"BETTER DEAD THAN BEING MOCKED"

'UNWANTED PREGNANCY AND ABORTION' – AN ANTHROPOLOGICAL STUDY ON PERCEPTIONS AND ATTITUDES

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ANTHROPOLOGY
Vienna
Evaluation
Unit

Doris Burtscher
doris.burtscher@vienna.msf.org
Catrin Schulte-Hillen
catrin.schulte-hillen@geneva.msf.org

Manisha Kumar Task Force RDC MSF
TF-coordinator@brussels.msf.org
Jean-François Saint-Sauveur, Medical director MSF
Brice de le Vingne, Operational director MSF
Eva De Plecker, SRH working Group MSF

Study managed by the Vienna Evaluation Unit/Anthropology
and the IO/Task Force for Safe Abortion Care
Editor Sandra Bauer-Wagner
Layout Romana Eigl
Vienna/Geneva, September 2018

*A Lega proverb says: "Better dead than being mocked". In relation to unsafe abortions, women and girls risk rather dying by performing an unsafe abortion than keeping the pregnancy and being mocked because they have an unwanted or unplanned pregnancy.

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Acknowledgements

I would like to thank all the people in North-Kivu/Mweso, Ituri/Mambasa and South-Kivu/Lulingu that worked with me and talked to me to make this study possible. My gratitude goes to all men and women, boys and girls who were willing to share their experiences and thoughts either individually or in groups and which allowed MSF better insight into the matters around unwanted pregnancy and unsafe abortion and action necessary to reinforce related action.

I would like to thank the MSF teams in the three projects, coordination and Bukavu TF coordination for their valuable support. I particularly want to thank my national and international MSF colleagues of the three projects for their professional attitude, their in-depth knowledge of the country and its people and our enlightening discussions.

A special thank goes to the local authorities in the DRC and the Ethical Committee of the University in Kinshasa, Ecole de Santé Publiqu and to the MSF ERB for validating this study.

Finally I am grateful to my colleagues in the Vienna Evaluation Unit, especially for the professional editing support and to the IO in Geneva for their professional guidance throughout the entire study process.

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Executive summary

Background and purpose

Unwanted pregnancy and unsafe abortion contribute significantly to the burden of ill health, maternal suffering and death in the Democratic Republic of Congo (DRC). MSF conducted a qualitative study to improve understanding of the vulnerabilities of women and girls with health care needs related to unwanted pregnancy and abortions, to better understand their health-seeking behaviour and to identify barriers that hinder women and girls from accessing health care.

This research is a compilation of a series of three studies: Mweso/North-Kivu, Mambasa/Ituri and Lulingu/South-Kivu. The research inscribes itself into a larger effort, referred to as Task Force, undertaken by MSF to reduce mortality and suffering resulting from unwanted pregnancy and unsafe abortion in the DRC. The Task Force presents a joint effort of all MSF operational centres, under the responsibility of MSFs medical and operation directors, and is responsible for commissioning this study.

The studies were conducted in three different provinces in the eastern part of the DRC: North and South-Kivu and Ituri between 9 May and 20 August 2017. The **project in North-Kivu** is located in a context with multiple armed groups and fluctuating frontlines. During periods of violence and resulting instability, which recur frequently, large numbers of people move and stay either in host families or overcrowded displaced camps, temporarily but sometimes for years in Mweso and villages around. The population is a mix of different ethnic groups including Hutu, Nande,

Hunde. It is delicate to refer to ethnic affiliations because the conflict includes interethnic dynamics. The **project in Ituri** is in a mining area with specific challenges regarding security in and around the official and unofficial mines, specifically in the area of the Reserve de Faune à Okapis (Okapi Wildlife Reserve). A variety of different ethnic groups live in and around Mambasa including the relocated minority communities of the *Bambuti* (Pygmy). The **project in South-Kivu** on the other hand is located in an enclave in the middle of a dense forest with a highly insecure environment but a homogenous population with one main ethnic group, the *Balega*.

The results of this study are intended to contribute to better treatment of women who have had an abortion and present with complications and consequential needs, and the identification of measures aiming to reduce the burden of unsafe abortion related complications and maternal death. These results are also intended to inform MSF operations, and to raise awareness and advocacy on one of the most important and entirely preventable causes of maternal mortality.

The general objective of the anthropological study is to understand and document perception of and attitudes towards unwanted pregnancies and induced abortion, among health care providers, the general population and local leaders in the DRC.

Methods

The research design is qualitative as the study aim required generating evidence and understanding of

the views, attitudes and experience of those involved with 'safe' and 'unsafe abortions' and unwanted pregnancies in the DRC. The methods used for data collection were in-depth interviews, participant observation and group discussions. A methodological triangulation of findings was undertaken to enhance the interpretation of data.

The study population is a composition of different groups of respondents in and around Mweso, Mambasa and Lulingu: women and men, health care professionals (Ministry of Health and MSF) in sexual and reproductive health care facilities and their various community intermediaries, resource people and key informants like community and religious leaders, local authorities, the general population in the study sites and health promotion team members. An important number of interviews were undertaken with victims of sexual violence particularly in Molokay and Epulu.

In **Mweso** the study team conducted 53 interviews, 45 in-depth individual interviews and 8 group discussions; a total of 75 persons were interviewed. In **Mambasa** the study team did 62 interviews, 41 in-depth individual interviews and 21 group discussions, totalling 109 persons. And in **Lulingu** 45 interviews, 38 in-depth individual interviews and 7 group discussions were conducted, totalling 67 individuals.

A purposive sampling method was applied. This short-term study is designed to provide answers to current operational questions. Gathered data will not amount to long-term or multi-sited anthropological fieldwork.

The main limitation of this study was the sensitivity of the topic because of the restricted Congolese abortion law. This limitation was reduced to a minimum by not talking directly about termination of pregnancy at the start of any interview but asking questions about problems related to sexual and reproductive health and which in most cases led to the subject of abortions.

The study protocol was submitted to the MSF Ethics Review Board and to the Ethical Committee of the University in Kinshasa, Ecole de Santé Publique. Informed consent was ensured for all respondents of the study.

Overview of findings

This report provides an analysis of perceptions and attitudes towards unwanted pregnancies and abortions from the perspective of the local population, local and religious leaders and health care providers from the governmental, private and traditional sector in the DRC.

The analysis suggests that the main **contributing factors to unwanted pregnancies** in all three projects are sexual violence and the lack of knowledge about sexual health, especially about the menstrual cycle and/or non-use of contraception. In Mambasa centre and in the two health zones Epulu and Biakato and in Lulingu transactional sex, especially as a means of livelihood, also appears as a contributing factor.

Key factors in women's and girls' decision to terminate a pregnancy comprise social constraints (reduced chances for marriage and school education), cultural (getting pregnant while still breastfeeding a child) and economic factors (lack of financial means to take care of an (additional) child). This is particularly relevant in case of pregnancy resulting from rape and unwanted pregnancies in younger and elder women/widows.

The reasons for **unsafe abortions** include the restrictive Congolese law, *Lega* traditional 'code', religious beliefs and norms, costs and distance to health facilities and stigma, all resulting in lack of access to save abortion care.

Contributing factors to unwanted pregnancies

1. Sexual violence
Sexual violence is said to be one of the major contributing factors leading to the high number of unwanted pregnancies in all the three project sites in the DRC.

In **Mweso** sexual violence is related to war and conflict in the area. Sexual assaults happen frequently in the surroundings of Mweso when women go for firewood to fetch water or to work in the fields. Around Mweso insecurity is still a big concern with ongoing clashes between different armed groups resulting in internally displaced people that congregate in camps in Mweso.

In the whole **Ituri region** sexual violence and rape perpetrated by armed groups in Mambasa centre, Epulu and Biakato has reduced significantly; however, sexual violence is still an ongoing concern. Nowadays sexual violence mainly happens in and around the illegal mines in the Okapi Wildlife Reserve (RFO, Reserve de Faune à Okapis) and in the mines around Biakato. Women *have to* go 'to the forest' where the clandestine[1] mines are found to sell goods and food items to the mine workers as they do not have any other means for survival – for themselves and their families. In and around the mines, they find themselves confronted with sexual assaults; they know the risk but have no choice. Additionally, domestic violence is a growing concern people face.

In **Lulingu** the Raia Mutomboko militia and armed groups, like the FDLR, are seen as the main perpetrators of sexual violence and rape out of wedlock, their behavior is explained by their long stay in the forest without women. Rape is intended to degrade the victim and her husband. Such rape cases are not only committed by armed groups but are also perpetrated by community members within a village and have a socio-cultural meaning. Sexual violence is related to interpersonal conflicts and happens among families and people who know each other.

Women who were sexually assaulted and/or raped are generally **highly stigmatised**, no matter if they are married or unmarried. A raped woman is said to 'go with shame after rape'. Therefore, women decide to keep silent about sexual violence. For girls and young women who were raped, the perspectives to find a husband and to get married are reduced drastically. Married women who were raped and got pregnant are stigmatized even more because they might be rejected by their husband, which is why women sometimes attribute the child resulting from rape to their husband in order not to jeopardize their marriage. Religion can also be a decisive factor. In Mweso, a Christian man would rather stay with his wife if she had been raped, whereas a pagan is said to likely leave her.

Families perceive rape as a dishonour for the whole family, which is why most women try to hide having been raped from other community members, from their families and from their husbands.

In Mweso as well as in Mambasa, a significant change in the perception of sexual violence since the 'Rwandan war' took place. Earlier experiences of sexual violence had a different notion. The tradition was called **kuterura** ("so*ulever de force" or "prendre la femme par force*"). When a young man wanted to marry a girl, he took her by force from her parents' house, had sexual intercourse with her, which in most situations meant he raped her, to 'label' her his wife. This tradition is a form of sexual violence but was not considered as such. People said sexual violence was always part of their society, yet its perception has changed; nowadays when men take a girl by force to sleep with her, they abandon her afterwards.

2. Lack of knowledge and use of contraceptives

Two additional important contributing factors for unwanted pregnancies in the Eastern part of the DRC are (1) lack of knowledge on issues of sexual health and particularly concerning the menstrual cycle and fertility, and/or (2) lack of use of contraceptives.

Reduced access to Education: In Mweso, especially girls from rural areas are said to not know their menstrual cycle and days of conception, therefore get pregnant unintendedly and may realize only late that they are pregnant. Women with school education seem to realize early that they are pregnant when they miss their menstruation.

(1) „Clandestine" is used in the sense of illegal. Respondents rather used the word clandestine than illegal.

Attitudes towards family planning and contraceptives were predominantly sceptical. Promoting family planning and encouraging women to use it was seen to be fostering infidelity and encouraging extramarital relationships or even prostitution. Some women state reluctance to using contraceptives because not having enough kids would lead to their husbands taking another wife to have more children. The use of condoms is either not acceptable and feasible in the marital relationship or rejected due to less pleasure from men. Young women have limited access to contraceptives through health centres because they fear being sent away and shamed for engaging into sexual relations before marriage.

In **Lulingu** attitudes and perceptions towards family planning were generally rather negative. Following *Lega* tradition, people are not used to family planning or contraceptives. People believe that a couple should have many children, using family planning resembles stopping 'birth'.

Fear of presumed side effects is a hindering factor to using contraceptives as well as wrong assumptions such as the condom staying inside the female genital organ. The methods used most often are contraceptive implants and injections (Depo Provera).

Influence of the church: The Church is predominantly against family planning. Religious leaders refer to the bible saying: *"be fruitful and multiply"*.

Preference for natural family planning over modern methods: In the Mambasa territory, family planning was understood in terms of 'natural family planning methods' like counting the days of a woman's cycle and avoiding sexual intercourse during the fertile days. In general, women feared side effects from modern contraceptive methods like the implant, the three-month-injection Depo Provera or the pill and would say that they caused cancer or infertility. When there is willingness to use contraceptives, girls often do not know where to get them or do not feel comfortable to ask for related services in the health structures.

Similar to Lulingu, women and teenage mothers in and around Epulu expressed strong concerns for breastfeeding mothers who would get pregnant while nursing a child. They openly said that in such a case it would be better to terminate the pregnancy to protect the 'living' child.

3. Transactional sex and unwanted pregnancies within marriage

Transactional sex and unwanted pregnancies within marriage were seen as main reasons for women's decision to terminate pregnancy in the **Mambasa** territory and in **Lulingu**. In Mweso, transactional sex is an issue as well, even though it did not emerge as predominant in the interviews.

Adult and married women likewise engage in transactional sex, which often results in unplanned pregnancies when contraceptives are or cannot be used.

In all three study areas, the long-lasting and ongoing political instability has left its marks on **social relations and traditions**, which are seen to contribute to the reality of transactional sex. In **absence of marriage perspectives and/or sustainable support from a husband** girls and young women, unmarried women with children, married women left at their own device and even widows end up engaging in transactional sex as a means of survival.

The root cause of the vicious circle, in which women find themselves caught all too often, can be found in the prevailing relationship between men and women in these areas. It is **determined by men's power and perceived superiority over women**. A man is almost never expected to be faithful to his wife; a woman in contrast will be despised by men and the society as a whole, if she engages in multi-partner relationships. Women are responsible for children's upbringing, with or without the support of the corresponding father.

In **Lulingu and Mambasa** some men say to feel challenged nowadays; young women revolt against these masculine concepts and trying to imitate the „white mentality".

In **Lulingu**, unfaithfulness within marriage represents the second largest factor for unwanted pregnancies. In Lulingu, the *Balega* have strict regulations how men and women and husband and wife respectively should behave in a marital relationship and above all during pregnancy. Different bodily fluids may not mix as this would affect a positive pregnancy outcome; thus, abortion is sought.

Contributing factors to request for termination of pregnancy

The main reasons stated for women to need or want to abort are manifold and can be summarised as follows:

- Cultural and community related factors: shame, stigma within the community, particularly in what concerns victims of sexual violence, but also pregnancy outside marriage, pregnancy while breastfeeding (in that case ToP is socially accepted), pregnancy resulting from relationship outside of marriage.

- Socio-demographic and financial factors: lack of financial means, marital status, young age, wish to continue studies, already having a high number of children to care for.

- Unwanted pregnancy resulting from rape or transactional sex: victims from rape perpetrated by armed groups or within the community (extended family, husband, sexual relations with/between minors) leading women to want to terminate the pregnancy or being forced to.

Unsafe abortion methods

Abortion methods vary in the three study areas. Enema (rectal/vaginal) are used in all three zones. In Mweso, women additionally use the traditional plant *cifubula* or the powder soap OMO diluted in water. In Mambasa women use herbal mixtures, insert a stick into the vagina to open the cervix, take toxic drinks, such as heavily salted water, or buy drugs in the pharmacy, like quinin or the prostaglandin Cytotec at varying dosages. In Mambasa, especially in the health zones

Epulu and Biakato, traditional methods are preferred by those who cannot afford medication or avoid formal channels (pharmacy, health structure) due to fear of stigma and doubts if confidentiality is observed.

In Lulingu women stated herbal drinks as a main means of abortion. Traditionally they used enema with papaya leaves and roots, today they use enema with salted water. In general, traditional methods decreased in Lulingu, because people saw the negative consequences of abortion resulting in women being advised to keep a pregnancy. However, abortions with drugs from pharmacies increased.

Abortion providers

The approach to abortion seems to depend to an important degree on women's financial means, meaning if they can afford to reach the next big city to get a safe abortion in an urban health structure. In Mweso, this is Goma, in Mambasa it is Bunia and in Lulingu it would be Bukavu. However, from Lulingu to Bukavu women would have to fly, walk or go by motorbike, reaching the city by car is not possible.

In **Mweso**, no information could be gathered concerning who is performing abortions because people are afraid to talk; social stigma and reject of the idea of abortion is high.

In **Mambasa**, women try to abort by themselves at their homes, are helped by another woman or their mothers or a friend. They go to traditional birth attendants, to retired or jobless nurses or to untrained health care providers who sometimes perform abortions in rented places, like small hotels in Mambasa. Abortions are also performed in health facilities, private or governmental, by qualified doctors and nurses.

In **Lulingu** many women seek support at the praying rooms, but in most cases, they are told to keep the pregnancy. For this reason and due to barriers in terms of distance and transportation, women also try to abort by themselves at their homes. Traditional healers, charlatans, and other medical staff perform abortions and deceive woman in telling them that there will only be a little bleeding, while in reality death can sometimes occur. The motivation of doctors and nurses to perform abortions seems to be often of financial nature.

Perception of abortions

In the community:
Opinions, perceptions and attitudes towards abortions differed greatly in the three study areas. Regarding the legal situation similar trends and viewpoints were suggested by the analysis together with a more open attitude and understanding to abort a sexual violence related pregnancy.

In **Mweso**, the general population, local leaders, religious leaders and local authorities reacted predominantly with outrage concerning safe abortion care for moral reasons. It was out of question that a medication and therefore safe abortion could be an option under certain circumstances. However, what people expressed, did not correspond to what we observed, since unsafe abortions are practiced widely in North-Kivu.

In **Mambasa**, a very different attitude was observed. Most of the general population, local leaders, religious leaders and local authorities perceived and considered medical care for termination of pregnancy as an appropriate solution to reducing maternal mortality and morbidity, if only the law would allow it. Legal fears of performing or seeking abortion were expressed but did not hinder individuals to proceed with their attempt. The focus of the concern seemed to be on the problem of maternal mortality and need to adequately respond to that reality.

In **Lulingu** the general population, local leaders, religious leaders and local authorities had mixed perceptions and attitudes towards abortions and rather dealt with it cautiously. Most respondents referred to the harming characteristics of an induced unsafe abortion such as the risk of dying, stigma, difficulties in finding a husband and in general terms it would be

a loss for the community as one does not know what the foetus would become in the future. Community members mostly referred to the Lega tradition, to the law and to religion.

The rejection of abortions was reasoned in relation to the *Lega* tradition. That way people impersonalise their attitude and distance themselves personally. It is not their own decision, but it is the identification with their ethnical background as *Lega*.

A more sympathetic attitude was expressed when it came to pregnancy resulting from rape, as it is understood that a girl or woman does not want to give birth to a child resulting from rape.

Religious and moral reasoning against abortions preponderated, while the legal status played the same role as religion and *Lega* tradition. Abortions are forbidden by the Congolese law and by Lega tradition that represents the 'traditional law' the *Balega* have to respect.

Specific tolerance was expressed regarding breastfeeding women, as *Lega* tradition prescribes a gap of two years between delivery and the next pregnancy. Pregnancy during breastfeeding the previous child is seen as extremely negative; abortion may be sought by the couple and that seems acceptable.

Amongst health care providers:
The perspectives of health care providers differed as well. Altogether **three approaches** were observed.

A number of health care providers either want to help but feel limited because of the legal situation. This means that some would perform abortions themselves if the law would allow; others would be willing to refer women to a place where safe care is accessible. Health staff in the Tumainis and other health structures also stated that they are blocked by the law as they receive many demands for medical abortions mainly from young girls. Some explained that it would help them greatly if the law could be changed.

Others try to convince women or girls to keep their pregnancy without judging them.

The third group are the ones who see abortions as a criminal act and condemn any form of termination of pregnancy. Their reasons are based on moral and religious arguments. In very general terms religion played a bigger and more important role in the perception of abortion care than the legal status of provision of abortion care.

When asked to put aside the legal status of provision of safe abortion care and to also put aside their faith, some of the staff said they could personally accept safe abortion care.

Doctors often referred to medical ethics and the oath they took. As a result, they do not want to know the reasons of abortion related complications when women present with such conditions because in their opinion their first responsibility is patient care.

Health staff underlined the wish for safe abortion care at hospital level because sometimes they are forced to send women who ask for an abortion away and then the next day these same women return with abortion related complications. Such complications related to induced abortions were not expressed in a condemning attitude towards the woman, she was not considered a criminal or that she should be denounced to the police etc. Respondents were instead worried about the (medical) problems women face and how to best treat them.

Health seeking behaviour and access to health care

In Mambasa and Lulingu incomplete abortions are treated at hospital level and nurses ensure related care in health centres. In Lulingu feedback on post abortion care and reception at the hospital was very positive.

In **Mweso** women usually contact traditional healers first and health structures only in serious cases. Barriers to access in **Mambasa** are abductions, distance, injuries and reporting to the police (because

this may lead to women presenting at the health structure too late), whereas in Mweso barriers are distance, the river and the insecure environment. In general, post abortion care is very sensitive in Mweso due to legal issues.

In **Lulingu** hospital, doctors and midwives reported that they receive many incomplete abortions. One doctor from the hospital spoke about 'periods' in which they receive numerous abortion related complications as if a certain person is doing it and others get to know about it and the number of induced abortions in the community increases. Health care professionals indicated that people tend to consult traditional healers first for general ill-health conditions and only come to the health structures if the illness of the patient has reached a serious, potentially life threatening, stage.

Costs for abortion

Prices were said to range from 50 to 300 USD for an abortion with a trained nurse or doctor. A doctor in Goma for example asks between 200 and 300 USD. In Mambasa Cytotec can be bought in the pharmacies secretly. For two pills 5 USD have to be paid, others might ask 10 USD. One sachet of OMO costs 200 (0,1USD) or 500 (0,3 USD) Congolese Francs. Traditional methods can be for free or one pays between 5 to 10 USD.

Conclusion

The interviews of this study shed light on the l**ack of decision-making power women have or are perceived to have regarding their sexuality, in marriage and outside**. In marriage, the predominant notion relates to the obligation to satisfy the demands and expectations of the husband (sex, many children, fidelity and acceptance of his lack thereof). Out of wedlock, the predominant notions include violence (rape) and socio-economic constraints (stigmatization, poverty, family isolation) which drive women and girls into transactional sex as a means of survival and child support.

The reasons why women and girls want or are forced to abort are complex. On the one hand they reflect traditional values and the stigma which women with unwanted pregnancy face. And on the other, there are the difficult living conditions in general, the traditional relationship between men and women and the socioeconomic constraints that women face.

Perceptions and attitudes about abortion vary somewhat across the three surveyed areas. In Mweso, abortions are seen as particularly reprehensible from a moral standpoint, but these statements seem contrary to the observations of a widespread practice

of abortion. In Mambasa, many see abortion as an appropriate solution to reducing maternal mortality, but legal considerations prevail; while these do not stop women from seeking abortions, they prevent health professionals from providing adequate medical care. In Lulingu, traditional Lega values combine with the influence of law and religion and are primarily opposed to abortion, but may become more tolerant in the case of a woman still feeding the baby.

Contrary to the prevailing critical narrative on abortion, the study **highlights a significant demand for abortions in all three study sites**.

The overall analysis suggests an **urgent need to foster dialogue on unwanted pregnancies and unsafe abortion, contraception and medical care**, both at community level and among leaders and authorities, as part of the MSF action

Abbreviations

ADF-NALU	Allied Democratic Forces-National Army for the Liberation of Uganda
ANC	ante-natal care
APCLS	Alliance du people pour un Congo libre et souverain
BCZ	bureau centrale de zone
CF	Congolese francs
CHW	community health worker
DRC	Democratic Republic of Congo
EPI	enlarged programme of immunisation
ERB	Ethics Review Board
FARDC	Force Armées de la République Démocratique du Congo
FDLR	Forces Démocratiques de Libération du Rwanda
FGD	focus group discussion
FP	family planning
HC	health centre
HGR	hôpital général de référence
HZ	health zone
IDI	in-depth interview
IDP	internal displaced people
MCZ	médecin chef de zone
MFP	medical focal point
MSF	Médecins Sans Frontières
MSP	Ministère de Santé Publique
MTL	medical team leader
MVA	manual vacuum aspiration
NDC	Nduma Defense of Congo
OCA	Operational Centre Amsterdam
OCBA	Operational Centre Barcelona
OCG	Operational Centre Geneva
PC	project coordinator
PEP	post exposure prophylaxis
PI	primary investigator
QG	quartier général (brothel)
RFO	Reserve de faune à okapis (Okapi Wildlife Reserve)
RM	Raia Mutomboki (angered citizens)
RTI	respiratory tract infection
RUSK	Réponse d'Urgence Sud Kivu
SRH	sexual and reproductive health
STI	sexually transmitted infection
SV	sexual violence
SVRP	sexual violence related pregnancy
TBA	traditional birth attendant
ToP	termination of pregnancy
TPR	termination of pregnancy on request
UTI	urinary tract infection
UWP	unwanted pregnancy
VSV	victim of sexual violence
WASH	water and sanitation for health

1 Introduction

1.1 Background

Since 37 years MSF is working in the context of the Democratic Republic of Congo (DRC). In terms of project budget and key areas of activities the DRC is amongst the "top 10 contexts" of MSF action every year since the start of the international typology studies in 2004.

In MSF's reproductive health and sexual violence care project statistics [(2)] from the last 3 years (2014 to 2016)

- **20 % of all assisted deliveries** under MSF responsibility were done in the DRC and
- **27 % of all victims of rape medically assisted** by MSF were seen in the DRC

Further, close to **20 % of reported abortion related complications** cared for in MSF's projects the same 3-year period where in the MSF projects in the DRC. In 2016 this translates into over 2.700 abortion related complications treated in MSF projects in the DRC, an increase seen from number in previous years – partly due to greater efforts in data collection and partly to the greater attention to this particular medical need. Abortion related complications in MSF data collection include both complications resulting from miscarriage and from an unsafe abortion. **Complications from safe abortion can be excluded**; their contribution to the caseload seen by MSF is insignificant:
(1) Evidence shows complications related to safe abortion are extremely low: adverse effects in 0.65 % of medication abortions [1] (induced by abortive drugs) and practically no mortality, for surgical abortion the risk is shown to be similar to that of a penicillin injection [2].
(2) Likely there are very few, if at all, health care providers for safe abortions available in the places where MSF works in the DRC.

The **distinction between complications resulting from miscarriage and those resulting from unsafe abortion attempts** is a difficult one; symptoms may be very similar and women are reluctant to say that they attempted to abort (taboo, fear of social and legal repercussions). However, the following evidence exists:

- Studies from different contexts [3-24] show that at least 50 % and up to 90 % of all abortion related complications result from unsafe abortion attempts.[(3)]
- Data from MSF reflects that 55 % of the women that had to undergo manual vacuum aspiration (MVA) for abortion related complication had attempted to abort [25].[(4)]

Every day women and girls approach MSF requesting medical care for termination of pregnancy and MSF has the opportunity to prevent unsafe abortion and related mortality and suffering.

This research is a compilation of a series of three studies conducted in three different provinces in the eastern part of the DRC, North- and South-Kivu and Ituri between 9 May and 20 August 2017.

1.2 The Mweso health zone[(5)] in North-Kivu

The Mweso health zone consists of 23 *'aires de santé'*. It is a health zone with a large (about 400 000) and widely dispersed population that has virtually no access to health care whether in times of stability or instability. During periods of violence and resulting instability, which recur frequently due to the very fluid frontlines, large numbers of people displace and stay either in host families or overcrowded displaced camps. There are different zones of control and very frequently the people living either behind frontlines or in areas of unclear control are especially vulnerable and at risk in terms of their health because they frequently sleep in their fields in order to avoid overnight robberies or violence. Furthermore, the number of other actors able or willing to provide assistance to these populations, outside of zones controlled by *Force Armées de la*

(2) MSF international typology data 2014-2016.
(3) When South-Africa liberalised its abortion law in 1996, studies found that related maternal deaths were reduced by 91% by 2000 and that the number of women suffering from infection resulting from unsafe abortion had halved over the same time period. When the anti-abortion law was abolished in Romania in 1989, maternal mortality rates halved within a year.
(4) OCG in Leogane, Haiti 2014, ref Activity report 2014 (p. 21-22).
(5) Please refer to the MSF Mweso project background document from 2017.

République Démocratique du Congo (FARDC), is very limited and they usually have to walk many hours and cross a front line in order to access even the most basic care. Naturally, this puts patients at increased risk of extortion, violence or simply depletion. Mweso hospital (HGR) serves as the only free quality secondary health care service for this large area.

1.2.1 Overview of MSF medical activities

The Mweso project is a primary and secondary health care project. The *hôpital général de référence* (HGR) has 300 beds and is the only free secondary health care hospital in the region. Hence, it takes a lot of resources and effort. In 2017 MSF was focusing on increasing outreach activities (see Annex 9.3). Two outreach teams divide the supported sites geographically into north and south.

Project sites:

- HGR Mweso
- Tumainis [6] (Kitchanga & Mweso)
- 5 health centres with a complete package of support, staffed by *bureau centrale de zone* (BCZ) who receive MSF primes: Bukama, Kashuga, Kalembe, Bibwe, Mpati
- 6 partially supported structures; right now most are only supported in terms of malaria, but they will soon be supported for diarrhoea and respiratory tract infection (RTIs) as well: Bushanga, Ibua, Rujagati, Malemo, Ihula, Kamonyi

Mweso HGR:

The services supported are:

- OT with a post op room and the surgery ward
- A maternity with the delivery room, gynaecology and obstetrics; the maternity staff also takes care of women in the *‚village d'accueil'*, which is where women with high-risk pregnancies can stay before the delivery
- Internal medicine
- Intensive care
- Paediatrics including the intensive therapeutic feeding centre (ITFC) and neonatology – with new buildings in place for ITFC and neonatology
- Cholera treatment centre (CTC)
- Lab
- Pharmacy
- Mental health/ psychiatry
- Tuberculosis (TB), multiple drug resistance tuberculosis (MDR-TB)/HIV

1.3 Context of the Mambasa territory[7] in Iuri

The territory of Mambasa is one of the five territories of the new Ituri Province, where several armed groups (including the ADF-NALU, poachers, FARDC, forest guards, etc.) rage, in particular because of the numerous mining squares (gold) located mainly in the protected area of the Okapi Wildlife Reserve (RFO). The proximity to the Province of North-Kivu (Beni Territory), which is still very unstable in terms of security (population movements, inter-communal conflicts, banditry, robberies, kidnappings, etc.), frequently destabilizes the area. Violence against civilian populations living close to quarries is pervasive, with significant medical and psychological consequences (sexual violence, physical trauma, kidnappings, etc.) The local health system is affected by major structural problems and access to primary and secondary care is extremely limited. Emergency care is non-existent.

1.3.1 MSF in the Mambasa territory

MSF is the only actor dealing with STIs and sexual violence in Mandima and Mambasa territories, although the data show that the number of victims of sexual violence is largely underestimated.

OCG's strategy in Mambasa is to provide medical care for people who have suffered sexual violence, treatment for STIs, and psychological support. Moreover, MSF works on the epidemiological surveillance of epidemic-prone diseases and the implementation of prevention activities. Finally MSF advocates with its partners for a complete and coordinated response to the essential needs of displaced populations (nutrition, WASH, shelter etc.).

(6) Tumaini means hope in Swahili; a Tumaini is a small health posts that provides SRH services for women and men.
(7) Please refer to the MSF project document CD 139 Mambasa from 2017.

- Mambasa project started on 13 January 2016, and medical activities started in mid-February in nine health centres (HC)
- OCG organized a workshop in July 2016 about a holistic strategy of sexual violence care with the involvement of all actors (police, families, medical staff etc.)
- OCG addressed the needs of displaced people when there was an influx into the Mandima health zone (HZ) in the second half of the year
- MSF decided to cease support to the NiaNia axis in order to consolidate its activities in the other two axes of Mandima and Mambasa.

1.3.2 Overview of MSF medical activities

MSF's intervention aims to strengthen the medical management of VSV and STIs in six health centres located on the strategic axes leading to gold mines. This reinforcement will be achieved, on the one hand through the deployment of an additional team (three teams in total) and on the other hand through the implementation of an e-care project to increase the quality of STI diagnosis and treatment.

- Mambasa HZ: Epulu, Binase/Bandisende, Molokaye HC
- Mandima HZ: Teturi, Biakato, Bella HC

Regarding the response to patients, victims of sexual violence, in addition to continuing the activity in the six health centres, we propose in 2018 a pilot model of medical and psychological care for VSVs at community level via listening boxes located in villages close to mines (mapping, sex education, family planning, VVS kits)

Epidemiological surveillance and EPREP to respond to the influxes of injured persons are an integral part of the project.

1.4 Context of the Lulingu project site

The project area of Lilungu health zone has 66.779 inhabitants and is located in the province of South-Kivu, in the district of Shabunda. The distance to the province capital Bukavu is approx. 400 km and requires access by plane. The zone is characterized by its remoteness and difficult access and hence by government neglect and lack of civil services (medical supply, security/police and infrastructure/roads/health centres).

The occurrence of minerals (rare earths, Coltan, Cassiterite) and the past regional conflicts (border crossing rebel groups from Burundi and the neighbouring districts) contributed to a conflict between the local populations that engage in illegal mining, different (criminal) armed groups who rob or control the local populations, (political) rebel groups and the Congolese army (FARDC). Consequently, the local populations suffer from marginalization, massive displacements (around 70 %), systematic (sexual) violence, torture, kidnapping, terrible sanitary conditions and a lack of medical support.

The closer political context of Lilungu is characterized by an alternating control of the zone either by armed militias (or sometimes coalitions of rebel groups) that have their base in the North of the zone, or the FARDC that temporarily manages to repel these groups and to secure the district capital (Tshonka) and its airport. The local populations flee accordingly, in pendulum movements, to escape the fighting but are also subject to violent assaults and high criminality from both sides in-between the military operations.

1.4.1 MSF in the Lulingu health zone[8] South-Kivu

MSF OCBA is present in the Eastern part of the DRC since many years. The intervention in Lulingu, in the territory of Shabunda in South-Kivu started in October 2015.

From the end of October 2014 to January 2015, multiple clashes took place between the FARDC (Force Armées de la République Démocratique du Congo) and the various RM (Raia Mutomboki) armed groups causing massive displacements of populations in the various axes but especially in those of Byangama and

(8) Please refer to the MSF OCBA document: Proposition intervention Zone de Santé de Lulingu, Sud Kivu, RDC", 31-07-2015, done by the RUSK and the Coordination Team of DRC.

Nyambembe. From 29th January to 4th February 2015, a RUSK (Réponse d'Urgence Sud Kivu) team carried out an assessment in Lulingu health zone, mainly on the Katchungu-Byangama and Nyambembe-Nduma axis, which aimed to investigate the humanitarian situation and the medical needs of displaced and/or returned populations to meet the most urgent health needs.

Following this assessment, the team observed:

- Increased vulnerability in the population in the axis. Inability to access basic health services, children <5 (and their families) were exposed to the harsh weather conditions with rain and no shelter.
- Dysfunction of health structures, some health centres had been closed for several weeks, head nurses had abandoned health centres and looting had taken place. There was also a lack of medicines that prevented any basic health care activity.

Following clashes in May and June 2015 between the different armed groups in Lulingu and the surrounding areas, about 70 % of the total population moved to different directions. Part of them took refuge in the forest, while others went to several villages on the southern axis (Katchungu-Shabunda).

In order to monitor this situation, the RUSK made another exploratory mission from July 23rd to 31st 2015 in the Lulingu health zone, more specifically in Lulingu city and the central and northern axis. The purpose was to evaluate the medical and humanitarian situation of the Lulingu health zone, focusing more specifically on the health status of the Lulingu population (returnees), as well as displaced persons in the two axes, central and north. The team focused on access to medical facilities, availability of drugs and referral system.

On the central axis, after the clashes that took place between the FARDC and the different RM groups, the population began to return timidly. Regarding the northern axis, still controlled by the RM, the population remained there. On both the central and northern axis, the health system was in a very precarious situation, with a total lack of inputs for the last three months and a total stoppage of the EPI.

In addition, the cost recovery system means that the population, which is in a very vulnerable and completely poor situation, could not access health

care for lack of money. Indeed, due to the insecurity that prevailed throughout the area during several months, all commercial and economic activities had completely ceased, as well as commercial flights on Tshonka airport, which completely enclosed the area.

1.4.2 Overview of MSF medical activities

At the time of the study in August 2017 MSF worked in the reference Hospital (HGR) in Lulingu with 100 beds in all the wards except internal medicine and supported six health centres: Tchampundu, Nyambembe, Nduma in the North Tshonka and Lukala in the centre and Byangama in the South.

In February 2018 MSF stopped supporting Tchampundu, Nduma and Lukala but continues working in the hospital in Lulingu, and in the health centres of Tshonka (axe Central) Byangama (axe Sud) and Nyambembe (axe Nord), as well as in the health centre of Matamba (axe Nord). MSF has also the following programs in the periphery:

- Malaria points (Point Palu six in total: Kananga and Mintonko in the central axe; Byundu, Swiza and Makala in the axe nord, Wankenge in the axe Sud)
- Advanced nutritional program (Programme Nutritionnel avancé six in total: as above)
- Advanced maternal program (Programme Maternel avancé four in total: Kananga, Mintonko, Swiza and Wankenge)

MSF works hand in hand with the MoH. The target population are children <15, pregnant women. MSF also supports all the emergencies and the referrals from the health centres to the hospital or to Bukavu.

1.5 Rationale for the study

A 2012 MSF International Board stated that “unsafe abortion and unwanted pregnancy contribute significantly to the burden of ill health, suffering and maternal mortality in the contexts where we work” and called upon MSF executives to increase action that will contribute to the reduction of related death and suffering.

- Data for 2016 indicate that 20 % of the over 16 000 abortion related complications reported by MSF projects around the world were reported from projects in the DRC.
- In the DRC typical methods of unsafe abortions include the induction of wooden sticks into the uterus, kicking and boxing the womb, ingestion of, herbal mixtures as well as their vaginal use, toxic drinks like heavily salted water and the powder soap OMO and various enemas either into the vagina or via the anus.

Since unwanted/unintended pregnancy and unsafe abortion contribute significantly to the burden of ill health, maternal suffering and death, we proposed in autumn 2015 a qualitative study to learn more about the vulnerabilities of women and girls with health care needs related to unwanted/unintended pregnancy and unsafe abortions, to better understand their health care seeking behaviour and to identify barriers that hinder women and girls from accessing health care.

This study is part of a larger effort, namely a Task force[9]. Termination of pregnancy in the DRC is legally restricted to interventions considered necessary to safe the pregnant woman’s life.[10]

(9) A "Task force" is an initiative born out of the recognition that some very concrete medical ambitions in MSF have proven tough to operationalize. Making safe abortion care available is one of these. A "Task force" is a political commitment of OCs (at least 3) through their medical and operation directors in the effort to move forward practically and to engage necessary means and support at all levels of the organization. It is a project with a concrete objective and a limited timeline. The creation of the Task Force "Strengthen MSF action in prevention of unwanted pregnancy and unsafe abortion in DRC" is shared by all OCs.

(10) Rape, incest and foetal malformations, the woman's physical or mental health or any social-economic reasons do NOT represent exceptions. For more information on the legal frame of abortions in DRC please go to: http://www.womenonwaves.org/en/page/4985/abortion-law-congo (accessed 23rd February 2017).

2 Objectives of the study

2.1 General objective

The overall objective is to reduce suffering and mortality related to unwanted pregnancy and 'unsafe abortions' in the Democratic Republic of Congo. The general objective of the anthropological study is to understand and document perception of and attitudes towards termination of pregnancy (ToP), including on request (TPR) and unwanted pregnancies (UWP), among health care providers, the general population and local leaders in the DRC.

2.2 Specific objectives

Unwanted/unintended pregnancies

- Understand local perceptions on conception, point in time when a woman/girl knows that she is pregnant, definition of beginning of life (point in time when the foetus in the womb is considered a baby)
- Investigate on differences in attitudes and perceptions of a pregnancy in a couple relationship and pregnancy through an adverse event (rape, incest, force, unwanted and unplanned)
- Analyse socio-demographic, cultural, family, environmental and economic conditions that give rise to unwanted/unintended pregnancies
- Collect data on social norms and behaviour regarding unwanted/unintended pregnancies (learn the various ways families, communities and local leaders respond to unwanted/unintended pregnancies; analyse their attitude towards women and girls with unintended pregnancies and the wish to terminate)
- Collect data on care providers' perceptions regarding unwanted/unintended pregnancies

Unsafe abortions

- Analyse socio-demographic, cultural, family, environmental and economic conditions that give rise to abortions
- Explore how women and girls feel about their experience of having gone through an abortion themselves/a friend/someone close
- Collect data on social norms and behaviour regarding abortions (learn the various ways families, communities and local leaders respond to abortions; analyse their attitude towards women and girls experiencing abortion related complications following an intent to abort)
- Collect data on care providers' perceptions on abortions
- Understand who is performing abortions, when, how and where

Perception of abortion care

- Assess the understanding/perception of the population/health care providers etc. on the DRC abortion law, if legal precautions have an influence on the provision of care
- Study the perception of the general population, health care providers etc. on the "illegal status" of provision of safe abortion care
- Look at how the acceptability of abortions may differ, in which situation, for whom

Perception of sexual and reproductive health care 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 and how they perceive the level of confidentiality in these services

2.3 Aim

The aim of this study was to generate evidence and understanding of the views, attitudes and experiences of those involved with 'safe' and 'unsafe abortions' and unwanted/unintended pregnancies in the Democratic Republic of Congo (DRC). The results can contribute to a better understanding of women's and girls' needs regarding unwanted/unintended pregnancy, an improved acceptance and better treatment of women who have undergone abortion and present with abortion related complications and the identification of measures aiming to reduce the burden of unsafe

abortion related complications and maternal death. These outcomes can then be used to directly inform MSF operations and could serve the purpose of awareness raising and advocacy on one of the most important and entirely preventable causes of maternal mortality.

3 Methods

3.1 Study design

The research design is qualitative as the study aim required an exploratory approach to understand and document perceptions and attitudes towards termination of pregnancy (ToP), including on request (TPR) and unwanted/unintended pregnancies (UWP), among health care providers, population and local leaders in the DRC [26]. The methods used for data collection were in-depth interviews, participant observation and group discussions. A methodological triangulation of findings was undertaken to enhance the interpretation of data, in-depth individual interviews were combined with group discussion, participant observation and document reviews [27, 28]. That way triangulation enabled an accurate representation of reality through use of multiple methods or perspectives for data collection [29].

3.2 Study settings

The first qualitative study was conducted in the province of North-Kivu in an OCA project in Mweso between 9th and 31st May 2017. This geographical area is characterised by a highly vulnerable population because of political instability (conflict, violence especially towards women, migration and population displacement due to internal and external conflicts etc.).

The second study was undertaken in in the province of Ituri in an OCG project in Mambasa between 6th and 30th July 2017. Like North-Kivu this area is also characterised by a highly vulnerable population because of political instability, the desperate economic situation in Epulu and Molokay because of the RFO[11] and the dynamics of sexual exploitation in the mining areas of Biakato and Teturi.

The third study was conducted in the province of South-Kivu in an OCBA project in Lulingu between 31st July and 20th August 2017. In the same way as North-Kivu and Mambasa, Lulingu suffers from the political instability (conflict and violence especially towards women) and the geographical particularity of Lulingu, reachable only by foot, motorbikes or by plane, migration and population displacement due to internal and external conflicts etc. The population in all three areas face difficult or reduced access to health care facilities, especially to sexual and reproductive health services (SRH), and the social and legal environment condemning unwanted pregnancies and termination of pregnancy.

Sexual violence in the DRC has been one of the most devastating aspects of the armed conflict that began in 1996 [30-34]. As a consequence, unwanted pregnancies and unsafe abortions persist as health hazards, especially jeopardizing women's sexual and reproductive health [8, 19, 21, 35-39]. A general worldwide trend regarding abortions can be experienced; the substantial decline in the abortion rate has stalled and the proportion of all abortions that are unsafe has increased [17]. Women still die because of unsafe abortions; safe abortion care has lagged behind and is not available in most of the contexts.

3.3 Study population

The study population was a composition of different groups of respondents in and around **Mweso**: women and men, health care professionals (MoH and MSF) in sexual and reproductive health care facilities and their various community intermediaries[12], resource people and key informants like community and religious leaders, local authorities[13], the general population in the study sites, TBAs, women with sexual violence experiences and health promotion team members. Study participants were purposively selected with the help of MSF and MoH staff and community health workers. Interviews were held in the Catholic Hospital in Mweso, in the different health centres MSF supports (Kitchanga, Kachuga, Bukama, Kalembe) and in the communities in and around these locations. The team did not visit Mpati and Mibwe due to insecurity in the area.

(11) Please refer to https://fr.wikipedia.org/wiki/R%C3%A9serve_de_faune_%C3%A0_okapis (accessed 3rd January 2018)

(12) Community intermediaries are TBAs, community health worker, community health promoters, etc.;

(13) When we refer to local authorities we refer to the police or any other political authorities. With community leaders we mean village leaders, village elders, etc.

In the second study site the research participants were also a composition of different groups of respondents in **Mambasa** centre and the two peripheral subprojects in **Epulu and Biakato**. Interviews were held in the general reference hospital (*hôpital général de référence* HGR) Mandima and in the private catholic hospital Mama wa Yesu in Mambasa, in some private health centres in Epulu and Biakato and in the different health centres MSF supports in the two health zones: Mambasa with Binase, Epulu and Molokay, and Mandima with Teturi, Biakato and Bella and in the communities in and around these locations. The team did not visit Bella due to time constraints.

In the third province the same study population was composed as it was in the previous two study sites and the team worked in **Lulingu and Lukala**. Interviews were held in the general reference hospital (*hôpital général de référence* HGR) Lulingu and in one private health facility of the Methodist church open since May 2017 in Lulingu and in the communities in Lulingu and Lukala. The team did not visit the peripheral projects in the South and North due to security constraints (armed groups active) and accessibility (spending hours to reach by motorbikes).

3.3.1 Sampling and study participants

In **Mweso** the study team conducted 53 interviews, 45 in-depth individual interviews and 8 group discussions. A total of 75persons were talked to.

In **Mambasa** the study team made 62 interviews, 32 in French and 30 in Swahili, 41 in-depth individual interviews and 21 group discussions. A total of 109 individuals participated.

In **Lulingu** the study team conducted 45 interviews, 23 in French and 22 in Swahili, 38 in-depth individual interviews and 7 group discussions. A total of 67 persons participated in an interview.

A purposive sampling method was applied. People of different age, from different ethnic groups and from different areas were selected to learn more about their perceptions, attitudes and personal experiences related to the focus of this study [28].

In **Mweso** only three individual interviews were undertaken with victims of sexual violence and only two persons spoke about the wish to receive safe abortion care. In no other discussion did any woman talk about a personal experience of an UWP.

In **Mambasa** territory a considerable number of interviews were undertaken with victims of sexual violence mainly in Molokay and Epulu and numerous women expressed either that they attempted to abort and it did not work out or that they wish to have access to safe abortion care, which stands in strong contrast to the findings from Mweso in North Kivu. Many women talked about personal experiences of an UWP. We did also interviews with ‘teenage mothers’ who appear sometimes with an age above teenage age, but they are called as such because they got pregnant first as teenagers.

In **Lulingu** an important number of interviews were undertaken with young men and women including ‘teenage mothers’. Results were quite different to Mweso in North-Kivu where moral attitudes towards ToP were expressed while in Mambasa in Ituri women openly spoke about personal experiences with UWP and expressed the wish to have access to safe abortion care. Additionally and particularly interesting one interview was done with a local anthropologist who highlighted and confirmed findings from the general population regarding ‘Lega tradition’ in relation with sexual and reproductive health matters.

Additionally, interviews were performed among the general population not directly linked to the services MSF provides. Households were randomly chosen to cover the geographical area of the project. MSF (medical and non-medical) and MoH staff was directly asked if they agreed to be interviewed.

3.4 Data management and analysis

3.4.1 Data collection

The first line research methodologies applied were individual interviews and participant observation; group discussions were conducted only with the general population, i.e. a group of men or a group of women or a group of 'teenage mothers' or students.

The PI conducted the in-depth interviews and group discussions with the help of local female and male interpreters. All conversations except one in Kitchanga (Mweso) were audio-recorded with permission of the participants. Additionally, handwritten notes were taken. A research assistant located in Bukavu transcribed the interviews. All data were converted into electronic versions with passwords for safety to ensure confidentiality. Original quotes from the interviews transcribed into French were translated into English by an anthropologist.

In-depth interviews

For data collection related to perceptions and attitudes towards UWP and termination of pregnancy in-depth interviews were conducted using a topic guide. This qualitative method provides an emic perspective, the insiders' perception [40]. Most of the interviews with health care providers took place where they worked in a quiet place and with people from the communities in their homes or a place they chose. With local authorities interviews were done in their offices or at their homes.

Group discussion

For group discussion participants were composed according to their gender, age and personal background. Victims of sexual violence and 'teenage mothers' were all interviewed separately as this was experienced to be more convenient for them.

Participant observation

Observations were carried out as part of the data collection as it gives account to what people say and what they actually do [41] and it exemplifies the "mundane and unremarkable features of everyday life" [27]. An important topic for participant observation in this study was how health care providers perceived and treated women who presented with SRH related matters at a health care facility. At the same time observation was also addressed towards patients and how they addressed the health care providers. In any case the anthropologist's job involves constant

observation [42]. Nevertheless, it has to be considered that the observers may influence the research setting, also referred to as the Hawthorne effect [43].

3.4.2 Data analysis

Audio-recorded in-depth interviews, group discussions and notes taken during interviews and participant observations were transcribed after data collection. Data analysis was conducted by the PI, then discussed with the study assistant for accuracy and quality assurance. The manual analysis involved a thematic content analysis by Mayring (2010). This means that the transcriptions were screened for relevant information, which was then organised, coded, categorized and interpreted. A category (label) was attached to the statements in order to structure the data [44]. The content was analysed in two ways: descriptively by describing data without reading anything into it and interpretatively by focusing on what might be meant by the responses [45].

Continuous reflection on data is part of the creative process of analysis and necessary for contextualising and linking of findings with theory. In order to work with the principles of good practice, the research process is clearly described in this report; validity of data is therefore ensured by presenting a "thick" description[14] of the research context and also by presenting deviant cases [46].

A methodological triangulation was applied; in-depth individual interviews were combined with group discussions, observations and document reviews [27 - 29].

3.5 Study limitations

This short-term study is designed to provide answers to current operational questions. Gathered data will not amount to long-term or multi-sited[15] anthropological fieldwork.

The main limitation of this study was the sensitivity of the topic because of the restricted Congolese abortion law. This limitation was reduced to a minimum by not talking directly about termination of pregnancy at the start of any interview but asking questions about problems related to sexual and reproductive health which in most cases led to the subject of abortions.

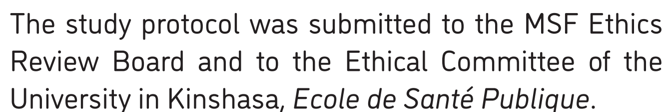
The translators were identified by respondents (interviewees) as MSF, which created response bias. This risk of bias was minimised by careful explanation of the role of the PI and her neutrality and strict assurance of anonymity and confidentiality.

Working with an interpreter can be limiting since the quality of the interpretation depends very much on the interpreter's soft and hard skills. Training the interpreter on soft and hard skills for the job mitigated this limitation.

Finally, qualitative data are always influenced by the presence of the researcher at the field site. In addition, the background of the researcher (gender, age, social status, origin, etc.) shapes the research process. This implies for the researcher to take a critical stance towards her position in gathering data and analysing the findings.

(14) Originating from Geertz (1973), a "thick" description of human behaviour is one that not just explains the behaviour but its context as well, such that the behaviour becomes meaningful to an outsider.
(15) Multi-sited fieldwork takes a comparative approach and studies phenomena at different sites and time periods.

4 Ethics



The study protocol was submitted to the MSF Ethics Review Board and to the Ethical Committee of the University in Kinshasa, *Ecole de Santé Publique*.

Informed consent was required for all respondents of the study. This was done orally in only a few cases as well as written. The informed consent was sought at the beginning of any individual interview or group discussion. Participants' confidentiality was respected and all data obtained through in-depth interviews were anonymised without inclusion of any personal identifiers such as names [47].

Verbatim quotations in dissemination materials like this report are designated by the interview number, age, sex and category of participant (e.g. male leader, 41 years, South-Kivu).

Interviews were tape-recorded when the respondent gave permission, which was obtained in all conversations. Additionally, the primary investigator took notes after the interview. Each respondent was assured of the confidentiality and privacy of the interview and informed that s/he is free to stop the interview at any time or refuse to answer any questions.

For the group discussions, informed consent was also obtained verbally or written. The translator introduced the aim and objective of the study. Participants were advised that they are free to leave the group at any time and can choose their level of participation throughout the session.

5 Major findings

This report provides an analysis of perceptions and attitudes towards unwanted pregnancies and abortions from the perspective of the local population, local and religious leaders and health care providers in Mweso (North-Kivu), in Mambasa (Ituri) and in Lulingu (South-Kivu).

The findings are presented according to the different understandings of women, girls, the general population, local leaders and medical staff only reflecting what was found in interviews with various respondents. We will elaborate on similarities and differences in perceptions in the three areas with the overriding purpose to design most appropriate MSF missions and programmes to improve the situations for women and girls.

To understand why unwanted pregnancies occur frequently in Mweso (North-Kivu), in Mambasa (Ituri) and in Lulingu (South-Kivu) and most often lead to unsafe abortions, we will elaborate on the reasons for unwanted pregnancies, which result from local perceptions on women's sexual and reproductive health as well as difficult living conditions in general. These reasons for unwanted pregnancies are in strong connection to the reasons for abortions, even though we cannot equate them, since unwanted pregnancies not always lead to abortions. We will, further on, go into unsafe abortion methods and their performers and costs. How abortion care is perceived will be analysed from the perspective of the community and health care providers. Women's health seeking behaviour and access to obstetric care as well as provision of sexual and reproductive health services including post abortion care will conclude this study.

We represent the voice of the people we talked to and will also use their language. To underline and strengthen the validity of what was said, quotes will feed in the presentation of the results.

Specific features in Ituri

Before going into the findings we would like to draw your attention on the specificity of the Okapi Wildlife

Reserve's extensive consequences on the population in the health zone of Mandima. The damage caused by the RFO to the people's economic activities represents a serious problem for their survival. Subsistence farming was the basis of people's life but because of the RFO they cannot plant anymore, as the animals would destroy everything.

This precarious situation forces families to depend either on women's small trading business, when they travel to the illegal mines selling goods or on women's transactional sex with employees of the different institutions related to the RFO or other NGOs in the area.

Specific features in South-Kivu

Expressions about sexual violence, the causes and the consequences that go along with it always had a connotation with the 'forest' as this is the place where the rebels live, act and attack. Lulingu is characterized by its remoteness and difficult access; it

is a geographically 'locked' municipality surrounded by a dense forest with an alternating control of the zone either by armed militias, the *Raia Mutomboki*[16], or the FARDC. In interviews and discussions respondents constantly referred to the 'forest' when talking about political conflicts and individuals confronted with these conflicts. The forest is the place where armed militias maraud but also where people hide during armed attacks. Women in and around Lulingu have to pass the forest to reach their fields for farming and harvesting; these fields are located outside and sometimes far from the villages. If families want to survive, women and sometimes also men need to reach their fields to get basic foods like manioc and cassava leaves (*sombe* in Swahili) and to collect firewood in the forest. Whenever women and people in general go from one village to the next one, they have to pass the forest with the risk of being assaulted or raped. That is why the forest became a symbol of danger and violence but also a symbol of rape and unwanted pregnancies. A sexual violence (by armed groups) related pregnancy is called a 'pregnancy of the forest 'or 'a child from the forest'. People also say 'she came with the pregnancy from the forest' or 'she had her pregnancy in the forest' which always means that the woman was raped by armed (militia) groups.

5.1 Unwanted/unintended pregnancies

5.1.1 Local perceptions on menstruation cycle and conception

Local perceptions on sexual and reproductive health as well as local features related to pregnancy and childbirth strongly contribute to unwanted pregnancies, which is why we analysed this wide spectrum of perceptions as a basis before going into the conditions that give rise to unwanted pregnancies.

(16) For further information on the Raia Mutomboki please refer to: http://congoresearchgroup.org/who-are-raia-mutomboki/ (accessed 19 July 2018).

5.1.1.1 Knowledge about the menstruation cycle

Knowledge levels of sexual and reproductive health are low in all three areas.

In **Mweso**, it depends very much on the education level, if women and girls understand their menstruation cycle and are aware of their days of conception. Especially women from distant places and remote villages lack knowledge and therefore get pregnant unintendedly not realising for some time that they are pregnant. Some women only realised their pregnancy in the sixth month or only when the child in the womb starts to move.

In **Mambasa**, it was also recounted that girls do not know their menstruation cycle and get pregnant without being aware that they are in their fertile days. In a group discussion with men in a Mbuti camp near Epulu they explained the way conception works as women's and men's 'blood' having to mix.

The sexual education that girls in this area traditionally received within the family does not seem to be part of young girls' upbringing anymore because of changing family dynamics, political instability and as a consequence of the high mobility of the population. If girls are educated at all, it is in the form of informal talks among adolescents. In earlier times it was part of a mother's responsibility to talk to her daughters from the age of 10 years on. Nowadays many girls grow up with relatives and not with their biological parents and the traditional education disappeared. Also, it depends very much on each family, their educational and economic status and their interfamilial relationships how mothers deal with their daughters' first menstruation. When a girl has her first menstruation, she will talk to her mother who will then only instruct her on what to do and what to use. Here again it depends on the financial situation of the family, if the girl can buy sanitary towels or if she has to use fabrics.

In **Lulingu**, the Balega do not have a formal traditional initiation for girls either. Girls normally are instructed

to 'life' by 'everyone' in the community. To prepare a girl for marriage, sexual matters, pregnancy and childbirth is entrusted to elder women; it can be the maternal or paternal grandmothers or aunts depending on who lives in the same household with the girl. In other families it is the mother.

Boys, on the other hand, can join the initiation, where they pass from childhood to adulthood, every five years, at the age of 11, 12 up to 18 years. They learn everything related to *Lega* tradition during the initiation period where they live in the forest with elder men for about two months. A boy becomes a man during the initiation. It is said that they meet the famous forest spirit *Kimbilikiti* and have to pass several dares to prove that they are qualified as men. They are considered to be 'newborn' when they 'exit' the initiation and they are not allowed to talk to female members of their community during one month. Boys learn, among other things, how to treat women and how to act as men in general and especially how to behave in a (marital) relationship.

5.1.1.2 Perception of the foetus

The perception of the foetus influences people's attitudes towards termination of pregnancy. The point in time when the foetus is considered a human being determines the time when people get more reluctant to terminate a pregnancy in a safe or unsafe way.

In **Mweso** the foetus is considered like water, without any form, in the very beginning of a pregnancy. At that stage the foetus is considered not viable. According to the majority of respondents the foetus is only considered a human being when it starts to move in the womb and the woman can feel the movements. Some concluded that this is in the fourth month of pregnancy; others said it would be in the third month.

In contrast, a few men suggested that the foetus is considered a human being from the moment of conception and therefore they considered termination of pregnancy (ToP) not tolerable, similar to religious leaders, who perceive a couple having sexual intercourse – regardless if it results in conception – the start of a human being, which means that even emergency contraception (EC) would not be allowed. The Seventh-day Adventist Church even states that the semen is already a human being, therefore family planning is forbidden, including condom use, as well as any form of termination of pregnancy.

In **Mambasa** the foetus is considered to be only blood in the first month of a pregnancy and not yet a human being. Therefore, a termination of pregnancy would be feasible. As in Mweso, the foetus is considered to be a human being after three to four months of pregnancy. Some respondents, however, suggested it is only viable with six months and another woman meant even if it was born with seven months it would premature and not viable.

> *"There are cases where a woman gets raped and she becomes pregnant; when the pregnancy is still too young – one month for example – there is nothing but blood, there is no human being yet; then, one can agree with the nurses [the medical staff] to take it away; one can abort [have a medication abortion] so that the reputation [of the woman] won't be spoiled, so that one would not get covered in shame. [...] If it is still small one can abort; but if it is already advanced [big] and you try to abort, one can die. In order not to die from abortions we leave them like that. [...] Before this will become a human being one can say that it is blood [damu in Swahili]."*
> GD women, Ituri

In **Lulingu**, among the *Balega*, a foetus is not considered a human being before birth. An induced abortion is considered killing a person because of the influence of the Church on Lega beliefs.

5.1.2 Local features related to pregnancy and childbirth

Women described socio-cultural determinants related to pregnancy and childbirth and elaborated on specific rules and regulations they have to respect as well as dangers they are exposed to during pregnancy.

5.1.2.1 Getting pregnant

In all three project sites, pregnancy is expected from every married woman, but considered unacceptable for an unmarried one.

In **Mweso**, unmarried girls who get pregnant have to leave school, are dismissed from their job – if it is connected to the Catholic Church – rejected by the community, banished from the Church and the school, expelled from home by the parents and in most cases abandoned by the man who made them pregnant. The reason for the pregnancy is irrelevant, even in case of rape, the girl and her family are the ones who have to bear the burden. A Congolese proverb says: *'If the unmarried girl gets pregnant, it is the burden of her family'*. From a religious perspective, pregnant unmarried women are considered deviating from the expected social norms and behaviour and therefore condemned as sinners.

In **Lulingu**, pregnant young girls traditionally have to leave their parents' house and stay with their paternal aunt until the child is born. They are viewed with an appraising perception and even more when rape is the reason for the pregnancy. Three months after delivery they are allowed to come back. Sometimes, after 10 or 20 years, the child's father can claim his child with a caution of one to three goats, which is quite likely, since a child signifies richness for the *Balega* and the biological father always 'owns' the child. A child without an ‚owner' will be stigmatised when it is born. A child born in the absence of his father, without an 'owner' who accepted the pregnancy as his and took responsibility, is called *museleka* meaning *„the child is like a tree that has fallen without having been cut"* (Lega proverb).

In all three areas a girl that is pregnant without a husband is seen as a '*femme libre*'. '*Femmes libre*' is the denomination for any 'free' woman, meaning a woman who is not married yet. In DRC '*femme libre*' is also the term used for 'prostitutes' or commercial sex workers and young girls engaging in transactional sex.

5.1.2.2 Moral rules to respect during pregnancy

In **Lulingu**, men and women have to follow moral norms and fulfil social obligations during pregnancy.

The *Balega* have strict regulations how men and women and husband and wife should behave in a marital relationship and above all during pregnancy. For women infidelity is strictly forbidden and a taboo. This is not the case for men, only when the wife is pregnant or breastfeeding, then the husband has to be faithful. The disease that would emerge from infidelity is called *Tshanga*[17].

A pregnant woman is supposed to continue practicing sexual intercourse with her husband to '*keep the path open*' for the delivery. If the husband lives or works far away from his wife, the child will be born weak. It is the husband who makes the child strong and healthy with his semen. From the fifth month of pregnancy onwards the couple must sleep in separate beds as the husband could kill the baby when having sex with his wife. This goes along with a ritual cleansing in the third trimester of pregnancy in order for the baby to be clean when it is born.

5.1.2.3 Diseases/conditions during pregnancy and childbirth

The most striking similarity in **Mweso and Lulingu** in terms of diseases that people believe they can suffer from during pregnancy and childbirth is a condition that develops as a result of infidelity causing a long and/or complicated delivery.

In **Mweso** the condition is called *Sanga*. It develops when the husband was unfaithful during his wife's pregnancy. The mixing of different body fluids is said to have negative consequences for the woman and the childbirth. The woman has to undergo a purification

(17) *Tshanga*, understood from its origin in Lega culture, is a social and moral regulation within Lega society. A medical doctor who received women 'suffering' from *Tshanga* explained that they all had an STI but told him that they had extramarital sex during their pregnancy and therefore would suffer from *Tshanga*. These women feel guilty and are afraid of complications during delivery.

ritual before delivery otherwise she would either face a long and difficult delivery, the baby could die or in the worst case the mother could die as well. For a woman to have a smooth and quick delivery, incisions are made on her belly.

In **Lulingu**, the disease is called *Tshanga*. In contrast to Mweso, it cannot only develop as a result of infidelity during pregnancy but also as a result of rape. Paradoxically, rape is referred to and perceived like infidelity – thus breaking a taboo. *Tshanga* literally means that the body fluids of two women or two men mix in one person. *Thsanga* can be 'diagnosed' in the praying rooms. Also, a traditional birth attendant can see when women are suffering from *Tshanga*. It is treated with confession and herbal medication to open the cervix. Once the woman or her husband 'confess', the delivery will continue smoothly. When discovered in the hospital and no one can be found to confess, the woman could die. Women additionally take *katulumona*[18] before delivery to ease and to push the delivery.

If the husband had extramarital sex, he must confess to his grandfather before his wife gives birth. If the married woman was unfaithful, she too has to admit what she has done before delivery. She has to talk to her maternal or paternal aunt or to her grandmother. Other than her husband who can confess openly, the woman has to do it secretly. If the woman's infidelity became known in the community as well, additionally to the treatment to avoid *Tshanga*, she is punished and has to pass through a sacrifice for reconciliation. Her family has to pay a goat and a ritual is performed with this goat. The same ritual is held in case the woman was raped to purify her body and to reunite her with her husband. A goat is slaughtered and the goat's blood is splashed over her hands and feet. If a woman, pregnant from rape, continues sexual relations with her husband, she will also develop *Tshanga*, and therefore also has to undergo a ritual purification to avoid the above-mentioned problems during delivery.

A female member from a local NGO working with victims of sexual violence (VSV) recounted that many men divorce their wives who have been raped out of fear of dying from *Tshanga*. They believe that they could die if they stayed with their wives, since a raped woman is considered impure.

In **Mweso**, additional conditions that were described by the respondents include *Ruhima*, which is a disease that affects the blood of the baby resulting in the baby being born with dark skin and sometimes it can develop black lines in the middle of the body later on. To protect it from this disease the mother should make incisions on the baby's body.

If a woman has an infection after her delivery, people say that she was bewitched. In such a case traditional medicine is used to treat her. People would say, '*She was eaten*'. To avoid haemorrhage after delivery, women are supposed to drink a certain medicinal plant[19] rich in iron constantly during the pregnancy. Another plant is recommended towards the end of the pregnancy, from the 8th month onwards, to prepare the woman for the childbirth but more precisely to open the cervix.

In **Lulingu**, a pregnant woman is not supposed to look out of the door without going outside during pregnancy as this could provoke a difficult delivery and the baby could get stuck during birth.

Bisiki[20] – genital warts – is a disease that women get when they go fishing in the fish farms. The condition was described as small white worms or pimples inside the vagina that have to be cut out as they would provoke the death of the baby during delivery.

(18) The literal meaning of *katulumona* is to evacuate something.
(19) I did not ask for the plant name as this would have been out of the scope of this study. The most important plant was the one that is used like oxytocin and this plant is known as Crassocephalum Bumbense S. Moore.
(20) This Swahili word literally means the rest of a cut branch of a tree men trip over when they walk in the forest.

5.1.2.4 Witchcraft in relation to pregnancy

In all three study areas people believe that witchcraft can endanger the unborn child.

In **Mweso**, pregnant women are supposed to limit their movements as they could step on a curse and as a consequence the pregnancy would not continue or the child in the womb could die.

When women get pregnant in **Mambasa** they try to protect their pregnancy from bad forces like sorcerers because they could steal the foetus or make the pregnancy disappear.

In **Lulingu** the Balega consider a woman's body especially vulnerable during pregnancy and an easy prey for witchcraft. They believe that, out of jealousy, sorcerers could try to kill the foetus in the womb and render the woman infertile. Therefore women fear death during pregnancy, for themselves and for the foetus, and they fear death during childbirth. To 'protect' themselves against miscarriage, women wear **amulets** around the breast, they drink a mixture of herbs and eat dried clay, scientifically known as geophagie(21) [48], during pregnancy, called *katulumona*. *Katulumona* can be made of herbs mixed with water to drink or it is the powder of dried clay the woman eats.

Women also go to the '*chambre de prière*' (prayer room) to protect themselves, their pregnancy and their fertility. In the praying room the *mutumishi* (servant of God) will pray for them to protect them, he is usually not paid with money but with goods, soap, sugar, some food etc.

5.1.2.5 Nutrition during pregnancy

Nutritional taboos are believed to harm a woman's pregnancy, her child and the child's growth, which is why pregnant women abstain from certain food.

Mambasa		Lulingu	
Nutritional taboos	**Believed danger**	**Nutritional taboos**	**Believed danger**
Adili (Fig.1), the yellow-backed Duiker), is only eaten by men, has a lot of blood and bleeds a lot	Pregnant woman would suffer from bleedings	Eating a lot in general	Child would grow too much and lead to long/complicated delivery
Red termites (Fig.2) that destroy houses by eating the wood; totem animal of *Budu* clan	They would destroy the placenta in the same way	Eggs and milk	Child would be born without hair
Totem animal of families	These animals protect the families; are not to be eaten by any family members	Pangolin is the totem animal for the *Balega*	No one is allowed to eat it
Other animals could provoke a difficult delivery	Delivery would be like the animal's movement	Intestines	Umbilical cord could get wrapped around the baby's neck
Pork (for *Nande* women, originally from North-Kivu, now living around Biakato)	Delivery would be like the animal's movement	Fish with scaled skin	Child would be born with scaled skin
		Gambian rat	Child would not come out like the rat does not come out of the ground
		Small shrimps	Child would be born without legs
		Opening food wrapped with banana leaves must not be closed again	Woman would symbolically close the cervix the child being 'wrapped' inside her

Table 1: Nutritional taboos in Mambasa and Lulingu

(21) Soil eating or geophagy is a widespread phenomenon in sub-Saharan Africa; pregnant and breastfeeding women eat clay. For more information please read this article: https://www.ncbi.nlm.nih.gov/pubmed/20889178

In Mambasa it was additionally mentioned that a pregnant woman's emotional state could transfer to the baby, therefore pregnant women should not be put under stress.

Fig 1: Yellow-backed Duiker

Fig. 2: Red termites (driver aunt)

5.1.2.6 Rituals and rules after birth

In Mambasa as well as in Lulingu there are symbolic gestures after birth expected from the husband.

In the whole Ituri region, the father of the child has to give a goat to the woman's family in case she delivered traditionally to symbolically replace the blood she has lost during childbirth. Additionally the baby's mother should receive cloths for the baby, which is the case in Mweso as well, and other items that are needed after childbirth.

In **Lulingu**, depending on the financial means of each family, women dance and sing and march to the hospital with music to pick up the mother. This represents an important moment for the woman as it 'shows' that her husband cares for her.

In both study areas husband and wife are not supposed to sleep with each other after childbirth. In some areas they are not allowed to have sex with each other until the child can walk.

In **Mambasa**, a man whose wife is breastfeeding a child is not allowed to have extramarital sex because the child could die if he would have sex with his wife at the same time. Consequently, the husband refrains from having sex with his wife and only has extramarital intercourse. Women have no other choice than to tolerate their husbands' behaviour in order to protect the child.

Among the *Bambuti*, a man who had sex with another woman, has to take a purification bath before touching his child otherwise the child would die.

In **Lulingu**, husband and wife should sleep in separate beds after childbirth to avoid sexual intercourse. Normally, this was imposed to couples until the child can walk. The wider sense was birth spacing and preventing another pregnancy.

> *"Here, when a woman is about to give birth to a child she has to have her bed separated, far away from the husband's one; and if you still have parents, that woman will move out to stay with her mother or with her grandmother until the child will start to walk; you ask him/her [the child] for something and s/he brings it to you ... then, now you'll find the way because the child has become a person."* male local authority, 75 years, South-Kivu

A child born from rape has to be purified because it is considered impure and the Lega community would not accept it otherwise. With the ritual purification the child is considered like a child from the family. For that reason, elderly women come to the hospital to give herbal treatments to pregnant women before delivery.

5.1.3 Having many children vs. infertility and miscarriage

5.1.3.1 The number of children

In **Mweso and Lulingu** the wish to have many children was observed likewise.

In **Mweso** families perceive many children as wealth and guarantee for their life or they see it with fatality and attribute it to God's wish. Men want many children because this proves their manliness. Women desire many children because they get the attention and satisfaction of their husbands and families-in-law, and because on the day of childbirth the woman is important and gets presents that represents luxury. The notion that a woman is only of value, if she can bear children also seems to be decisive in the wish for many children. A woman who already had a certain number of caesarean sections or is in her menopause, has no value anymore.

In **Lulingu** men aspire to have many children because they represent wealth and ‚richness'. Some spoke about 12 to 13 children. The *Balega* view childbirth as a divine gift. A *Lega* proverb says, *'we refuse the pregnancy, but we cannot refuse the child.'* The *Balega* consider the child more important than the pregnancy. This is why unwanted pregnancies happen and are recognized as such, but the woman or girl should still keep the child. Every child is seen as a 'power and force' that enters the family. Ideally, a family should have many children because the *Balega* perceive themselves small in number. They speak about the wide area they occupy and the few individuals they are. Another *Lega* proverb says *‚Mwana bwato'*. *Mwana* is the child and *bwato* is the pirogue (dugout canoe), which means the child is the pirogue. Human beings build the pirogue but then it is this pirogue that will carry them to cross the river. In other words, the *Lega* raise the child in the hope to be raised one day by this same child when they are old.

5.1.3.2 Infertility

In relation to the strong wish of families to have many children, infertility is a very highly stigmatising condition for women in all three study areas.

In **Mweso** the absence of pregnancy after marriage evokes worries, stress as well as feelings of insufficiency and failure in women, as in most cases they are held responsible. An infertile woman is shunned and discriminated first by her husband and then by the whole community. Her husband will either divorce her, he can ask the dowry back that he had to pay to his wife's family before marriage or he will take another/second wife.

> *"In the community we consider her [the infertile woman] as useless und immediately the man remarries. The husband remarries and she has no access to the fields."* midwife, 39 years, North-Kivu

In **Mambasa** infertility is considered a matter of destiny and God's fate. It is said to be the result of prostitution, having had sex with too many different man, unwanted pregnancies and abortions.

In **Lulingu**, the situation is quite similar. A sterile woman has no place in the community. If a woman does not get pregnant within a short period after marriage, not only the husband but mainly his family or mother-in-law will push him to take another wife. In one particular case education was explained to be the cause for infertility because educated women might have had other men before getting married.

5.1.4 Conditions that give rise to unwanted/unintended pregnancies

5.1.4.1 Features of the relationship between men and women

The long-lasting and ongoing political instability has left its marks on social relations and its traditions going along with it. The specific features of the relationship

between men and women contribute to unwanted pregnancies to a great extent.

The dowry, rights of men and their superiority

In all three study areas the husband has to pay a dowry[22] to his wife's family and thereby he obtains certain **rights over his wife**. One of these rights is that he can expect and demand sexual intercourse whenever and wherever he wants, how and how often. If the wife refuses, he will either beat her or engage in extramarital relations, which he is allowed to do (apart from certain exceptions). Women are seen as slaves for their men. Additionally, they have to carry out a high daily workload (nourishing the family, going to the fields, harvesting, fishing), whereas men sometimes only idle around, drink and talk and impose their hegemonic behaviour, as women recount. The relationship between man and woman is determined by men's power and perceived superiority. They are of the opinion that women should submit to them. Furthermore, a man is not expected to be faithful to his wife; a woman in contrast is despised by men and the society as a whole when she engages in multi-partner relationships.

In **Mambasa** a great number of respondents referred to the Muslim inhabitants in the area[23] who brought the '*Arabisation*' and the polygamous tradition to the country and in consequence the idea of having concurrent partners was entrenched.

In **Mweso**, specifically, women are not allowed to initiate sexual intercourse in some ethnic groups. They are not allowed to talk about it or to talk about sexual issues in general. In a group discussion, men emphasized that it is also not well perceived if a woman expresses her feelings of love to a man.

In **Mweso and Mambasa** women complained about men's behaviour of treating them as objects of pleasure that can be 'used' at any time in whatever way, for sex, for work and to bear children.

> *"The woman is first of all an instrument of pleasure for the man. When you are in need of a woman, or you need to be satisfied on the spot well, you have to look for a woman whoever it might be, no matter which one, that is a bit the conception here. And also the conception we have about a woman, – that she is a weak person who has not enough physical strength and even considering her place in the society; she is a person, which is a bit inferior as compared to men. Thus, one can abuse them as one likes because one knows that I, the man, am always superior, I have a right over her, that she belongs to me."* Male doctor, 45 years, Ituri

In **Lulingu**, women also reported that their husbands would not travel, so they can never 'rest' and get pregnant continuously because they have to accept sleeping with their husbands, even during menstruation, which in former times was a taboo. However, men also felt that younger women would start to challenge these masculine concepts and try to imitate the 'white' mentality in Mambasa and Lulingu.

The quality of marriage and the perception of infidelity

Women are caught up in a vicious circle that started with the meaning of marriage having been lost. **Especially in Lulingu**, marriage is nowadays understood as the husband taking care of his wife financially. Once the dowry is paid, the husband does not care for his wife anymore. Marriage is limited to sexual intercourse and cohabitation. Women are not adequately cared for, which can result in poverty. Poverty, on the other hand, forces women to engage in transactional sex for survival, which can result in unwanted pregnancies as well as STIs. Women who are unfaithful are again seen as prostitutes and lose their value and dignity in front of their husbands, which is why the quality of marriage will deteriorate even further or the husband might divorce his wife, which will drive women

(22) In Lulingu, e.g., the dowry consists of a number of goats (five to seven), cloths, pots and money (100-200 USD), depending on what the woman's family asks and how much the men's family can afford. After marriage the couple should stay in their own house.

(23) Muslims first came in the 18th century to the eastern part of the country mainly for commercial reasons. For more information please refer to: http://insamer.com/tr/muslims-of-the-democratic-republic-of-the-congo-drc_1090.html (accessed 7th June 2018).

further into poverty. Women also get jealous because their husbands engage in extramarital relations and therefore do the same. Pregnancies resulting from extramarital sex of women are always unwanted, accompanied by the wish to abort. Wives of ex-rebels, who participate in reintegration programs in bigger cities, might also engage in extramarital relations during the absence of their husbands. Pregnancies resulting from such relations are unwanted as well and women want to abort by all means, because they are afraid of their husbands' reaction. In this day and age, people marry easily and divorce easily. The dowry might have to be paid back to the husband's family, which can sometimes pose a serious problem for the wife's family as they have to find the same value to reimburse. This again can lead to poverty and the woman is forced to engage in transactional sex as a means for survival, which, in turn, can result in unwanted pregnancy.

In **Mambasa** women also spoke about their difficult situation in terms of marriage and unwanted pregnancies. They are either not satisfied by their husbands because they engage in extramarital relations and as a consequence, like in Lulingu, do the same, whereby they risk unwanted pregnancies or the couples constantly quarrel at home, the husbands do not take care of their wives, drink too much alcohol and force their wives to have sex.

Sexual desire and infidelity

In **Mweso and Mambasa** numerous men recognised that they cannot be faithful to their wives and that they need other women and constant sexual intercourse to satisfy not only their sexual desire but also their self-perceived maleness. Additionally, it was said that it makes men proud to have many women they have sex with. It proves their virility and their maleness.

In **Mambasa** interviews suggested that this need to prove their masculinity and maleness is a result of conflict and war because men lost their role as breadwinners. They cannot work in their fields anymore because rebel groups would kill them, so only women work in the fields because they would 'only' get raped.

Birth spacing

In **Mambasa and Lulingu**, husband and wife are traditionally separated after birth to avoid another pregnancy. This is called birth spacing. However, since the couple should not have sexual intercourse until the child can walk or is at least two years old, this tradition constitutes another situation where men struggle to remain faithful to their wives. They might engage in extramarital relations during that time, which can result in the wife's jealousy and her consequently acting in the same way thereby risking an unwanted pregnancy; or women rather prefer their husbands having extramarital relations than getting pregnant again while breastfeeding a child.

> *"Another pregnancy kills a breastfeeding baby."* Local chief, 75 years, South-Kivu

In **Lulingu**, some couples ignore birth spacing, which can result in the wife getting pregnant while still breastfeeding another child. This is considered a taboo, which is why she will immediately stop nursing the child. In such cases the couple may decide to have an abortion in order not to harm the breastfed child. This situation is the only one where abortion is „socially accepted" in this area.

> *"The woman should not give birth to another child, only after two years; but if the woman falls pregnant before two years, the husband has the obligation to bring this woman to the hospital, and the husband signs the abortion. Here, the tradition cannot restrain, if a married woman falls pregnant and the child is not yet two years old, the family authorizes the abortion. Here, among the Balega, if the woman gets pregnant and the baby is not yet two years old, that baby must die."* Male anthropologist, 31 years, South-Kivu

5.1.4.2 Sexual violence

Sexual violence is one of the main reasons for unwanted pregnancies in all three study areas.

Perception

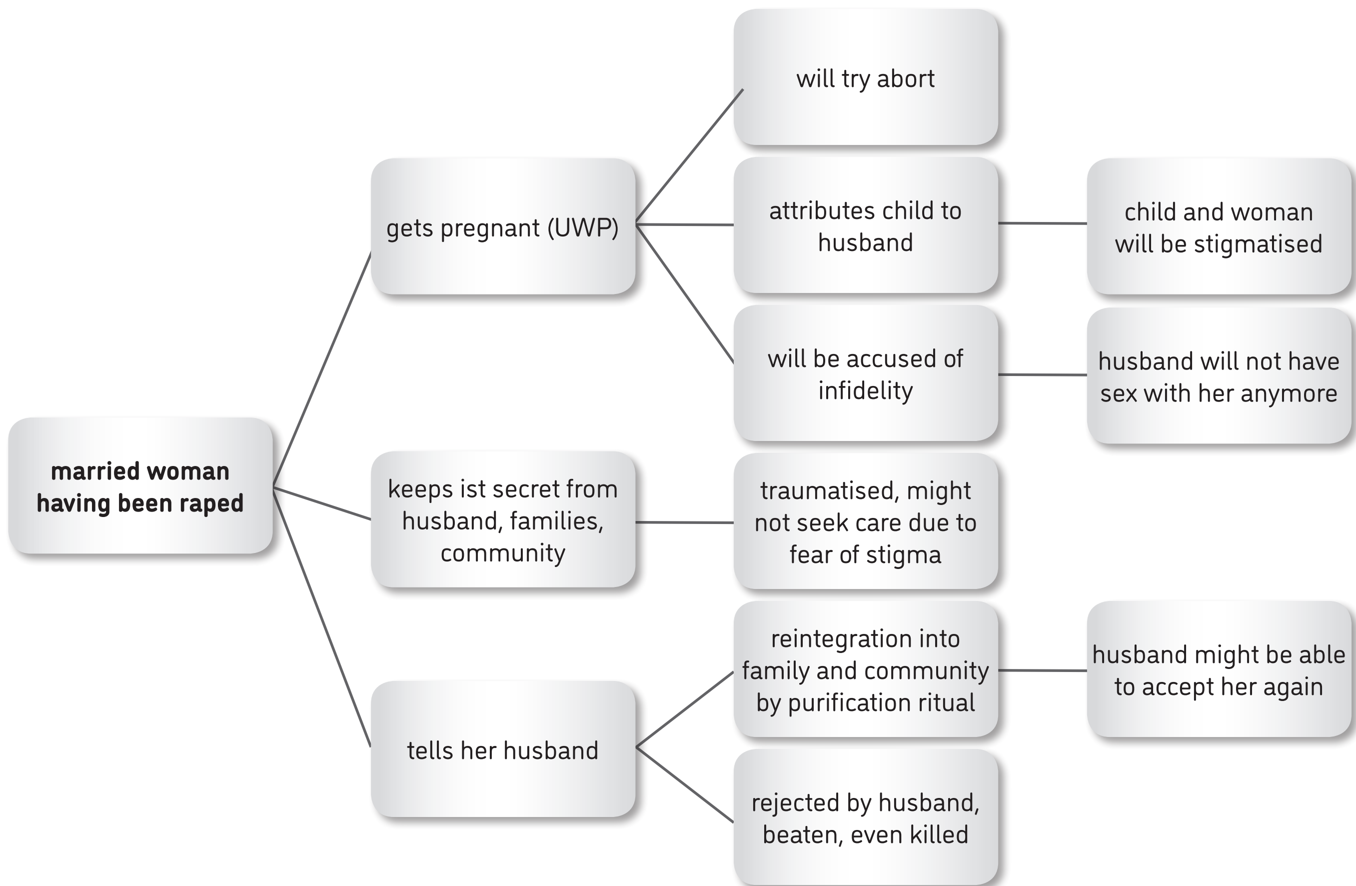
Victims[24] of sexual violence are highly stigmatised – no matter if married or unmarried – and the stigma not only affects the victims but the family as a whole. Rape is perceived as dishonour. In a group discussion with women in Lulingu, one woman said, 'When you were raped, you have destroyed the house (meaning the marriage)'. This means raped women are blamed for having experienced sexual violence and they do feel guilty for what happened. Men also hold women guilty for having unwanted pregnancies as a result of rape.

(24) In this report we will use the term victims and not survivors as we represent an emic view and therefore use the wording of respondents and they spoke about victims. And we will talk only about women and girls as this report refers to SV in relation to unwanted pregnancies and safe abortion care.

In **Mambasa** respondents reasoned that sexual violence happens towards women and girls because they are too sexually dressed in the aggressor's opinion by wearing mini-skirts, tight cloths, showing their breast etc. This perception was mainly shared by male respondents and mostly local leaders. Furthermore, a raped woman is seen as a woman that belongs to everyone. In a village close to Epulu some even called raped women prostitutes despite knowing that they were forced. Due to victim-blaming and stigma, victims of sexual violence prefer not to talk about it, if they can hide what happened. Women fear repercussions, often do not trust the health facility and therefore do not seek care. Women and their families are also afraid of retaliation, if they would go to court, which is why they prefer to stay mute.

In **Lulingu**, people explained that sexual violence was always part of their society, yet its perception changed. Nowadays when men take a girl by force to sleep with her, they abandon her afterwards.

Sexual violence against married women

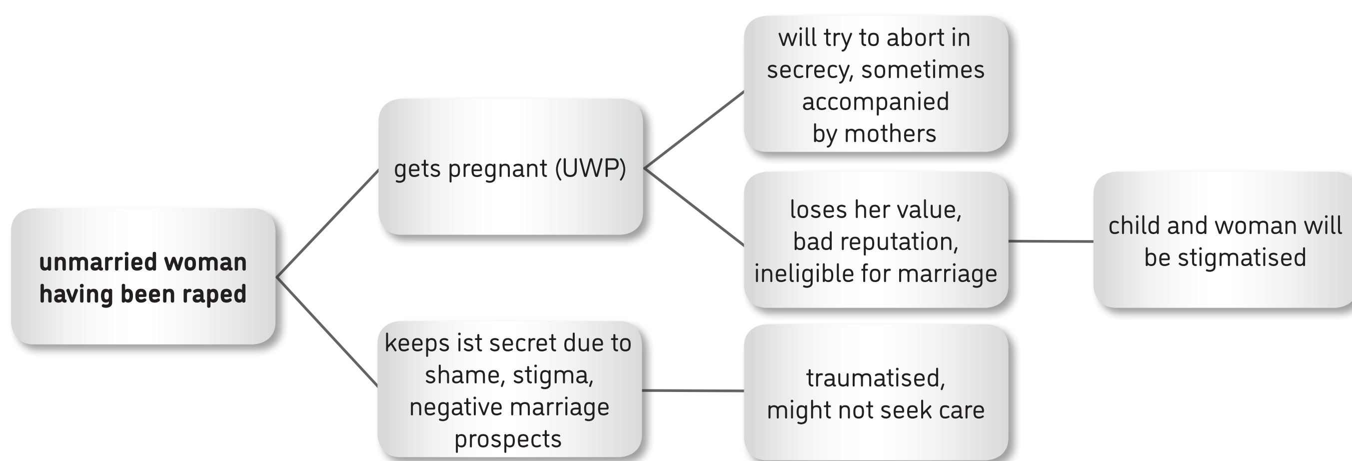


Graph 1: Difficult situations married women face when having experienced sexual violence

In **Mweso**, religious leaders differentiate between a pagan or a Christian in terms of men's behaviour. The Christian would rather stay with his wife if she had experienced sexual violence, but the pagan would leave her. Moreover, one of them said that they would express their condolences to the husband. Sexual violence within marriage is a crucial issue in all three study areas. In Biakato and other locations it is difficult for married women to prevent unwanted pregnancies within marriage because their husbands force them to have sexual intercourse. Even if women know that they are in their ovulation time and risk a pregnancy, they cannot avoid intercourse and feel powerless.

In **Mambasa** some people think that sexual violence related pregnancies have reduced but in reality women and girls just do not talk about it because they feel ashamed and fear losing their husbands.

Sexual violence against unmarried women



Graph 2: Difficult situations unmarried women face when having experienced sexual violence

Families in general do not want others to know if their daughters have been raped as this makes them ineligible for marriage.

In **North-Kivu** respondents particularly underlined the fact that there are more women than men in the society anyhow, so a young girl with a child from rape would have difficulties finding a husband, since it is already difficult for childless girls to find a potential future spouse.

Perpetrators of sexual violence

In **Mweso**, sexual violence is strongly related to war and conflict in the area. Sexual assaults happen frequently in the surroundings of Mweso when women go for firewood, to fetch water or to work in the fields, which they have to for survival and to try to find work. Around Mweso insecurity is still a major problem with ongoing clashes between different armed groups, resulting in internally displaced people that congregate in camps in Mweso. Especially displaced women and girls are sexually exploited because of the vulnerable situation they live in; however, sexual violence does not happen inside the camps. A local authority said that sexual aggression is a way for the armed groups to show that they are here. He described it as a form of sabotage. They try to destroy the social construction of a community as a whole, e.g. women are raped in front of their men. Sexual violence happens because rebel groups live in the forest, separated from their families for a very long time, and they want to display their power.

In **the whole Ituri region**, in Mambasa centre, Epulu and Biakato, sexual violence and rape has reduced significantly, however, sexual violence is still an ongoing concern. Nowadays sexual violence mainly happens in and around the illegal mines in the Okapi Wildlife Reserve (RFO, *Reserve de faune à okapis*) and in the mines around Biakato. In the clandestine mines around Epulu, the Maï-Maï commit ongoing attacks. Women are raped, men are beaten and humiliated and then forced to have sex with the women who have been raped. Women's dilemma is that they have to go 'to the forest' where the clandestine mines are – at a distance of one and a half to two days walk from the village through the dense forest – to sell goods and food items to the mine workers for survival. They are forced by the difficult living conditions, as they do not have any other means for survival for themselves and their families. Usually women from one family do not go together in one group because if they would be attacked, all of them could be dead. Therefore, they split into different groups. Sometimes they even have to sleep in the forest, which represents an additional danger. Armed groups are aware of this illegal trafficking to the mines. These women and their accompanying men are an easy 'prey'. Many of the women were already raped several times as recounted by a psychosocial staff.

> *"There are certain [women] who say to themselves: but I have been raped about three times. So, I accept the situation as it is and if I have to die, I will stay like that. I have no other choice. So, that's a bit the problem that we face and the women we hear during the consultation. There are collective rapes, there are women who say to themselves: well, I wasn't raped alone, they raped us 8, they raped us 10 and this is a situation that is known by the community. So, I don't find it that important to get treatment, I'm not the only one, I comfort myself when I see the other women."* Male psycho-social staff, 39 years, Ituri

Another potential risk for women to get exposed to sexual violence is going to fetch water in the early morning hours, since water sources are far away from the village and women have to walk a long way. In Mambasa centre it is said that now it is rather the 'non-armed' men who commit sexual violence and rape.

In **Lulingu**, militia groups are said to perpetrate 90 % of the cases of sexual violence, however, it was also said that rape cases have reduced since the militias were pushed back to the forest by the FARDC. Respondents explained their aggressive behaviour with their long stay in the forest without women. 10 % of rape cases occur within the community (by unemployed people and bandits) in villages among families and people who know each other like neighbours etc. as a form of revenge. By violating the woman, the perpetrator, a community member, actually wants to humiliate the husband. Sleeping with the wife of another man is the most humiliating act one can do to a *Lega* man. A large number of rape cases also happens within marriage because men impose sexual intercourse. Respondents working in the psycho-social support facilities and NGOs supporting victims of sexual violence acknowledged, that rape cases only seem

to have been decreased, whereas they are just not reported.

Regional forms of sexual violence

In **Mweso**, the occurrence of sexual violence did not change much over time but the notion of sexual violence was different in the past. The tradition called *kuterura (‚soulever de force')* was common, meaning when a young man wanted to marry a girl, he took her by force from her parents' house, had sexual intercourse with her, which in most situations meant he raped her, in order to 'label' her his wife. This tradition can be seen as a form of sexual violence but was not considered as such.

In **Mambasa**, the same tradition was called *okuhamba omukazi ('prendre la femme par force')* and it was likewise widespread. Some respondents recognised that this form of sexual violence still happened until recently in certain areas.

In **Lulingu**, another form of sexual violence people referred to is committed by pastors in the *'chambre de prières'* and by traditional healers who tell women that they should have sexual intercourse with them in order to get cured or as remuneration for their services.[25]

5.1.4.3 Lack of knowledge of sexual and reproductive health

In the Ituri region the lack of knowledge of sexual and reproductive health came up more frequently as reason for unwanted pregnancies, whereas in Mweso and in Lulingu it was mentioned only by a few and only by male respondents, who consider women responsible for preventing an unwanted pregnancy rather than themselves.

In numerous interviews in Mambasa women and girls emphasised that knowing the menstruation cycle would also mean knowing if a risk of pregnancy existed. Young girls from primary school do not seem to know how to avoid a pregnancy because they do not know their menstruation cycle. Due to this feature coming up, many respondents from the health care provider and health promotion side proposed to focus more on sensitisation and information on sexual and reproductive health matters and contraceptive use.

5.1.4.4 Lack of knowledge about and use of contraceptives

Counting the fertile days, avoiding sexual intercourse during these days as well as birth spacing (separating husband and wife after birth) were mentioned as traditional or natural family planning methods.

Discussions about contraceptives provoked rather moral and negative reactions. **In all three study areas** it was emphasised that a couple should have many children.

In **Mweso** men emphasised that promoting family planning and encouraging women to use it would prevent a woman to be a good woman, because a good woman has to have many children. This somehow correlates with women's understanding that they do not want to use family planning because not having enough kids would lead their husbands to taking another wife for having more kids. Family planning is also seen as a threat because it could encourage extramarital relationships and prostitution, as women could hide their infidelity by using contraceptives without risking a pregnancy while their husbands are abroad.

In **Mambasa** a male respondent from the *Bila* ethnic group compared family planning with punishing men as having many children means wealth for a family.

In **Lulingu** family planning and contraceptives were especially difficult to discuss among couples. Mostly it is only the women who get the information – if at all – during ante- and post-natal care. Respondents continuously referred to the *Lega* tradition and stated that people are not used to family planning or contraceptives and that a couple should have many children. It was understood in the sense that couples who use family planning would stop 'birth'.

(25) Such events are illustrated by Congolese artists who criticise with their paintings the crisis in the country, the political situation and sexual exploitation.

In all three areas people are not well informed about contraceptives. In **Mweso** most women and girls said that they did not know what was available, how to use it and where to get it. In **Mambasa** lack of knowledge about different family planning methods was reported in interviews with teenage mothers. Those who were aware of contraceptives said that there would be side effects, which is why they stopped using them. A teenage mother, who had her first pregnancy when she was still at school, has seven children now at the age of 33. She does not want to have more children and said she would use abstinence as a family planning method. In a group discussion with teenage mothers in **Lulingu** they confided that they are not well informed about contraceptive methods and do not feel comfortable asking for it.[26] In other interviews with pregnant women who stayed at the *Binyola*[27] in the hospital, they admitted that they do not know anything about family planning and contraceptives and only know that they can get pregnant when they have intercourse with their husband.

Perception of contraceptives

Perceptions on contraceptives were mixed, most striking being the notion of men's reduced pleasure in condom use, condoms being used by or with prostitutes and women's fear of side effects in other methods such as the contraceptive implant, Depo Provera or the contraceptive pill. Condom negotiation seems to be difficult for women in general; in marriage condoms are not acceptable or feasible at all.

In Lulingu, respondents affirmed that women can only use contraceptives if their husbands allow it. Condoms are said to be used by young men, moto-taxi drivers, schoolboys and young women, referred to as 'jeunes femmes libres'. However, it was specified that in reality only a few of these groups would really use condoms because it reduces their pleasure, others mentioned that 'it is like eating a sweet in a plastic' and others again complained that it would reduce their libido.[28] However, it was further discussed that since MSF came to the area and the HP teams sensitise and explain about family planning and contraceptives, women feel more at ease to use them.

In a group discussion with youth in **Mambasa** a female participant emphasized that younger men use condoms. A community sex worker explained that she also uses condoms, as she would not trust men. In a discussion in a private clinic in Epulu a doctor explained that the *Bambuti* use traditional plants for contraception, similar to a commercial sex worker who spoke about a traditional plant she uses in order not

(26) This problem was discussed with the MSF hospital nurse who then, together with the HP team, started to propose sensitisation about contraceptives for young girls.
(27) The *Binyola* is a place at the hospital in Lulingu with three different rooms, each with several beds, where pregnant women can stay until delivery.
(28) Another interesting point to look at would be how CSW and women in general are able to negotiate condoms.

to get pregnant. The woman explained that she uses the leaves of a plant she gets from the forest around Epulu, she cooks the leaves and drinks three glasses every six months.

In **Mweso** women who engage in transactional sex usually ask their clients to use a condom, but if the clients proposed to pay more without a condom, they might accept. In a group discussion a man, asked if they used condoms, said that he needed eight rounds (eight times sexual intercourse) in one night with the same woman, which would mean needing eight condoms a night multiplied by seven days a week. That would make 56 condoms a week. He wanted us to understand that it was difficult to constantly use condoms with such a high number of sexual intercourses. Other people emasculated this and stated that these men used drugs like 'Viagra' and other potency pills to make them virile and sexually excited.

Contraceptive methods that are most often used in **Mweso** according to different health staff are contraceptive implants and injections (Depo Provera), in **Lulingu** women prefer the contraceptive implant for five years.

Concerning side effects, women in **Mweso** who tried contraceptives said to have experienced strong ones and therefore stopped using them. Family planning is seen as dangerous and many understand that it could lead to infertility. People talked about constant bleeding and for that reason they could not engage in sexual intercourse with their partners. Apart from the fear of side effects, younger female respondents spoke about rumours that the condom would stay inside the female genital organ. In Mambasa women and girls who were aware of contraceptives also feared side effects from methods like the implant and Depo Provera and they said the pill would cause cancer, which is why they stopped using family planning methods. A health promotion team member in Lulingu reported about complaints regarding the implant 'Jadelle'. Women were saying that it is difficult to use because they sometimes experience continuous bleedings and belly pain for two weeks. This is similar to findings from the other two study areas.

Role of the Church

In contrast to the attitudes in Mweso and Mambasa, a Catholic priest **in Lulingu** said it would be great if first the young girls could be advised about faithfulness and only then they should be taught about family planning. It has to be pointed out that he was open towards contraceptives to protect unmarried girls from unwanted pregnancies and unsafe abortions and showed a positive attitude towards post-exposure prophylaxis to prevent conception. He even affirmed that he could talk about it in church. In **Mweso** the Church is completely against family planning. Priests and pastors preach recreation rather than limiting the number of children. Religious leaders often referred to the bible saying "*be fruitful and multiply*" as an answer to the question what they think about family planning and contraceptives. Religious leaders also tried to underline the fact that in some situations family planning would be the least concern on peoples' mind. They were mainly referring to the many internally displaced families in and around Mweso who struggle to survive. A Catholic priest in I**turi** said that once a woman has had intercourse (be it through rape or consented), she might have conceived already; taking post-exposure prophylaxis would mean killing a human. The Catholic Church does not allow condoms; this was confirmed by a Catholic priest and by male and female respondents with a Catholic background.

Availability and costs

	Mweso	Mambasa	Lulingu
Health centres and hospitals	Condoms for free, except for the hospital run by the Catholic Church, where contraceptives are not available at all	Condoms for free; and distributed after sensitisation sessions	Condoms for free
Private pharmacies	3 condoms for 100 CD (0,06 USD)	3 condoms for 100 CD (0,06 USD); contraceptive implant (5 yrs.) for 6 USD; Depo Provera (3 mths.) for 0,6 USD	3 for 200 CD (0,12 USD) twice as much as in Mweso and Mambasa because transported via plane
Perception of availability	Access to and use of contraceptives only an option for those who live in the surroundings of Tumainis and health institutions (health promotion and sensitisation activities); difficult if people live in the forest in small villages because they do not have the infrastructure there	Girls often do not know where to get contraceptives or do not feel comfortable to ask for it, whereas adolescents from Mambasa confirmed that they could access condoms for free; respondents wished to get better access to contraceptives	‚Prudence', the name of the local condom brand, was mentioned several times

Table 2: Costs of contraceptives and availability in comparison

5.1.4.5 Transactional sex and the reasons behind it

In **all three study areas**, the years-long and ongoing political instability influenced social relations and traditions, which relate to transactional sex that, in turn, provokes unwanted pregnancies particularly in Mambasa and Lulingu, whereas in Mweso transactional sex was not predominant in the interviews, even though it is an issue as well.

In **Mambasa centre** many young women work in the so-called QG (*quartier générale*), which are brothels and called *'maison de tolérance'* in French. Women and young girls live under the authority of a woman or man who offers these girls and women to men who come for a beer and sexual intercourse. These young women and girls are expected to animate men to drink and are then also available for sexual intercourse.

Epulu is said to be an environment of prostitutes and that men search their women elsewhere. In a group discussion with three men they explained that on the one hand the reason is that in Epulu there are living more men than women but on the other hand, in these men's views it is related to the educational level of these women.

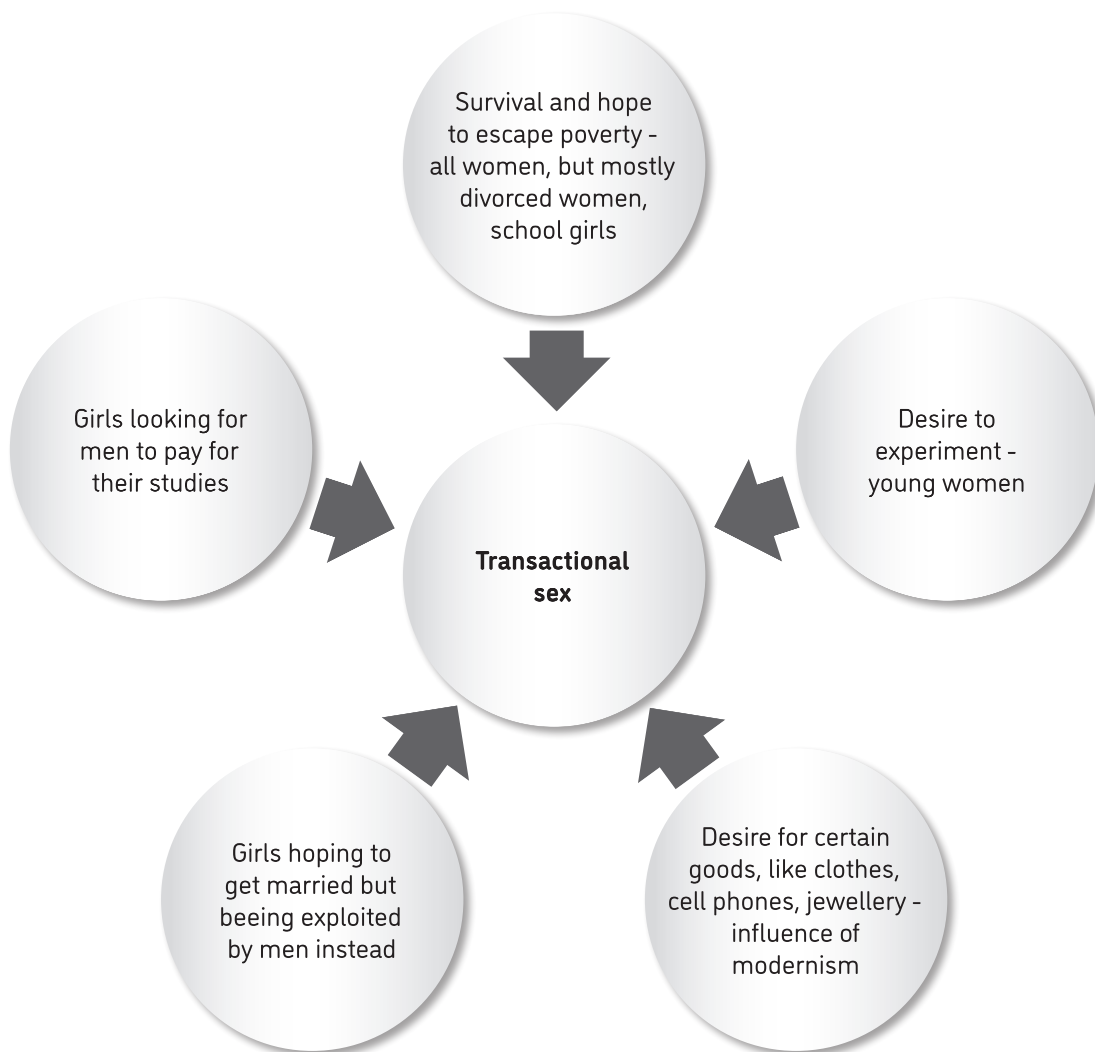
In the health zone **Biakato** the situation is very much concentrated around the so-called QG where girls live and 'work' for the reasons mentioned above. Most of these girls have fled the insecure environment in North-Kivu. In a group discussion with a group of policemen they said that in Biakato *"prostitution breaks the record"*. It seems that young girls from North-Kivu try to find their living in this area and end up in brothels. When there is no exchange with goods prizes may range from 500 Congolese Francs (0,3 $) to 20 000 Congolese Francs or even 20 $. In the QG prizes are paid directly to the owner of the institution but sexual intercourse takes place either in a hotel or

at the home of the client. In a group discussion one CSW replied to the question how much the client has to pay to the owner of the brothel that it would depend on the prize the girl would ask. Other respondents said that it is the owner of the QG who negotiates the prizes and who is directly paid by the client.

Lulingu has one QG (Quartier General = brothel) in the centre of the town, integrated in the Bar *'Mille Etoile'* near the market. The Bar has several rooms on the backside for sexual intercourse and works as follows: The manager of the Bar employs young women from 'outside' Lulingu. The (four) girls he engages are from Bukavu, Shabunda, Kindu, Kisangani or other places in the area. He specifies that there are *'filles libres'* in Lulingu and they would want to work in his Bar, but he does not employ them to avoid negative repercussions from their parents. He travels to these other places, chooses the girls, brings them to the hospital for examinations and thereafter engages them with a contract[29] for six months to one year. These girls work in his Bar, serve drinks, animate the clients and are available for an intimate encounter when required. A room costs 2,5 USD. A girl can receive 5, 10 or 20 USD from a client depending on the time they will spend together and their agreement. The Bar is constructed in a way that the clients can discretely move with a girl to the rooms. They enter from the street side and exit via the backside to the rooms. The beers are more expensive; they cost around 3 to 4 USD because they come by plane. The Bar opens at 2 pm until midnight. The owner emphasises that he advises the girls to use condoms and to not accept intercourse without. He states that the girls would be tested every week at the HGR in Lulingu for HIV and STIs. In case of pregnancy the girl has to stop working.

The clients of the Bar are from Lulingu and areas around, including the mines, and they are different kinds of people, including NGO employees. In a discussion with one of the young women working in the same Bar, she confirmed what the Bar owner had said. She acknowledged that she is happy with the conditions and the payment and emphasized that since she works in the Bar, the owner is lucky because they have a lot more clients than before. She explains about her work and the prizes she concludes with the clients. Different from the findings of the other two study areas, this woman is employed in the Bar and the clients pay her directly and not the manager of the Bar.

(29) He said he pays the girl 100 000 Congolese Francs (62 USD) per month. One of the CSW said she gets 100 USD.



Graph 3: Reasons for transactional sex in Mambasa and Lulingu

In **Mweso** divorced women and school girls engage in transactional sex for survival as well and consequently might face unwanted pregnancies. Displaced women and young girls would likewise engage in sexual intercourse in exchange for something to eat. School girls also experience unwanted pregnancies in love relationships often connected to some material exchange or through forced sex in power relations (teacher, supervisor or principal). According to the majority of respondents Mweso has become a place for 'prostitutes' because of the NGOs and the men employed by these NGOs. Girls start with transactional sex at an increasingly young age and they seem they have the 'silent' agreement of their parents.

5.2 Abortions

In numerous interviews respondents recounted experiences with safe and unsafe abortions. At times they talked about others in their social surroundings or in their community, sometimes about themselves. The reasons for abortions are manifold and go along with the conditions that give rise to unwanted and unintended pregnancies, even though we cannot equate them. How safe or unsafe an abortion will be is determined by social, financial and practical factors.

5.2.1 Reasons for abortions

For the following reasons women wish to terminate a pregnancy:

- **Stigma against unmarried pregnant women**

Pregnant unmarried women are confronted with stigma and shame. Socio-cultural reasons mark this ongoing stigma within families and communities who do not accept an unmarried mother with a child. The general attitude is therefore *"better dead than being mocked"*. If unmarried women face unwanted pregnancies, they do everything they can to clandestinely 'remove

it'. Young girls or students usually do not inform the family about out of fear of rejection.

> *"There is an aphorism that says the following for the problem of fearing death, "Better dead than being mocked". She can have fear of death but she sees: if I stay like that, without owner, without husband, I can be mocked, it's better to do like that [abortion]; she does it out of constraint. But she knows well that it is death, it is dangerous, there is a danger ahead, but she does it to avoid being ridiculed, being seen badly."* GD men, South-Kivu

- **Young age and living conditions**

Girls who are too young or still live in their parent's house want to abort for these reasons and also because of the stigma they would face as unmarried pregnant women.

- **Lack of knowledge how to raise and take care of a child**

- **Lack of financial means**

Young women who got pregnant unintendedly and lack financial means perceive it better to abort because they would not be able to care for the child. Victims of sexual violence wish to abort because of the difficult living conditions and because they would not be able to 'care'[30] for the child. In case of an unsafe abortion, the reason for it might be lack of financial means to ask for a medication abortion in a hospital or health centre.

- **Wish to continue studies**

School girls want to terminate their pregnancy because they want to continue school. They said they do not dare to ask for contraceptive because they do not want to be seen going to the clinic and if their parents would know that they took contraceptives, they would beat them.

- **High number of existing children**
- **Breastfeeding child and pregnant again**

Having a breastfeeding child and getting pregnant again is a taboo and considered shameful in the society. In such cases women want to abort by all means and this is also the only loophole in the negative perception spectrum concerning abortions where aborting is socially and culturally 'accepted'. Additionally, it is even recommended in such cases in order to protect the breastfeeding child.

- **Pregnant from transactional sex**

Women who got pregnant from transactional sex can be girls, unmarried women, married women or commercial sex workers. They all have different reasons for engaging in such relationships. Most of the commercial sex workers in Mweso already had more than one child and explained that they work as commercial sex workers because they do not know how to raise their children otherwise. This shows very bluntly that the relation between unwanted pregnancies and the need for abortions is a vicious circle.

- **Pregnant from sexual violence**

This includes women who got
  - pregnant from sexual violence within marriage,
  - pregnant from rape by armed groups and threatened to be killed or to abort,
  - pregnant from rape within extended family,
  - pregnant from rape within the community;

- **Married women not allowed to use contraceptives within marriage**

Until recently married women needed the consent of their husband to use family planning and, in absence of it, they would find themselves with unwanted pregnancies and the desire to abort.

- **Father of the child would be unknown**

It was continuously emphasized that **a child should know its father**. This was the most important element related to sexual violence related pregnancy (SVRP) because **a child from a SVRP would not be able to attribute its identity to its father**. A child is called by its father's name, child of X for example, or people say this is the child of so-and-so. A child who cannot name a father is automatically stigmatised. Most of these children are called after the armed group that

(30) In French it was expressed that it was related to the 'encadrement' of the child.

was present in the area; respondents spoke of children named FDLR or NDC (Nduma Defense of Congo).

- **Not ready to have a child**

If women or girls do not feel ready to have a child or do not want to have a child per se, they might want to abort.

- **Forced to abort by someone else**

This includes women who are
  - forced to abort by a man who engaged in a relationship with a minor and wants her to abort because the parents of the girl could pursue him,
  - forced to abort by man who engaged in an extramarital relationship;

- **Not in love anymore**

Married women, who do not love their husbands anymore and the unborn child was conceived in a quarrelling relationship, might want to abort.

5.2.2 (Unsafe) abortion methods – *kutosha mimba*

Different methods are used to terminate a pregnancy. In **Mweso** it was difficult to get information about abortion methods as people were reluctant to speak about any means used to abort. They often said they do not know or only medical personnel would know; they do not want to be perceived as someone who knows. The main means people use are the famous and well known traditional plant *cifubula*, which is called 'local oxytocin' medication because it is used like oxytocin and it 'operates' like oxytocin, and the powder soap OMO, which women normally use to wash their cloths. Respondents recognized that the traditional herbs would work better than the liquid soap. In **Mambasa** especially in the health zones Epulu and Biakato, traditional methods are preferred by those who cannot afford medication due to fear of stigma and doubts if confidentiality is observed. Herbal drinks are used most often. Especially the *Bambuti* are famous for their knowledge about traditional herbal medications and specifically drugs to end a pregnancy. In **Lulingu** herbal drinks and enema were mentioned most often, even though the use of traditional methods decreased because people saw the negative consequences and abortions with drugs from pharmacies increased. In the villages around Lulingu like Nyambembe, Nduma, Tchampundu, Malaka etc. „socially accepted" abortions (pregnant with a breastfeeding child) are performed with a TBA who would ask the pregnant women to sit on a traditional round stool, made of woven tree branches, on which she has placed medicinal plants that will then provoke the abortion. In Lulingu this traditional way of aborting got lost. Nowadays such abortions are done in the hospital with a paper the husband has to sign to avoid legal repercussions for the medical person who performs the abortion.[31]

(31) When asked in the HGR of Lulingu, if such abortion cases happened, a medical doctor said no but maybe he is not aware because he is from Bukavu; in August 2017 he was working there since eight months.

	Mweso	Mambasa	Lulingu
Plant methods	Traditional plant *cifubula* (used to ease delivery, in case of prolonged labour, but mainly to provoke an abortion)	Herbal drinks; ingestion of herbal mixtures, e.g. fresh, crushed manioc leaves as well as their vaginal use	Herbal drinks; Ingestion of herbal mixtures as well as their vaginal use; Herbal medication *katulumona* (high dosage)
Toxic drinks	Diluted OMO with a lot of foam (causes diarrhoea, provokes contraction and abortion)	Heavily salted water	Heavily salted water
Enema	Enema	Enema	Enema (traditionally with papa-ya leaves and roots; today with salted water)
Instruments	Inserting a stick into the vagina to open the cervix (only mentio-ned once)	Inserting a stick – a manioc stem – into the vagina to open the cervix	Inserting a stick into the vagina to open the cervix
Medication from pharmacy	Most of the respondents could not name the drugs, they just ask for in the pharmacy. Miso-prostol (Cytotec) is available on the local market.	Quinin or the prostaglandin Cytotec; easily accessible	Quinin and paracetamol

Table 3: (Unsafe) abortion methods

5.2.3 Performers of unsafe abortions and abortion locations

In general, it depends on women's financial means if they can afford to reach the next big city to get a safe abortion in an urban health structure. In Mweso, this is Goma, in Mambasa it is Bunia and in Lulingu it would be Bukavu. however, to reach Bukavu women would have to fly, walk or go by motorbike, reaching the city by car is not possible. Since abortion is restricted under Congolese law, it is done clandestinely.

In **Lulingu**, it was especially difficult to get answers on who performs abortions as people do not want to talk about it and are afraid to point at someone, since it is illegal and they could be accused, in case it does not work.

5.2.3.1 Non-medical

If women or girls want to abort but cannot consult medical staff or go to a hospital, they try to abort by themselves at their homes – mostly with herbal drinks or salted water and enemas – try to assist each other, find friends who help them, or mothers help their daughters. If it does not work, it might end in death or continue as an unwanted pregnancy. In **Lulingu** many women also seek support at the praying rooms but in most cases they are told to keep the pregnancy as these are religious place.

5.2.3.2 Medical

Abortions are performed by qualified or less qualified doctors or nurses, retired or jobless nurses, untrained health care providers called charlatans, traditional healers or matrons.

In all three areas it occurs that medical personnel accepts payments for a medication abortion but only pretends to help terminate a pregnancy, whereas in reality they do not give the right medication. In such cases women feel betrayed and reason that instead of ‚opening the cervix' the medical staff closed it, which is why they have to continue with the unwanted pregnancy. Some said it is because medical staff fear the consequences but somehow also want to 'satisfy' the women, others said they just want to get the money.

In **Lulingu** charlatans and other medical staff perform unsafe abortions and deceive woman in telling them that there will only be a little bleeding, while in the end it is often death.

5.2.3.3 Locations

In **Mambasa** abortions are performed in the health facilities, private or governmental, by qualified doctors and nurses, by doctors who do it at their homes or rent a room in a small 'hotel', in the HGR in front of the MSF office in Mandima, in health centres in Epulu by medical staff.

In **Lulingu** it was mentioned that it is possible to have an abortion done in the hospital if one has a friend there among the medical personnel.

5.2.4 Costs of unsafe abortions

The costs vary greatly depending on how, who and where the induced abortion is performed. It also depends on the negotiation and the relationship between the person who asks for it and the one who performs the abortion.

	Mweso	Mambasa	Lulingu
Plant methods	for free	for free or between 5 to 10 USD	
OMO	1 sachet for 200 (0,1 USD) or 500 (0,3 USD) Congolese Francs		
Medication	1 badge of 4 pills Misoprostol (Cytotec): 5 USD[32]	2 pills Cytotec: 5 USD; others might ask 10 USD or ask for a doctor's prescription	
By medical staff	for free if related to medical staff;qualified nurse around Mweso: 40 USD; qualified nurse in Goma: 150-200 USD; medical doctor in Goma: 200-300 USD	qualified nurse or doctor: 50-200 USD	for free if related to medical staff; 20-100 USD (generally prices are lower than in the other areas)

Table 4: Abortion costs

(32) For the moment it is forbidden to sell cytotec in the DRC because of its use for abortions, however, it is still available and people sell it secretly.

In Lulingu some fix the cost for an abortion in relationship to the one who is responsible for the pregnancy and wants the woman or girl to abort. For example, in case of a married man who wants to keep it a secret, he will provide the money for the abortion; such persons are often asked a higher price. Additionally, it was reported, that if the woman or girl does not have sufficient money or no money at all to pay for the abortion, she would be asked to pay with sexual intercourse.

5.3 Perception of abortions

5.3.1 People's perceptions and attitudes concerning termination of pregnancy

Opinions, perceptions and attitudes towards abortions differed greatly in the three study areas. Regarding the legal situation similar trends and viewpoints were suggested by the analysis together with a more open attitude and understanding to abort a sexual violence related pregnancy.

In the majority of interviews with the general population, local leaders, religious leaders and local authorities in **Mweso** questions regarding the perception of medical care for termination of pregnancy were answered with great outrage. It was out of discussion that a medication and therefore safe abortion could be an acceptable option under certain circumstances. The responses in almost all the conversations were negative. People referred to crime, killing, murder and sin when talking about termination of pregnancy. However, what people think and express, does not correspond to what they actually do, since unsafe abortions are practiced widely in North-Kivu.

> *"Inducing an abortion, that's not good, you can do this to protect yourself from a problem that can happen, but in general, this is not acceptable, because that's murder. For us Congolese, we even have the Article 153 and 154 if we induce an abortion, it is punishable, and we can get arrested for 20 years. Based on the belief, even in front of God, it's not good to have an abortion, but considering the problems of life, under certain circumstances, you don't have the [financial] means to live, someone can decide to abort."* GD men, North-Kivu

In **Mambasa**, a very different attitude was observed. Most of the general population, local leaders, religious leaders and local authorities perceive and consider medication abortion to terminate a pregnancy an appropriate solution for reducing maternal mortality and morbidity, if only the law would allow it. Legal fears of performing or seeking abortion were expressed but do not hinder individuals to proceed with their attempt. In strong contrast to findings from North-Kivu answers were supportive for medical and safe abortion care. People do understand and 'see' the widespread problem of unwanted pregnancies and have witnessed numerous individuals dying because of complications related to unsafe induced abortions. However, in the health zone of Mandima around Biakato, which has a great influx of Nande refugees from North-Kivu, answers were similar to Mweso/ North-Kivu, where abortion is perceived as a crime and a sin.

> *"There are these girls who experience unwanted pregnancies that they didn't expect. Now they'll seek how to abort those pregnancies with pharmaceutical products or even with traditional products; they use leaves to drink, they also do purges and sometimes this provokes death; … when they look for someone who can advise them to a similar program [medication abortion], they are ready for that; because they also ask us when we pass by the quarters; there are girls who approach us and ask 'could MSF help us in that sense?"* male CHW, Ituri

In **Lulingu** the general population, local leaders, religious leaders and local authorities had mixed perceptions and attitudes towards abortions and rather deal with it precautiously. Community members mostly referred to the Lega tradition, to the law and to religion. Respondents view termination of pregnancy challenging mainly because of the Lega tradition that condemns abortions. People do not perceive abortions

inhuman but they said that the *Lega* tradition does not allow it, thereby impersonalising their attitude and distancing themselves personally. That way it is not their own decision, but it is the identification with their ethnical background as Lega.

> *"This is a taboo of the [Lega] tradition, because you are a killer, you are a murderer, you kill the people. The one who aborts he kills, that's how it is seen here according to the tradition. And if we see a woman that aborts, this is not a woman; that's what we say here."* Female psych-social staff, 44 years, South-Kivu

A particular feature of the *Lega* tradition is that abortions are strongly prohibited because one never knows who the foetus would have become. It could be a loss for the community because the person could have become someone great and important, like a minister or even the president.

In **Mambasa and in Lulingu** people were open to talk about abortions, explained how, where and by whom they are performed.

5.3.1.1 The influence of the law

The influence of the law was a bigger issue in Mambasa and Lulingu than in Mweso.

In **Mambasa** the legal status played a bigger and more important role than religious and moral attitudes towards provision and perception of termination of pregnancy. In various interviews respondents referred to the legal situation that hinders them to perform or to ask for a medication abortion. Local authorities do not discuss the matter but refer to the law that prohibits abortions and allows it only if the life of the mother is in danger.

In **Lulingu** the legal status played the same role as religion and *Lega* tradition regarding attitudes towards perception of termination of pregnancy. People differentiated between the political and the traditional level. Abortions are forbidden by Congolese law and by *Lega* tradition, which represents the 'traditional law' the *Balega* have to respect, even though individuals abort clandestinely anyhow. Fear of legal repercussion seems to be a serious concern for women and girls who therefore are forced to perform abortions under unsafe conditions. What was confusing to understand was why rape cases are rarely reported, but abortions are seen as 'criminal' and everyone involved should be reported to the police.

In **Mweso** female respondents thought abortions could be reduced, if the person performing it would be punished.

5.3.1.2 Influence of religion

In **Mweso** religion plays a bigger and more important role than the legal status of perception and attitudes towards termination of pregnancy. Religious leaders spoke about abortion in very moral terms calling it a sin, crime or murder. They explained that abortions are not allowed under any circumstances and that God said *"be fruitful and multiply"*. They rather emphasized that women should have numerous children instead of 'killing' them. Fatalistic ideas were also stated repeatedly. People said it was God's will and he would take care of the child when it was born. They referred to God who not only had created the human creature but also guided them.

In **Mambasa** religious and moral reasoning does not prevail over legal considerations but the influence of the Catholic Church on its members is still a great barrier for women (and men) to overcome moral concerns in relation to abortion. A local chief explained that God has planned how many children a woman should get and that she could risk infertility with an abortion. For religious people safe abortion care is not an acceptable solution to prevent unsafe abortions.

In **Lulingu** religious and moral reasoning is a real concern. For many people religion is the reason why they cannot 'accept' an abortion or think abortion is a bad thing. Abortions are seen as a sin because *"you kill a person"*. Numerous respondents referred to

God who gave the pregnancy, so how can men abort something given by God. The Catholic Church would excommunicate a person who had carried out an abortion and not only the woman or girl would be found guilty but her family as well.

5.3.1.3 Fear of stigma

Due to fear of stigma women and girls hide their pregnancy, do not want to talk about it and do not want to go to a health facility to abort because they feel ashamed and are worried about confidentiality. Thereby they risk exceeding the first trimester when a termination of pregnancy would still be possible. If at all, girls ask their friends, schoolmates or other persons they know about traditional – mostly unsafe – abortion methods. Sometimes they talk to their mothers or other relatives. Girls rather try to terminate their pregnancy under unsafe conditions than being stigmatised.

5.3.1.4 Fear of death

On the one hand, people's attitude in **Lulingu** is that *"we are not afraid that the girl could die, it is better to die or to risk death with an unsafe abortion than to be exposed to stigma because of the pregnancy"*, on the other hand people explained that they fear more for the life of the woman or girl when performing an unsafe abortion than for ending the life of the foetus. These findings are contradictory but pertinent and are influencing factors for the decision-making process of women and girls, who are constantly told that abortions are bad because they could die. In a group discussion with five 'teenage mothers' who had altogether 15 children – one had five, one had four and the three others had two kids each – we asked them if they ever thought about an abortion. They altogether stated very clearly that they were afraid to die.

5.3.1.5 Spontaneous abortions

In **all three areas** potential causes for miscarriage were said to be mainly malaria, heavy loads, heavy working in the fields and in general the hardship of life and stress caused through the conflict in the area. Traditional herbal medications taken for other ill health conditions could also provoke abortions. Sexually transmitted infections (STI) were considered a cause for spontaneous abortions as well. As a cause for STIs women mentioned germs one can contract in the water. In contrast medical personnel stated multiple partners and relationships, which men and women entertain, as reasons.

A particular ritual of the **Balega** in **Lulingu** is that they will not grieve if a foetus dies because the foetus was not considered a human being yet. It will be buried without a coffin and without any ceremony. The body of the foetus will only be covered with special leaves but not with a cloth. If the body was covered with a cloth, the mother would not get pregnant in the future anymore. Furthermore, the mother is not allowed to attend the burial.

5.3.2 Health care providers' perspectives on termination of pregnancy

In **Mweso** the perspectives of health care providers differed. Altogether three approaches were observed.

A number of health care providers either **want to help but feel limited because of the legal** situation. This means that some would perform abortions themselves, others support to refer women to other health care providers. Health staff in the Tumainis and other health structures also stated that they are blocked by the law as they receive many demands for medication abortions mainly from young girls. Some explained that it would help them greatly if the law could be changed.

Others **try to convince** women or girls to keep their pregnancy without judging them.
The third group are the ones who see **abortions as a criminal act** and condemn any form of termination of pregnancy. Their reasons are based on moral and religious arguments.

When asked to put aside the legal status of provision of safe abortion care and to also put aside their faith, some of the staff said they could personally accept safe abortion care.

Doctors often referred to medical ethics and the oath they took. As a result, they do not want to know the reasons of abortion related complications when women present with such conditions because in their opinion their first responsibility is patient care. Sometimes it is difficult to differentiate between an induced and a spontaneous abortion, since women always try to hide provoked abortions. Generally, minor complications are said to be treated in the health centres, whereas mayor complications are brought to the hospital.

In **Mambasa** health care providers' perspective regarding access to medical care for termination of pregnancy was positive. It was not directly declared during the conversations but indirectly it was understood that many of them perform abortions themselves, doctors and nurses likewise, even though legal concerns persist.

Health staff explained how difficult the situation is in the country because of ethical, moral, religious and legal reasons that impede the provision of safe abortion care. They wish for medication abortions to be approved at hospital level because sometimes they are forced to send women away who ask for an abortion and then come back the next day with abortion related complications. Such complications related to induced abortions are approached with a rather sympathetic attitude. Women are not morally judged or considered a criminal or being denounced to the police etc. Respondents were instead worried about the (medical) problems women face and how to best treat them. Some respondents conveyed that abortions are in fact performed in some public health structures. In **Lulingu** medical personnel at hospital level refuses to perform abortions either because they are afraid of the law – if something went wrong, they would lose their job – or because they refuse to perform them categorically. Some traditional healers do not support abortions because of religion. Some medical staff referred to the medical oath within which they promised to protect and safe life not to kill persons. Others limited their rejection and were more sympathetic in case of pregnancies related to rape. From the different axes where MSF intervenes, it was reported that women ask for medication abortions in the health centre and it seems that medical staff has an open attitude as they were complaining that MSF should provide the drugs for medication abortions.

It was said that „socially accepted" abortions (pregnant with breastfeeding child) can be done in some public health structures with a paper the husband has to sign in order for the medical person who performs the abortion not having to fear legal repercussions.

5.4 Health seeking behaviour and access to health care

5.4.1 Access (to obstetric care) and barriers

Women's access to health care facilities generally depends very much on the perception of the place for delivery and the costs.

From the point of view of health care professionals people in **Mweso** tend to consult traditional healers first for general ill-health conditions and only come to the hospital if the illness has reached a serious medical level, jeopardizing the person's life. In case of problems during delivery people also first turn to traditional healers or traditional birth attendants who try to help with herbs that work like oxytocin. In case of complications due to an unsafe abortion people tend to wait and try to manage the condition at home or with the person who provided the abortion until they urgently need professional medical assistance. In very remote areas and when delivery happens unexpectedly childbirth takes place at home. Women from isolated places can also come to the hospital some time before the due date to stay in the *Binyola*.

In **Mambasa centre, Epulu and in the Mandima healthzone** deliveries generally take place in the

health centres or hospitals as it is highly discouraged by health promotion to deliver at home and even forbidden by law. Biakato with its mines all around is a rather wealthier area and families can afford to deliver in the clinics. There is also a bigger number of private clinics in Biakato while in Epulu there is only one, which was installed by the RFO. The prices for deliveries in governmental structures are the same. In numerous interviews outside Mambasa center but mainly for the *Bambuti* population in and around Epulu and Molokay it was said that deliveries still take place at home.

In **Lulingu** it is similar. Deliveries generally take place in the hospital or in health centres in the periphery. It is now forbidden by the state to deliver at home and people are encouraged through health promotion and sensitization to deliver at health care facilities.

Barriers for seeking care include lack of financial means, environmental conditions, such as distance, bad roads, difficult means of transport and insecurity that might lead to abductions, the issue of infidelity, lack of knowledge, distrust in the health facility (Epulu), the way women are perceived – a good woman delivers alone at home – as well as other distractions such as the praying rooms in Mweso that women often consult first.

If women have no direct access to health care, they deliver at home due to lack of financial means. If fees have to be paid – as it is the case for deliveries in governmental structures – women rather turn to traditional birth attendants and traditional healers to help during pregnancy and childbirth. Sometimes the herbs taken may provoke an abortion unwantedly. People use traditional medicine out of cultural reasons but also due to poverty and lack of access to health services. People attribute high effectiveness to some of these traditional herbs and have faith in their use. They acknowledged that they are not always satisfied with Western medicine, therefore refer to traditional medicine at the same time. Sometimes it is out of practical reasons, as women do not want to leave their families to go to the health facility. It is easier and more convenient for them to take traditional drugs. They also want to avoid leaving their husbands alone and therefore do not want to stay in the hospital for a longer period of time. Women are stressed that their husbands could take another wife while they are in the hospital or see other women to satisfy their sexual desires. In most of the interviews with men they asserted that they would need regular sexual intercourses and could not stay without it in case their wife lived in another place.

5.4.2 Provision and perception of SRH services, 72-hour services, post abortion care

5.4.2.1 Perception of services in general

In **Mweso** MSF services are well known as MSF operates in the area since many years. MSF services, not only at the hospital but also in the Tumainis, as well as health promotion activities are widely implemented and highly appreciated. People know that MSF provides free care in the hospital but in Kitchanga, for example, women complained that they do not have access to free health care anymore since MSF has left the hospital (due to security reasons). There were no adverse opinions about the provision of health care related to SRH. All the people interviewed were grateful and pleased that MSF was in the area to support the hospital and different health care structures in the distant areas. The community health workers (CHW) are considered a great help in sensitising women in the area in and around Mweso to come to deliver at the hospital.

The MSF project in **Mambasa** only started in 2016 with activities focusing on sexual violence and STIs, therefore the services are not well known yet. Anyhow, the different communities are familiar with MSF as an organization. MSF intervenes in the wider area around Bunia since many years during numerous emergencies. Respondents frequently referred to the care MSF gave to victims of sexual violence during the 2012 attacks of the Morgan rebels around Epulu.

The hospital in **Lulingu** has a waiting area (*Binyola*) with two rooms and 14 beds for women with difficult deliveries who live outside Lulingu. This *Binyola* is well known and well accepted. Some women were said to come late as they wanted to shorten the stay for childbirth at the hospital. But it was acknowledged that women come to the hospital since MSF is in the area. Respondents continuously repeated that MSF and its health promotion teams are good for the area and that MSF should stay. The feedback concerning post abortion care and reception at the hospital was very positive.

5.4.2.2 Perception of the 72-hour services

In **Mweso** respondents constantly emphasized that in places where MSF is present with its services people are aware of it and have access to care, also to care for victims of sexual violence, known to be 'the 72-hour services'.

The 72-hour services are implemented all over the area in **Mambasa centre and the two health zones** and the community health workers sensitise the various communities in and around the two zones to access health facilities to prevent HIV, STIs and pregnancies.

Additionally, it was said that the population is informed in the areas where MSF intervenes and conducts health promotion activities.

The 72-hour services are implemented all over the area where MSF intervenes and at hospital level in **Lulingu**. Most of the people who have been in contact with the health promotion team and know the services well. Others have never heard about it and therefore delay. If women and girls reach a health facility within the 72 hours, it depends on how the personnel is welcoming them and if they trust the staff working there.

5.4.2.3 Post abortion care

In **Mweso** all doctors interviewed said that they only rarely see post abortion cases in the hospital but also specified that they do not always differentiate between complications due to an unsafe or spontaneous abortion. A local authority said that the circumstances of the complications are discussed only between the health care staff and the woman.

In **Mambasa** centre doctors confirmed that they receive numerous incomplete abortions and treat the consequences at hospital level as well as nurses do in health centres. Health staff spoke about failed induced abortions they see in the health facilities, when women come with bleedings and other abortion related complications. They recounted finding manioc stems inside the vagina or that women had taken quinine or Cytotec.

In **Lulingu** many incomplete abortions at hospital level were confirmed. It was said that it is mainly young girls who come with serious bleedings.

5.4.2.4 Barriers to access post abortion care

Barriers to access post abortion care include stigma, abduction by armed groups, restricted access in relation to financial means, fear of repercussions as well as legal and moral attitudes in general.

In many interviews it was referred to the prevailing stigma that hinders women and girls to access post abortion care within the 72 hours. Normally, the girls try to hide that they have induced the abortion and they do not denounce the person who has performed it.

Attacks by armed groups have reduced but are still widespread. Access to the 72 hours service can be hampered when the woman or girl is abducted or they cannot reach a health facility because either they are severely injured so that they cannot walk or they are too far away.

Access to safe abortion care is restricted and only allowed in cases where the life of the mother would be in danger, does not exist officially or does not exist at all. It depends on the financial means of women and girls or the men who is responsible for the pregnancy, if they have access to a 'safe' way of ToP. The high costs of abortions performed by a doctor or a nurse force women and girls with less financial resources to seek cheaper and often unsafe methods.

Victims of sexual violence are often afraid to access SRH services because the perpetrator threatens them not to consult these services.

In **Mweso** access to post abortion care is very sensitive as there is the legal and moral ban on the intent to terminate ones' pregnancy.

6 Conclusion

The interviews of this study shed light on the lack of decision-making power women have or are perceived to have regarding their sexuality, in marriage and outside. In marriage the pre-dominate notion is related to the duty to satisfy the husband's demands and expectations (sex, children, faithfulness and the acceptance of his lack thereof). Outside of marriage the pre-dominant notions are sexual violence (rape) and social violence (stigma, poverty, isolation from the family), which pushes women and girls into transactional sex as a means for (family) survival and child support.

The study results suggest **an important demand for termination of pregnancy** in all three areas.

In Mweso and Mambasa induced abortions are happening, mainly in secrecy and under insecure conditions. In Lulingu and surrounding areas it is unclear if medication abortions are happening in secrecy in the public health structures, but they are certainly happening outside the health structures. Induced abortions take place clandestinely and under insecure conditions. In all three study areas, financial means improve the likelihood of access to less unsafe methods of induced abortion.

Reasons why women want or need to abort are complex and reflect the traditional relationship between men and women in these areas, social constraints, traditional views and difficult living conditions in general.

Abortion methods range from various traditional – „natural" – methods to pharmaceutical ways. For various reasons women try to abort by themselves, are helped by the family, friends or the community. Abortions are also performed in some public health structures by trained professionals, even though the law prohibits interventions like that.

People's perceptions and attitudes concerning termination of pregnancy vary in the three study areas. In Mweso, abortions are perceived morally reprehensible but people's thoughts and expressions are contrary to their actions (since abortions are practiced widely). In Mambasa abortions are perceived an appropriate solution but legal concerns exist, whereby these legal fears do not hinder women to try to abort anyhow. In Lulingu the prevailing leitmotifs are legal, religious and moral concerns in relation to the *Lega* tradition, whereas abortion becomes exceptionally socially and culturally 'accepted' in case a woman gets pregnant while breastfeeding another child, since this would be a taboo.

Health care providers in Mweso and Mambasa share religious and moral concerns in terms of termination of pregnancy, whereas health staff in Mambasa has a more sympathetic attitude towards abortions and complications related to induced abortions. Legal concerns prevail in all three study areas, whereas health staff in Lulingu seems to refuse performing abortions due to these legal concerns and health staff in Mweso does not want to know the reasons of abortion related complications because they see their foremost responsibility in patient care, no matter the reason.

In terms of **health seeking behaviour and access to health care**, in Mambasa and Lulingu incomplete abortions are treated at hospital level and nurses ensure related care in health centres. In Lulingu feedback on post abortion care and reception at the hospital was very positive. In Mweso women usually contact traditional healers first and health structures only in serious cases. Barriers to access in Mambasa are abductions, distance, injuries and reporting to the police (because this may lead to women presenting at the health structure too late), whereas in Mweso barriers are distance, the river and the insecure environment. In general, post abortion care is very sensitive in Mweso due to legal issues.

The complete analysis suggests an **urgent need to foster dialogue on these sensitive issues** as part of MSF action.

7 Annex

7.1 References

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