to live in an urban area than all women of reproductive age.**

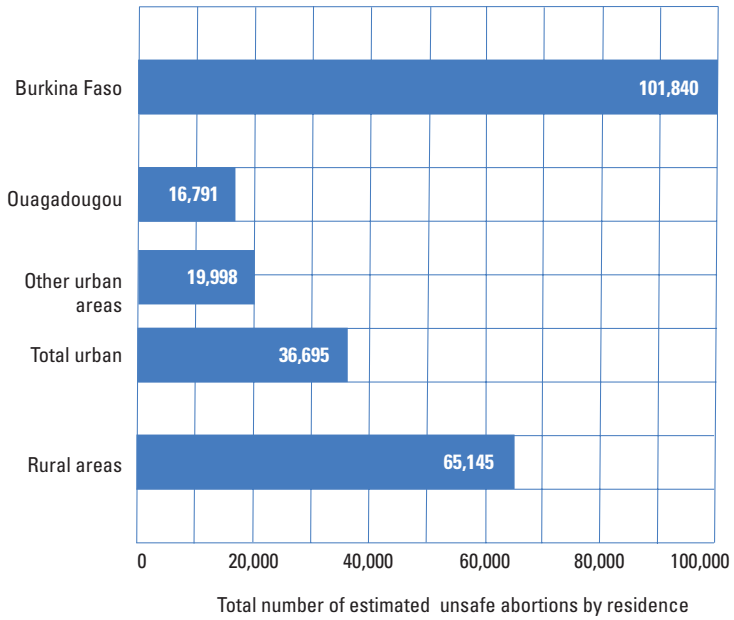
| Characteristic | Women who had a recent abortion | All women aged 15-49 |
|---|---|---|
| **Age** | | |
| 15–24 | 65 | 41 |
| 25–34 | 24 | 29 |
| ≥35 | 11 | 30 |
| **Number of children** | | |
| None | 65 | 24 |
| 1-2 | 24 | 34 |
| ≥3 | 11 | 42 |
| **Education** | | |
| None | 53 | 80 |
| Primary | 20 | 11 |
| ≥Secondary | 27 | 9 |
| **Residence** | | |
| Other urban areas | 25 | 10 |
| Ouagadougou | 11 | 12 |
| Rural areas | 64 | 78 |

**Sources** References 4 and 30.

FIGURE 2.1

**The estimated abortion rate is higher in urban areas than in rural areas (2008).**

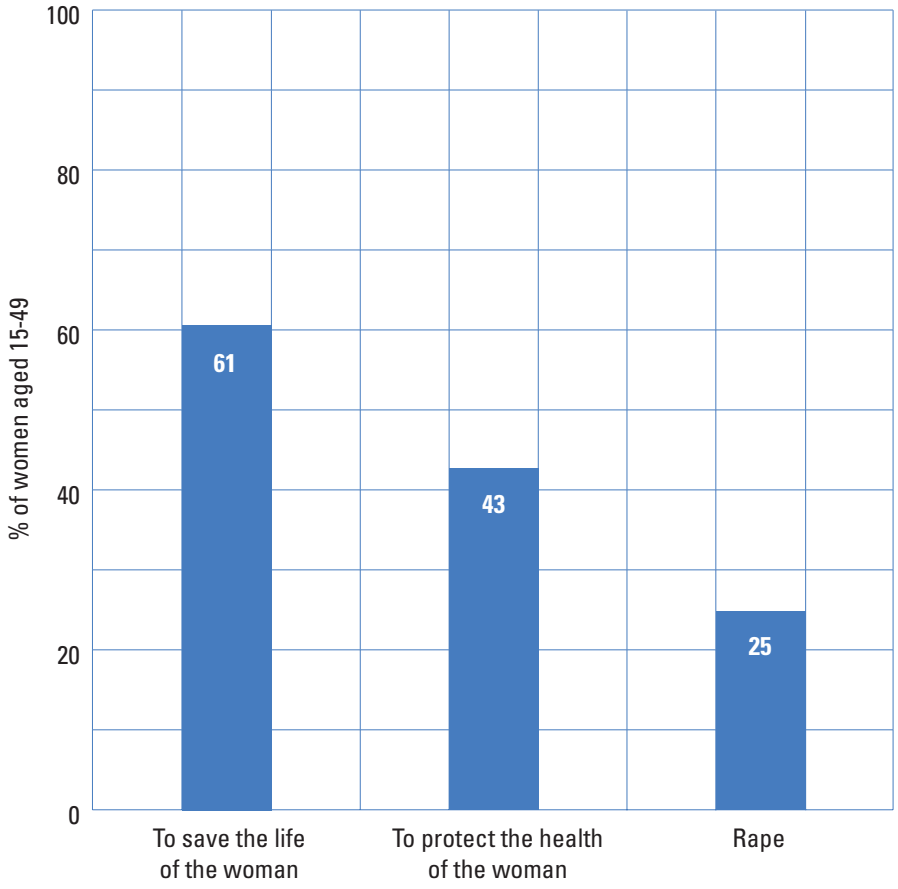



**Sources** Reference 4 and 26.

FIGURE 2.2

**Six in 10 women of childbearing age consider abortion acceptable or somewhat acceptable to save a woman's life, and four in 10 to protect her health**




**Source** Reference 30.

**TABLE 3.1**

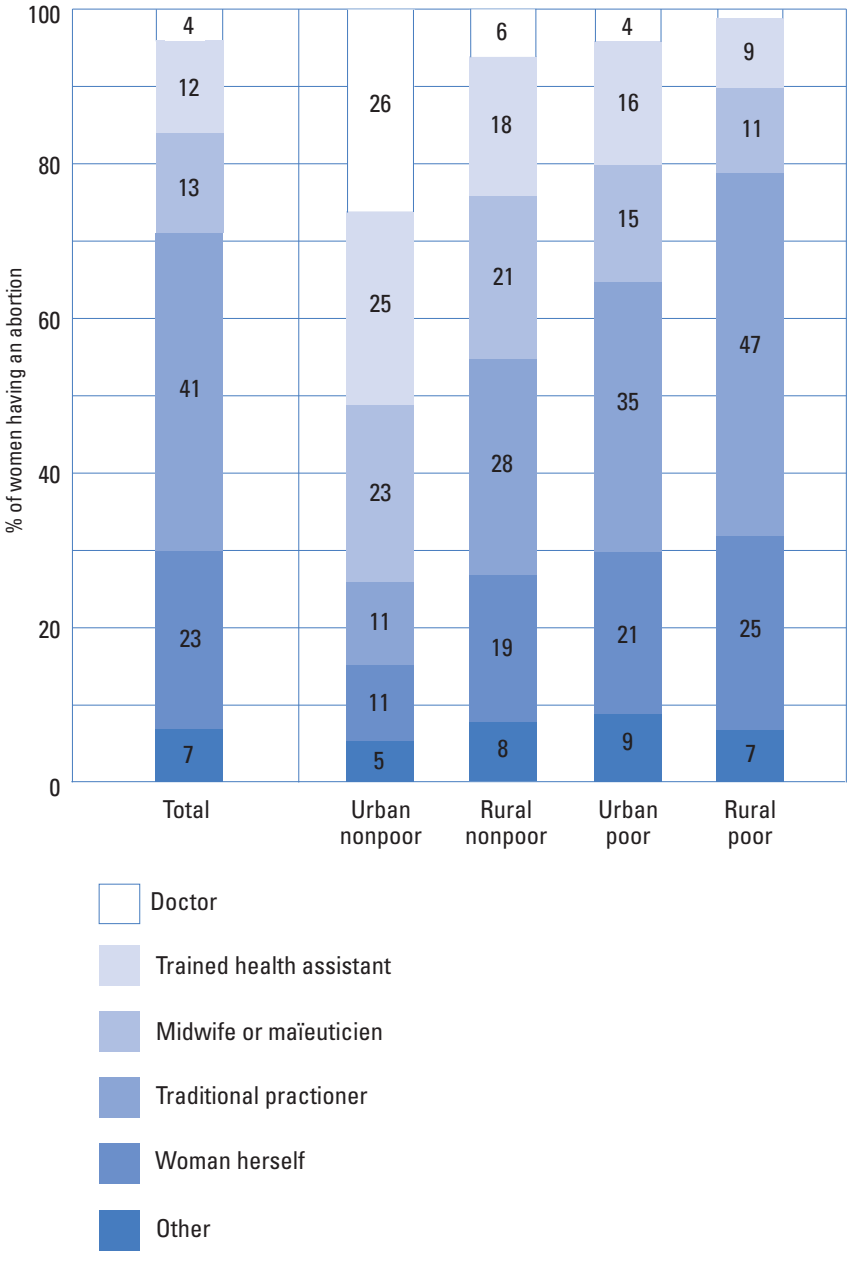
## Average cost of an abortion (in Francs CFA), by type of provider according to location of abortion

| Type of provider | Urban | Rural |
|---|---|---|
| Doctor in a private office | 32,182 | na |
| Doctor in a clinic/hospital | 27,306 | na |
| Rural doctor | na | 2,926 |
| Trained health assistant | 28,281 | 14,140 |
| Midwife/maïeuticien | 23,405 | 12,190 |
| Traditional practitioner | 6,339 | 3,901 |
| Woman herself | 1,463 | 975 |

**Notes** In 2008, US1$ was equivalent to 487.6 Francs CFA. na=not applicable.
**Source** Reference 25.

**FIGURE 3.1**

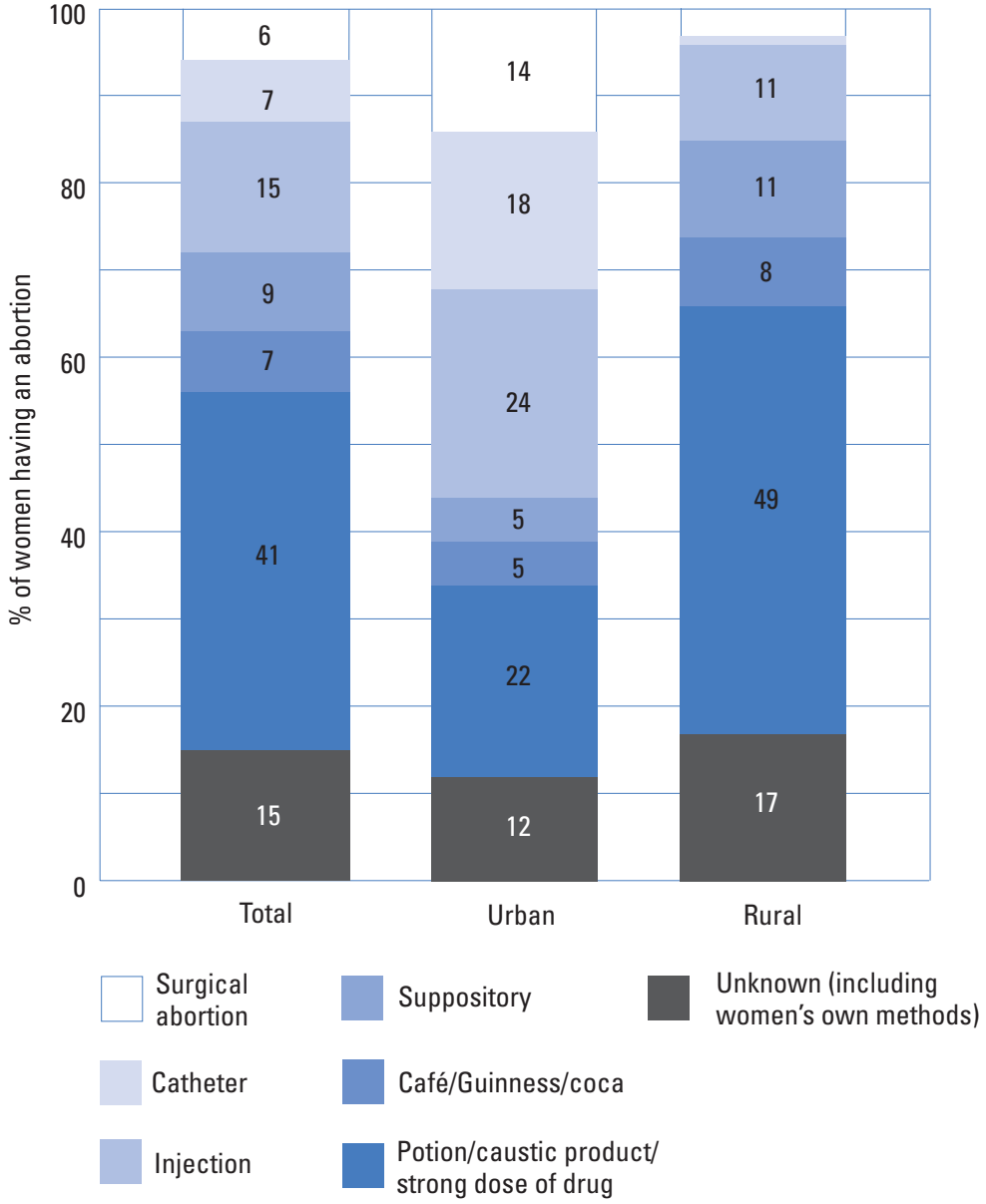
## Many women who want an abortion—especially those who are poor—go to unskilled practioners or end their own pregnancies.




**Note** Percentages may not total to 100 due to rounding. **Source** Reference 26.

**FIGURE 3.2**

## Women in rural areas are much more likely than urban women to use dangerous, home-based abortion methods.




**Note** Percentages may not total to 100 due to rounding.
**Source** Reference 30.

**TABLE 4.1**

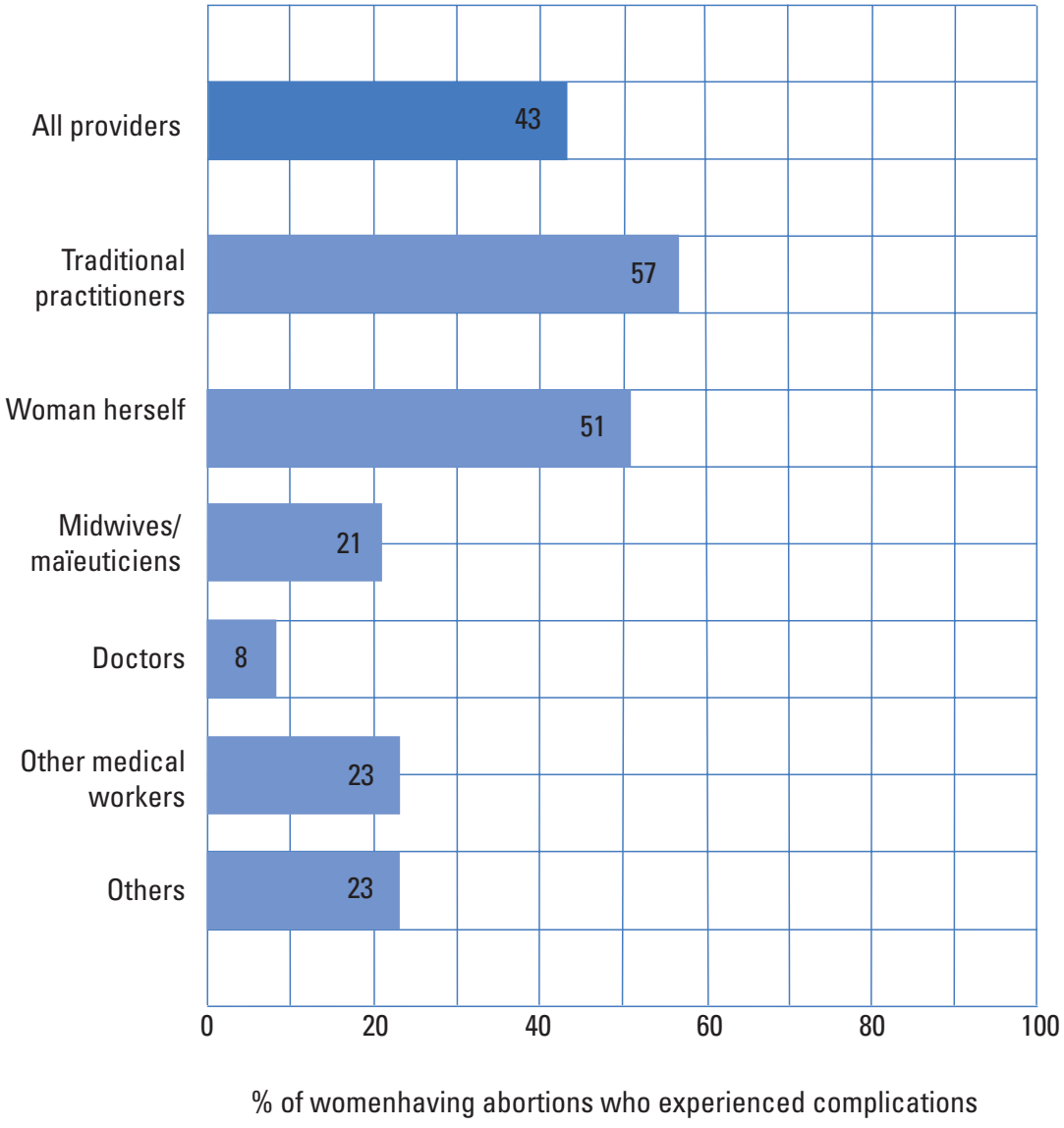
## Proportion of women who experience abortion complications and the proportion of women with complications that do not receive care by level of poverty and residence

| Residence and poverty level | % of women who had an abortion and experienced complications | % of women who had complications but did receive treatment |
|---|---|---|
| Urban nonpoor | 23 | 9 |
| Rural nonpoor | 32 | 22 |
| Urban poor | 42 | 28 |
| Rural poor | 46 | 41 |
| All women | 43 | 39 |

**Source** Reference 26.

**FIGURE 4.1**

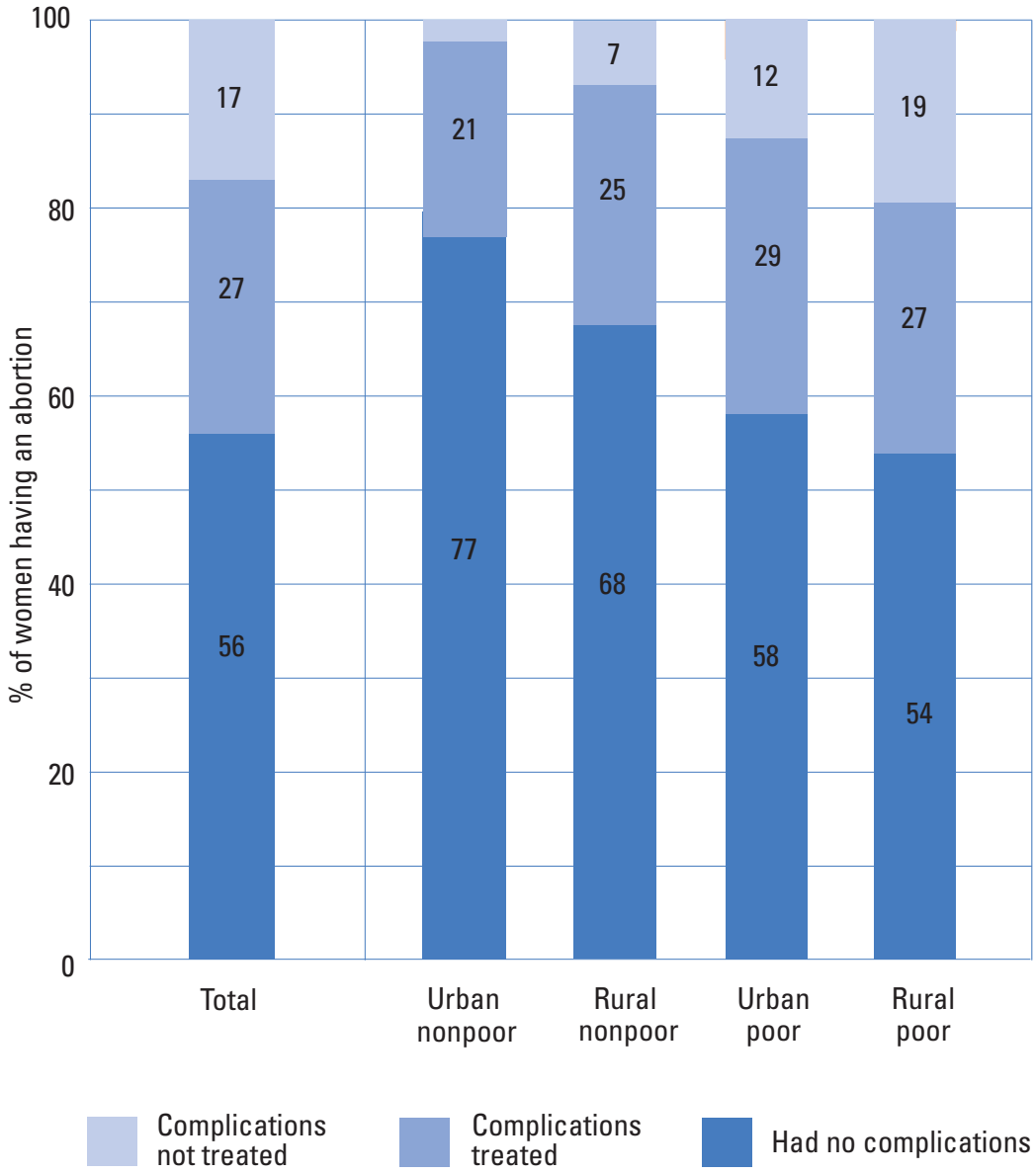
## Women who obtain abortions from unskilled providers and those who self-induce have the highest complication rates




**Source** Reference 26.

**FIGURE 4.2**

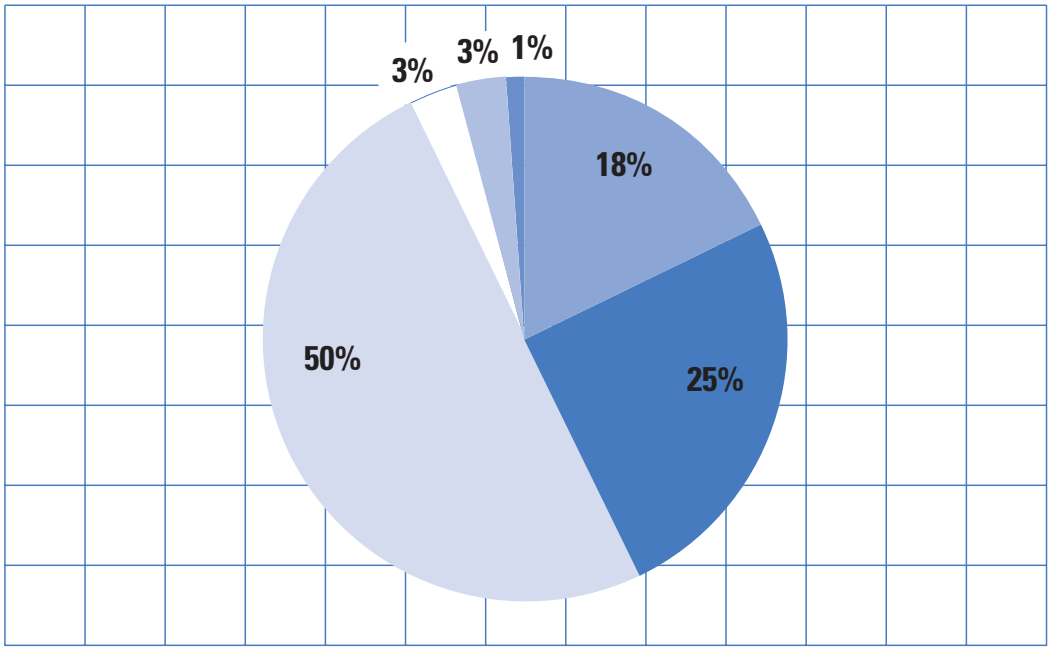
## Almost one in five poor rural women who have an induced abortion experience complications that go untreated.




**Note** Percentages may not total to 100 due to rounding.
**Source** Reference 26.

FIGURE 4.3

## Half of all women treated for complications from unsafe induced abortion receive care from primary health care facilities.



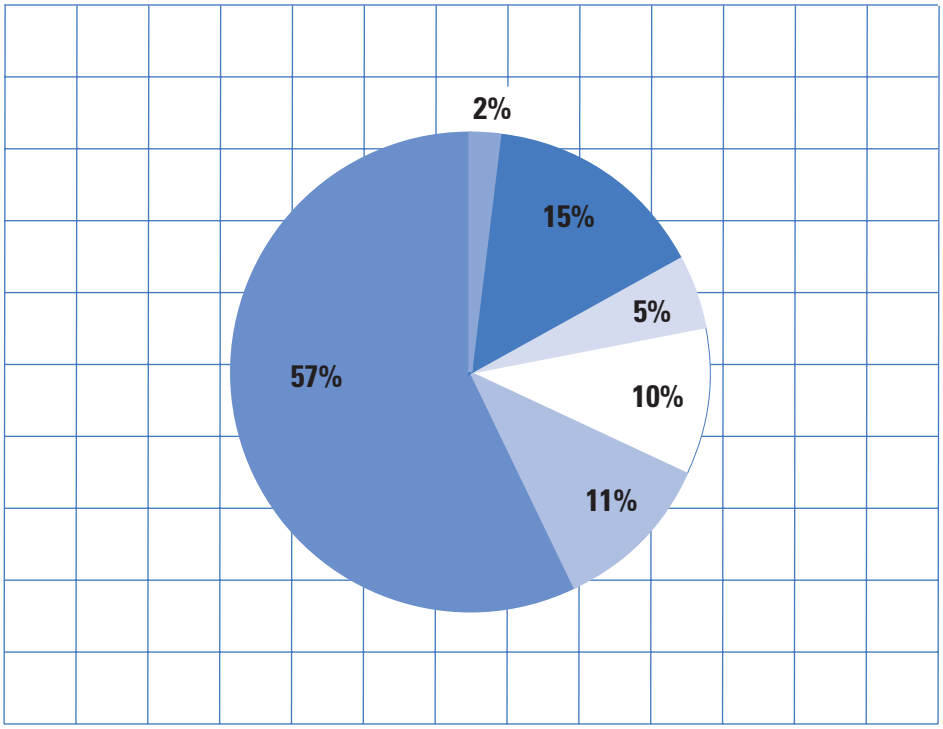

% of women receiving abortion-related medical care

- Centre Hospitalier Universitaire (CHU)/Centre Hospitalier Régional (CHR)
- Centre Médical avec Antenne Chirurgicale (CMA)/Centre Médical (CM)
- Centre de Santé et de Promotion Sociale (CSPS) ou Dispensaire/Maternité isolée
- Clinique d'accouchement
- Cabinet infirmier
- Clinique/Polyclinique

**Source** Référence 30.

**FIGURE 5.1**

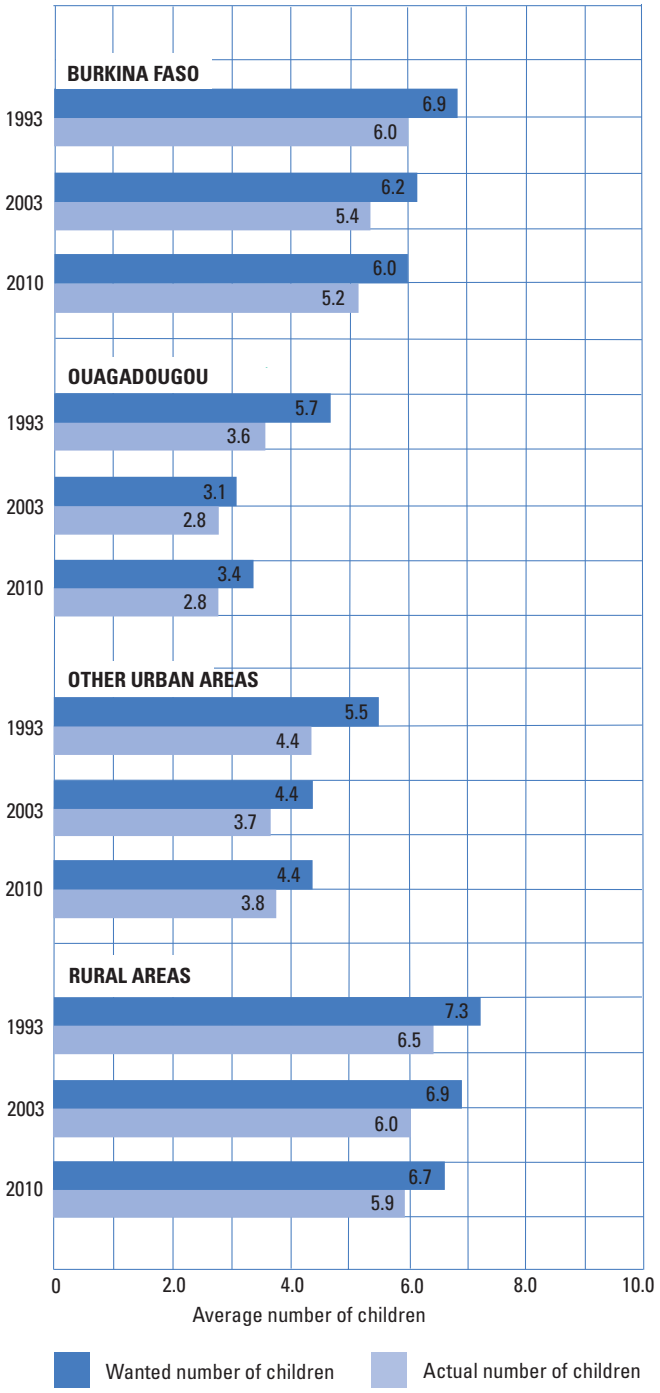
## In Burkina Faso, three in 10 pregnancies end in an unwanted or mistimed birth or an induced abortion.




**Source** Reference 25.

**FIGURE 5.2**

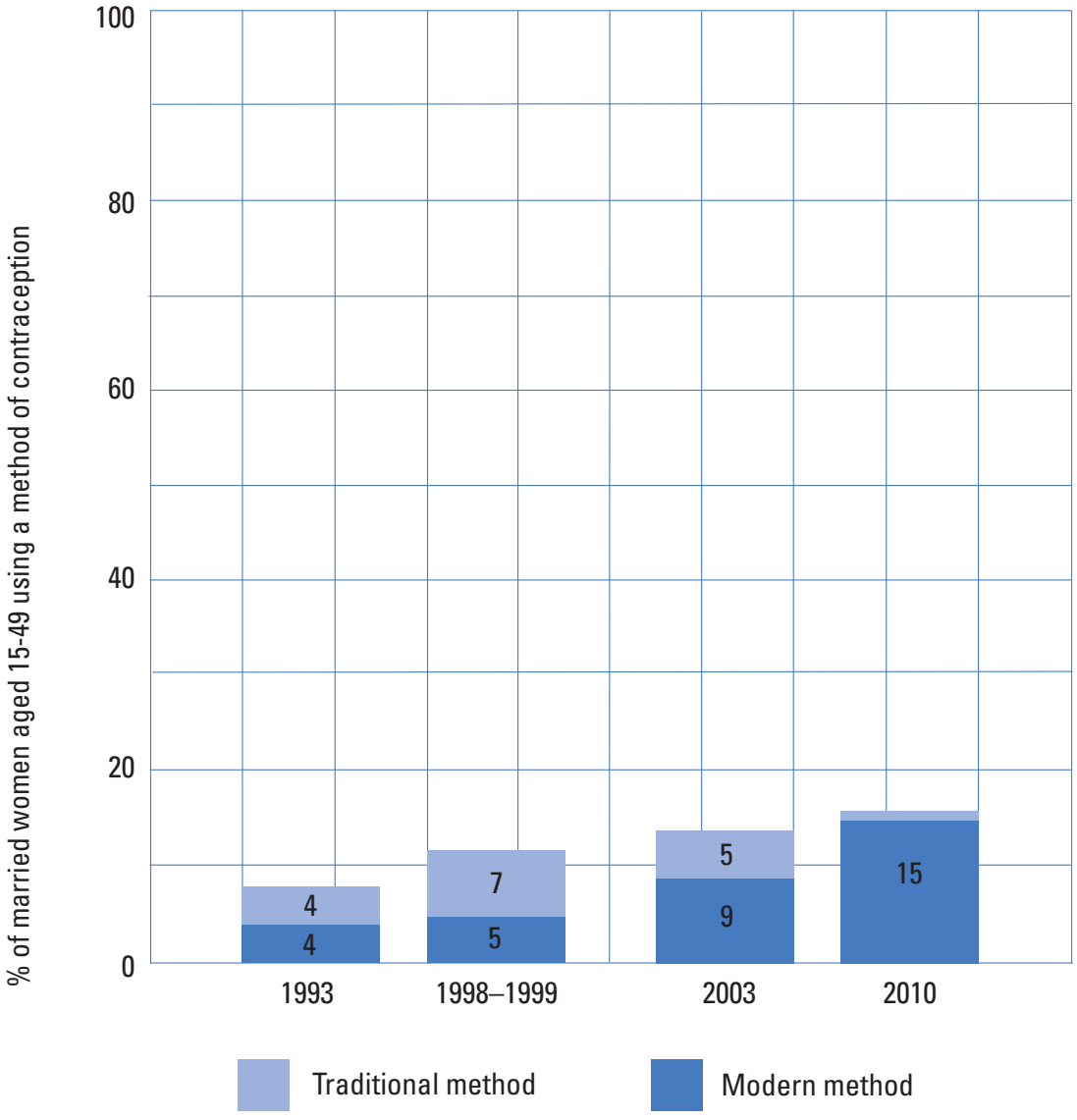
**Average family size is slowly declining, but women are still having more children than they want.**




**Sources** References 4, 7 and 12.

**FIGURE 5.3**

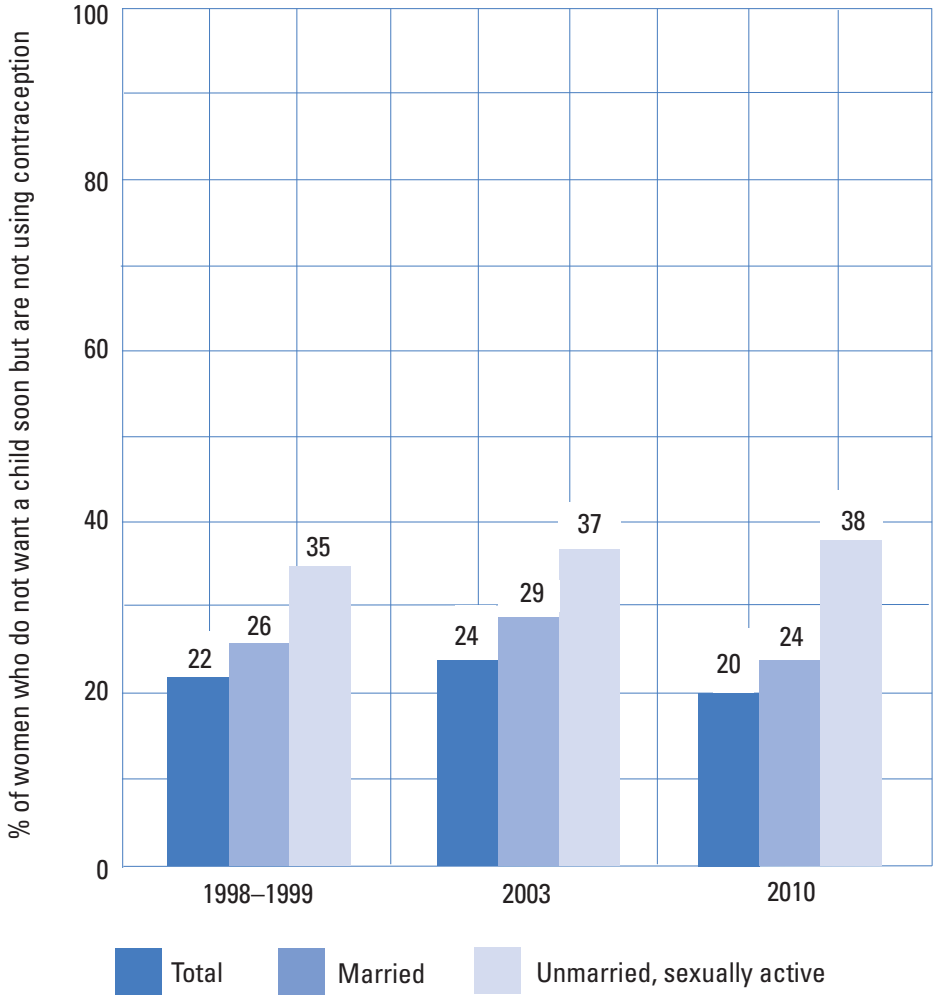
## Contraceptive use among married women of childbearing age is slowly rising, but still very low.




**Sources** References 4, 7, 12 and 13.

**FIGURE 5.4**

## Unmet need remains high in both married and unmarried women of childbearing age

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