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Sexual behaviour and emergency contraception in Africa

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Extended abstract

Context

While the West African region is entering into a process of fertility decline, and is experiencing the development of pre-marital sexuality and the reduction of post-partum abstinence, numerous indicators still point to the existence of unmet contraceptive needs. Thus, despite important national and international policy efforts to promote better access to contraception in Africa, the prevalence of modern contraceptive use remains low. An important proportion of women in union wanting to delay or stop childbearing still do not use contraception. In this context of changing sexual and reproductive norms and low use of medical contraception, the recourse to unsafe abortions to regulate women's fertility is a major public health issue. WHO estimates this frequency at 31 abortions per 1000 women aged 15 to 49 in West Africa, and the trend seems to be higher, even increasing, among educated and urban women according to recent studies. The practice of unsafe abortion exposes women to important risks of morbidity and mortality, since abortion procedures performed illegally and in unsanitary conditions result frequently in complications (sepsis, haemorrhage).

Pharmaceutical industries have recently developed a new type of emergency contraception composed exclusively of progesterone (levonorgestrel), shown to be as effective as previous forms of emergency contraception while inducing fewer side effects. This new product is not subjected to medical counter-indications and can be sold over-the-counter; it is in the process of being approved for distribution in most African countries. This new product could represent an efficient means towards the reduction of women's unmet contraceptive needs, and thus towards the reduction of deaths and complications related to unsafe abortions. Moreover, in the context of the HIV-AIDS epidemic, the introduction of this new form of emergency contraception could help in integrating STI prevention and family planning strategies, emergency contraception being a back up to condom failures.

Since 2004 a comparative study is conducted in 4 capitals of African countries: Burkina Faso, Ghana, Morocco and Senegal[1]. The main objective of the study is to examine whether (and how) emergency contraception will complement or replace other medical contraceptives in African context. To reach this objective, we study more specifically: a) the *acceptability* of emergency contraception by men and women, b) the situations in which the use of emergency contraception is particularly adapted, and the specific obstacles to its use, we also analyse the place of this method in regard to other fertility regulation practices.

Conceptual framework

[1] Emergency Contraception in Africa (ECAF). This project is financed by the European Commission (6th PCRD), contract no.510 956

In classical approaches studying preventive and contraceptive practices, one considers that risk is a data preceding the actors' social experience, that is to say that it is defined par medical institution, and one seeks therefore to find out why individuals confront themselves to this risk or not. It is not the position adopted here. In the ECAF research, risk (whether it is pregnancy or STI) is a social construction. Indeed, individuals build their own definition of risk, that is not necessarily a two-sided opposition: present / absent risk, but that can integrate different levels of risk (from very minor to very important), according to the relational and epidemiological context they are in. Hence, for instance, a woman can judge it enough to use a spermicide, because she believes her partner to be reliable as far as faithfulness is concerned, whereas objectively, she has no certainty. Depending on the situations, the individual can find himself / herself in a risk denial process or, on the contrary, can stick to the preventive definition, without this conscience of the risk necessarily leading him / her to protect himself / herself (taking pleasure and other sexually related issues into account). In this perspective, the occurrence of an unprotected sexual relationship makes sense as an element, surely particular, of the relation. Risk taking can therefore allow actions meant to consolidate the relation or terminate it. Moreover risk taking is built within the sexual interaction and depends on social, economical, cultural, physical ressources each partner will provide.

This perspective leads to apprehend risk taking (whether it concerns STI or pregnancy) not as the analysis *central element* anymore but indeed as the *revealing element* of social relationships that structure sexual activity seen as a social activity.

As any other social practice, sexual practices find themselves in several social relations simultaneously, for instance gender, class and generational relations. To analyse each partner's representations and expectations on one hand, and to report the negociation conditions on the other hand, gender relations appear more structuring, both on a theoretical and an empirical observation point of view.

Hence socio-cultural scenarii can suggest very different models for men and women, or, on the contrary, very similar. Individuals may not retain the same elements, *acquired during their familial education as well as in ulterior re-interpretations that may build up through reactions and interactions in their environment.*

Most often, men and women do not have the same conception of sexuality, or more exactly of the opportunity to have or not a sexual intercourse at such or such a time, and do not always have the same anticipation of the risks and consequences this intercourse may have. These differences can be analysed within a gender perspective.

However, gender social relations, even though without a doubt the most structuring, are not the only ones to model sexual practices. Sexual behaviour is a step-by-step elaboration that is linked back to age as well as generation, and that we know is constituted differently according to the belonging of the individuals to a certain social and cultural category.

Partners do not necessarily agree to have a sexual intercourse at the same moment. They may as well have different opinions about the modalities of a preventive practice, they may fear different risks, which can create tensions. Moreover, in the implicit or explicit negociation held between both partners, elements related to affection, emotion, desire and pleasure may strongly mediate, in certain relational configurations, the social relation game. The understanding of sexual practices and of their consequences must not therefore be reduced to taking social relations into account, even sexual, and other capitals than social capitals must be notified (for instance the purpose for which the intercourse is suggested, accepted, refused, imposed). What is involved in a sexual exchange is not isolated from other dimensions of the

individuals' life. Sexuality can be exchanged for something non-sexual, beyond prostitution, and allow, for instance to keep a partner, to have a less conflictual everyday life.

Data and method

Data collected are qualitative. In each capital country, in-depth interviews (life histories) has been conducted with women (n=50), men (n=25), aged 18 thru 35, some having used EC or and some having not. The respondents have been selected on pre-established quotas in contrasted social groups (age, union status, educational / social status). Providers who distributed EC have also been interviewed too (n=15). In this paper we focus on men and women data.

In order to analyse the large set of interviews we have collected in the 4 countries (4 x 75=300) we use specific methods of analysis. First, each interview is analysed in its totality, leading to the construction of a portrait for each interview: these portraits are used to reconstitute how each singular history participates to the process under investigation, that is, the (un)appropriation of contraception and EC. This analysis help us grasp the contrasts and similarities (in terms of meanings or practices) between groups of men, women. Second, we performed a classical analysis according to themes: identify recurrent themes, their variations across interviews, and link them to the respondents' characteristics. These analyses are performed with the assistance of qualitative analysis software: Nvivo.

Results

These preliminary results show that contraceptive failure are embedded in the articulation of conflicting social logics which depend simultaneously on reproductive and sexual norms and gender relations. It shows that contraceptive failures occur in specific situations and that the use of EC is influenced by pre-existing experience of modern contraception and the beliefs associated to that use.

In this communication we will present a typology of situations that lead women to face contraceptive failure and examine if EC could be used or not. More specifically, we built a classification of various couple experiences of contraceptive strategies and negotiation in specific life contexts: occasional, premarital or marital. Eleven groups of situations has been identified that our presentation will describe in detail:

1. Contraception is not thought
2. Ignorance
3. socially stigmatized sexuality
4. Procreation as an issue to be natural
5. planned motherhood
6. Total adhesion to contraception
7. motherhood wanted by partener
8. Getting pregnant to get married
9. Rape
10. Aid prevention as a priority
11. Ambivalent women

For each situation, the main barriers to use EC will be analysed.