



**UNWANTED  
PREGNANCIES  
AND ABORTIONS**

**COMPARATIVE ANALYSIS  
OF SOCIOCULTURAL  
AND COMMUNITY  
DETERMINANTS**

PALESTINE | PERU | BURKINA FASO  
DEMOCRATIC REPUBLIC OF CONGO



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The ideas and opinions presented in this report do not necessarily represent the views of the AFD.

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## ACRONYMS AND ABBREVIATIONS

**DRC**

Democratic Republic of Congo

**FP/SRH**

Family Planning/Sexual and Reproductive Health

**HCMC**

Health Centre Management Committee

**HIV**

Human Immunodeficiency Virus

**IEC**

Information Education Communication

**IUD**

Intrauterine Device

**LAM**

Lactational Amenorrhea Method

**Lasdel**

Laboratory for Study and Research on Social Dynamics and Local Development

**MCHC**

Mother and Child Health Centre

**MDG**

Millennium Development Goals

**MdM**

Médecins du Monde

**MVA**

Manual Vacuum Aspiration

**NAHP**

National Adolescent Health Programme

**NGO**

Non-Governmental Organisation

**RH**

Reproductive Health

**SCO**

Civil Society Organisation

**SDG**

Sustainable Development Goals

**SRH**

Sexual and Reproductive Health

**STD**

Sexually Transmitted Disease

**UN**

United Nations

**UNRWA**

United Nations Relief and Works Agency for Palestinian Refugees in the Near East

**UWP**

Unwanted Pregnancy

**WHO**

World Health Organisation



# NARRATIVE SUMMARY

## SEXUAL AND REPRODUCTIVE HEALTH: INTERNATIONAL SOCIAL AND POLITICAL CONTEXT

The International Cairo Conference on Population and Development (1994), followed by the International Conference on Women in Beijing (1995) played key roles at the global level in advocating for women's reproductive rights and working to overturn laws criminalising abortion. For more than 20 years, advocates have swung into action in every arena (such as SDG and MDG) to "ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes".<sup>1</sup>

On the ground, however, it is clear that individuals – women and men alike – are still finding it difficult to achieve a healthy state of physical, emotional, mental and social well-being regarding their sexuality and reproductive health. These difficulties are evidenced by the high incidence of unwanted pregnancies (UWP) and unsafe abortions. Adolescents and young people are especially vulnerable to these sexual and reproductive health problems, as demonstrated by the results presented in this report. The results are based on four studies that examined UWPs and abortions, with a focus on the population of adolescents and young people aged 15-24.

For all individuals, the main issues surrounding UWPs and abortion involve access to reliable information, quality SRH services that are not limited to family planning (FP) and a social, legal and healthcare environment conducive to sexual and reproductive rights, without discrimination on the basis of age, gender, religion or marital status (WHO, 2015; Delaunay, Guillaume, 2007).

## STUDY OBJECTIVES

MdM addresses the UWP issue in a number of countries in Latin America, the Caribbean, Africa, the Middle East and Eastern Europe. More specifically, MdM initiated a programme that seeks to Help reduce maternal mortality and morbidity from unwanted pregnancies in the four countries involved in the study: Burkina Faso (Djibo district and Ouagadougou), Palestine (Gaza Strip),

Peru (Villa El Salvador District – Lima region) and the Democratic Republic of Congo (Kinshasa).

The objective of this global study is to provide a comparative analysis of the sociocultural and community determinants of abortions and unwanted pregnancies, particularly in the 15-24 age group in the four surveyed countries.

More specifically, the study aims to:

- **Analyse sociodemographic, cultural and family conditions as well as the social, economic and political environment that gives rise to abortion and unwanted pregnancies;**
- **Collect data on social norms, popular representations and cultural perceptions regarding sexual and reproductive health in local communities;**
- **Learn the various ways families and communities respond to unwanted pregnancies and abortions;**
- **Identify the community and healthcare stakeholders who play a role in managing contraception, abortions and unwanted pregnancies;**
- **Collect data on care providers' perceptions and behaviour regarding abortions and unwanted pregnancies;**
- **Examine the quality of the therapeutic relationship between patient and care provider in SRC facilities;**
- **Understand patients' perceptions of health facilities concerning the quality of sexual and reproductive health services, the availability of care, how well informed they are about the available services, and their level of trust in these services;**
- **Make recommendations for guiding the strategy for responding to unwanted pregnancies and abortions in the community.**

The objectives were refined during the surveys based on the realities on the ground, such as the importance of religion and consideration of conflict and insecurity situations.

1 - <http://www.un.org/sustainabledevelopment/fr/objectifs-de-developpement-durable/> [consulted on 14.12.2015]

## MAJOR STUDY RESULTS

### Structural obstacles in the provision of SRH services

Although contraceptives and SRH services are theoretically available in all of the surveyed countries, they are not always accessible to the entire population. All four countries suffered from a large number of structural problems in the provision of services, including stock shortages, lack of workers trained in SRH and FP counselling, especially services geared toward adolescents, limited geographic accessibility and high costs for contraceptives, consultation and transport to a health centre. It is clear that real access to sexual and reproductive health services does not meet the commitments made by governments at the international level.

### Health effects of the social and legal environment

In these social and institutional contexts, abortions and unwanted pregnancies significantly contribute to the morbidity and mortality of young and older women, including those in the 15-24 age group (but not only). Our results show that girls pay a heavy social price when they have an unwanted pregnancy, with major health effects. Whether in Burkina Faso, DRC or Peru, they are often excluded from the family and social group, are stigmatised by the community and must abandon their studies. Rarely supported by their family, they also suffer the loss of their partner in many cases, leaving them economically marginalised. This social climate often explains their delay in seeking prenatal care or deciding to have an abortion. Due to the criminalisation of abortion in the surveyed countries, this decision carries major risk for the health and safety of women as well as those seeking to provide them with moral support, as evidenced by the many interviews conducted in the four countries.

### Social context surrounding the provision of services: interlinkage between community and care providers

While these harmful environments have already been described (Delaunay, Guillaume, 2007), our study's major contribution has been to document, at the global level, the role that unequal gender relations, cultural representations and religious beliefs play in responding to unwanted pregnancies and unsafe abortions – not only in families and communities but among care

providers as well. This interlinking of social norms and values has consequences for the quality of care, a situation discussed in detail in this report.

## MAJOR RECOMMENDATIONS

This report has three major recommendations for reducing the effects of abortions and unwanted pregnancies and improving abortion-related laws, which are ripe for change in response to changing social environments.

### Improve the quality and accessibility of sexual and reproductive health services (SRH)

Current and future healthcare professionals (medical or allied healthcare students) are the major care providers so it is necessary to provide them with the proper training and information on sexual and reproductive health during their formal and on-the-job training. They must also receive solid and consistent grounding in professional ethics in order to genuinely improve the quality of care and practices. Lastly, it is essential to improve the accessibility and quality of SRH services in health facilities, especially those designed for adolescents and young people.

### Develop multi-faceted IEC strategies

It is important to develop strategies for informing the population about SRH and changing related perceptions and behaviours. The focus must be placed on sexual and reproductive rights, gender equality and human rights in general to achieve a positive and long-lasting transformation of the way individuals, families, the community and health professionals perceive SRH. Because the lack of information and biased attitudes about contraception, UWPs and abortion have a significant impact, it seems crucial to strengthen IEC strategies in various overlapping areas.

### Change public policies and the body of laws

Political decision-makers play an obviously important role in facilitating change in societal perceptions and individual behaviours. As a result, they must be encouraged to improve or revise laws to ensure they better meet societal needs and changes. To do so, advocacy, with the help of civil society, remains the best means of modifying national laws and policies.



# INTRODUCTION

As part of its projects, Médecins du Monde France (MdM) asked the Laboratory for Study and Research on Social Dynamics and Local Development (Lasdel) to conduct four studies on the sociocultural determinants of unwanted pregnancies and abortions in Burkina Faso, the Democratic Republic of Congo (DRC), Peru and Palestine. The studies were essentially based on a qualitative approach, and included an ethnography of sexual and reproductive health services, contraceptive demand and use in a family and community context, and political and technical means of preventing and responding to unwanted pregnancies and abortions.

This report presents cross-cutting and specific data for each country. It starts with an analytical comparison of national contexts and a description of the services provided. It then describes the main sociocultural determinants of unwanted pregnancies, and the related individual, community and institutional perceptions and responses. It also examines perceptions and management of induced abortions. Finally, it provides recommendations that seem appropriate for all four contexts.

## 1.1. SEXUAL AND REPRODUCTIVE HEALTH IN THE SURVEYED COUNTRIES: HEALTH, SOCIOCULTURAL AND HEALTH POLICY CONTEXT

The study mainly concentrated on urban areas in the four countries concerned: Villa El Salvador, Peru; Kinshasa, Democratic Republic of Congo; and the Gaza Strip in Palestine. Burkina Faso was the only country where both urban and rural environments were studied, namely the urban Bogodogo district and rural Djibo district.

These urban contexts are characterised by certain constant factors whose magnitude can vary from one city to another, but whose main features can be described as follows:

- "young" cities [in countries where young people aged 15-24 represent on average 20% of the population]<sup>2</sup>;

- densely populated cities with all of the attendant problems, including promiscuity, unplanned urbanisation and lack of access to basic services, such as sanitation, drinking water, electricity, and social and health services;

- cities that have experienced or are currently experiencing large waves of migrations and population displacements (sometimes due to an internal and/or external conflict), which make cities very multicultural; a strong religious influence (mainly Christianity in Peru and the DRC, Islam and Christianity in Burkina Faso, and Islam in Palestine),<sup>3</sup> which guides government decisions on sexual and reproductive health. Religion retains a significant influence on family and community practices and representations in the areas of sexuality, family values and women's role. For example, in Gaza, governed by Islamic law, contraception is accepted for spacing out births but not for limiting family size and abortion is restricted.

- cities and regions experiencing violence, especially toward women, which may take different forms and be of varying severity depending on the country – for example, machismo in Peru and sexual violence in the eastern part of the DRC, which is then "exported" to other regions, etc. – and which, more generally, serves to maintain a high level of gender inequality.<sup>4</sup>

In terms of health, the little comparative data available on adolescent fertility and contraceptive prevalence among women of reproductive age shows a rather mixed picture. In the DRC and Burkina Faso, contraceptive prevalence is fairly low while unwanted pregnancy rates remain high. In Peru, while the contraceptive prevalence rate is much higher, the unwanted pregnancy figures still remain very high. Palestine has a contraceptive prevalence rate of 50% but we were unable to find figures on the rate of unwanted pregnancies. The lack of statistics is, of course, symptomatic of these issues' sensitivity and the fact that the public authorities do not view them as a public health problem.

2 - In 2015, the 15-24 age group represented: 19.9% of the population in Burkina Faso; 17.8% in Peru; 19.5% in the Democratic Republic of Congo; and 21.7% in Palestine. (United Nations, Department of Economic and Social Affairs, Population Division 2015).

3 - In Burkina Faso, 61.6% of the population identifies as Muslim and 23.2% as Catholic (2011). In Peru, 81.3% of the population is Catholic and 12.5% evangelical Christian (2007). In the DRC, 50% of the population

is Catholic, 20% Protestant, 10% Muslim and 10% follows syncretic or local religious practices. In the Gaza Strip, Muslims, mainly Sunnis, make up 98-99% of the population (2012). Source: CIA The World Factbook, field listing: Religion, <https://www.cia.gov/library/publications/the-world-factbook/fields/2122.html>

4 - A large number of Congolese have fled rural areas due to armed conflict and insecurity in the eastern part of the DRC.

TABLE 1: MAIN SRH INDICATORS IN THE SURVEYED COUNTRIES

Country	Adolescent fertility (number of births per 1,000 women)	Contraceptive prevalence (in-union women of reproductive age, all methods combined)	Unmet contraceptive needs	Rate of unwanted pregnancy
Burkina Faso	117	16 – 17%	25%	32% (DHS* 2003)
Democratic Republic of Congo	168	18 – 20%	24%	56.5% (PMA 2020, 2014)
Peru	48	69 – 73%	6%	53.2% (ENDES, 2014)
Gaza Strip (Palestine)	48	48,4%	17%	NA

\*Demographic and Health Survey  
Source: Global Statistics, WHO, 2014, UN 2011 and PCBS, 2010.

In general, unwanted pregnancies among adolescents are considered a significant problem by the population, health professionals, authorities and partners in the four surveyed areas. The major reason for concern is adolescent health, followed by an unwanted pregnancy's long-term effect on the girl's life, the need to drop out of school, rejection by the family and other issues. By definition, it is hard to gain access to statistics on illegal abortions but unsafe abortions are also seen as public health problem by the population, health professionals, authorities and partners. In Peru, according to available data, illegal abortions were the third leading direct cause of maternal death from 2002-2011 (MINSa, 2013).

**Adolescent vulnerability factors are comparable in the four situations: educational level, place of residence (rural or urban) and level of socioeconomic well-being<sup>5</sup>.**

In legal terms, the four countries included in the survey all have restrictive abortion laws, i.e. abortion is banned and punished,<sup>6</sup> both for the woman having the abortion and the person who aborts the foetus or helps her to abort it. A therapeutic abortion is only allowed when the mother's health is a risk, and this requires the consent of at least two doctors (three in the DRC).

5 - This indicator is based on information about household ownership of certain durable goods (television, radio, car, etc.) and housing characteristics (availability of electricity, source of drinking water, type of sanitation, floor covering material, number of rooms used for sleeping, type of cooking fuel, etc.).

6 - See the summary table on the various laws on pp. 24-25 of this report

## STUDY METHODOLOGY

The studies took a socioanthropological approach with an essentially qualitative focus. The protocols were submitted for approval to national research ethics committees in each country. Field researchers received training and the survey tools were tested by the researchers to ensure that the concepts, analytical framework and data collection tools and strategies were completely appropriate. The different stages were as follows: i) literature review, ii) field survey (data collection by various methods) and iii) data analysis.

### 2.1. LITERATURE REVIEW

The first stage was a literature review to collect statistical data. The goals included comparing and establishing differences among the four countries and collecting press articles on UWP, abortion, newborn abandonment and related topics to gain a better understanding of the social representations depicted in the media. These secondary data, both qualitative and quantitative, also helped guide our choices when writing interview questions.

### 2.2. COLLECTION OF EMPIRICAL DATA

The data was gathered by sociologists and ethnographers supervised by a principal field coordinator and a general coordinator overseeing all of the sites. Field researchers and supervisors met regularly during the data collection phase to iron out any difficulties and review progress on the survey topics in order to recommend appropriate solutions.

#### 2.2.1. DATA COLLECTION METHODS AND TOOLS

In all four countries, data was collected from November 2014 to August 2015 using qualitative methods, including individual interviews, observations and focus groups. Direct observations took place in Family Planning/Sexual and Reproductive Healthcare (FP/SRH) and post-abortion centres. This involved observing consultations with adolescents and the general population in SRH centres to determine motives, concerns about preventing UWPs, care providers' responses to their inquiries and the management of UWPs and abortions.

The qualitative data collection tools were the interview and focus group guides, which served as a structural framework for the topics of interest. The guides were developed by type of respondent. Interviews were conducted with care providers (doctors, midwives, nurses), community health workers and social workers, girls and young women who had experienced a UWP, community representatives (religious, nonprofit) and other resource people depending on the region. The focus groups brought together adolescents, young women and men, community members (adult women and men, representatives from religious and nonprofit organisations) and care providers.

In the field, each ethnographer kept a daily dashboard to note the significant facts and observations and whether additional information needed to be collected or confirmed depending on respondents' availability. These dashboards were important documents that enhanced the analytical process and data interpretation.

Some of the additional quantitative data was gathered using an SNIS (National Health Information System) matrix, previous studies, health statistics directories, and demographic and health surveys. In certain countries, we had access to routine statistics available in health centres where medical consultations take place. The statistics also concern the following subjects: the availability of human and material resources; the types of services provided; the availability of supplies and equipment; the adequacy of the physical plant; the monitoring and oversight of health care and prevention services and the system of on-site registration; the level of use; service coverage; organisation, operations; etc.

#### 2.2.2. SURVEY TARGETS AND SAMPLING TECHNIQUE

Four groups of respondents were systematically interviewed and observed: young women and men aged 15-24; health workers and their various community intermediaries; the adolescents' mothers and fathers; and resource people and community organisations with any influence on young people's fertility, marriage, moral standards and mobility. All categories of respondents from the selected neighbourhoods were interviewed. The "resource person" category included the usual leaders, including clergy; the district officer; the public health authorities (district management team); health centre management committees (COGES);

community health workers; traditional midwives; community organisations; the media; and others.

The choice of sampling technique was well thought out. All respondents were selected for the survey on the basis of their involvement in the research topics. We strictly adhered to the various respondent categories and subcategories. The sample size was not determined in advance. We followed the information saturation principle within each respondent subcategory. To do so, we assigned each respondent category to a single field researcher, who could determine the level of saturation over time. Identifying people to interview within respondent categories was done on the basis of the "snowball" technique, which involved asking each participant for referrals to another person who would be appropriate for the survey.

### 2.3. DATA PROCESSING

All interviews were recorded, transcribed, then coded using QDA Miner or NVivo software. A content analysis was then performed on the respondents' comments, descriptions of observations, etc. The quantitative data extracted from the available study registers and reports was summarised in order to provide information for certain key behavioural and knowledge indicators related to SRH among young women and men.

### 2.4. LIMITATIONS OF THE STUDY

The studies were delayed everywhere except Palestine due to administrative procedures. This led to time constraints and problems meeting with or organising resource people and respondents. In certain countries, we encountered a lack of rigorous and reliable quantitative data. The available statistics are not collected according to the same periodicity, criteria or methods in the four countries. Very few abortions are reported in most of the countries. The available data sometimes concern a region or city, sometimes a specific population.

We encountered a certain number of difficulties while collecting data, particularly in the Gaza Strip, such as unavailability of participants during Ramadan.

UWPs and abortion remain sensitive topics that are hard to discuss due to the stigmatisation and taboos surrounding sexuality, especially for adolescents. As a result, in certain areas, such as Peru, it was extremely difficult to arrange interviews with young women who

had had a UWP or abortion. This same problem arose when seeking men for interviews or focus groups. In the Gaza Strip, it was also very difficult to interview unmarried women on these issues given that current social and moral norms strongly condemn sexual relations outside of marriage.

Because the time allotted for field surveys was relatively short (three to five weeks), we were unable to develop additional strategies for recruiting respondents or make further inroads on the ground by forging trusting relationships with resource people. In Peru, the delay in launching the study and its relatively short duration, which also coincided with the country's national holidays, also limited the number of respondents we were able to recruit. This gave more weight to the interviewed care providers, most of whom were already aware of SRH rights due to the efforts to MdM and other NGOs in the district under study.

In the Gaza Strip as well, the lack of time led to the unfortunate absence of certain key players during the interviews. We felt, for example, that teachers played an essential role in relaying information in their communities, but due to the lack of time we were unable to analyse that role more thoroughly. Nor could we conduct an in-depth analysis of the type of contraceptive methods used in hospitals and health centres even though such an analysis would have provided excellent insight into the practices and perceptions surrounding these issues. These various factors should serve as avenues for exploration in a future study.

# FROM PROVISION TO USE OF CONTRACEPTIVE METHODS

## 3.1. PROVISION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

In the four surveyed regions, the various modern contraceptive methods are theoretically available (hormonal, barrier, chemical and permanent – except in the Gaza Strip, where permanent methods are prohibited) and traditional methods also exist (withdrawal, rhythm method, etc.). The different modern methods are available at public and/or subsidized health centres, may be free or require full or partial payment, and/or may be conditioned on civil status, as in the Gaza Strip. They can be found both in pharmacies at market prices and in the informal sector (street vendors, etc.).

The morning-after pill is also available in the four surveyed cities/regions, most often for payment in private pharmacies, making them unaffordable for low-income women. In Peru, for example, even though the morning-after pill is included in the Ministry of Health's list of contraceptive methods, a legal and political debate is currently blocking its (free) distribution in public health clinics. They do, however, remain available in pharmacies, usually requiring a doctor's prescription.

Lastly, in all four countries, families, religious leaders, certain NGOs and others encourage young people to remain abstinent, preferably over every other contraceptive method.

Although all of these methods are theoretically available, people in all four countries face the same obstacles in gaining access to them: cost (even if the method is free, they must pay for transport and consultations); distance (not all methods are available at all the centres); availability (stock shortages); and lack of trained personnel combined with the poor quality of family planning services.

Women face social obstacles in addition to these structural factors, such as the key role played by their male partners in the decision whether to use contraception, with their formal authorisation sometimes required. Similarly, the high social value placed on large families

(as in the Gaza Strip) and the importance of women's traditional gender role as a mother within a couple can make their decision to use contraceptives more difficult because it runs counter to the social norms inculcated by those around them. Moreover, often due to a lack of appropriate counselling by the health services, many women interviewed were concerned about the contraceptives' side effects, particularly a fear of sterility and/or actual side effects. And these concerns might lead them to avoid or abandon modern contraception, limiting their acceptance of such methods.

To gain access to available contraceptives methods, adolescents must first have a medical consultation with a care provider. They face many obstacles, however, and these are more or less similar in the four surveyed regions: the need for authorisation from a parent or guardian in the case of a minor; insufficient funds to pay for the health centre's services, medical consultation and/or contraceptives; lack of confidentiality; and no facilities dedicated to adolescent health (with trained staff, information tools, awareness of specific needs, etc.). In the surveyed countries, the sexuality of unmarried young people is socially and morally condemned, which results in their very limited access to contraception (Delaunay, Guillaume, 2007). Because of this strong moral condemnation, especially by doctors and health workers, setting up this type of facility for unmarried people (girls and young women) would be almost unthinkable in, for example, the Gaza Strip.

Illegal in all four surveyed regions (except under certain conditions, such as incest and when the mother's health is in danger), abortions are not provided in public health centres and/or facilities run by the national health insurance scheme (unless they do so secretly). Post-abortion care, regardless of the type of abortion (spontaneous or induced), is usually part of the basic package of services offered by health facilities, but the staff are often inadequately trained and methods are not up-to-date. At present, most specialists and the WHO recommend manual vacuum aspiration while a D&C is the method most often mentioned by care providers.

Lastly, it should be noted that the four countries have committed to improving sexual and reproductive health – including services for adolescents (except in the Gaza Strip, where this issue cannot officially be discussed in relation to unmarried women). To meet this commitment, the countries are taking a

rights-based approach [i.e. sexual and reproductive health is a human right] and are also gradually orienting their policy toward the primacy of women’s rights in sexual and reproductive health.

### 3.2. AVAILABILITY OF CONTRACEPTIVES

The availability of contraceptives is similar in the four countries covered by this study. Most of the contraceptive methods are available in the formal pharmaceutical sector as well as the informal sector of alternative medicine. Most respondents reported that users could easily find contraceptives in health centres, pharmacies, hospitals and clinics (private, NGO, etc.) and even from certain national and international organisations (NGOs, United Nations agencies, etc.), e.g. from UNWRA, the UN Palestinian refugee aid agency in the Gaza Strip.

The methods mentioned include modern contraception such as injectables (Depo-Provera), the IUD, spermicides, male and female condoms, the birth control pill and the Jadelle implant as well as traditional methods such as CycleBeads, the rhythm method and the Lactational Amenorrhea Method (LAM). In

addition to these temporary methods, permanent contraception is also possible – sterilisation. Peru has centres that specialise in tubal ligations. In the Gaza Strip, while sterilisation is strictly and officially prohibited, there are reports of tubal ligations being performed in secret.

Despite the availability of contraceptives in all four contexts (Burkina Faso, Peru, DRC, Palestine), information is not being disseminated at a level commensurate with the availability of contraceptives.

Moreover, the countries often suffer from stock shortages of the most popular contraceptives, with variations per country. This occurs in both health facilities and pharmacies. In Peru, for example, all Mother and Child Health Centres (MCHC) in Villa El Salvador have documented supply problems. The contraceptive supply shortages in public health centres are a recurring problem that limit women’s opportunity to freely choose the type of contraception they would like to use. We were told by a health professional in Peru, for example, that *“we don’t have consistent access to contraceptive methods, especially female condoms, which often aren’t available in the public health network”*.

TABLE 2: COMPARISON OF CONTRACEPTIVE AVAILABILITY IN THE SURVEYED COUNTRIES

Country	Availability of contraceptives
Burkina - Ouagadougou	Contraception can be purchased in any health facility and hospitals, pharmacies, street vendors, etc. offer a wide variety of contraceptive methods. There are, however, shortages of contraceptive supplies.
Burkina - Djibo	Contraception is widely available – in local pharmacies, public and private health centres, maternity services and hospitals.
Peru	Available in the public health network, pharmacies, hospitals, and private and government health centres. <i>“We don’t have consistent access to contraceptive methods”</i> Available everywhere for everyone, but with regular shortages. <i>“Female condoms often aren’t available in the public health network”</i> The supply shortages limit women’s opportunity to freely choose the type of contraception they would like to use. Despite the wide variety of contraceptive methods available, all of the Mother and Child Health Centres in Villa El Salvador have documented supply problems.



<p>DR Congo Palestine -</p>	<p>Materially and technically available: in private pharmacies for those who use the male condom and birth control pill and in government hospitals for those who prefer injectables, implants or sterilisation. Contraceptives are available in health centres and the street (by educators) and sold by drug retailers (street vendors and traditional pharmacies).</p>
<p>Gaza Strip</p>	<p>The availability of methods depends on marital and legal status. They are more or less available in all five districts, government and UNRWA clinics and hospitals, private clinics and hospitals, clinics and hospitals run by certain NGOs, community health centres, and pharmacies.</p>

Source: Country study reports, Lasdel/Médecins du Monde, 2015

### 3.3. ACCESSIBILITY OF CONTRACEPTIVES

While contraceptives are relatively available, they are not always accessible – financially, geographically, culturally – to all women (and men), particularly young people. In the four surveyed countries, access to contraceptive methods varies rather widely. In certain cases, they are distributed free of charge or sold at an affordable price to all users, according to information gathered during the survey. In the Democratic Republic of Congo, for example, as in the three other cities surveyed, users reported having access to contraceptives, which are subsidised and may be distributed free of charge. They are available at NGOs and health centres and can sometimes be purchased for affordable prices in the market (hospitals, health centres, pharmacies, street vendors, etc.), but that is not the general rule.

Cost is a major factor of accessibility, especially for young people, who rarely have sufficient funds of their own. As a result, among all the contraceptive choices, condoms are more accessible to the young due to their lower cost.

There are other accessibility problems as well and they vary by country. In the DRC, where contraception is illegal for minors, certain types of contraceptives are promoted by the public authorities and their partners, especially for young people (male and female condoms), but the country does not have a sufficient supply to meet the needs of the population. Other problems encountered include damaged products, approaching expiration dates, etc.

The Gaza Strip has no law preventing anyone from getting and using contraceptive methods, but user access can be limited by civil status (“differential treatment” between refugees and citizens, Ashour et Watt, 2010), marital status and location. Even though population density is extremely high, certain areas at a distance from the cities, particularly towns in the border regions of the south-eastern Gaza Strip, have fewer public health facilities.

**TABLE 3: COMPARISON OF ACCESS TO CONTRACEPTIVES IN THE SURVEYED COUNTRIES**

Country	Access to contraceptives
Burkina - Ouagadougou	Private and public health centres and street vendors distribute and sell contraceptives, which are affordable for most users. However, they can be harder to find during certain seasons. Contraceptives are affordable, as evidenced by frequent comments like the following: <i>"It was easy to find contraception. It's not hard to get contraceptive methods. It wasn't complicated. Young people can afford condoms because they're less expensive."</i>
Burkina - Djibo	Contraceptive methods are often free or low-cost. Everyone can afford them. The main barriers are distance, illiteracy and stigmatisation of young people in health facilities.
Peru	Contraceptive methods are distributed free of charge in the public health network following a family planning (FP) consultation. They are affordable across all income levels. Shortages of contraceptive supplies in public health centres are a recurring problem.
DR Congo	Contraceptive methods are either low-cost or distributed free of charge, making them affordable to everyone. Some types of contraceptives are promoted (an assessment of the UNFPA Third Programme notes that in the area of FP, the DRC gives priority to raising awareness about and distributing male and female condoms), but there are insufficient supplies to meet the population's needs. Other problems encountered include damaged products, approaching expiration dates and stock shortages.
Palestine - Gaza Strip	Medical contraception is widespread and easily accessible, with contraceptive methods free of charge for most of the population and easy to find for most users despite differences in civil status, marital status, location and stock shortages. <i>l'emplacement géographique et l'existence de ruptures de stock.</i>

Source: Country study reports, Lasdel/Médecins du Monde, 2015

### 3.4. PERCEPTIONS OF CONTRACEPTIVES

Contraceptive methods are sometimes perceived positively as: an effective way to space out pregnancies and thus better look after children, prevent diseases (with condoms), reduce the number of children raised by parents and grandparents, and reduce the number of children forced to live on the street. This perspective is shared by a large number of health professionals.

Many users, however, have a negative perception of contraception. In their view, they always run the risk of side effects when using modern contraceptive methods. The most frequently mentioned are sterility and/or illness. Furthermore, these negative perceptions may be passed on or reinforced by certain health professionals:

*"Age 20 is the earliest and the girl must already have two children. We often give them to married couples because a husband's permission is required. Single girls don't use implants – only condoms."*

health professional, Kinshasa

Condoms are also viewed as having negative effects, mainly on sexual pleasure (by limiting direct physical contact): *"My husband wants nothing more to do with it! He says condoms make a woman sterile when they're used too often and they also don't give him enough pleasure. My husband doesn't like condoms"*, says a young woman in the DRC.

In addition to their perceived effects on health (sterility) and pleasure, contraceptive methods are also sometimes viewed as encouraging bad behaviour, such as prostitution and multiple sex partners. From

this perspective, contraception is not meant for everyone but primarily "for married women" and thus "not appropriate for girls". The promotion of contraception among young people is often seen as encouraging them to have sexual relations, which society considers unacceptable outside of marriage.

In short, the populations of the surveyed regions are knowledgeable about contraceptive methods, to a certain extent, but a number of sociocultural, economic and environmental (geographic) barriers limit their use.

**TABLE 4: COMPARISON OF PERCEPTIONS OF CONTRACEPTIVES IN THE FOUR COUNTRIES**

Countries	Perceptions of contraception
Burkina Ouagadougou	Contraceptives are perceived as a beneficial practice for both women and men. It provides the family with good physical and financial health by allowing it to space out births and prevent unwanted pregnancies. It's the best way or an effective way to plan births. However, there are perceptions that contraceptive methods can sterilise women, cause long-term health problems and diseases, and lead to early menopause. Some men forbid their wives from using contraception because in addition to its alleged sterilising effects, they believe it encourages bad behaviours, such as prostitution and multiple sex partners. In their view, the use of contraception runs counter to responsible sexuality.
Burkina Faso Djibo	Except for the churches, contraceptives are deemed beneficial but high-risk. They are also viewed as the province of the socially marginalised (ill-bred girls, etc.), as evidenced by the following quotation: <i>"In our country, if a girl secretly takes contraceptives it's because she wants to run around with men; otherwise, it's not acceptable for a girl to plan her births. If she doesn't have a husband, why is she planning her births?"</i>
Peru	Methods that are seen as otherwise good are considered capable of making periods completely irregular. They make women sterile, cause cancer or reduce libido and sexual pleasure. Giving condoms to teenagers is like telling them, <i>"Go have sex"</i> . The use of contraceptives, especially condoms, has a negative connotation because contraception is perceived as an invitation to begin having sex at an early age. <i>"I think contraceptives can be a good thing when women receive proper guidance and use them correctly because they're taking care of themselves and won't have unwanted pregnancies, and there won't be abandoned children or children with health problems. So it's positive when there's proper guidance and use."</i>
DR Congo	Negative perception: ineffective, with side effects (even dangerous for fertility and virility), condoms are seen as reducing sexual pleasure and limiting physical contact ( <i>"it takes away the natural feeling"</i> ) while insidiously leading to sterility. The methods available are not designed for all population categories. Positive perception: contraception is good because it reduces the number of births ( <i>"the number of unwanted pregnancies has recently declined in the community"</i> ). It allows users to avoid pregnancies, prevent diseases (with condoms), space out births, reduce the number of children raised by parents and grandparents and reduce the number of children forced to live on the street.

<p>Palestine - Gaza Strip</p>	<p>In Gazan society, "limiting" births is viewed as contrary to Allah's will. <i>"In our religion, it's forbidden to say that you only want two children, for example. Mothers should continue to give birth to their children normally and should only stop if it affects their health."</i></p> <p>Woman</p> <p>During informal discussions, however, some women say they only want a certain number of children:</p> <p><i>"I'm 27 and have two children and two's enough! (laughs) Because I work and so I can give them a good education!"</i></p> <p>Social worker</p> <p>Contraception is tolerated, however, for spacing out births.</p> <p><i>"I myself use it because I wanted to space out my pregnancies. I used contraception until my daughter was two and then I got pregnant again six months later. That's the main reason why women use contraception - to space out their pregnancies. They don't want to get pregnant 40 days after giving birth. That's all."</i></p> <p>Doctor, Gaza City</p> <p>When contraception is viewed as a way to space out pregnancies rather than to limit births, it is perceived as beneficial and necessary:</p> <p><i>"We're all for contraception!"</i></p> <p>Doctor</p> <p><i>"Contraception and family planning in general are a good thing."</i></p> <p>Woman</p> <p>Contraception is sometimes perceived as having a certain number of risks for the woman's health:</p> <p><i>"The use of the pill can cause serious problems for the mother's health after a while."</i></p> <p>Woman</p>
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Source: Country study reports, Lasdel/Médecins du Monde, 2015

### 3.5. USE OF CONTRACEPTIVES

Even though respondents in the four contexts have basic knowledge of the available contraceptive methods, the use of contraceptives remains at a low level. The contraceptive prevalence rates are relatively high in the Gaza Strip and Peru, all age groups combined: 48.5% in the Gaza Strip and from 69% to 73% in Peru, according to the available statistics. This shows a proper level of social acceptance as well as health services that meet users' contraceptive needs.

The rates in Burkina Faso and the DRC are very low due to the various factors revealed by the study: a lack of information on contraceptive methods, a low level of social acceptance of contraception, difficulty of access and other factors.

**TABLE 5: COMPARISON OF CONTRACEPTIVE USE IN THE FOUR COUNTRIES**

Country	The use of contraceptives
Burkina - Ouagadougou	Many girls and married women do not use these methods.
Burkina - Djibo	Young people are more likely to use male condoms due to the perception that they <i>"protect you from sexually transmitted diseases and unwanted pregnancies"</i> . Most users are familiar with contraceptive methods, but few use them. As a result, the rate of use is very low.
Peru	Male condoms are often promoted for their dual preventive role as a contraceptive and protection against STDs and HIV. Women use birth control pills and monthly injections. <i>"Everyone uses contraceptive methods, both married and single people."</i> The pill, the Jadelle implant and Depo-Provera are widely used by women and girls. Hormonal methods include birth control pills, monthly or quarterly injections, and implants (Norplant, Implanon). We also heard about the IUD, better known as the copper-T [T de cobre]. <i>"I used the copper-T as well as birth control pills and ampoules. I used all three."</i>
DR Congo	<i>"Everyone uses contraceptives, both married and unmarried women - as long as you already have two children."</i> In the DRC, the use of contraception remains generally low and certain categories of the population have difficulty gaining access. Only women who already have "enough" children are allowed to use contraception. Methods like the Jadelle implant are considered to be effective and have no undesirable side effects of any significance. The best-known modern methods are male condoms, injectables and birth control pills. <i>"Young people and even older adults use male condoms."</i> Use of contraceptive methods: According to the Ministry of Health (2013-2014), the overall percentage of contraceptive use by women throughout the DRC is 19%, divided between modern methods (8%) and traditional methods (11%). The rate is 11.5% in the 15-19 age group (lowest rate of use), modern and traditional methods combined and 22% in the 20-24 age group. In Kinshasa more specifically, according to PMA 2020 (2014 data), 35.6% of women aged 15-49 use a contraceptive method, with 21.6% choosing a modern method and 14% a traditional one. But 45% of unmarried, sexually active women in the 15-24 age group use a contraceptive method.

Palestine -  
Gaza strip

The contraceptive prevalence rate is relatively high at 48.4%.

*"This entire generation takes or uses contraception. [...] I myself use contraception. Many people use a contraceptive method in Gaza."*

Doctor

Women use the IUD, birth control pills (progesterone, microgynon) and Depo-Provera injections.

*"The IUD is the best method because it has no side effects."*

Woman

Women sometimes choose contraceptive methods based on their level of comfort with them.

*"I use condoms because it doesn't affect my hormones compared to pills, which affect my weight and hormonal balance."*

*"I wanted to use the IUD but the doctors discovered I was anaemic so now I use condoms."*

*"I use the pill because it's more convenient and reliable and there's no risk of becoming sterile."*

Women

Men often use condoms (male) but are also partial to so-called "natural" contraception, i.e. withdrawal.

*"Natural contraception is the best method."*

Man.

Source: Country study reports, Lasdel/Médecins du Monde, 2015



## CROSS-CUTTING AND SPECIFIC DETERMINANTS OF UNWANTED PREGNANCIES

An unwanted or unintended pregnancy is a pregnancy that happens to a woman who does not want children or does not want them at the time the pregnancy occurs. The number of unwanted pregnancies (UWP) was estimated at 86 million out of 208 million total pregnancies in 2008. Around half of UWPs lead to abortions, of which 21 million are unsafe, i.e. carried out under inadequate health and safety conditions (Sedgh et al, 2012).

### 4.1. SITUATION OF UNWANTED PREGNANCIES IN SURVEYED COUNTRIES

In the four surveyed countries, UWPs are considered a major issue. Generally associated with adolescents, UWPs also occur among single and married adult women.

*"People vulnerable to unwanted pregnancies? Before, we used to talk about young people but now you'd have to say it's everywhere! [laughs] Even in families! It's too much; anyway, at first I also thought it was just the young but now you see it everywhere."*

Care provider – Ouagadougou, Burkina Faso

Each country, however, has its own specific characteristics. In Peru, the most vulnerable groups are adolescents and adult married women whose income and decision-making ability are curtailed by machismo and domestic violence. In Burkina Faso, even though married women are also affected, the most vulnerable group is adolescents between the ages of 14 and 18 who tend to be either students, bar servers or small business employees (cleaning, retail, etc.). In the DRC and Gaza Strip, women of all ages, social classes and civil statuses are concerned, even though adolescents seem to be more vulnerable in the DRC.

### 4.2. VARIOUS DETERMINANTS OF UWPS

*"The most vulnerable are adolescents because they generally aren't careful about protecting themselves by using a contraceptive, due to lack of knowledge. Another reason is that they generally get pregnant when they're drunk or high on drugs. These are girls with very disorganised lives; they're quote unquote disorganized – because sometimes they have a lot of problems at home. But there are older women who have quote unquote stable marriages, but they also get pregnant by accident, sometimes because the method failed or their husband forced them or he tells them it's their fault because they didn't take the necessary precautions so they got pregnant. Sometimes they don't want a child for economic reasons or because of conflicts with their spouse. Even in a stable marriage, there are unwanted pregnancies, especially due to economic reasons and conflicts with the spouse."*

Social worker – Peru

Several factors help explain UWP situations. These factors may vary depending on whether the person is a girl/young woman or an older woman and whether she is single or married. Among married women, for example, UWP cases are generally the result of pregnancies at short intervals due to a contraceptive failure, the impact of social norms (which promote high fertility in marriage) or a pregnancy resulting from an adulterous affair. There are a variety of reasons for UWPs among girls as we are going to see; they reflect a set of vulnerabilities facing girls and young women (Ouédraogo and Sunby, 2014).

In Peru, the DRC and Burkina Faso, peers (other adolescents and young people) apply various forms of social pressure to encourage early sexual experiences. The fact that sexuality is a taboo subject in both families and society as a whole strengthens the influence adolescents and young people have on each other (sharing of information and experiences). Also worth noting are the specific beliefs and representations surrounding sexuality held by young people, such as the value of the first sexual experience and the value of sexual relations at gold panning sites. These various factors promote unwanted pregnancies among the young.

In the Gaza Strip, the sociopolitical context, which is marked by armed conflict, further exposes women to sexual violence or casual sexual relations:

*"During the war, some men took advantage of the situation and had affairs with women. Being in a small, narrow shelter with other people created a sense of intimacy and led to these affairs."*

Female lawyer, Gaza City.

Sexual violence is a problem in almost all surveyed areas, but particularly in the DRC and Peru, where it occurs frequently, including within married couples. **In situations of violence toward women, including within the family, condemnation of rape and the use of emergency contraception to prevent an unwanted pregnancy both remain difficult issues.**

Another important factor that is common to all four countries is family and population poverty, which leads to situations of vulnerability that take various forms:

- In Peru: situations of family anomie in which the prolonged absence of parents from the home make it hard for them to pass on certain values to their children, leading to an increase in their vulnerability and exposure to the risk of a UWP.

- In the DRC: girls often practice transactional sex to meet their basic daily needs.

*"The parents' poverty or the lack of resources to meet their children's needs. Especially girls. When the girl is unsatisfied, she tries to get something on the street from a guy and he won't just let her go; he'll try to sleep with her. If they have unprotected sex, she'll get pregnant. The influence of friends and her social circle. For example, if the girl sees her friends dressing better than her, she'll try to find a boyfriend so she can get money to buy clothes."*

Women, discussion group

- In Burkina Faso, sexual relations are monetised in urban areas and gold panning sites to compensate for parents' difficulty in meeting their family's basic needs or to pay for school fees in cities.

- In the Gaza Strip, certain types of economic and social dominance give rise to sexual abuse and even incestuous relations, as explained by this respondent:

*"We used to think that poverty was one of the reasons women would have affairs – at work, for example. In exchange for sexual relations with the employer, she would receive financial support or keep her job. But there are also cases where the child's father is the*

*woman's brother or father. We don't hide these cases because it's a public issue that should be exposed and a solution should be found. There are also cases of men helping their brother's children when the brother dies; they provide financial support in exchange for sexual relations with the girls. They can do that because they have power over them."*

Female lawyer, Gaza City

These various factors combine with the non-use or poor use of contraceptive methods. These problems with using contraceptive methods are one of the main determinants of UWPs [Guttmacher Institute, 2011; Bankolé et al, 2013; Guillaume, 2005; Bajos et al, 2013; Zuehlke, 2010]. In Peru and the Gaza Strip, the use of contraceptive methods has a normative aspect, i.e. not using them means "not taking care of yourself" or "being uneducated":

*"The people most vulnerable to UWPs and abortions are those who are unfamiliar with family planning methods and don't use family planning. Or they use them but incorrectly."*

Doctor, Gaza City

A number of factors play a role in the non-use or poor use of contraceptive methods, such as the negative representations surrounding them, as we saw above, as well as cultural factors and financial and geographical barriers to access.

**But the major issue is men's refusal to use condoms or let women use contraceptive methods – a refusal that women cannot always overcome due to their weak decision-making and negotiating power.**

In Burkina Faso and the DRC, even when some women use contraceptive methods without the knowledge of their partner, this raises the issue of treatment compliance, which exposes them to the risk of a UWP.

#### **4.3. CROSS-CUTTING AND SPECIFIC CONDITIONS OF UWP MANAGEMENT**

In general, both individuals and the community react very negatively to UWPs. Girls who find themselves in this situation experience a certain degree of vulnerability within the family and community. This vulnerability increases when the partner refuses to acknowledge paternity or the girl does not know who the father is. In

Peru and the DRC, the situation is always viewed negatively at first before being accepted with resignation.

### 4.3.1. FAMILY AND COMMUNITY MANAGEMENT

The occurrence of a UWP immediately casts a shadow over the relationship between the girl and her family. In general, girls with a UWP face a high risk of being rejected or thrown out by their family and social circle. Rejection should be understood as a means of punishing the girl for the deviant behaviour represented by the premarital pregnancy. The community generally disapproves of premarital sex, with its potential for pregnancy (Ouattara et al, 2009; Ouattara and Storeng, 2008; Rossier et al, 2013; Rossier, 2007). Because of the dishonour felt by the family, girls in this situation are often rejected or even banished from their community.

*"I was doing fine living with my aunt. My parents are dead. When I got pregnant, I went to live with my in-laws because my aunt threw me out of her house. My aunt wasn't happy because she had a baby and wanted me to help her with housework. When I got pregnant without realising or wanting it, she threw me out."*

Girl, DRC

After the girl is initially rejected due to a UWP and following negotiations, she can sometimes return to her family after giving birth, depending on the situation. In some cases, she may be taken in by the father's family if he acknowledges paternity.

*"Family members think you brought shame on them, that you should've gotten married first. They'll throw you out so you won't stay with them while you're pregnant. But there are some people who will let you come back to the family after you have the baby. For example, my father didn't want me to stay home when I was pregnant. All he did was insult me. But after I came here to give birth, he started telling me I can go back home if I want. Some people don't want the girl to stay with her family while she's pregnant because they think it's shameful."*  
Pregnant girls focus group discussion, Ouagadougou, Burkina Faso

Girls dependent on their family may suffer from psychological harassment. Those who receive no family

support are forced to postpone or abandon their studies or find a job in order to devote themselves to their pregnancy and child. In Peru, some girls who are thrown out or renounced by their family, just like migrants who have no relatives in the city, are forced to live with their partner's family. Students are no longer expelled from school (laws have been changed to prohibit expulsions), but various forms of stigmatisation against pregnant girls still take place.

Some girls are fortunate to receive support from their family members once they get over the initial shock of learning about the pregnancy.

In the DRC, NGOs support girls who decide to keep their babies before they give birth, but do not provide support to those with a UWP. These girls are often rejected at first by their parents and seek refuge from another member of their family (usually an aunt or sister), or possibly the child's father if he acknowledges paternity, until they give birth. After childbirth, the girl may return to her family, depending on the circumstances, but her education often suffers.

In the Gaza Strip, married women with children and a UWP face a social norm that requires carrying a pregnancy to term. Women are caught between the demands of society and their own personal aspirations, which do not necessarily match. They must choose between carrying the pregnancy to term (with the encouragement of their family) or brave social and moral disapproval by having an abortion.

*"I had two boys and a girl when I discovered I was pregnant. My first thought was how to get rid of the baby by trying all the methods I could use. And I had a lot of arguments with my husband about it."*

Woman, Gaza Strip

*"When I discovered I was pregnant, I started to think about an abortion method because my previous child was very young, only a few months old, and I couldn't get pregnant at that time."*

Woman, Gaza Strip

Among young people, the girl – and sometimes her mother – are mainly responsible for managing the UWP. When the partner does not acknowledge or accept the pregnancy, the young girl/woman has no other choice but to manage it herself. Boys rarely face disapproval in UWP situations. In Peru, it is reported

that some boys voluntarily leave school to work so they can help support their child.

In Burkina Faso, men demonstrate three different attitudes when facing a UWP: 1) denial of paternity due to the girl/woman's supposed infidelity or because they believe they used a condom, for example. As a result, they refuse to play any financial or material role in managing the pregnancy; 2) acknowledgement of paternity, but a refusal to help pay related expenses; and 3) acknowledgement of paternity, but a refusal to let the girl bring the pregnancy to term. In this case, the man forces the girl/woman to get an abortion and provides the necessary funds. These are more or less the same attitudes found in the DRC. We only found a few cases in which the boys/men – and their family – acknowledged and accepted the pregnancy and supported the girl/woman until childbirth and then took care of her and the child.

#### 4.3.2. HEALTH AND SOCIAL SERVICES FOR UNWANTED PREGNANCIES

Peru has a protocol for the free and complete management of both unwanted and planned pregnancies as part of the national Ministry of Health strategy for reducing maternal mortality. UWP cases are not treated any differently from planned pregnancies, but special attention may be paid for reasons of age and physiological risks. Various health professionals participate in this system, including psychologists and social workers who work with girls having trouble accepting their pregnancy.

In the DRC, Burkina Faso and the Gaza Strip, there are no specific health programmes for managing unwanted pregnancies. The health services mainly manage them by providing advice to girls, encouraging them to accept their pregnancy and not resort to abortion, then directing them to a health centre for prenatal care. In the DRC, the Ministry of Health has set up the PNSA (National Adolescent Health Programme) to discourage early pregnancy and improve the care provided to pregnant adolescents and young women in health centres. There are also training programmes for health workers that stress the importance of communicating and building a relationship with adolescents.

In the four surveyed countries, women with a UWP are encouraged to carry their pregnancy to term

regardless of whether they are single girls or married women. Health workers say they receive requests for abortions from women with unwanted pregnancies; officially, these abortion requests are turned down based on certain principles, including ethics, the law and especially morality and religion.

*"For me, as a Muslim, I don't recommend abortion. Forget it! Even at the hospital – never! If a woman comes in and the condom broke, or there's some other mistake or the contraceptive wasn't used correctly, I give her a morning-after pill if it's within five days. I help her. But if she's pregnant, it's her fault!"*

Doctor, Gaza

Unofficially, however, abortion does take place, performed both by health workers and other providers, sometimes with the complicity of mothers, who help their daughter get an abortion by giving them advice and recommending techniques.

# ILLEGAL ABORTIONS: CROSS-CUTTING AND SPECIFIC PERCEPTIONS AND PRACTICES

## 5.1. DEFINITIONS, LEGAL FRAMEWORK AND CONTEXT

"Illegal abortion" refers to cases in which the national criminal code provides for penalties against women who have had an abortion or those who performed the abortion. Illegal abortions can be safe when performed by qualified medical professionals under proper hygienic conditions or using a drug-induced method, and by following the recommended dosages and timeframes. Abortions are less safe, however, in areas with restrictive laws. Criminalisation acts as a barrier to access for this type of care, while the need for abortion is not declining as a result of the restrictions (WHO, 2015). Lacking a legal alternative, women will seek illegal abortions that carry risks, i.e. using unsafe techniques by unskilled providers often at an advanced stage of pregnancy, which increases the risks of complications, such as infection, haemorrhaging or an incomplete abortion (Lesieur, 2013).

As part of the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995, the international community characterised unsafe abortion as a major public health risk. National governments were called on to reform punitive laws toward women who must resort to clandestine abortions and ensure them access to high-quality services for treating complications resulting from these abortions.

In the four countries chosen for this study, abortion is prohibited and punished by law. While these countries authorise therapeutic abortions, they are either governed by strict criteria or by vague wording subject to the interpretation of several doctors and religious dignitaries, making the law more difficult to apply.

As a result, in the surveyed countries, the restrictive legal frameworks concerning abortion limit women's decision-making power as well as their social and health opportunities, and have major health consequences that can sometimes turn deadly.

**TABLE 6: LEGAL FRAMEWORK GOVERNING ABORTION IN THE FOUR SURVEYED COUNTRIES**

Country	Definition
<b>Burkina Faso</b> 1996 Criminal code	<p><b>Art. 383 :</b> Any person who causes or attempts to cause an abortion on a pregnant or putatively pregnant woman, regardless of her consent, by means of food, beverages, medicines, manipulations, violence or any other means whatsoever, shall be punished by imprisonment of one to five years and a fine of CFAF 300,000 to 1,500,000.</p> <p><b>Art 384 :</b> A voluntary termination of pregnancy may be practiced at any time if two physicians, one of whom practices in a public health facility, attest after examination that continuation of the pregnancy threatens the woman's health or a strong probability exists that the unborn child is suffering from a particularly serious [disorder] recognized as incurable at the moment of diagnosis. In the case of established rape or incest, the public prosecutor establishes evidence of emotional distress and the pregnant woman may request a termination of pregnancy from a physician within the first ten weeks.</p>
<b>R.D. Congo</b> 2004 Criminal code	<p><b>Art. 165.</b> Any person who causes an abortion on a woman, by means of food, beverages, medicines, violence or any other means whatsoever, shall be punished by imprisonment of five to fifteen years.</p> <p><b>Art. 166.</b> Any woman who voluntarily has an abortion shall be punished by imprisonment of five to ten years.</p> <p><b>Art. 32.</b> Code of medical ethics: The practice of abortion is legally prohibited. In terms</p>

	<p>of therapeutic abortion, and taking into consideration ideological reservations, therapeutic abortion is authorised only when it is the sole means of saving the life of a mother who is in serious danger.</p>
<p><b>Peru</b> 1991 Criminal code</p>	<p><b>Art 114. Self-induced abortion:</b> A woman who causes her own abortion or consents to its performance by another person is subject to not more than two years' imprisonment or to the provision of community service for 52 to 104 days.</p> <p><b>Art. 115. Abortion with consent:</b> A person who causes the abortion of a pregnant woman with her consent is subject to one to four years' imprisonment. If the woman dies and the person could have prevented this outcome, the sentence shall not be less than two years nor exceed five years. [Art. 116. This sentence shall be doubled if the woman does not consent to the abortion and dies from the procedure.]</p> <p><b>Art. 117. Increased punishment due to the practitioner's position:</b> Any physician, midwife, pharmacist or other medical professional who abuses his or her science or skill to cause an abortion is subject to the punishment provided for in articles 115 and 116 and the loss of the right to practice his or her profession.</p> <p><b>Art. 119. Therapeutic abortion:</b> An abortion performed by a physician with the consent of the pregnant woman or her legal representative, if necessary, is not punishable when it is the only means of saving her life or preventing serious and permanent injury to her health. [The medical criteria are regulated by the National Technical Guide, which standardises the comprehensive procedure for providing pregnant women with therapeutic abortions before 22 weeks with informed consent; the guide was published in 2014]</p> <p><b>Article 30- General Health Law:</b> A physician who treats a person injured by a knife, injured by a bullet, [...] or by any other type of violence that constitutes a criminal offence punishable under law or <b>when there is evidence of a criminal abortion</b>, is required to report this information to the competent authority.</p>
<p><b>Palestine - Gaza strip<sup>7</sup></b></p>	<p><b>Abortion is illegal</b> according to the many legal codes followed locally (Jordanian and Egyptian criminal codes, Sharia law, Palestinian Basic Law, Islamic Law and others)</p> <p><b>Therapeutic abortion</b> is permitted before the 40th or 120th day of pregnancy when the woman's life is in danger but the law remains subject to the interpretation and agreement of the mufti (religious dignitary) and the opinion of two doctors.</p>

It should be stressed that in Peru and the DRC, prison sentences are lighter for women who consent to their abortion than for abortion practitioners. In Peru, the law calls for a specific punishment of care providers, who risk both imprisonment and the loss of their right to practice their profession. The law also requires doctors to report women who have received an abortion and sought post-abortion care. Since 2014, a medical guide developed by Peru's Ministry of Health has provided guidance to care providers on the pathological criteria relating to therapeutic abortion and treatment protocols.

While the populations are aware that abortion is prohibited by law, they are not always familiar with the

penalties, which reduces their dissuasive effect. The fear of negative social sanctions, especially those that are religious in nature, often appears to carry greater weight than the fear of legal punishment. Respondents do, however, emphasise the legal possibility of therapeutic abortion even though they do not always mention or know the specific conditions required.

*"Abortion isn't good. It's a sin before God. And even the State condemns the act. If they catch you, you'll go to jail. Even if the pregnancy is only two days old, a life has already begun and you have to protect it jealously. It's not good. They have to stop doing that. But there are also exceptions when a woman gets an abortion to save her life. That's not*

7 - Source: Data from the survey conducted for MdM in the Gaza Strip and The Greens 'Les droits des femmes' (Women's rights), Background notes per country at the initiative of M. Kiil-Nielsen and M. Cornelissen, FEMM Green Eurodeputies in the European Parliament, <http://www.greens-efa.eu>

[eu/fileadmin/dam/Documents/Background\\_notes/110308\\_Final\\_Fr.pdf](http://fileadmin/dam/Documents/Background_notes/110308_Final_Fr.pdf) [consulted on December 2015].



*a problem. But for me, no abortion is good. It's a sin.*  
Interview at an adult men's group – Kinshasa, DRC

According to our surveys, abortions are rarely reported. Those involved – the women and practitioners, whether health professionals or others – are judged in court and imprisoned.

*"It's hard to fight these practices because the law's not doing its job. There are people practicing abortion but they've never been convicted, and there are even some who are getting rich from it. ... The practice just keeps spreading."*

Counsellor – Djibo, Burkina Faso

*"Nothing will happen to her! We just document her case so her family will know that she tried to abort the baby without being married. As doctors, we have to do that. The family has to know! In addition, she rarely comes alone; her mother or her sister often comes with her. And then we have an emergency committee in the hospitals for cases of rape, illegal abortions, those types of things. This group needs to know that there are cases of incomplete induced abortion among unmarried women. There are always single women that end up pregnant!"*

Doctor – Gaza Strip

The fear of being reported, however, remains a significant factor that explains the delay in seeking post-abortion care or reporting a miscarriage.

*"I only know that the law bans abortion, but I don't know which article of the law does. Illegal abortions are performed in this community because we often hear about deaths following an abortion. It's common and we also see girls and women who come for treatment late or several days after an abortion."*

Gynaecologist – Kinshasa, DRC

*"[When I was] almost two months [pregnant, my friend] took me to a doctor [...]. And he told me he could do a D&C. He did it one day. I had very bad complications afterward, very strong pain, my stomach really hurt, I bled for a week, two weeks. It didn't stop – like a period, but it didn't stop. I went to see this doctor regularly **because I was afraid to go anywhere else** and the most complicated thing was finding the money to pay for it. But let's just say that between my friend and me..., I sold my clothes to school friends, to whoever I could, until I had enough money..."*

Woman, 22, who had an abortion at the age of 15,  
Villa El Salvador, Peru

The number of clandestine abortions is difficult to estimate due to their illegality. It is possible, however, to estimate the number of women in each country who have had an abortion based on post-abortion medical records.

## 5.2. UNSAFE ABORTIONS: SOCIAL AND PRACTICAL CONTEXT

While women of any age may want to have an abortion in response to an unwanted pregnancy, it should be noted that certain women are more vulnerable than others. Because UWPs and abortions are strongly stigmatised both socially and morally, women rarely talk about the subject and only among themselves. They are generally aware of the risks associated with clandestine abortions and often seek information by word of mouth about safe methods and/or providers. However, due to the fact that abortion is illegal and strongly stigmatised, especially among women with poor financial, educational and interpersonal resources, some have no other choice than to resort to dangerous methods either alone or from poorly trained or untrained providers. Unsafe abortions are both an effect and revealing cause of women's inequality and social vulnerability.

### 5.2.1. GIRLS AND YOUNG WOMEN: THE FEAR OF SOCIAL STIGMA

In all four contexts, girls and young women stand out as the most vulnerable to the risks of illegal abortion due to their young age, lack of financial resources and especially their single status and the social and religious condemnation of sexual relations before marriage, which acts as a major obstacle to contraceptive access [Delaunay, Guillaume, 2007].

Shame was regularly mentioned as was stigmatisation by the community. Women with UWPs are frequently thrown out of the family home in Burkina Faso, as they are in Peru and the DRC. The inadequate support provided to girls with a UWP who are banished from the community, or who fear banishment, appears to explain the resort to abortion. In some cases, however rare, the family might encourage the abortion when the parents consider a pregnancy shameful in the light

of religious and social norms. If the pregnancy is the result of rape, the woman may also be stigmatised in environments where victims are often blamed for the rape. The fear that a partner, whether young or older, will fail to take responsibility and the fear of finding themselves alone without any means of support also come up during the women’s narratives.

The fathers’ families who take in pregnant girls or young mothers thrown out by their own families constantly remind them of their mistake in having sex and children before entering into a union recognised by the community. The girls and young women are harassed, reprimanded and criticised for their deviant behaviour at every opportunity. These criticisms take a major psychological toll on self-esteem, limiting women’s capacity for autonomy and decision-making.

It should be stressed that in Peru and the DRC, we noted that girls are more open to the idea of abortion and are less likely to mention morality and religion. They put their comments in context, justifying their choice of abortion by talking about the need to continue studying or working to further their life goals. In Burkina Faso, on the other hand, girls in Ouagadougou have a more negative view of abortion, tending to focus on the religious prohibition.

The literature indicates that abortions take place during the two extremes of women’s childbearing years (Cosío-Zavala, 2007), with single girls and older married women seeking abortions for various reasons:

- A desire to space out births (exhaustion from repeat pregnancies, particularly in the Gaza Strip, where the average number of children per woman is 5.1);
- A desire to limit the number of births (unmet need for contraceptives);

- Poverty and limited resources;
- Poor marital relations, domestic violence, marital rape.

Certain older women, however, express regret and a feeling of guilt for having had an abortion, with a strong focus on morality and religion. Older women who have not had an abortion express the same disapproval of the procedure.

**It should be recalled that the vulnerability of girls and women results from a context of asymmetrical gender relations in which men’s decision-making power takes precedence.** (Cosío-Zavala, 2007). We can assume that in these environments, certain women living in situations of great insecurity due to a rape or violent spouse may turn to abortion as a way to regain control over their body and life by preventing a child from forever linking them with violent men and traumatic experiences.

### 5.2.2. ILLEGAL ABORTIONS: METHODS AND PROVIDERS

We found five types of abortion methods used by women: i) food products, ii) chemical products, iii) traditional medicines, iv) medical methods and the use of modern medicines (indicated for abortions with side effects on the uterus or the development of the foetus or determined to be abortifacients), and v) physical methods. Some of these methods are known to be dangerous and can be physically harmful or cause severe poisoning. Medical methods that are incorrectly performed can also be deleterious to a woman’s health, particularly improper manipulations, overdoses/insufficient doses and drug interactions.

**TABLE 7: ABORTION METHODS MENTIONED BY THE POPULATIONS IN THE SURVEYED COUNTRIES**

Type of method	Burkina Faso	DR Congo	Peru	Gaza Strip
<b>Food products</b>	Instant coffee mixed with an antibiotic; alcohol; sugar mixed with paracetamol; Coca-Cola mixtures			Brew of cinammon and ginger. High consumption of certain foods, like dates and salt.

<b>Chemical / caustic products</b>	Ingestion of blue dye. Insertion of bleach or laundry detergent into the uterus.		Insertion of soapy solutions or laundry detergent into the uterus (rare).	Breathing of chemical substances
<b>Traditional medicines</b>	Ingestion of brews, "angiran" and Vernonia amigdalina (Bitter leaf)	Papaya leaf poultices inserted into the vagina. Ingestion of boiled roots.	Ingestion of herbal tea. Cleansing of vagina with plants (rare).	Ingestion of herbal tea.
<b>Medical or drug methods</b>	Misoprostol (urban areas); other drugs (paracetamol, antibiotics)	Injections, misoprostol (purchased in a pharmacy), vermoz, quinine, decaris, D&C	Misoprostol (purchased in a pharmacy), injections, D&C, MVA (manual vacuum aspiration)	Misoprostol <sup>8</sup> purchased in a pharmacy, D&C
<b>Physical methods</b>	Insertion of sharp objects (e.g. spoke). Ingestion or insertion of pieces of glass.		Insertion of sharp objects (rare); deliberate falling	Jumping, running, carrying heavy objects, blows to the abdomen and stomach

Certain methods are used by women either alone or surrounded by friends or the female members of their family. In these cases, food, chemical and physical methods are most likely to be used. Women also self-medicate with drugs purchased in pharmacies or on the street.

When women have access to traditional healers or midwives, traditional medicines seem to take priority. In Burkina Faso, however, traditional healers also use sharp objects, with harmful effects on the woman's body and health.

Women may also seek help from care providers, most of whom have no specific training or knowledge with regard to performing abortions. That is the case in the DRC, the Gaza Strip and Peru, where health professionals (doctors, midwives, nurses and medical students) offer abortion services for a fee in public health facilities (DRC) and private offices (DRC, Gaza Strip and Peru). In these situations, the facilities may not be adequate, either due to the lack of the necessary hygienic conditions or inadequate technical equipment.

Drugs are often used for abortions, sometimes alone or in combination with a D&C. Medications include misoprostol (also known by its brand name Citotec, which can also be used for self-induced abortions) and injections of substances that dilate the uterus. Our data indicate, however, that antibiotics are not always given in conjunction with surgical procedures to prevent or treat infections nor as part of treating incomplete abortions, especially when the patient has no access to trained care providers. Women must pay for all of these procedures and drugs, which are often very expensive and thus prohibitive for low-income women. The high cost can force women with fewer resources to seek cheaper methods that are often less effective or safe, or only use part of a method, i.e. take low doses of misoprostol, which poses a major risk.

It is worth noting that in Peru and the Gaza Strip, trained doctors and midwives can perform abortions (by D&C or MVA) under proper hygienic conditions. It is also noteworthy that these procedures are out of reach for most women due to their high cost.

8 - During focus groups, Gazan women mentioned 'abortion pills' purchased in pharmacies; doctors said they were referring to Misoprostol.

*"If you have money or if you know people in the hospital who are doctors or health workers, you can get an abortion much more easily in the hospital. There also wasta for abortion!"<sup>9</sup>*

Social workers, Gaza City

### 5.3. ABORTION PRACTICES AND REPRESENTATIONS

In general, abortion practices and representations vary depending on the stakeholder and within the same category of stakeholder: care providers, men (fathers, husband, partners), and community and religious representatives. Each type of stakeholder is caught in a web of specific norms and representations, reproduced or reinforced depending on the circumstances or deviating from them. These norms and representations shape the context in which women operate and take their decisions.

#### 5.3.1. CARE PROVIDERS AND ABORTION

We found three attitudes among care providers in the four countries:

##### Help with getting an abortion

Some care providers directly help women get illegal abortions. While in some cases this involves referring them, often in a neutral manner, to qualified professionals in order to limit unsafe practices (Peru), others provide this service for a fee to supplement their low income (DR Congo). The latter are not always trained in the procedures they practice, as we have already shown.

##### Simple and free support

Another attitude consists in supporting women who express a desire for an abortion without referring them to abortion providers or offering their own services for a fee. This involves helping women weigh the obstacles and options surrounding an unwanted pregnancy.

##### Dissuasion

Lastly, many care providers actively try to dissuade women from having an abortion. Their reasons vary and may include moral and religious arguments; doctors' role in preserving the natural order, in which abortion is a reprehensible practice; the fear of legal penalties; and the risks to women's health of illegal abortions performed by unqualified providers.

##### Rarely do health professionals mention women's right to take decisions about their own body.

The few professionals who support women's desire for an abortion mainly argue from a public health perspective, convinced that without their help women will resort to unsafe practitioners and/or methods.

*"You know what, if you've decided, you're the one who knows; [we] pretend that I don't know anything, that I've never given out a doctor's name, nothing. "Okay, ma'am", because if not, it's worse if you want to know; the worse thing is if they go to a clandestine place where they're really going to risk their life. Because if I tell them "no", if I close the door on them, that means they'll go looking themselves, they'll go knocking on doors anywhere and they might put their lives in danger."*

Social worker – Villa El Salvador, Peru

Care providers who condemn abortion tend to focus on the religious prohibition and, to a lesser extent, on the legal ban.

*"Abortion is a sin according to the Bible. But I also know that the government doesn't allow this act. I don't know what makes them commit this act. I myself feel they're murderers and that they'll be judged by God on judgement day."*

Nurse – Kinshasa, DRC

We found that care providers are not always familiar with the protocols and medical methods used for safe abortions. Due to their position, they are more familiar with cases of illegal abortions performed with less effective methods under poor hygienic conditions that have serious effects on women's health (called "butchers" in Burkina Faso) and that receive post-abortion care.

#### 5.3.2. MEN'S ATTITUDES AND PARTICIPATION

We also found that abortion is almost always a woman's issue. They are better informed than men about the various methods as well as the women of their acquaintance who have had an abortion. Some women feel forced to hide their abortion from their partners because they fear their disapproval, which partly explains men's low level of knowledge about this practice. In the Gaza Strip, most of the male respondents reported that they had never known a woman

<sup>9</sup> - The Arabic term wasta refers to a patronage system of connections that a person calls on to get services, a job or information. The term can be translated as 'string-pulling' or 'knowing the right people'.

who had had a UWP or wanted to have an abortion, despite statements by women that they had asked their husbands for help in getting an abortion.

As a result, men have ambivalent attitudes toward abortion. According to certain studies, these attitudes vary based on their level of emotional commitment to the partnership [Guillaume, Lerner, 2009]. Most of the male respondents in the four surveyed countries expressed disapproval, citing religious reasons, the value of having a large family – particularly in the Gaza Strip and Palestine in general, where big families bestow "social prestige" [Memmi, 2014] – and women's responsibility for contraception.

*"If a woman wants an abortion, I try to keep her from having one because, whatever happens, it's not good to lose a baby, especially if the mother's health isn't in danger."*

Man – Gaza Strip

In focus groups with adolescents in Peru and Burkina Faso, some young men cited the psychological and emotional consequences and the risks to women's health to justify their disapproval of abortion. In Burkina Faso, secondary school students specifically mentioned religious punishment and social exclusion.

When facing a UWP, those who do not condemn abortion only provide slight support, which might involve contributing money for the woman to purchase drugs or pay for the abortion. This contribution is often made under threats and restrictions set by the woman, who retains the decision-making power and/or the responsibility for the abortion. As a result, the men remain restricted (by themselves or the woman) to their traditional gender role as a provider of funds, with only slight involvement in reproductive decisions concerning contraception or abortion.

*"It's either the man who acknowledges paternity who pays or his parents if he doesn't have a job or any money. The girl's parents pay in certain cases – if the man denies paternity or the girl refuses to reveal the name of her boyfriend. If it's a married woman, she or her husband pays."*

Interview with a group of men – Kinshasa

We found only a few situations in which the man pressures the woman to have an abortion, especially due to the financial burden of supporting another child.

*"I was happy when I learned I was pregnant, but my husband didn't want the baby. I had a lot of arguments with my husband about it. I tried to get rid of the baby by falling down the stairs but it didn't work. I finally carried the pregnancy to term and had the baby; I was very happy because I really wanted this baby! I only tried to abort the baby to please my husband."*

Woman – Gaza Strip

### 5.3.3. ATTITUDES OF RELIGIOUS LEADERS AND MORAL JUDGEMENTS

Abortion is condemned in the dogma of the monotheistic religions of Catholicism, Protestantism and Islam, the major religions in the surveyed areas. On a personal basis, a few religious leaders expressed support for therapeutic abortion to save the mother's life, but most remain opposed to any form of abortion.

Religious leaders use the terms "prohibition", "sin" and "divine retribution" for anyone involved in the practice of abortion. This disapproval manifests itself in daily life by the woman's exclusion from religious rituals and prayer, which amounts to an exclusion from the religious community.

Religion-based moral arguments are also frequently mentioned by care providers and other members of the community. Abortion is condemned by the entire society and anyone involved is perceived negatively; viewed as morally disgraceful, they are stigmatised as a result. They are also characterised as criminals, murderers, immoral and dishonourable individuals, and people who will always carry within themselves the abortion's aftereffects.

**Girls and young women who refuse to carry a pregnancy to term are thus seen as deviating from social norms, which dictate that motherhood is closely tied to a woman's gender status.** Young single women, especially in the DRC but in Burkina Faso and Peru as well, are thus caught in an ambivalent situation due to the strong moral and religious disapproval toward UWPs, facing all of the above-mentioned social consequences and condemnation of abortion. We have discussed the representations according to which abortion is believed to affect girls' ability to be good wives because the moral and physical effects of their abortion allegedly lead to sterility or disabled children. Certain representations are

based on the empirical fact that some women suffer complications from unsafe abortions.

## 5.4. POST-ABORTION CARE

Depending on the country, if post-abortion care is available, it is not accessible to every woman, either due to the lack of adequate local facilities, the lack of trained health professionals or the fact that a cost is involved. This care consists in using an ultrasound or clinical exam to diagnose whether the abortion is complete, then using an MVA or D&C<sup>10</sup> to clean out the uterus if any tissue remains and managing any complications, particularly by administering antibiotics to prevent or treat infections.

Complications result either from improper practices, such as the use of inappropriate instruments, poor hygienic conditions or the provider's lack of skills, or delays in seeking care for incomplete abortions or other complications due to women's fear of being reported and/or mistreated by care providers. In both cases, the risks are haemorrhaging and infections, which can lead to sepsis and the woman's death or major damage to her reproductive organs. We found deficiencies at the services responsible for post-abortion care; in Burkina Faso, for example, the delay in treatment can sometimes have fatal consequences for the woman. Similarly, while the Ministries of Health have protocols for post-abortion care, they are sometimes poorly disseminated or care providers have little familiarity with them, leading to major gaps in knowledge about methods and procedures.

In addition to these technical deficiencies in post-abortion care, women may also suffer from being stigmatised by health professionals who disapprove of abortion, either for moral and religious reasons or because they criticise them for risking their health. This disapproval might take the form of abuse toward the women, who may be openly reprimanded, insulted or mistreated by care providers, some of whom believe it is their duty to "punish" them. Moreover, despite the medical emergency, some women who have had an abortion might be left without care in the waiting room because they are not seen as needing emergency attention or in order to punish them for having an illegal abortion. This sometimes-voluntary negligence by health professionals, added to the delays in treatment, end up increasing the complications.

**These results highlight the tensions between the community's norms and values on the one hand and standards of care on the other. While these care providers are acting in line with community representations or practical standards, their attitude contradicts medical ethics and official standards.** These standards recommend that health professionals "commit to ensuring high-quality care for treating abortion complications, including in situations in which the law prohibits abortion, thus maintaining the autonomy and physical and moral integrity of the patient and providing appropriate and timely counselling concerning regular and emergency contraceptive methods to prevent repeat abortions and their harmful effects on health" (Ventura, 2001). Care providers also have a responsibility to ensure patients' right to medical confidentiality and unbiased care even though laws in certain countries require them to report women who have had an abortion to the police.

However, a number of health professionals interviewed in the four countries state that regardless of their personal beliefs, their primary role is to care for women and restore their health in line with medical ethics. They refuse to report women who come for post-abortion care after induced abortions, believing they should be working to protect women's health rather than acting as police officers.

<sup>10</sup> - The WHO recommends that D&Cs be replaced by MVAs (WHO, 2012). The D&C method is less safe than the MVA procedure because its risk of complications is three times higher than that of MVAs and it is considerably more painful for women.



## CROSS-CUTTING RECOMMENDATIONS

The four studies demonstrate that in order to reduce unwanted pregnancies and the consequences of unsafe abortions, **it would be advisable for multiple stakeholders to take certain measures in a number of areas**. These stakeholders include MmM and other CSOs (in partnership), the education system, health services, churches, religious denominations, the media, opinion leaders, political decision-makers and members of parliament. We broke down the main cross-cutting recommendations resulting from our studies into three major categories.

### 6.1. IMPROVE THE QUALITY AND ACCESSIBILITY OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES (SRH)

Current and future health professionals (medical and allied healthcare students) should be given priority for receiving specific training and information on SRH, UWPs and abortions so that they can provide them in turn. In the four surveyed countries, it appears necessary to improve the quality and accessibility of SRH services in health facilities, especially those targeting adolescents and young people. The main cross-cutting recommendations resulting from our studies are as follows:

- **Strengthen care and treatment resources and incorporate SRH services as much as possible** into the minimum package of local health services, including post-abortion care;
- **Ensure the ongoing availability of contraceptive methods** throughout the country, including in rural areas, by means of local strategies and, if necessary, progressive strategies for reaching young people wherever they are;
- **Ensure that SRH services and contraceptive methods are available at the lowest cost possible** or even free of charge, including in cases of UWPs and post-abortion complications;
- **Improve the training of health professionals**, including those in the private sector, in the areas of SRH

and post-abortion care. This should include changing their often-negative representations about contraception and abortions as well as raising their awareness about the importance of intake and confidentiality of discussions on these issues, particularly with young people, with the aim of improving the quality of care and services;

- In the event of a spontaneous or illegal abortion, **improve post-abortion care** and promote effective, non-invasive post-abortion care methods. During the training of health professionals, the focus should be placed on medical ethics in the provision of services, and counselling sessions should regularly address post-abortion contraception.
- **Coordinate SRH service providers**, especially any vertical programs targeting SRH, health services responsible for primary health care, social services, municipalities, technical and financial partners, local and international NGOs;
- **Improve knowledge of UWP and abortion issues** to provide a greater understanding of these issues and develop appropriate solutions, including:
  - Working with traditional healers to better understand their knowledge and practices while informing them of the risks and less risky methods, with the aim of developing working relationships (referrals);
  - Include verbal autopsies (audits) of maternal deaths resulting from unsafe abortions in order to improve care and treatment;
  - Improve the quality of quantitative data on SRH, UWPs and abortions as well as qualitative data (for example, to enhance practices and knowledge in relation to socioeconomic, family, environmental, cultural, religious and other constraints or to produce in-depth case studies on methods of interaction between health professionals and populations). Confidentiality must be respected during any process to improve data collection.

## 6.2. DEVELOP IEC STRATEGIES FOR PROVIDING INFORMATION ABOUT SRH AND CONTRACEPTION SERVICES AND CHANGE RELATED PERCEPTIONS AND BEHAVIOURS

Given that the lack of information and biased perceptions about contraception, UWPs and abortion have major consequences, it seems crucial to **strengthen IEC strategies in various complementary areas:**

- A first step should be a review of IEC: who are the players, what are their messages, who is their target audience, what methods do they use, etc. And if possible, compare the results achieved by the various IEC programmes. This review could be supplemented with a socioanthropological analysis (interviews, observation), i.e. a content analysis (does it reinforce certain stereotypes?), observation of interactions, etc.
- **Different types of messages** should be considered:
  - i. Practical information on sex education, contraceptives, UWPs and abortions, especially with the goal of promoting greater awareness of the various contraceptive methods;
  - ii. In addition to simply providing information, it will be necessary to conduct information campaigns focused on independent decision-making;
  - iii. On a broader scale, it is important to generate more discussions about sexuality in society at large in order to break taboos and promote acceptance of individual decision-making and self-determination concerning sexuality and childbearing, particularly as they relate to women.
- Next, it will be necessary to **tailor messages to the target audience**; IEC strategies must be developed not only for young women but for young men and families/relatives as well, with a special focus on vulnerable populations (street children, orphans, young people living at certain locations, such as gold panning sites in Burkina Faso, etc.).
- **Various channels could be chosen to spread the messages**; to that end, it will be helpful to target (with appropriate resources):
  - i. Young people's local environment, in particular: family and community settings (via SCOs and social services, for example); primary and secondary schools; job training facilities and universities (via teachers and peer groups, for example); churches

and places of worship (via their officials); and places where young people work and get together;

- ii. Society more broadly, i.e. the media and others active in mass communications (theatre actors/troupes, well-known personalities popular with the young, etc.) have a key role to play. It is therefore important to raise their awareness, expand their knowledge and improve their communication skills in the area of sex education (in terms of both content and methods).

- In general, it appears that problems related to UWPs and abortions reflect a lack of women's decision-making power over their sexuality, emotional life and fertility, leading to the conclusion that is important to pay special attention to gender and focus on building women's capacity to act in society.

## 6.3. CHANGE PUBLIC POLICIES AND THE BODY OF LAWS

Political decision-makers have a role to play in enabling or facilitating changes in societal perceptions and individual behaviour by:

- **Developing or strengthening national policies** to promote SRH rights and gender equality and to recognise UWPs and abortions as issues of public health and general interest;
- **Relaxing the laws** governing the sale and promotion of contraceptives, including those targeting young people;
- **Filing a petition** to decriminalise abortion in order to reduce the number of unsafe abortions.

## CONCLUSION

Médecins du Monde initiated this study with the goal of improving its operations in line with realities on the ground. The study covered certain areas in Africa (DRC and Burkina Faso), the Middle East (Palestine, specifically the Gaza Strip) and Latin America (Peru).

The country studies investigated the "universal" elements and "rules" in society's stance toward sexual and reproductive rights. The idea was to find approaches and practices common to all surveyed countries as well as those specific to certain countries. These sociocultural determinants are analysed in relation to the sexual and reproductive health services provided by government health facilities or private providers. We moved from an interventionist outline of the issue to a basic approach that is based not on objectives seeking to change practices but rather on simple research questions exploring possible solutions. Our aim was to understand the way society develops sexual and reproductive norms in the studies' sociocultural contexts.

We spent time with health system professionals and their patients as well as individuals who support and have personally experienced the relevant traditions, with the aim of collecting statements and analysing approaches relating to sexual and reproductive rights. The survey results revealed some very important lessons.

In the four contexts, sociocultural norms that restrict individual sexual and reproductive rights coexist with the gradual introduction of contraceptives by NGOs and public health services as well as the emergence of social dynamics that are trending toward self-control over the body and sexuality.

Despite the difficulties involved in the availability and reliability of statistics, the study found a higher incidence of abortions and unwanted pregnancies in Africa (Burkina Faso and DRC) than in the Middle East (Gaza Strip in Palestine) and Latin America (Peru). This situation may be explained, at least in part, by assuming that religion plays a larger role in the Gaza Strip (Islam) and Peru (Catholicism) than in Burkina Faso and the DRC. The Gaza Strip and Peru are more culturally homogeneous than Burkina Faso and the DRC, which have more heterogeneous societies and greater religious diversity with more-tolerant beliefs.

In both cases, family relations (parents, in-laws, spouses) influence sexual practices and set the direction for pregnancies despite social protection. Networks of friends or acquaintances encourage behaviours that predispose both young single and married women to sexuality and unsafe abortions.

The study found gender inequalities bound up with this two-fold risk – a vulnerability tied to age and young women's socioprofessional and economic status as well as abuse of women, who do not always have the right to control their own bodies.

After completing these studies, we believe it is necessary to continue conducting research on certain issues we were unable to explore further, with the goal of improving both knowledge and development operations:

- the commodification of young people's bodies (in this case, girls' bodies): types and consequences. Some girls, as we learned in the DRC and Burkina Faso, are living in social conditions that lead to the commodification of their bodies (school, trade, mining, flight, human trafficking, slavery, abuse, etc.). The conditions that trigger and facilitate commodification are not yet well known. We also need to learn more about the effects of commodification on girls' sexual and reproductive health.
- the social dynamics surrounding moral (shame) and sexual values. Certain moral values, such as shame, govern young people's and women's sexuality: the shame of becoming pregnant and having a child before marriage, of losing a husband, etc. Society's relationship to shame is a social construct that changes over time, just like any cultural phenomenon. How do these changes occur? At what pace? What are the decisive factors? What is shame's impact on abortions and unwanted pregnancies? How do families use shame to influence young people's sexuality?;
- intrafamily negotiations about contraceptive use (between spouses, between mother-in-law and daughter-in-law, between relatives, etc.). The first use of contraception among adolescents, and women in general, often requires negotiations with a close relative, who may be the spouse, spouse's mother, guardian, etc. How does kinship determine the way these

negotiations are conducted? While the marriage relationship clearly plays a role in this choice in all of the countries, the mother-in-law's influence is essential in the Gaza Strip. Every woman must inform her mother-in-law that she intends to use contraceptives. She must also let her know when she leaves the house for any type of errand. How is the use of contraceptives negotiated between a woman and her mother-in-law, and between the husband, wife and mother-in-law?

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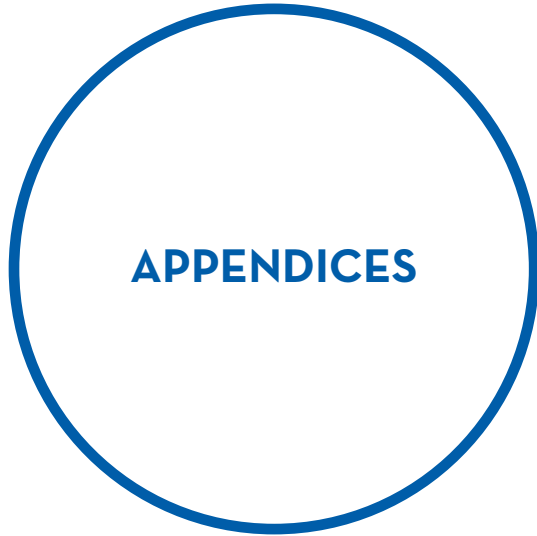
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**APPENDICES**



## APPENDIX 1. STUDY'S TERMS OF REFERENCE (JULY 2014)

### CALL FOR PROPOSALS

#### CONSULTANCY for a:

**'Cross-cutting study and comparative analysis of the sociocultural and community determinants of abortions and unwanted pregnancies, particularly in the 15-24 age group.'** – Multi-country study

### I. CONTEXT

#### A. BACKGROUND INFORMATION

While the international community has undertaken positive initiatives in support of maternal health, a major determinant of maternal mortality has never really been taken into account since the recommendations of the Cairo conference in 1994: the prevention and management of unwanted pregnancies (UWP). Progress has run into strong opposition at both the national and international levels, resulting in few and limited advances in this area. In 2008, it was estimated that 86 million out of 208 million pregnancies worldwide were unwanted.<sup>11</sup> Unsafe abortions are estimated to account for 47,000 maternal deaths each year.

MdM has learned from its projects that:

- Women face numerous barriers (legal, financial, sociocultural, health-related and geographic), which contribute to the occurrence of UWPs and/or make it harder to manage them.
- Despite restrictive laws, women commonly resort to abortion in response to UWPs.
- There are no family patterns for providing sex education to young people in families and communities, resulting in little knowledge of ways to manage UWPs, especially among the young.
- There is a significant but unmet need for SRH care for women.
- Girls are particularly vulnerable to the risk of abortion and unwanted pregnancies and require a level of care that remains inadequate at the present time.

As a result, MdM has made UWP prevention and management a priority issue and is involved in a specific programme dedicated to this topic, which still receives too little attention from the world community. One expected outcome is the documentation and sharing of UWP determinants. To that end, plans call for a socioanthropological study of the four projects included in this programme. This study seeks to refine the teams' findings and translate them into measurable goals in order to adapt our approaches accordingly and disseminate information about the realities experienced by respondents.

#### B. BRIEF PROJECT DESCRIPTION

MdM addresses the UWP issue in a number of countries in Latin America, the Caribbean, Africa, the Middle East and Eastern Europe. More specifically, MdM has just initiated a programme that seeks to help reduce maternal mortality and morbidity from unwanted pregnancies in four countries: Burkina Faso, the Democratic Republic of Congo, Palestine and Peru. The programme has four main goals:

- Analyse and take into account the barriers to preventing and managing UWPs;
- Improve services for preventing and managing UWPs in health facilities;
- Build rights holders' capacities in order to ensure their access to services and ability to influence these services;
- Promote the adoption of public policies that give greater weight to UWP prevention and management issues.

With this call for proposals, MdM is seeking to benefit from the skills of researchers specialising in sexual and reproductive health issues, with the aim of conducting a large-scale study on the topic of unwanted pregnancies (UWP) in four countries of operation. The study's overall objective is a cross-cutting and comparative analysis of the UWP issue. With this cross-cutting expertise, MdM is also seeking to strengthen its international visibility on this topic and support its advocacy efforts.

<sup>11</sup> - Singh et al., *Unintended pregnancy: worldwide levels, trends, and outcomes*, Studies in Family Planning, 2010

## II. OBJECTIVES

### A. OBJECTIVES

#### General objective of the overall study

The objective of the overall study is to provide a comparative analysis of the sociocultural and community determinants of abortions and unwanted pregnancies, particularly in the 15-24 age group in the four countries involved in the study.

#### Specific objectives of each country study

- Analyse sociodemographic, cultural, family, environmental and economic conditions that give rise to abortions and unwanted pregnancies;
- Collect data on social norms, popular representations and cultural perceptions regarding sexual and reproductive health in local communities;
- Learn the various ways families and communities respond to abortions and unwanted pregnancies;
- Identify the community and healthcare stakeholders who play a role in managing contraception, abortions and unwanted pregnancies and abortions;
- Collect data on care providers' perceptions and behaviour regarding abortions and unwanted pregnancies;
- Examine the quality of the therapeutic relationship between patient and care provider in SRC facilities;
- Understand patients' perceptions of health facilities concerning the quality of sexual and reproductive health services, the availability of care, how well informed they are about the available services, and their level of trust in these services;
- Make recommendations for guiding the strategy for responding to unwanted pregnancies and abortions in the community.

The objectives can be refined based on the realities in each context. In the DRC (Kinshasa) in particular, we would like more in-depth research into the link between unwanted pregnancies and gender-related violence and the way violence and sexually transmitted diseases are managed.

### B. STUDY REGIONS

#### Surveyed countries:

Burkina Faso (Djibo district), DRC (Kinshasa), Palestine (Gaza), Peru (Villa El Salvador district – Lima region)

The study will be conducted in the four countries unless security or operating conditions prevent the completion

of the field work. This will be discussed by the research team and steering committee as necessary.

### C. STUDY SCOPE AND USERS

These studies will provide information essential to the quality of the projects. They will be used internally by the teams, but the results may also be disseminated to our partners so they can take fullest advantage of them. The study will also be distributed to the MDM network and may be published on its website as well. The data may also be used for scientific research and publications subject to prior authorization.

## III. METHODOLOGY

### A. METHODOLOGY

The research team is expected to use qualitative data collection techniques specific to socioanthropological studies, such as observation, interviews and focus groups.

The survey methodology should be described in the proposal.

### B. COORDINATION MEETING: EVALUATION STEERING COMMITTEE

An MDM steering committee will monitor the study's progress.

An initial coordination meeting between the steering committee and the research team will define the study's specific terms of reference. Moreover, plans call for a coordination meeting with the field teams to tailor the study protocol to each country's realities and constraints.

In-person meetings and conference calls on the study's progress will be regularly conducted with the steering committee. The coordination meetings may also be conducted by videoconference and will not necessarily require travel to an MDM facility.

### C. KEY DOCUMENTS

The following will be available:

- Key project documents (for example, exploratory mission report, etc.)
- Previous survey reports and data collected in the field
- Documents on the UWP programme
- Latest visit reports (desk, etc.)
- Monthly reports
- National strategic plans and other general documents

## APPENDICES

with general data on country-specific vulnerability and population issues, if this information is available from the field teams





