ABORTION PRACTICES AND THEIR CONSEQUENCES ON THE HEALTH OF WOMEN IN CÔTE D’IVOIRE

EXECUTIVE SUMMARY
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The research team would like to thank all the people and institutions that helped with this study, notably the health and social structures of the districts of Soubré and Méagui who helped us with data collection and with identifying the target audience for the study.

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This study focused on practices regarding clandestine abortion and was aimed at understanding the logic, practice and perceptions surrounding this and which are determined by the restrictive legislative framework in the country.

The study was notably aimed at:
➔ Analysing clandestine abortion practice, focusing on abortion via the use of medication;
➔ Identifying the various stakeholders (families, partners, healthcare professionals, etc.) involved in the abortion process (decision-making and practice of the procedure itself);
➔ Analysing the pathways for accessing clandestine abortion services;
➔ Analysing the practices of healthcare professionals post-abortion as well as the discourse on abortion in the profession;
➔ Analysing the social and health consequences of abortion on women;
➔ Understanding the current gap between the reality of clandestine abortion practice and the existing structures created by the institutions of Côte d’Ivoire.

This report is the result of the analysis of 82 interviews. The sample group was categorised as follows:

➔ Women who had had an abortion (35);
➔ Women who had had post-abortion care in healthcare facilities (12);
➔ Healthcare providers involved in treating post-abortion complications (14);
➔ Other stakeholders, members of the entourage or who have had an influence or involvement in the process (traditional abortionists, the father of the foetus, friends, doctors, nurses, people who sell medication, etc.) (16);
➔ Stakeholders from institutions in Abidjan (5). A more detailed table presenting the sample is included in annex 5 (page 100 of the full report). The study focuses on two cities: Soubré et Méagui. They were chosen because they represent the perimeter of Doctors of the World’s intervention on the issue of unwanted pregnancies.

For this socio-anthropological study into clandestine abortion we based ourselves on the following hypothesis: the restrictive legal framework has led to the growth of a market for clandestine abortion where there is both a wide demand and a wide offer of abortion services. This piece of research adopted a solely qualitative approach.

What were the lessons learned during this study?
REGARDING THE ANALYSIS OF THE DEMAND FOR ABORTION

Analysing the data of the social and health context allowed us to identify a key aspect regarding the abortion market in Méagui and Soubré—the availability of clandestine abortion services. In Méagui the lack of an offer for treatment has led to the creation and spread of alternative, informal care structures and mechanisms. In Soubré the widespread presence of medication of Chinese origin, that people refer to as “Chinese medicine”, and of medicinal plants that trigger abortion led to the structuring of a quite remarkable offer of clandestine abortion services, making it much easier for women to get an abortion. In this context three main lessons were learned when analysing the demand for clandestine abortions.

Lesson learned #1: the majority of the women seeking abortions are young, single students. Unwanted pregnancies often occur amongst vulnerable women who are socially and economically dependent, who do not understand how to properly use contraception and who misuse condoms. As a consequence, ‘accidental’ pregnancies increase the demand for abortions.

Lesson learned #2: due to the lack of access to preventative measures the voluntary termination of pregnancy, despite being prohibited, is increasingly used in these regions as a means of reducing the number of births. In addition to this is the aforementioned availability of clandestine abortion services and of Chinese abortion products. A combination of these two factors has led to earlier sexual liberation and a lax use of contraception despite the efforts made1 to raise awareness amongst young people in these regions on the topic of sexual and reproductive health.

Lesson learned #3: restricting access to the voluntary termination of pregnancy has not led to fewer abortions. Banning abortions has simply led to the creation of an informal abortion market with all the associated health risks for those who take this option. The reasons why a woman may choose to undergo a clandestine abortion are diverse: contraception is not always easily accessible whereas clandestine abortion services are, and some women decide they do not want to keep the foetus due to a fear of shame and dishonour.

Lesson learned #4: in Benin, Burkina Faso (Baxerres et al, 2018) and Ghana (Atakro et al, 2019) young people’s fear of their parents, their desire to continue with their education and the socio-economic situation of women have been identified as key factors in the decision to undergo an abortion. This is also true in Soubré and Méagui. The study shows, however, that amongst young people and teenagers in Soubré and Méagui there is an additional factor which leads women to take the path of clandestine abortion: the misuse of contraception.

REGARDING THE ANALYSIS OF THE OFFER OF ABORTION SERVICES

Lesson learned #1: each individual experience of abortion is unique and is hard to share with others. Often these women believe that finding out they are pregnant, taking the decision to abort and going through with the procedure are things they should suffer through in silence.

In interviews with women who had had abortions we often had to take breaks during

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1 According to a survey focusing on knowledge of sexual and reproductive health and on the barriers to access to contraception and to family planning services. The survey targeted teenagers and young people aged 10-24 in public high schools and sixth-forms in Soubré, Méagui and Buyo. 79.3% of respondents had already heard people talking about contraception.
their stories, they often found it difficult to recount what happened or could not remember going through the various parts of the abortion process. These difficulties highlight how much suffering these women endured.

The ban on abortion means there is no legal forum to talk to women about how they should behave in such circumstances. They are thus left to deal with their experiences of abortion on their own, relying on information acquired from informal networks. Whilst information about pregnancy is often acquired from loved ones, including friends and the father of the foetus, the decision to abort is often based on information about abortion gathered from the informal markets for abortion products. These markets are often structured as a sort of mediation system between potential users, former clients and a certain minority of healthcare staff. Informal abortions lead to an increased health risk due to the poor advice being shared in these informal networks.

**Lesson learned #2:** the ban on abortion has allowed the practice of clandestine abortion to prosper. In these two regions the dominant method is that of Chinese medication. The use of this abortion medication in Soubré and Méagui can be explained by the fact that it is widely available, that women trust in the efficacy of the products and because of the status and legitimacy of those involved in this network. The methods for accessing these products (with a tier-based pricing system and purchase options) are often part of an informal buyer-seller network where the sellers need to make money to survive but mistrust any outsiders to the network.

**Lesson learned #3:** Misoprostol is not often in stock in pharmacies in these two regions. The study has outlined that this lack of stock is the logical consequence of a gradual withdrawal of this product in the area by Pfizer laboratories. Misoprostol is almost non-existent as an abortion solution in Soubré and Méagui. The use of Chinese medication, which the market regulation authorities for pharmaceutical products are unable to properly control, is much more prevalent in these regions. The gradual withdrawal of Misoprostol and the alert sent out by the Ministry for Health about misuse of this product have created an opportunity for this Chinese medication to become even more dominant in the abortion services market.

**Lesson learned #4:** no matter the abortion method used the offer of abortion services is always kept quiet and in a restricted circle. Communication on the topic of abortion solutions depends on the pre-existing relationship between the intermediary and the service provider and between the intermediary and the woman requesting an abortion. This network bases itself on the experience of abortion of those involved and on the supposed efficacy of the products used. It is very rare that anyone questions the proficiency of the person providing the service, they are often seen as a saviour by women requesting an abortion, as someone helping to solve the problem of their pregnancy. When the abortion is carried out the women are often completely unaware of the risks and potential complications of the procedure.

**Lesson learned #5:** forcing pregnant women into informal abortion networks has put their health at risk, especially when they face complications following the procedure.

**REGARDING TREATMENT FOLLOWING COMPLICATIONS**

**Lesson learned #1:** forcing pregnant women into informal abortion practices and the varying points of view on post-abortion complications have an impact on the choice of treatment pathways. We have identified two treatment circuits for post-abortion
complications: the informal circuit and the formal public health structures. In both of these circuits the strategies taken to manage post-abortion complications depend on the following factors: the points of view of those involved, cost concerns, accessibility and expected gain.

Lesson learned #2: going to hospitals for treatment for post-abortion complications is a strategy used by these women to “legalise” the treatment for their abortion after having the procedure in itself carried out in the informal sector. These women are well aware of the rules allowing public health staff to treat post-abortion complications and use false declarations to explain how they got into this situation. They are also well aware that it is the duty of public health staff to treat post-abortion complications as such treatment is aimed at improving their health and/or saving their lives.

REGARDING SOCIETY’S PERCEPTION OF THE CONSEQUENCES OF ABORTION

Analysing society’s perception of the consequences of abortion has highlighted how opinions on clandestine abortion vary greatly amongst women before they have had the procedure and after it has been carried out. Generally clandestine abortion is perceived, before the procedure, as a radical solution to the ‘problem’ of an unwanted pregnancy, showing a certain resilience at this difficult time. After the procedure has been carried out, however, this ‘saviour’ idea about abortion is replaced, amongst most women, with regret at having gone through with it, with a deep feeling of guilt and with increased awareness of the risks associated with the choice they took.

The study has also outlined that women who have had a clandestine abortion often suffer psychologically from the experience. Given the lack of psychological support following an abortion they try to deal with the trauma by devoting themselves to religion or through denial. In addition to the psychological impact, going through the experience of an abortion can also have an impact on relationships: there can be a deterioration of relationships with friends and family as well as a deterioration and a crumbling of affection in the romantic relationship (possibly even leading to an end of the relationship).

The increased post-abortion awareness of the risks involved often leads these women to a more rigorous use of contraception in the future.

REGARDING THE ANALYSIS OF THE INSTITUTIONAL SET-UP REGARDING CLANDESTINE ABORTIONS

Lesson learned #1: in Soubré and Méagui there are two different perceptions of the legislation on abortion amongst the various stakeholders: (i) denial of the true scale of this phenomenon on the behalf of the State (ii) inconsistencies in the application of the law due to a criminalisation of the consequences of clandestine abortion rather than punishing the practicing of the clandestine abortion procedures.

Lesson learned #2: there are divided views amongst healthcare professionals on the relevance of the legislation on abortion. There are those who support the legislation (4/14 health service providers) and those who would prefer to see it changed (10/14 health service providers). The first group believes that the severity of the legislation is a positive thing as its aim is to protect women’s health by helping protect them from the risks of clandestine abortions. The second group, however, believes that legislation allowing abortion under certain conditions would ensure that women have access to safer abortion services.
and would reduce the number of women turning to the informal sector with all of its inherent risks.

**Lesson learned #3:** Côte d’Ivoire ratified the Maputo Protocol in 2003 but has never felt obliged to apply the Protocol’s specific measures on abortion. An amendment to the Ivorian abortion law was made in 2019 regarding cases of abortion in the context of rape. The law remains, however, as rigid as ever regarding the idea of allowing women to decide what to do with their bodies in the situation of an unwanted pregnancy. In the discourse of State representatives in charge of public policy on sexual and reproductive health it is clear that they evoke the principle of sovereignty as the reason why this Protocol, ratified by the State of Côte d’Ivoire, has not been properly put into practice.

**Lesson learned #4:** on the topic of abortion we have observed contradictions amongst non-state actors, some of whom try to discreetly have an influence on the legislation. If any initiatives to guarantee access to safe abortions for all women do exist they must be very discreet. The religious authorities, who have a certain political influence on decisions regarding sexual and reproductive health, have taken on a less conservative stance than the State. The religious authorities would widen the scope for abortions to include not just cases where the mother’s life is in danger but also for cases of rape and incest.

Based on the results of a socio-anthropological study into clandestine abortion practices and their impact on women’s health the research team would like to make the following recommendations:

**TO THE MINISTRY FOR EDUCATION AND THE MINISTRY FOR HEALTH**

1. We must move towards a clearer vision regarding education on sexual and reproductive health. Regarding the issue of education on sexual and reproductive health—as part of the prevention policy against HIV/AIDS, STIs, unwanted pregnancies and high-risk abortions amongst young people—some of the conclusions of the study into unwanted pregnancies in the school environment (Akindès, 2016), carried out by the team on behalf of the Ministry for Education, remain relevant today.

After analysing the offer provided in secondary education on the topic of sexual and reproductive health the study has highlighted six weaknesses which limit our schools’ ability to meet the demand for sexual education.

These weaknesses are:

A. The level of qualifications and skills of the staff assigned to this topic.
B. The impact of the cultural values of those providing education on sexuality.
C. The current teaching encourages abstinence but does not sufficiently highlight the other alternatives for protection.
D. Information about puberty is not provided at the right time, it must be taught at the exact age when pupils are becoming sexually active.
E. Education on sexual health does not sufficiently take into account the issues of gender and power relations when identifying dangerous behaviours.
F. There is a lack of a true national policy for education on sexual and reproductive health.

The literature (Haden, 2009) on experiences in various countries regarding prevention efforts and the handling of the consequences of unwanted pregnancies demonstrates that
in order to implement an effective strategy for reducing the number of unplanned pregnancies amongst young people and adolescents, and thus to reduce the number of high-risk abortions, States should directly tackle the various factors which influence the social trajectory of young people and which lead them towards early pregnancy. The Mission recommends that the Ministry for Education and the Ministry for Health work on defining a public policy on sexual education in Côte d’Ivoire. Such a policy must be part of a framework guided by a philosophy on national education on the topic of sexual and reproductive health. In order to achieve this the Mission recommends that a summit be organised on the topic of the sexual health of young people in the school environment. Looking objectively at the current behaviours of young people and adolescents this summit would focus on the type of sexual education programme to be implemented in Côte d’Ivoire. The programme could be inspired by the framework drafted by the European region of the WHO, which is also facing several challenges related to sexual health (WHO, 2013), whilst adapting this framework to the sociological and cultural reality of Côte d’Ivoire.

The rise of STIs, HIV/AIDS and the recent phenomenon of unwanted pregnancies in the school environment have made young people’s sexuality a major cause of concern for the people of Côte d’Ivoire. The recent rise of these issues must lead us to rethink the current patchwork approach to these problems and to consider an alternative to our current solutions. We need a global policy for how to improve sexual health. The objective of such efforts would be to offer young people sexual education focused on their real “needs” in terms of knowledge and based on the realities of their lives. Such an alternative approach to sexual education would have to overcome the obstacles of fear and prejudice and would allow young people “to learn not just about the risks but also about their options so that they can develop a positive, responsible attitude towards sexuality” (WHO, 2010: 5).

There are four reasons which justify adopting such an approach:

**Reason #1:** the response to the consequences of the current prudish approach to young people’s sexuality has been rare initiatives (awareness raising campaigns, distributions of condoms and education programmes for sexual health which adopt a moralistic approach and which are completely out of sync with the reality of young people’s sexual activity) which are often poorly coordinated.

**Reason #2:** several studies (Kohler et al, 2008; Mueller et al, 2008) have shown how sexual education provides young people with the information and know-how required to take healthy, informed decisions on sex, protecting themselves from the dangers of early pregnancies and high-risk abortions.

**Reason #3:** the right of the child to information, granted under the UN’s 1989 Convention on the Rights of the Child and ratified by the overwhelming majority of member states, authorises adopting such an alternative approach. We should remember that under Article 13 of this Convention “the child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas

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2 The current sexual education programmes can be split into three separate categories: 1/ Programmes which are mainly or entirely focused on encouraging abstinence until marriage. These programmes are called “Comment dire non” (“How to Say No”) and “Abstinence seulement” (“Abstinence, That’s All”); 2/ Programmes which outline abstinence as an option but which also identify the different forms of contraception and “safer sex” practices. Such programmes often refer to the notion of “comprehensive sexual education”; 3/ Programmes which include elements of category two but which situate these elements in the wider context of personal and sexual development. Such programmes are often referred to as “Holistic Sexual Education Programmes” (WHO, 2010: 14-15).
of all kinds”. Furthermore, it is outlined under Article 19 of the Convention that countries must take educational measures to protect children, especially from sexual abuse.

**Reason #4:** due to the earliness of sexual activity amongst young people and the extent of this activity an urgent change of approach is required. We must tackle the issue of young people’s sexuality head on. On the other hand, a political framework for such an alternative approach will only be possible if all stakeholders unite. Such a political framework would imply consulting partners from the education system as well as young people and all bilateral and multilateral partners involved in putting together the offer of resources and services relating to sexual and reproductive health in schools. Such a framework would require a clear, pragmatic definition of the government’s vision on sexual and reproductive health which would need to be aligned with the policy on population growth. This vision would then be implemented via awareness-raising campaigns, via the advice and services provided on the topic of sexual and reproductive health by civil society organisations and via the activities led by health centres. Once such a policy has been defined it must be backed up with sufficient financial resources in order to be successful and in order to implement the measures and initiatives outlined in the plan. The plan would be aimed at reducing or even completely eradicating this phenomenon.

The Mission suggests that three dimensions be taken into account, based on the lessons learned during the analysis of the causes of the evolution of the phenomenon of unwanted pregnancies and clandestine abortions in Côte d’Ivoire and the response to this issue, in order to guide this framework: (i) Whilst highlighting the importance of abstinence, which is the safest choice and which helps young people and adolescents avoid falling into the pitfalls of getting involved sexual activity too soon, the public authorities should also propose back-up solutions to abstinence. This would allow young people and teenagers to take informed decisions based upon their own values. Such an option must be added to the various curricula; (ii) The factor of gender and power relations in sexual transactions should also be included in the curricula. The difficulty for girls in negotiating the use of condoms, due to an imbalance in decision-making power between boys and girls, is often what leads to unprotected sex and its various inherent risks; (iii) It is essential that we involve young people in the work to design communication programmes aimed at raising awareness of their right to information on the topic of sexual health and the dangers associated with sexual activity. Discussions with young people must be at the heart of any future national policy for sexual health, working with them to build up the concepts of responsible sexuality and responsible sexual practices, in order to ensure that this policy truly captures young people’s attention.
TO THE NGO DOCTORS OF THE WORLD

We recommend:

2. Sharing the conclusions of the present study as well as the conclusions of the other studies on the causes and consequences of clandestine abortion carried out amongst members of parliament, online activists, rappers and slammers. Sharing this information will help to raise awareness about the consequences of the criminalisation of abortion and will help the general public to cast aside a moralistic perspective of this phenomenon.

3. Putting an end to the idea of opposition between the State and non-state actors in order to involve online activists and slammers in the awareness-raising initiatives so that these campaigns can be led by local people, who are the ones most affected by this issue.

4. Creating summaries and a documentary based on the present study which could then be used in the social dialogue on this topic.

5. It has become clear that developing partnerships with research centres and universities is necessary. Such partnerships would enable us to carry out studies into the stumbling blocks in our path and would strive to make the State change its stance on the issue of abortion. These studies would allow the stumbling blocks to be clearly highlighted in any lobbying initiatives. Developing such partnerships would help provide support for the movement which is raising awareness in order to have The Maputo Protocol, and notably Article 14C of the Protocol, properly applied in Côte d’Ivoire.

TO THE MINISTRY FOR HEALTH, THE NGO DOCTORS OF THE WORLD AND ALL OTHER DEVELOPMENT PARTNERS

6. Efforts to improve education on sexual and reproductive health must continue. Due to the fact that forcing women to opt for informal abortion services clearly poses a major health risk, awareness raising initiatives must be launched in order to give women who wish to have an abortion objective advice on what methods to use.

7. There is still only very little literature in Côte d’Ivoire on the rapid change of sexual habits and there have not been enough evaluations of the educational needs arising from such a change in sexual practice. Due to these changes, sexual behaviour should be further analysed, as should the relationship that young people/adolescents have with contraception. We must better understand these changes in order to better adapt the response in terms of education on sexual and reproductive health. The Mission recommends that the Ministry for Health build partnerships with the sociology and anthropology departments of Ivorian universities in order to launch studies into the reality of young people’s sexuality with the aim of using such studies to guide public education policy regarding sexual and reproductive health.
TO THE MINISTRY FOR HEALTH

We recommend:

8. Improving the treatment system in hospitals for post-abortion complications. Strengthening this system implies training for staff on the ethical and moral considerations regarding treatment for post-abortion complications as well as providing the health structures with sufficient resources to provide such care.

9. Improving access to Family Planning services.