UNWANTED PREGNANCIES AND ABORTIONS

SOCIOCULTURAL AND COMMUNITY DETERMINANTS

DJIBO DISTRICT
BURKINA FASO

MÉDECINS DU MONDE

PROVIDING CARE AND BEARING WITNESS

For more than thirty years, Doctors of the World has been active in projects related to Sexual and Reproductive Health (SRH). By the term SRH, MdM refers to "a state of complete physical, mental and social well-being and not merely the absence of disease or disability, in all matters relating to the reproductive system and to its functions and processes".[1]

Over the last twenty years, governments and international institutions have eventually given the needed political priority to SRH. Several agreements adopted by a number of countries show this commitment and provide a strategic framework in which SRH projects can be implemented. MdM relies on this framework to promote the respect and implementation of sexual and reproductive rights in the areas where it operates.

WORLDWIDE

225 MILLION
WOMEN DO NOT HAVE ACCESS TO SAFE AND EFFECTIVE CONTRACEPTION

22 MILLION
UNSAFE ABORTIONS ARE ESTIMATED TO TAKE PLACE EVERY YEAR

ALMOST **50,000 WOMEN**
DIE EVERY YEAR FOLLOWING AN UNSAFE ABORTION

MdM-FRANCE IN BURKINA FASO

Maternal deaths are a major problem in Burkina Faso. The situation is particularly critical in the Djibo health district, where MdM began to work in 2010. Since 2014, our teams have worked on a project to strengthen the provision of safe and effective preventive and curative SRH services in the Djibo district. The project focuses on unwanted pregnancies, taking action in 4 areas:

- Analysis of barriers to the prevention and management of unwanted pregnancies
- Support to healthcare structures to improve SRH practices, especially regarding family planning services and post-abortion care.
- Community mobilization on SRH rights and capacity-building of civil society organizations and law operators in the area.
- Advocacy for access to SRH rights and services, with a focus on access to contraception for young people and to safe and legal abortion.

IN BURKINA FASO

18.2%
OF ALL WOMEN OF CHILDBEARING AGE (15–49) USE A MODERN METHOD OF CONTRACEPTION

24%
OF WOMEN HAVE AN UNMET NEED OF CONTRACEPTION

1 IN 3
PREGNANCIES IS UNINTENDED

1 IN 3
OF THESE UNINTENDED PREGNANCIES ENDS IN ABORTION

1 - ICDP - International Conference on Population and Development, Cairo, 1994

THE STUDY

UNWANTED PREGNANCIES AND ABORTIONS IN THE DJIBO DISTRICT, BURKINA FASO. AN ANALYSIS OF SOCIOCULTURAL AND COMMUNITY DETERMINANTS

Indicators of maternal morbidity and mortality remain quite critical in many developing countries. One of the major determinants of this situation, which is unfortunately hardly responded to, is the prevention and care of unwanted pregnancies (UPs). Burkina Faso is a country where the situation remains critical. Women face many barriers that promote the occurrence of UPs, hinder their access to healthcare, and lead to unsafe abortions.

The relationship between UPs and abortions is well established by populations. Both phenomena affect adults, adolescents & young people. Within the considered age group, abortions are mainly attributed to UPs. Secondary school students in the province, waitresses in pubs and young people working on gold mining sites are considered the most vulnerable populations, but high school students are mostly highlighted.

Determinants of UPs and abortions among adolescents and young people are:

- both socio-cultural and religious, with the salience of representations of sexuality and premarital fertility;
- economic, in reference to the difficulties encountered by households to meet the (basic) needs of children;
- linked to health due to the difficult access to and lack of use of contraceptives.

Prevention of UPs and abortions is essentially built around sensitization mechanisms about sexual and reproductive health involving health actors, local associations and NGOs, educators, etc. These activities target young people, but also parents. Abstinence is presented by interviewees as the appropriate strategy to prevent UPs among young people. In a context of increasing premarital sexuality, contraceptive use is critical.

UPs do not benefit from a particularly supportive system. At family and community levels, even if changes are increasingly observed, concerned individuals are often rejected by their families until delivery. Visited associations and social services do not have special programmes devoted to such situations. Support may consist either in advising victims to persuade them not to resort to abortion, or in managing family disputes consecutive to UPs. In health centres, the same mechanisms are observed; support is mainly provided through advice and guidance towards antenatal care.

Despite being a cause of maternal morbidity and mortality, **induced abortions are subject to strong disapproval both within communities and among health staff.** Such social stigma against abortions is in line with the national context of legal restriction, about which populations are well informed. Because of social censure, abortions are performed clandestinely, which makes it difficult to notify and impossible to technically manage. They have serious consequences, and may even lead to death in some cases.

Post-abortion care is considered more suited to spontaneous abortion situations. Care after induced abortions would require specific protocols because of the methods and risky conditions in which they are practiced. These treatments would therefore be adapted to the clinical condition of the patient, who has to bear the brunt of the financial cost.

Despite knowing about health consequences of abortions, **the different actors are reluctant to possible legalisation of the practice.** Moral and religious values regularly coexist with the healthcare provision context. The actions considered by interviewed stakeholders concern training and education on sexual and reproductive health of various categories of the population, especially young people and adolescents, as well as the promotion of contraceptive use.

KEY RECOMMENDATIONS

At the community level:

• Awareness must be strengthened a religious leaders and household heads taking into account both women and men.

• Families must be educated about the need for moral, technical and material support to help young people and adolescents to cope with UPs, so as to reduce abortion factors.

At the health centre level:

• The minimum packages of SRH activities must be strengthened, and especially technical facilities and competences for post-abortion care.

• Health workers' preconceptions or negative prejudice in relation to UPs should also be reversed.

Towards young people:

• Sexual education activities initiated in secondary schools in the province must continue.

• These activities need to be expanded to other places of vulnerabilities: pubs, gold mining sites; spaces should also be promoted where young people (boys and girls) could access without special constraints to information on sexual and reproductive health, contraceptive methods and their prescription.

Towards local authorities:

• It is necessary to implement measures to actually apply the law, at least in relation to authorised abortion in three legal conditions (mother's health at risk, incest or major congenital malformation).

• Real involvement is needed to set up the technical platforms required for post-abortion care, to fight the stigma against girls with UPs and to prevent contexts favourable to UPs, such as existing practices in gold mining sites, etc.

MdM CALLS ON BURKINA FASO'S DECISION MAKERS TO:

• Reduce legal barriers related to therapeutic abortion and other authorized cases of abortion (rape, incest) and ensure legal consistency between the provisions found in the penal code, the public health code and the Reproductive Health Law.

• Formally include sexual education within education programs (primary and secondary education sector).

• Guarantee access to free contraceptive methods for adolescents.

• Improve training for health and education professionals in contact with women and girls at risk of or affected by UPs, to reduce stigma and for a better prevention and management of the issue.

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