



“You must first save her life”: community perceptions towards induced abortion and post-abortion care in North and South Kivu, Democratic Republic of the Congo

Sara E Casey ^a, Victoria J Steven,^b Julianne Deitch,^b Erin Files Dumas,^c Meghan C Gallagher ^d, Stephanie Martinez,^b Catherine N Morris,^b Raoza Vololona Rafanoharana,^e Erin Wheeler^f

a Director, RAISE Initiative, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University, New York, NY, USA. *Correspondence:* sec42@columbia.edu

b Research Assistant, RAISE Initiative, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University, New York, NY, USA

c Technical Advisor, Sexual and Reproductive Health and Rights, CARE USA, Atlanta, GA, USA

d Doctoral Candidate, Department of Population, Family and Reproductive Health, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD, USA

e Program Manager, Sexual and Reproductive Health, CARE DRC, Goma, Democratic Republic of Congo

f Contraception and Abortion Care Advisor, International Rescue Committee, New York, NY, USA

ABSTRACT: *Structural barriers such as a restrictive legal environment, limited medical resources, and high-costs inhibit access to safe abortion in the Democratic Republic of the Congo (DRC); these barriers are exacerbated by two decades of conflict. Socio-normative barriers further complicate access to safe abortion and post-abortion care (PAC) in DRC, where fear of abortion-related stigma may lead women to avoid PAC services. Programme partners support the Ministry of Health to provide good quality contraceptive and PAC services in North and South Kivu, DRC. This paper presents results from focus group discussions that explored community members' attitudes towards women who induce abortion and their care-seeking behaviour in programme areas. Results indicate that while abortion stigma was widespread, community members' attitudes towards women who induced abortions were not one-dimensional. Although they initially expressed negative opinions regarding women who induced abortion, beliefs became more nuanced as discussion shifted to the specific situations that could motivate a woman to do so. For example, many considered it understandable that a woman would induce abortion after rape: perhaps unsurprising, given the prevalence of conflict-related sexual violence in this area. While community members believed that fear of stigma or associated negative social consequences dissuaded women from seeking PAC, a majority believed that all women should have access to life-saving PAC. This commitment to ensuring that women who induced abortion have access to PAC, in addition to the professed acceptability of induced abortion in certain situations, indicates that there could be an opening to destigmatise abortion access in this context. DOI: 10.1080/09688080.2019.1571309*

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Introduction

When implemented in accordance with World Health Organization guidelines, induced abortion is a safe, low-risk medical procedure.¹ However, when performed in insanitary conditions, with hazardous methods, or by an inadequately trained

individual, abortion is unsafe and may result in adverse health outcomes.² Complications from unsafe abortion account for an estimated 7.9% of global maternal mortality, and 9.6% of maternal deaths in Sub-Saharan Africa.³ Both the incidence and health burden of unsafe abortions are

disproportionately concentrated in low-resource settings, where approximately 97% of the 25 million annual unsafe abortions occur.²

While restrictive laws often render safe abortions more difficult to acquire, they are frequently ineffective at curtailing the incidence of abortion.⁴ Restrictive laws instead push women to resort to unsafe methods.⁵ Structural barriers, such as a restrictive legal environment, lack of trained healthcare providers and essential medical equipment, and high costs, further restrict access to safe abortion care;⁶ humanitarian crisis can exacerbate these barriers, due in part to the collapse of health systems, interrupted access to contraception, and the prevalence of conflict-related sexual violence.^{7,8}

Abortion stigma

In much of the world, normative barriers may further complicate access to safe abortion care. Despite the commonality of abortion (approximately 56 million abortions are performed globally every year), negative perceptions of it persist.² Although also present in countries with liberal abortion laws, stigmatising attitudes towards abortion are often more pronounced in restrictive contexts.⁹

Building on the theoretical framework developed by Link and Phelan, Kumar et al conceptualise abortion stigma as deriving from a transgression of communal norms regarding the perceived fundamental traits of womanhood such as motherhood, protectiveness, and sexuality exclusively in pursuit of procreation.^{9–11} Once a woman has deviated from the aforementioned feminine ideals, society labels her with negative attributes.¹⁰ Common pejoratives attributed to women who induce abortions include descriptors such as promiscuous, sinful, and immoral.⁹ Ultimately, society excludes these women from the general population and subjects them to overt discrimination, potentially resulting in negative health and social outcomes.¹⁰

In contexts where abortion is highly stigmatised, the social consequences for women who induce can include spousal or familial abandonment, loss of marriage prospects, and societal exclusion.^{12–14} Women who have induced abortions may strive to keep their procedure a secret to avoid the associated social costs, which contributes to the paucity of reliable data as well as sustaining the illusion that induced abortion is rare, deviant, and against the norms of a community. This

“mutually reinforcing cycle of silence” thus places further pressure on women who have induced abortion to avoid disclosure and propagates abortion stigma.¹⁰

Although there is limited empirical evidence regarding the health impact of abortion stigma, many researchers have hypothesised that the threat of these social costs and desire for confidentiality could influence women to seek clandestine, unsafe abortion services or delay or avoid life-saving post-abortion care (PAC).^{9,10,12,15–21} For example, despite recent legislation permitting abortion in certain circumstances, a quarter of maternal deaths in Kenya have been attributed to complications from unsafe abortions.²² Women in Kenya pursued abortions outside of facilities as they believed the social risk associated with being identified as having induced an abortion outweighed the physical risk of pursuing an unsafe, but potentially more discrete, abortion.²² Demonstrating the strength and pervasiveness of abortion stigma, patterns of care avoidance have also been observed in contexts in which abortion is legal but highly stigmatised.²³

Study context

The Democratic Republic of the Congo (DRC) has signed and, in 2008, ratified the Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa (Maputo Protocol), a legally binding treaty which authorises abortion in cases of rape, incest, foetal impairment and to preserve the mental or physical health or life of the woman.²⁴ Although ratification suggests agreement with the Protocol’s standards, necessary changes to national law have not yet been made. In March 2018, DRC published the Maputo Protocol in the official journal, initiating a legislative process to align national law with the Protocol’s standards. However, Congolese law is generally interpreted to permit abortion only to save the life of a woman, resulting in limited access to safe abortions. In addition to legal and structural barriers, abortion is also highly stigmatised in DRC.²⁵

A recent study estimated an abortion rate of 56 per 1000 women aged 15–49 in Kinshasa,²⁵ higher than the estimated global rate of 35 abortions per 1000 women aged 15–44.²⁶ Given the restrictive Congolese legal, structural, and normative environment, coupled with the fact that the majority of abortions in Sub-Saharan Africa are unsafe,² it is likely that many of the abortions occurring in

DRC are dangerous and could lead to life-threatening complications. However, PAC utilisation remains low in DRC, suggesting that the majority of women undergoing abortion do not receive proper medical care.²⁵ Low PAC utilisation is consistent with DRC's poor performance with regard to other sexual and reproductive health indicators, including one of the highest maternal mortality ratios in the world at 846 maternal deaths per 100,000 live births and modern contraceptive prevalence of just 8%.²⁷

In the eastern regions of DRC, nearly two decades of conflict and instability have contributed to a weakened health system, unable to adequately respond to health needs. Since 2009, CARE, the International Rescue Committee (IRC), and Save the Children have collaborated with the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative at Columbia University to support the Congolese Ministry of Health (MOH) to provide good quality contraceptive and PAC services in North and South Kivu. Technical assistance to the MOH included capacity building and supportive supervision of health workers, provision of necessary equipment and supplies, and community mobilisation activities.

RAISE and its partners conducted a programme evaluation in 2016–2017 to better understand the barriers and facilitators of access to and use of PAC services in North and South Kivu, DRC; this paper presents findings from one component of this evaluation. Given the hypothesised link between abortion stigma and negative care-seeking behaviour, this paper explores community perceptions of women who have induced abortion and attitudes towards these women's use of PAC.

Methodology

Study design, participants and data collection

This paper presents findings from focus group discussions (FGDs) conducted in six rural health zones of North and South Kivu. Twenty-four FGDs were conducted, four in each of six supported health zones: six with women aged 18–24 ($n = 61$), six with women aged 25–45 ($n = 63$), six with married men aged 18–29 ($n = 62$), and six with married men aged 30–45 ($n = 60$). The FGDs took place in September 2016 and April 2017 in the four health zones in North Kivu, and in February 2017 in the two health zones in South Kivu.

Semi-structured FGD guides were adapted from IPAS and previous qualitative research conducted

by the authors and included these themes: how women induce abortion (who helps them, methods used), reasons why a woman would induce abortion, community perceptions of women who induce abortion and care-seeking behaviour after an induced abortion. Following a five-day training on research ethics and methods, FGDs were led by four male and eight female facilitators in North Kivu, and one male and two female facilitators in South Kivu. Participants in the specified age groups were recruited by village health committee members. All FGDs lasted one to two hours and were conducted in local languages in a private room to ensure the confidentiality of the discussion. FGDs were audio-recorded, transcribed and translated into French for analysis. The researchers reviewed the French transcriptions to check the quality of translation and reverted back to the facilitators when clarification was needed.

Data analysis

The transcripts were first read by the research team to identify overarching themes for the creation of draft codebooks organised by general themes and sub-themes. After discussing the draft codebook, electronic files containing the French transcripts were uploaded to NVivo (QSR International Pty Ltd) for coding. Several transcripts were coded separately by two to three researchers using the draft codebooks and the results were discussed to revise the codebooks, adding, deleting or collapsing codes as necessary.

Once codebooks were finalised, coding was performed independently by three researchers. The consistency of coding was assessed by inter-coder reliability; disagreements were discussed and resolved until the inter-rater agreement was in the 90th percentile range. All transcripts were coded by two researchers, and selected transcripts were coded by a third researcher to ensure reliability and validity of the coding. Finally, using a thematic analysis the data were interpreted and presented using the respondents' own words as illustrations. Themes were then compared across the group demographics to explore potential differences between age or gender groups.

Ethical considerations

Verbal informed consent was obtained from all participants. No participant names were recorded in the transcripts. Only study staff had access to the recordings. Ethical approvals for the study were obtained from the Institutional Review

Board of Columbia University and the Institutional Ethical Commission of the Catholic University of Bukavu (DRC).

Results

Participants in all FGDs acknowledged that induced abortion was a common occurrence in their community, and many provided personal anecdotes regarding friends and family members they believed had induced abortion. Several broad themes emerged during analysis, and the results were organised according to these thematic areas, including initial perceptions of induced abortion, perceived social and health consequences of induced abortion and abortion stigma, perceived motivations for induced abortion, and community reactions towards women who induce abortions. Few differences were observed between age or gender groups; therefore, data are presented here in aggregate.

Initial perceptions of induced abortion

In all FGDs, initial reactions towards induced abortion were overwhelmingly negative. Many community members cited the perceived criminality of induced abortion as justification for their disapproval of the procedure. Accordingly, some believed that women who induced abortions should face criminal repercussions.

“They should be in prison without exception.” (Woman, 18–24 years)

Many participants described induced abortion as unchristian, immoral, or transgressing the norms of their community. FGD participants explained that inducing abortion violated the social norms and behaviours expected of women in their culture, and undermined the role of mother and care-giver attributed to female community members.

“The person or woman or girl who did this act, they can no longer consider her as a woman in the home ... because she lost a creature who may have brought benefits to the community.” (Man, 30–45 years)

The majority of participants advocated that a woman with an unintended pregnancy should not seek an abortion; rather, many suggested that she should initiate a contraceptive method after giving birth to avoid a similar situation in the future. As such, most participants perceived a

clear link between avoiding unintended pregnancies and reducing the incidence of induced abortion.

“Instead of committing a crime, it’s better to go to the health centre. I ask for a family planning method so that it stays in my body.” (Woman, 25–45 years)

“That is why many women, instead of interrupting a pregnancy each time, they prefer to use pills to plan their births.” (Man, 18–29 years)

Perceived social consequences of induced abortion and abortion stigma

Given these initial negative perceptions, community members indicated that a woman who induced an abortion would encounter social costs in the community; participants in all FGDs applied negative stereotypes to these women such as prostitute, sorceress, and murderer.

“Me, I think, we must start to fear these women ... as these women are witches who kill children, are criminals.” (Woman, 25–45 years)

Some community members worried that a woman who induced abortion could be more likely to harm others in the community.

“If she manages to terminate a pregnancy, you too, she cannot fail to kill you.” (Man, 18–29 years)

In some instances, the stigma associated with a woman who induced abortion could spread to those in her immediate social network.

“This woman who terminates pregnancies, the community cannot support her, will begin to fear her. And if someone comes to her house and eats and drinks even water, he too will also be discriminated against because he is with a witch, a criminal.” (Woman, 25–45 years)

As a result of these damaging stereotypes, women who induced abortion were perceived to have lost value within the community. Many participants highlighted that women who induce abortions could face social penalties, such as spousal or familial abandonment, loss of marriage prospects, or being the object of judgment or gossip by community members.

“The whole family will unite and sit together in order to see how to ban the woman because she doesn’t deserve to remain in this family because she kills children.” (Woman, 25–45 years)

Others suggested that a woman who induced an abortion would be ostracised from the community.

“She does not deserve to live in society.” (Man, 30–45 years)

Many community members believed that a woman would go to great lengths to induce an abortion in secret to avoid these associated social costs.

“Really to say terminating a pregnancy, it’s something secret, many prefer that the nurses don’t even know about it ...” (Man, 18–29 years)

Perceived health consequences of induced abortion and abortion stigma

Community members believed that a woman who induced an abortion could suffer an assortment of negative health outcomes including infertility, morbidity, and death.

“There are times [one] can give the medicines for terminating the pregnancy, but unfortunately this pregnancy refuses to end and causes the death of the pregnant woman.” (Man, 30–45 years)

Compounding the perceived health risks, many community members noted that a woman who induced an abortion may avoid or delay care-seeking behaviour due to fears that her abortion would no longer be a secret.

“If I left for the hospital who will pay the fees for me? I want die at home instead of people laughing at and insulting me all the time, better to stay home!” (Woman 25–45 years)

“Women also hesitate [to go to the health center] because it’s shameful, she can’t say that she terminated because she’s a woman at home with her husband, they may think that it’s an accident, but she will be ashamed.” (Man, 30–45 years)

Many community members suggested that young unmarried women would be more reluctant than married women to utilise PAC services.

“The girl will be ashamed to go to the health centre. She’ll say: when I [had sex] no one knew ... It’s a secret between me and my boyfriend and we’re not allowed to do this. So, if I go to the hospital, people will know what happened to me. This will lead the girl to make the choice to stay home. There are even girls who die at home.” (Woman, 18–24 years)

Other community members suggested that the threat of criminal repercussions could dissuade a

woman who induced an abortion from seeking PAC.

“She asks herself do I want to go to the hospital, when I’m asked, what do I say to the nurse? Do I say that I aborted because I took medicines from the forest? ... I’ll be ashamed to talk to them, or even they’ll put me in prison Me, I want to stay home; if it’s death, I want to die at home instead of going to prison.” (Man, 30–45 years)

Perceived motivations for induced abortion

While community members initially professed to hold extremely negative opinions towards induced abortion, attitudes towards women who induced became more nuanced as the discussions progressed. Upon further discussion, participants in all FGDs showed some empathy towards some of these women by organically identifying certain situations in which they believed induced abortion could be, if not acceptable, perhaps understandable. Participants expressed less judgment towards these women when discussing specific situations in which a woman or girl may find herself than they had when speaking of women who induce more generally.

Overwhelmingly, community members agreed that young unmarried women were most likely to induce abortion. Community members suggested many reasons that they may do so, such as not being ready to become a mother, having an unsuitable partner, being unmarried, or lacking the financial resources to properly take care of a child.

“Maybe this boy who impregnated her lacks financial means, she’ll be forced to marry him and expect to live in poverty and sees that she’ll be useless in life. She thinks that it’s better to terminate the pregnancy than to marry this boy.” (Woman, 25–45 years)

“When she has this pregnancy at age 18 or 20 without having prepared her life ... She wonders how she will be carrying this child and with this pregnancy who will still love her. She doesn’t even have [clothing]. She’ll have to abort.” (Man, 18–29 years)

Others suggested that a parent, usually the mother, may even help a daughter to induce an abortion in order to remain in school.

“She could be a student and her parent wants her child to finish school, or maybe the boy impregnates her and yet the girl doesn’t love him and the parent can advise her child to terminate the pregnancy.” (Women 25–45 years)

According to many participants, premarital sex or having a child out of wedlock was highly stigmatised in the community and becoming a teenage mother would negatively impact a girl's future marriage prospects and enrage her parents. As such, many suggested that a young unmarried woman may induce an abortion to avoid the social consequences associated with becoming an unmarried mother.

“The biggest reason pushing girls to abort is fear. ... She'll think that people will make fun of her, my friends will make fun of me. I'll have no peace in my family ... shame can push the girl to abort.” (Woman, 18–24 years)

In addition, participants in most FGDs suggested that a woman who became pregnant from rape should have access to an abortion. Participants discussed the prevalence of sexual assault perpetrated by the various armed groups in the ongoing conflict and acknowledged, sometimes explicitly, that a woman who had been raped may seek an abortion to avoid the shame associated with giving birth to an unknown combatant's child or the economic and emotional burden of raising a child without a father.

“You find a rapist on the road, you're alone, who will force you to have sex unwillingly, now after this act, you end up with a pregnancy, but it's an unwanted pregnancy not of interest. What will be the first reaction? The first impression is to go to the hospital or health center, the second is to decide to terminate this pregnancy.” (Woman, 25–45 years)

“Well, this woman who got [pregnant] through sexual violence, she could be forgiven.” (Man, 18–29 years)

Upon further discussion, community members also provided a litany of factors that could motivate a married woman to induce an abortion. While not providing explicit approval, participants discussed situations in which they could empathise with the reason a woman may choose to induce abortion. Many community members suggested that a married woman may be left with no choice but to abort if her husband was unsupportive or abusive.

“I can be married, my husband leaves, he returns with nothing: no salt, nor soap, nor sandals, not even a pagne [cloth], but when the time comes for the marital act, he turns back into a husband even against your will. Wouldn't anyone provoke an abortion because you suffer alone while the

person you're with doesn't care about you?” (Woman 25–45 years)

“When she also sees that the father is irresponsible, he who got her pregnant, so this bothers the woman ... finally she decides and goes to induce an abortion. So this is a problem for almost all married women here.” (Man, 18–29 years)

Additionally, some community members suggested that a married woman living in poverty would be motivated to induce an abortion if she lacked the financial resources to provide for a child.

“I am going to simply add that the lack of means can be the cause of abortion ... In many families, you give birth in difficult conditions; with difficulty, you find clothing for the baby to be born. In addition, you won't even have money to pay the maternity at the hospital. ... in addition, upon realizing that she doesn't have money to feed her other children, she will thus decide to terminate.” (Woman, 18–24 years)

Community members believed a woman may choose to induce an abortion if she had recently given birth or already had many children.

“We have seen that a woman gave birth; when the child is 6 months old, the father finds that his wife has just gotten pregnant again ... she cannot bear to have another child while the one she has not yet reached a year and a half, she decided that this abortion should be done.” (Man, 30–45 years)

Pregnancy as a result of infidelity, especially in the context of the husband travelling or being otherwise absent, was also identified as a potential reason why a woman would seek an abortion. Respondents indicated that married women would do so to avoid domestic violence, spousal abandonment, and social stigma.

“It can happen that the husband is travelling and the woman continues to cheat with other men; when she gets pregnant, she will also do her best to end the pregnancy before her husband knows it.” (Man, 30–45 years)

Finally, and often explicitly, many participants believed that abortion was permissible in order to save the life of the woman.

“I can say that there is a path that can cause abortion. When the nurse finds that the pregnant woman is risking her life because of the pregnancy she has, the nurse makes the decision that rather than losing

the tree, it's better to cut the branch causing the problem. For this pregnancy, the nurse uses his knowledge and expertise to protect the mother of the child.” (Man, 18–29 years)

Community reactions towards women who induce abortion

Though many community members initially stated they would participate in shaming or punishing a woman who induced an abortion, many participants softened their approach as they discussed reasons that motivated women to do so. While rarely stated, a few participants concluded that it was inappropriate to judge a woman who induced an abortion for any reason, recognising that the decision to induce an abortion was personal rather than communal.

“All you need to know is that each person has her problems, and these same problems differ to some unknown degree; I can terminate it for my own reasons ... another has her own reasons that I do not know. In this point of view, really, one can terminate without anyone else’s intervention because it’s an individual problem.” (Woman, 18–24 years)

Other FGD participants advocated against mandating criminal charges for women who induced abortions.

“We don’t want to jail people. We shouldn’t wish for that quickly.” (Man, 18–29 years)

Additionally, while many community members acknowledged that prejudice towards a woman who induced an abortion may exist initially, some maintained that with time, the woman could be reintegrated into society.

“Well, it’s just to give her advice that she never does this nonsense again, and reintegrate her into the community, she’s a human person despite these abortions, despite what she did.” (Man, 30–45 years)

Some community members agreed that while inducing an abortion presents social costs for a young unmarried girl, it was possible that she still could find a husband and contribute meaningfully to the community.

“There are people who will tell the boy that the girl he is courting has already had an abortion; but if he loves her, he won’t take this into account and will marry her.” (Woman, 18–24 years)

Similarly, some FGD participants believed that the anticipated social consequences for a married woman inducing an abortion could be mitigated, such as when a couple may decide to induce an abortion together, including if the wife was pregnant from rape by a member of an armed militia group.

“You, the husband, you find that there are difficulties in giving birth to the first, the second, the third ... we find that there’s collaboration in the household and they decide to contact a doctor to facilitate this intervention of terminating this pregnancy and this gives the first child the chance to avoid malnutrition.” (Man, 30–45 years)

“Because we are here with the [rebel group] in any case, they raped many women when they happened to go looting. And they have sex with your wife and she gets pregnant ... And you are there, you cannot then go and gossip about her in the village because you are not the father. Well, if she gets pregnant, I can authorize her to terminate it.” (Man, 18–29 years)

Finally, the vast majority of FGD participants perceived a clear link between the health risks posed by unsafe abortion and the vital role of PAC in reducing abortion-related morbidity and mortality. Many participants claimed they would either advise a woman who induced abortion to seek medical care or personally escort her to the health facility for PAC.

“I can refer her to the hospital because she must receive medical care because she’s a person who has value in the community; the community needs her because it’s not to say that if you have an abortion, inevitably you’re finished; or you won’t do good anymore because you terminated a pregnancy.” (Woman, 18–24 years)

Even amongst those vehemently opposed to abortion, community members almost unanimously agreed that a woman who induced should have access to PAC, and that they would help her reach care.

“Really, if there are problems it gets tougher, leaving her at home isn’t the solution, and even if the parents harass her that they will kill her this time, when it reaches the point where it becomes worse ... she’s at risk of dying because of this little love, you’ll say, I’m going to look for a motorcycle, I have a sick person, quick to the health centre.” (Man, 18–29 years)

“Even if she does it secretly, you can first send her to the health center despite what she did without your consent, you must first save her life.” (Man, 18–29 years)

In line with community members’ belief that all women were entitled to PAC, many participants explained that health care workers must provide non-discriminatory care to all women, regardless of whether the abortion was induced or spontaneous.

“The nurses never send anyone away; they must always treat them.” (Woman, 25–45 years)

Discussion

Community members overwhelmingly confirmed that induced abortion was common in their communities, notwithstanding the legally and socio-normatively restrictive environment. The widespread nature of induced abortions reported by participants reflects findings presented in other studies regarding the high incidence of induced abortion in DRC.²⁵ Additionally, participants overwhelmingly believed that young, unmarried women induced the majority of abortions in their communities; while this assumption is consistent with beliefs held in many contexts, data suggest that adolescents do not constitute a disproportionate percentage of induced abortions in low and middle-income countries.²⁸

FGD participants also suggested that induced abortion was highly stigmatised in their communities; women who induced abortions were perceived to have diverged from the behaviour expected of nurturing, maternal women. As seen elsewhere in the literature, community members were quick to attach pejoratives to women who transgressed these gendered social norms, labelling them as prostitutes, sorceresses, and murderers.^{9,10} Similar to findings from other settings, participants in this study indicated that a variety of anticipated social repercussions would ensue for women who induced abortions, including spousal and familial abandonment, loss of marriage prospects, overt discrimination, and exclusion by the community.^{22,29} As hypothesised by Kumar et al and observed in other settings, community members predicted that fear of these anticipated social costs influenced women to keep their induced abortions a secret, thus perpetuating the notion that abortion is non-normative and reinforcing the cycle of stigma.^{10,13,22,29}

Many community members predicted that fear of stigma and associated negative repercussions led women who induced abortions to avoid seeking PAC, placing them at an elevated risk for debilitating injuries and death. As community members believed that younger women were more likely to induce abortions, some indicated that the negative impact of abortion stigma on care-seeking behaviour could be even more severe among young unmarried women. These results add to the growing body of evidence that hypothesises a link between women’s fear of stigmatisation and negative social consequences and low utilisation of PAC services.^{9,16,20,21}

While initial opinions of women who induced abortions were mostly negative, community members expressed more nuanced perceptions as they discussed factors that could motivate a woman to do so. This is consistent with other results suggesting that while abortion may be considered socially unacceptable, people suggest exceptions for women in specific circumstances.^{9,23} When first asked about women who induced abortion, participants referred to them as criminals and murderers. Then, as they discussed reasons why women choose to induce abortions, participants used language that suggested empathy for women in certain situations. While this may not mean they found induced abortion acceptable, they appeared to understand, and perhaps even related to, women and girls in some circumstances who seek induced abortion. Evidence of the association between empathy and attitude change suggest this empathy may be the start of acceptance.³⁰ Given the prevalence of sexual violence during the conflict in North and South Kivu,³¹ it is unsurprising that rape was often cited as an understandable, and sometimes explicitly as an acceptable, reason for abortion. As a further sign of nuance, many participants indicated that regardless of the stigma associated with abortion, in practice they would not permanently ostracise a woman who induced an abortion from their community.

While many community members harboured negative attitudes towards induced abortion, these conservative beliefs did not correlate with universal disregard towards the fate of women who induced abortions. The overwhelming majority of participants recognised the health risks associated with unsafe abortion and believed all women should have access to PAC after induced abortion. This incongruity between the perceived

immorality of abortion and women's entitlement to non-discriminatory healthcare has been observed in other contexts. For example, a study in Zambia demonstrated that while the majority of respondents perceived abortion to be immoral, they also expressed wide support for abortion health services in order to ensure the safety of women who choose to induce abortion.²³ Additionally, the researchers discovered that perceiving abortion as immoral was not correlated with opposition towards abortion legalisation.

Given the perceived social and health consequences of abortion stigma, these findings indicate a pressing need to further engage community members to address negative attitudes towards induced abortion in North and South Kivu. The nuance present in participants' views on abortion represents a potential opportunity to engage community members in constructive conversations towards shifting community norms, thus disrupting the culture of silence surrounding induced abortion. However, robust abortion stigma research is limited as are evidence-based interventions to address negative beliefs towards women who induce abortion in low-income settings.^{10,32} This is troubling, as lawmakers and public health practitioners working in DRC, as well as other normatively restrictive contexts, require empirical evidence to design appropriate policies, interventions, and programmes to address abortion stigma's impact. Given the recent domestic momentum to expand legal abortion access in DRC through publication of the Maputo Protocol in the official journal, addressing the adverse impacts of abortion stigma must be prioritised in order to remove normative barriers hindering access to health services. Additionally, while community beliefs and attitudes contribute to abortion stigma, available evidence indicates that provider bias can also be a powerful care-seeking deterrent; as such, future research should include both community members and health providers to better document and understand the impact of abortion stigma in diverse contexts.^{12,15,18,19}

Limitations

While FGD facilitators were not staff of the three partner organisations, participants may have tried to provide the responses they believed the researchers desired. As induced abortion is a taboo subject in DRC, social desirability bias may

also have influenced participants' responses, especially in the early negative reactions to women who induce abortion. However, given the consistency between the results of this analysis and evidence from other abortion stigma studies, the researchers do not believe this bias significantly impacted the validity of the results. Additionally, given the multi-year presence of the partners' programmes in these areas, knowledge, attitudes, and behaviours regarding contraception and PAC may be more liberal among study participants as compared to the general population in DRC, thereby limiting the generalisability of the study results. Given this study's focus on community perceptions towards women who induce abortions, personal accounts of experiencing abortion stigma first-hand were not requested in the groups.

Conclusion

Given the high maternal mortality in DRC, low PAC utilisation, and the perceived harmful impact identified by study participants that abortion stigma has upon PAC-seeking behaviour, engaging communities in discussions regarding discriminatory beliefs towards women who induce abortions is critical to break down normative behaviours that impede access to life-saving medical care. While the recent progress integrating the Maputo Protocol into Congolese law was a necessary step towards reducing legal obstacles to obtaining safe abortion, decriminalising abortion alone is insufficient to reduce unsafe abortion. Interventions must prioritise addressing abortion stigma and engage communities to shift social norms to be less discriminatory towards women who induce abortion.

Findings from this study indicate that despite widespread abortion stigma, attitudes towards women who induced abortions were far from one-dimensional. Rather, community members expressed a range of opinions towards these women, tempering their reactions depending on the factors motivating a woman to induce. Regardless of the perceived morality of induced abortion, an overwhelming majority of study participants believed that women should have access to PAC and therefore improved health outcomes. This openness to providing life-saving medical care for women who have induced abortion, in addition to empathy for inducing abortions in certain

situations, indicates an opening to reduce abortion stigma and liberalise abortion access in this context.

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ORCID

Sara E Casey  <http://orcid.org/0000-0002-8476-0327>

Meghan C Gallagher  <http://orcid.org/0000-0001-7572-962X>

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Résumé

Des obstacles structurels, comme un environnement juridique restrictif, des ressources médicales limitées et des coûts élevés, inhibent l'accès à un avortement sûr en République démocratique du Congo (RDC); ces obstacles sont exacerbés par deux décennies de conflit. Les restrictions socio-normatives compliquent encore l'accès à l'avortement sûr et aux soins post-avortement en RDC, où la peur de la stigmatisation liée à l'avortement peut inciter les femmes à éviter d'avoir recours aux services de soins post-avortement. Les partenaires du programme aident le Ministère de la santé à assurer des services contraceptifs et de soins post-avortement de qualité au Kivu Nord et Sud, en RDC. Cet article présente les résultats de discussions par groupes d'intérêt qui ont étudié les attitudes des membres de la communauté à l'égard des femmes qui avortent et leur comportement de recherche de soins dans les régions du programme. Les résultats indiquent que si la stigmatisation liée à l'avortement est très fréquente, les attitudes des membres de la communauté à l'égard des femmes qui avaient avorté n'étaient pas unidimensionnelles. Même s'ils ont exprimé initialement des opinions négatives à l'égard de

Resumen

Las barreras estructurales tales como un contexto legislativo restrictivo, recursos médicos limitados y altos precios, inhiben el acceso a los servicios de aborto seguro en la República Democrática del Congo (RDC); estas barreras son exacerbadas por dos décadas de conflicto. Las barreras socio-normativas complican aun más el acceso a los servicios de aborto seguro y atención postaborto (APA) en la RDC, donde por miedo a sufrir estigma relacionado con el aborto, algunas mujeres evitan los servicios de APA. Los socios del programa apoyan al Ministerio de Salud en la prestación de servicios de anticoncepción y APA de buena calidad, en el norte y sur de Kivu, RDC. Este artículo presenta los resultados de discusiones en grupos focales que exploraron las actitudes de integrantes de la comunidad hacia las mujeres que inducen el aborto y sus comportamientos relacionados con la búsqueda de servicios en las zonas del programa. Los resultados indican que aunque el estigma del aborto era generalizado, las actitudes de la comunidad hacia las mujeres que indujeron abortos no eran unidimensionales. Aunque inicialmente expresaron opiniones negativas sobre las mujeres que inducen el aborto, las creencias se

ces femmes, les membres de la communauté ont nuancé davantage leurs convictions lorsque la discussion a abordé les situations concrètes qui peuvent inciter une femme à avorter. Par exemple, beaucoup jugeaient compréhensible qu'une femme interrompe sa grossesse après un viol, ce qui n'est guère surprenant compte tenu de la prédominance de la violence sexuelle en rapport avec le conflit dans cette région. Si les membres de la communauté pensaient que la crainte de la stigmatisation ou des conséquences sociales négatives associées dissuadait les femmes de demander des soins post-avortement, une majorité d'entre eux pensaient que toutes les femmes devaient avoir accès à des soins post-avortement d'importance vitale. Cette volonté de garantir l'accès des femmes aux soins post-avortement, jointe à l'acceptabilité déclarée de l'interruption de grossesse dans certaines situations, indique qu'il pourrait y avoir une ouverture vers une fin d'une stigmatisation de l'accès à l'avortement dans ce contexte.

volvieron cada vez más matizadas a medida que la discusión abordó las situaciones específicas que podrían motivar a una mujer a hacerlo. Por ejemplo, muchas personas opinaron que es entendible que una mujer induzca un aborto después de ser violada, lo cual quizás no sea sorprendente debido a la prevalencia de violencia sexual relacionada con el conflicto en esta región. Aunque los miembros de la comunidad creían que el miedo a sufrir estigma o consecuencias sociales negativas asociadas disuade a las mujeres de buscar APA, la mayoría opinaba que todas las mujeres deben tener acceso a servicios de APA que salvan vidas. Este compromiso para garantizar que las mujeres que inducen el aborto tengan acceso a la APA, además de la aceptación profesada del aborto inducido en ciertas situaciones, indica que podría haber una abertura para desestigmatizar el acceso a los servicios de aborto en este contexto.