



## Abortion in two francophone African countries: a study of whether women have begun to use misoprostol in Benin and Burkina Faso <sup>☆,☆☆,★,★★,☆☆☆</sup>

Carine Baxerres<sup>a,\*</sup>, Ines Boko<sup>b</sup>, Adjara Konkobo<sup>c</sup>, Fatoumata Ouattara<sup>d</sup>, Agnès Guillaume<sup>e</sup>

<sup>a</sup>Institut de Recherche pour le Développement – MERIT (Université Paris Descartes), Centre Nobert Elias, EHESS, Centre de la vieille charité, 2 rue de la Charité, 13002 Marseille, France

<sup>b</sup>Université Abomey Calavi, Faculté des Sciences de la Santé, CERPAGE, Cotonou, Bénin

<sup>c</sup>EHESS de Marseille / Université Ouaga 1 Pr. Joseph KI-ZERBO, 01 BP 182 Ouagadougou 01, Burkina Faso

<sup>d</sup>Institut de Recherche pour le Développement – LPED (AMU/IRD), Centre Saint Charles, Case 10, 3, place Victor Hugo, 13331 Marseille, Cedex 03, France

<sup>e</sup>Institut de Recherche pour le Développement (IRD), Centre Population et Développement, UMR IRD - Université Paris Descartes, 45 rue des Saints-Pères, 75006 Paris, France

Received 28 April 2017; revised 16 October 2017; accepted 22 October 2017

### Abstract

**Objectives:** This study aimed to document the means women use to obtain abortions in the capital cities of Benin and Burkina Faso, and to learn whether or not use of misoprostol has become an alternative to other methods of abortion, and the implications for future practice.

**Study design:** We conducted in-depth, qualitative interviews between 2014 and 2015 with 34 women – 21 women in Cotonou (Benin) and 13 women in Ouagadougou (Burkina Faso) – about their pathways to abortion. To obtain a diverse sample in terms of socio-demographic characteristics, we recruited the women through our own knowledge networks, in health facilities where women are treated for unsafe abortion complications, and in schools in Benin.

**Results:** The 34 women had had 69 abortions between them. Twenty-five of the women had had 37 abortions in the previous 5 years; the other abortions were 5–20 years before. Pathways to abortion were very different in the two cities. Lengthy and difficult pathways with unsafe methods often led to complications in Ougadougou, whereas most Cotonou women went to small, private health centers. Six of the 37 abortions in the previous 5 years involved misoprostol use, and were all among educated women with significant social and economic capital and personal contact with clinicians.

**Conclusions:** Use of misoprostol for abortion has appeared in both Cotonou and Ougadougou in the past 5 years. Evidence that the use of misoprostol for abortion occurred among women with the most access to information and resources in this study suggests that increased awareness of and use of misoprostol in both countries is likely in the coming years.

**Implications:** Although no pharmaceutical company that produces misoprostol has as yet tried to obtain marketing authorization in either Burkina Faso or Benin for gynecological-obstetric indications, making its use more potential than actual for the time being, international advocacy for access to medical abortion is growing rapidly and is likely to lead to many changes in this picture in the coming years.

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**Keywords:** Abortion care-seeking pathways; Medical abortion; Misoprostol; Unsafe abortion; Francophone African countries; Africa

<sup>☆</sup> Funding: This work was supported by the French Muskoka Fund, managed by UNICEF through its West and Central Africa Regional Office in Dakar, Senegal.

<sup>☆☆</sup> Ethical approval: The research was approved by the Comité d'éthique de la recherche de l'Institut des Sciences biomédicales appliquées) in Benin and Comité d'éthique pour la Recherche en Santé in Burkina Faso.

<sup>★</sup> Conflict of interest: All authors declare no conflict of interest.

<sup>★★</sup> Permissions: No permissions were required.

<sup>☆☆☆</sup> Peer reviewers: Prof. Thieba Blandine, Université de Ouaga 1, Burkina Faso, [thieblan@yahoo.fr](mailto:thieblan@yahoo.fr)

Dr. Ernestina Coast, Professor, London School of Economics, London UK, [e.coast@lse.ac.uk](mailto:e.coast@lse.ac.uk).

\* Corresponding author.

*E-mail addresses:* [carine.baxerres@ird.fr](mailto:carine.baxerres@ird.fr) (C. Baxerres), [inesboko@yahoo.fr](mailto:inesboko@yahoo.fr) (I. Boko), [kkonkoboadjara@yahoo.fr](mailto:kkonkoboadjara@yahoo.fr) (A. Konkobo), [fatou.ouattara@ird.fr](mailto:fatou.ouattara@ird.fr) (F. Ouattara), [agnes.guillaume@ird.fr](mailto:agnes.guillaume@ird.fr) (A. Guillaume).

<https://doi.org/10.1016/j.contraception.2017.10.011>

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## 1. Introduction

Given the reality of unwanted pregnancies in the context of highly restrictive abortion legislation in many countries, medical abortion pills seem to be a solution for both individual women and public health. Although medicines have specific rules for administration that must be followed and should be supervised by a health professional [1], medical abortion opens a window to opportunities for uses that are completely outside medical control. There has been little documentation to date of self-use of misoprostol in Africa, however, with or without professional involvement, particularly in Francophone countries [2], which we will discuss later. In contrast, in both Brazil and the Dominican Republic, self-medication with misoprostol was described as early as 1986–87 [3–5].<sup>1</sup> Its use has spread widely since the 1990s and, according to some experts, has been at least partly responsible for the significant decline in maternal mortality observed in countries where its use has become common [7].

Abortion laws in Africa are among the most restrictive in the world, and medical abortion use is less developed than elsewhere. Yet, African women do turn to abortion in case of unplanned or unwanted pregnancies, as shown by estimated abortion rates of 31 per 1000 (in West Africa) and 38 per 1000 women of reproductive age overall (in Northern Africa). These vary by region, but attest to widespread practice, despite restrictive laws [8]. Curettage and especially manual vacuum aspiration (MVA) are currently the most commonly used methods, alongside so-called traditional methods [9]. Moreover, maternal mortality from unsafe abortion has remained high across Africa, and abortion remains one of the major causes [10].

Given this context, we wanted to learn what means women are using to have abortions in two Francophone African countries where we have been working for several years, Benin and Burkina Faso. We wanted to find out whether or not medical abortion with misoprostol is currently serving as an alternative to less safe abortions: There is a complex risk continuum that depends on method use, and “informal use of misoprostol has added a layer complexity to the continuum of safety” [11]. We conducted a qualitative study in order to gain insights into abortion methods used and pathways to abortion in Cotonou in Benin and Ouagadougou in Burkina Faso, which we report in this paper.

### 1.1. Abortion law and practice in the two study contexts

Benin and Burkina Faso share a colonial past that has shaped current restrictions on access to safe abortion. For many years, the “French Law of 1920” prohibited access to both abortion and contraception [12].<sup>2</sup> This law was repealed in 1986 in Burkina Faso by the revolutionary government of Thomas Sankara, and in 2003 in Benin as part of legislation

on sexual and reproductive health (Loi n°2003–04 du 03 mars 2003). Abortion is now legal in both countries in cases of risk to the woman’s life, rape, or incest, and in cases of malformation of the fetus [13]. However, in practice, access to safe abortion is more theoretical than actual. Women face major barriers, including lack of knowledge of the law by women and health professionals; medical authorization being required for abortion in case of risk to the woman’s life and fetal malformation; legal authorization needed in cases of rape and incest; and the opposition of some healthcare providers [14]. Considerable stigma also surrounds the use of abortion, as it conflicts with social and religious norms that value high fertility and that consider the fetus a human being [15].

There are no official government statistics on the practice of abortion in either Benin or Burkina Faso. In Burkina Faso, the abortion rate is estimated as 25–28 per 1000 in Ouagadougou and 42 per 1000 in other cities [16]. No such data are available for Benin. The vast majority of these were illegal abortions obtained with unsafe methods. Only 6% of the women in this study reported having had a safe surgical abortion, while around 50% had used traditional methods (various potions, high doses of caustic products such as bleach or laundry soap, and vaginal insertion of coffee, Coca-Cola or Guinness), 15% had used hormonal methods, and the rest had used methods such as insertion of a catheter or suppository or unspecified methods. In Benin, there are no available data on abortion, legal or illegal, but data on complications associated with clandestine abortions attest to its widespread practice [17].

One important element to consider regarding abortion is that in both countries the use of modern contraceptive methods is limited. Among women living with a partner in Cotonou, only 12% were using a modern method of contraception in 2011–12 [18]. In Ouagadougou, the prevalence of modern contraceptive use in 2010 was higher: 33% of women living with a partner were using one of these methods [19]. The prevalence of modern contraceptive method use in both countries is higher for sexually active single women, but there is again an important difference between Benin (24% of users) and Burkina Faso (58%). In spite of these differences, however, total fertility rates were comparable between Ouagadougou and Cotonou (3.4/3.6). Emergency contraception is available over the counter in both countries, but according to DHS data, the level of knowledge of it was low, less than 20% of married women and 32–38% of sexually active unmarried women, while the use of emergency contraception was less than 1% [18,19].

## 2. Methodology

### 2.1. Methods and measures

We conducted in-depth interviews between 2014 and 2015 in order to study the women’s pathways to abortion and the methods used. In both countries, we focused on the

<sup>1</sup> In 2005, the World Health Organization included mifepristone and misoprostol on its Essential Medicines List [6].

<sup>2</sup> Several other Francophone countries are still subject to this law, including Senegal, Mali, and Côte d’Ivoire.

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