



Unwanted pregnancy and abortion Experiences of women in Malawi



"Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving."

Mahmoud Fathalla, MD, PhD
Former President of FIGO



ICW members see first-hand a manual vacuum aspiration instrument, used to treat incomplete abortions.

The International Community of Women Living with HIV/AIDS (ICW) is the only international network run for and by HIV-positive women. The branch of ICW in Malawi is organized and managed by a group of HIV-positive volunteers.

ICW was founded in response to the desperate lack of support, information and services available to women living with HIV worldwide and the need for these women to have influence and input on policy development. ICW was formed by a group of HIV-positive women from many different countries attending the 8th International Conference on AIDS held in Amsterdam, The Netherlands, in July 1992. HIV-positive women shared stories and strategies for coping and devised action plans for the future. An important achievement at this first ICW pre-conference was drawing up the "Twelve Statements". These statements relate to the issues and needs facing all women living with HIV worldwide and form the basis of our organization's philosophy.

Website: <http://www.icw.org/about-ICW>

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We would very much like to thank all of the women who participated in our community dialogue sessions and who so kindly shared these stories and personal testimonies. We sincerely hope that their willingness to relate these experiences will lead policymakers to adopt measures that will reduce and prevent unwanted pregnancies.

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PREFACE

From March through June 2009, members of the International Community of Women Living with HIV/AIDS (ICW) in Malawi carried out dialogues with community women on unwanted pregnancy and abortion in the three regions of the country with assistance from the international NGO Ipas. This was the third phase of an ongoing project, in which Ipas supported ICW to offer education and capacity-building to women from NGOs and community groups on gender and reproductive health and rights in relation to HIV/AIDS. During the dialogues, ICW members used training exercises, presentations and small-group discussions to offer information about contraception, pregnancy and the differences between unsafe and safe abortion. Some sessions also included two experts who provided more detailed information and answered questions: Fannie Kachale (Deputy Director, Reproductive Health Unit, Ministry of Health) and Orace Valani (Banja la Mtsogolo).

During the project, it became apparent that community women were familiar with the issues of unwanted pregnancy and unsafe abortion, either through personal experience or contacts with family members and friends who had faced an unwanted pregnancy. Since the government of Malawi was carrying out a strategic assessment of the country's situation regarding family planning, unwanted pregnancy and abortion, ICW decided to record some of the project participants' testimonies as a contribution to the data collection. The stories were recorded during interviews and group discussions.

Many women living with HIV do want to have children and they should certainly not be denied this right. However, they — like women of unknown or HIV-negative status — at times face an unwanted pregnancy. A number of factors contribute to this situation.

UNAIDS has noted that many barriers exist to women's economic independence, such as lack of education (only about 31% of girls being enrolled in secondary schools), problems in owning property and receiving inheritances, and women having primary responsibility for the care of orphaned children.¹ When women are dependent on others for their income, they will not be able to assert decision-making power if this contradicts what those people want.

Overall, condom use is low and some women's and girls' male partners prevent them from using contraceptives, as evidenced by the following remarks made during a study of perinatal transmission prevention programmes:²

¹ UNAIDS. August 2004. *Fact sheet: Women, girls and HIV/AIDS in Malawi*. <http://womenandaids.unaids.org/documents/factsheetmalawi.pdf>

² Jacqueline Rose Chinkonde, Johanne Sundby and Francis Martinson. 2009. The prevention of mother-to-child HIV transmission programme in Lilongwe, Malawi: why do so many women drop out? *Reproductive Health Matters*, 17 (33):143-151

“Even when I tell my husband about HIV risks, he does not listen to me. As you know, men do not listen to what women say. If my husband had agreed to use condoms, maybe I would be protected, but as things are, it is difficult.”

“My husband refuses condoms. He says he is already dead. I may be against having unprotected sex, but as a woman, this does not carry any weight.”

In addition, violence against women increases their vulnerability to both HIV transmission and unwanted pregnancy. As a government representative stated in October 2008: “Gender-based violence is a persistent problem for women and girls in Malawi. It reinforces subordination of women and further promotes sexual abuse which leads to injury, HIV infection and unwanted pregnancies.”³

Girls and women in our country, including those living with HIV, need to have safe means of dealing with unwanted pregnancies, but their options are limited. A lack of access to emergency contraception means that they either must carry the pregnancy to term, which may place them in very difficult and challenging life circumstances. One health-care worker interviewed in a 2009 study here in Malawi reported meeting an HIV-positive woman during her seventh unplanned pregnancy; the health-care provider remarked that neither the woman nor her seven children are alive today.⁴

The other option for a woman facing an unwanted pregnancy is to seek a clandestine and unsafe abortion, which may have particularly risky effects if they are not on antiretroviral therapy and have immunocompromised health.

The stories shared during our dialogue sessions also highlight the fact that many younger women and adolescents are dealing with unwanted pregnancies. In the absence of legal, safe and affordable abortion services, women who are desperate for an abortion are pushed into undergoing unsafe procedures despite the risks involved. The director of the Malawi Human Rights Commission (MHRC), Dr. Aubrey Mvula, has noted: “Malawi needs to move forward and significantly promote the health of women and the girl child by making sure that all dangerous pregnancies acquired through unwanted, ill-advised and accidental sexual activities or economic problems need to be terminated on that basis.”⁵

³Rosely Makhumula. 14 October 2008. *Statement by Mrs. Rosely Makhumula, Deputy Permanent Representative of the Republic of Malawi to the United Nations*. New York, Permanent Mission of Malawi to the United Nations; <http://www.un.org/womenwatch/daw/documents/ga63/malawi.pdf>

⁴Karen Stefiszyn, Mmatsie Mooki and Yohannes Tesfagabir. June 2009. *Addressing the reproductive health rights of women living with HIV in Southern Africa*. South Africa, Centre for Human Rights, University of Pretoria.

⁵Pilirani Semu-Banda. 29 April 2009. Women’s group sues govt over abortion rights. IPS News; <http://www.ipsnews.net/africa/nota.asp?idnews=46671>

We believe that the evidence in this booklet challenges the government to re-examine the extent to which it is fulfilling its duties and commitments towards the improvement of reproductive health rights for women in our country. A discussion on the legal and policy environment relevant to reproductive health will be helpful in such interrogation.

Please note that pseudonyms are used in all cases to identify the women involved as we are committed to preserving the confidentiality of the women who so kindly and bravely shared their stories.

WOMEN'S STORIES AND TESTIMONIES

Women with unwanted pregnancies who had an abortion: some safe, some unsafe

Josephine

I know a girl who was orphaned when both of her parents died of HIV infection. Aged 14 years, she was living in a village with her two brothers and a sister. There came a man and he told her that he wanted to help them in exchange for sex with her. Josephine did not know about emergency contraception. She had sex with this man in exchange for money and then she became pregnant. The man refused to marry her.

When Josephine decided to have an abortion, she was already six months pregnant because she didn't know the early signs of pregnancy. There was a certain woman in the village who told Josephine to go a traditional birth attendant in a nearby village.



Josephine went there and a cassava stick was introduced into her vagina up to the neck of the cervix. No advice was given to her. It took 48 hours before the actual abortion was done; she aborted a male foetus.

After one week, she became sick. In the end, she went to a hospital and there they had to remove her uterus. She was informed about this during post-abortion care. The loss of her womb was a long-term physical effect of the unsafe abortion. The long-term social effect was that her loss of fertility affected her chances of marriage, since culturally it is believed women must have children. A woman without children is considered a source of shame to some communities.

Martha

It was in the month of March when Martha came back from school because she was not feeling well. No more than an hour after she arrived, she fell down suddenly nearby a toilet, crying loudly for help. When her mother asked Martha what happened, she explained that she had severe pain in the lower part of her abdomen.

Martha was quickly taken to one of a community hospital, where the doctors felt her condition was too serious for them to handle. They referred her case to a larger hospital.

When she arrived, the physicians saw her severe condition but she was not taken straight to the operating theatre.

The doctor who handled Martha's case explained to her parents that she had had an unsafe abortion in which she had used tablets to terminate her pregnancy. Unfortunately, the doctor said, some remains were rotting in Martha's uterus. Due to her weak condition, the doctor did not do anything; Martha was just taken to the intensive care unit. A tube was inserted into her nostrils and she was also given several tubes for letting out urinary and uterine remains. Martha was in bed for almost a month. The good part of it is that she is still alive."

Betty

My younger cousin, 15-year-old Betty, became pregnant but she didn't want her parents to know about this. Her mother was away visiting another relative and Betty took the opportunity to secretly go to a traditional doctor to procure an abortion. Even though she started feeling unwell immediately after seeing this person, she did not confide in any family member what had happened. Her mother did not suspect what had happened as she did not think that her daughter could do such a thing. For a whole month, Betty struggled to pretend that she was not too sick. However, she was suffering from severe stomach pains and was bleeding profusely.

By the second month after the abortion, Betty was getting too weak and it was getting harder for her to conceal the extent of her ailment, even though she tried to explain it away as a migraine headache. All this time, she was refusing to be taken to hospital and was just taking paracetamol tablets.

Later, when she became worse, Betty confessed that her actual problem was 'her stomach.' When my mother probed hard, she finally disclosed that she had procured an abortion. We immediately took her to hospital, where she immediately underwent an operation. But since two months had passed, most of her internal organs were rotten. Betty was very ill, and she died three days after the operation.

Joyce

When I was 24 years old, I already had three children but I was not married. I then became pregnant for a fourth time. I wanted to end the pregnancy but didn't know where to go until a friend told me about a herbalist. I went to this herbalist when I was two months pregnant because I had also heard from other people that she helped with abortions. I went alone because I didn't want anyone to know I was going for an abortion.

The herbalist took a stick from a *chigwada* (cassava) plant, and inserted it deep inside my vagina for 20 minutes. Then large clots of blood started to come out; she told me to leave the stick inside and that the clots would eventually force the stick out as well.

I went home bleeding profusely, and had terrible stomach pains that only got worse. When my mother asked what was wrong with me, I lied and told her that I had malaria. She did not believe me and kept asking me now and again what was wrong. After the pain I went through, after 48 hours I finally revealed to her that I had an unsafe abortion and my mother rushed me to the hospital. I was so sure I was going to die because I left the cassava stick in my vagina. The health-care providers were not happy with me.

Mary

My husband did not allow me to use contraceptives. Then I discovered that I was pregnant again when my last-born child was only five months old. My husband began to pressure me, telling me that if I wanted to keep the marriage, I should have an abortion. I wanted the marriage.



In order to abort, I initially took 10 paracetamol tablets, but nothing happened. Then I began drinking liquids containing gathered kitchen soot (*mwaye*), because I had heard that this also induces abortions. Again, this did not work.

In the end, because I was still pregnant, my husband beat me so badly one night that I miscarried in the morning. That was eight years ago. I have not conceived since. I don't know if that is because the beating caused some serious problems in me or if it is because of the *mwaye* that I drank during that time.

Katherine

I had heard about contraception, but I was not yet ready to use it following my pregnancy. I thought that I couldn't get pregnant so soon, but then I got pregnant after I had given birth only four months earlier. I was under pressure because I knew I would face society's disapproval. Also, I was generally worried about my baby's wellbeing.

So without even notifying my husband, I tried to induce an abortion by drinking a *chilambe* concoction (herbal mixture). When this did not work, I was even tempted to take in surf (a washing detergent). I was afraid because I had watched someone die after using that method, but still I did it. I had the abortion and, lucky enough, all went well. I am fine now and now I am on the pill.

Sarah

When my 17-year-old daughter, Sarah, told me she was suffering from malaria, a certain instinct told me that was not true. I asked her aunt to question Sarah about whether her sickness was not something related to pregnancy, but she refused to say so.

Two days later, I insisted that we go to the nearest mission hospital. When Sarah started to tell the clinical officer the same malaria story, I blurted out: 'I have not noticed her having her monthly periods for the past three months. So I suggest that you check everything.'

This is probably what saved her life, because after examining her abdomen, the clinical officer decided to conduct a vaginal examination. The room was immediately engulfed by such a bad smell! The doctor pulled out [from her vagina] a stick that had gotten retained during the abortion procedure.

After he confirmed that it was due to an abortion, we came to a central hospital. Sarah had to have an operation because the procedure had damaged her intestines; her uterus was removed because it was damaged. She has already been admitted for three weeks now but she is still quite sick. A few months later, she was still recovering.

Marian

I got pregnant when I had just finished my grade 12. I was being kept by my aunt at her house. When she discovered that I was pregnant, she chased me away from her house and I had nowhere to go. I told a friend of mine about my pregnancy and she told me to use a cassava stick, which I tried for sometime but it did not work. By then the pregnancy was growing and it was now three months.



I then went to a private clinic, where I told the doctor about it. He performed a safe abortion and the pregnancy was terminated. I am glad that it was done at the hospital where it was safe. If I had continued with inserting the cassava, maybe I would have injured myself.

Christine

I know of a 15-year-old girl who was in Standard (grade) 8 and she had a boyfriend. Her parents arranged a marriage for her. They wanted her to get married to her late elder sister's husband because they wanted her to take care of the children her sister left.

When she came back from school, she was told that she would not continue with her studies because her sister's husband was waiting to marry her. By then she was also already four months pregnant by her boyfriend. She told her mother about the pregnancy and the mother took her to a private clinic where she underwent an induced abortion. Christine was charged 2,5000 kwacha (about US\$ 17), which her mother paid.

After the abortion was done, Christine went home where she was bleeding heavily. After some hours, she had lost a lot of blood and she died.

Karen

When I was 16 years old, I was in form two at school and about ready to write my exams. I had two boyfriends and a sugar daddy. The sugar daddy was giving me money to use at school. This man impregnated me but he was not ready to take any responsibility because he had his own wife. So he told me to go for abortion.

I went to a private clinic, where they asked me how many months pregnant I was. I told them it was three months and they charged me 3000 kwacha (a little more than US\$21), which I paid.

They did the abortion and everything went well. I was told to come back after 48 hours. They gave me antibiotics and analgesics and after that I was feeling better. The problem and the sad thing is that I contracted HIV from that sugar daddy.

Deborah

When I was 19 years old, I had two children and a husband. He died in December 2008, because he was HIV-positive. Before he died and while he was sick, we were using condoms to prevent further infection. One day, after we had sex, I noticed that the condom was broken. A month later is when my husband died. After two months, I realized that I was pregnant.

I decided to go for an abortion because of many conditions: I was a widow, I was HIV-positive, I was not working and I could not afford to raise another child. I went to the ART clinic at a government hospital. There, they referred me to the gynaecology clinic, where the abortion was done by using dilatation [vacuum aspiration]. It was successful and I am now a happy woman looking after my two kids.

Women with unintended pregnancies who did not have an abortion

“...[f]orced abortions, forced contraception, coerced pregnancy and unsafe abortions each constitute violations of a woman’s physical integrity and security of person”

– Special Rapporteur on Violence against Women, R. Coomaraswamy, 1999

Joan

We had our first three children within a space of four years. When I was pregnant with my third child, my husband instructed me to get an abortion and he was clear that this decision was not negotiable. He took me to a private clinic.

The clinical officer must have read the desperation on my face, and he requested that my husband leave the room so that we could talk in private. When I told him that the abortion was

my husband's idea, he told me that he would help me out by demanding an excessive amount of money for the service, with the hope that it would be beyond my husband's means. He underestimated my husband, because though we were turned back that day, he managed to source the required amount later. Luckily, he just gave me the money and let me go by myself.

When I reached town going towards the hospital, my conscience could not allow me to continue with the journey. Instead, I went into the shops and used the money to buy the baby's needs. As I am talking now, I have a healthy boy, who is three years old.

Anne

When my husband discovered I was two months pregnant with our fourth child, he gave me no peace and demanded that I should have an abortion. I tried every method I had heard of – *muwawani*, *mwaye*, *mitsitsi ya msatsi*, *taking quinine tablets* – but surprisingly nothing happened. In the end, the pregnancy had progressed too far so I just quit trying to do it and opted to have a baby instead.

Elizabeth

I first fell pregnant when I was 16 years old, when I was about to write my primary school leaving examinations. My dad gave my mother money to take me to a local woman who was reputed to be in the business of procuring abortions. Luckily for me, when we reached her house, she was drunk and we were told to come back the next day.

My mother just gave me the money so that I could go by myself. I remembered my friend who had earlier died at the hands of the same woman, and I decided I would not go. So instead I left home and went for a long walk, so that my parents would think that I had indeed gone to the woman. When I went home, I lied to my parents, saying that the mission was successful. Later, they discovered that I was still pregnant and they sent me to a mission hospital. But by this time, it was too late to do anything about my pregnancy.

APPENDIX 1

Policy measures advocated at the community dialogue sessions

- Hold more community dialogue/education sessions – also at schools – on topics like safer sex, pregnancy, contraception and abortion so that women become more knowledgeable and are better able to contribute to community discussions, advocacy and policy-making regarding reproductive health.
- Develop and distribute more materials on contraception.
- Educate and sensitize community members about emergency contraception so that unwanted pregnancies can more often be prevented. Especially make sure that young girls and boys know about emergency contraception.
- Increase the number of women receiving information and education about the differences between unsafe and safe abortion care.
- Legalize safe abortion in Malawi so that girls/mothers and other women can freely request this service.
- Ensure that hospitals have a client-friendly atmosphere so that girls and women feel comfortable asking for reproductive health services.



“HIV-positive mothers who become pregnant are making a responsible choice for the children they already have if they end the new pregnancy early and in a safe way.”



“Child dumping could be avoided if women have early pregnancy termination and if the law permits the women to do so under some circumstances. These circumstances could be: to protect her physical health, to protect her mental health, in cases of rape and incest, for socio-economic reasons (if a woman has already several other children and cannot afford another child), if she is living in a situation of ongoing violence, if the pregnant girl is not yet mature and able to raise a child.”

APPENDIX 2

Health statistics for Malawi

Basic health indicators (source: USAID Country Health Statistical Report, Malawi, May 2008)

Indicator	Value	Year
Total population	13,931,831	2008
Urban residents	17%	2004
Population younger than 15 years	46%	2008
Women aged 15–19 years	801.516	2008
Women aged 15–49 years	3,106,785	2008
Estimated number of women living with HIV 15 years and older	500,000	2005
Life expectancy at birth	43,5 years	2008
Healthy life expectancy female	34.8 years	2002
Healthy life expectancy male	35 years	2002
Population living on less than \$1/day	20.8%	1990–2005
Health expenditures as part of gross domestic product	9.3%	2003

Maternal health indicators (source: USAID Country Health Statistical Report, Malawi, May 2008)

Indicator	Value	Year
Total fertility rate	6	2004
Modern contraceptive use - all women	22.4%	2004
Modern contraceptive use - married women	28.1%	2004
Women aged 20–24 years who gave birth before age of 20 years	63.2%	2004
Number of live births	582,211	2008
Maternal mortality ratio	1,100 per 100,000 live births	2005
Infant mortality rate	90.6 per 1000 live births	2008
Under 5–years mortality rate	163.1 per 1000 live births	2006

APPENDIX 3

Excerpt from the Protocol to the African charter on Human and Peoples' Rights on the Rights of Women in Africa

Article 14: "1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

- a) the right to control their fertility;
- b) the right to decide whether to have children, the number of children and the spacing of children;
- c) the right to choose any method of contraception;
- d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS;
- e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
- g) the right to have family planning education."

Article 2: "States Parties shall take all appropriate measures to:

- a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
- b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
- c) protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."

APPENDIX 4

Statements of Treaty Monitoring Committees to the Government of Malawi

CEDAW Concluding Observations, 2006:

Paragraph 31: "...The Committee is alarmed at the persistent high maternal mortality rate, particularly the number of deaths resulting from unsafe abortions, high fertility rates and inadequate family planning services, especially in rural areas, low rates of contraceptive use and lack of sex education...."

Paragraph 32: "The Committee urges the State party to continue its efforts to improve the country's health infrastructure and to ensure sufficient budgetary allocations for accessible health services. It calls on the State party to integrate a gender perspective in all health sector reforms, while also ensuring that women's sexual and reproductive health needs are adequately addressed. In particular, the Committee recommends that the State party undertake appropriate measures to improve women's access to health care and health-related services and information, including access for women who live in rural areas. It calls upon the State party to improve the availability of sexual and reproductive health services, including family planning information and services, as well as access to antenatal, post-natal and obstetric services to reduce maternal mortality and to achieve the Millennium Development Goal to reduce maternal mortality. It encourages the State party to seek technical support from the United Nations Population Fund in these areas...."

Committee on the Rights of the Child, Concluding Observations, 2009:

Paragraph 53: "The Committee notes with appreciation the improvements made in the area of adolescent reproductive health and voluntary counselling and testing for HIV/AIDS. However, the Committee notes with concern the high levels of early pregnancy in the State party and unsafe abortions and STIs."

Paragraph 54: "The Committee recommends that the State party, taking into account the Committee's general comment No.4 (CRC/GC/2003/4) on adolescent health and development in the context of the Convention on the Rights of the Child, increase its efforts to establish more child-friendly programmes and services in the area of adolescent health and to obtain valid data on adolescent health concerns through, inter alia, studies on this issue."

APPENDIX 5

Addressing the needs of HIV-positive women for safe abortion care A publication of ICW, June 2008

Why positive women access abortion care

HIV positive women may need abortion care for various reasons. Rates of violence against positive women are high [2]; when sexual assault is involved and a woman cannot access emergency contraception, she may want to terminate a resulting unwanted pregnancy. HIV positive women may access abortion services because they deliberately and thoughtfully choose not to have a(nother) child. Lack of access to appropriate contraceptives, and little or no control over decisions regarding childbearing leads to unplanned and unwanted pregnancies. Our research shows that women who already have children when they are diagnosed may feel less desire to have more [3]. HIV positive women have also chosen abortions because of fears that our pregnancy would lead to our own poor health or death, so rendering our older children motherless; and that our babies might also contract HIV or be unhealthy or die soon after birth: which would cause immense suffering for the baby and grief for our families. WHO has also noted that, although the available data are limited, HIV positive women appear to have higher risks of stillbirths and spontaneous abortions (miscarriages), which may require post-abortion care [4].

“When I lived with him, I got pregnant. I decided on my own to have the abortion and get sterilised at the same time at a hospital. I did that because I had the infection. Because... wasn’t the baby in my body?”

Woman in Thailand [1]

“...the doctors also found out I was pregnant. I did not want to have a child at this stage and requested the pregnancy be terminated. The doctors only agreed to the termination on condition that I consented to sterilisation. I had no option.”

Woman in South Africa [5]

Nevertheless, ICW members and other HIV positive women have been denied safe abortion care or have been “asked” to agree to sterilization in order to access abortion services. This is a violation of our rights to unbiased health care, self-determination, to decide the number and spacing of our children, to freedom from gender-based discrimination, and to freedom from inhuman treatment [6].

Coerced abortion

We also know of examples where HIV positive women have been forced or feel pressured by health-care workers to have abortions. HIV positive women may “choose” to have an abortion because they are misinformed about the possible impact of a pregnancy on their health and that of their child; they may be told that the risks of perinatal transmission are high. Such misperceptions can be heightened by health workers who promote a view that HIV positive women should not have children. Indeed, a number of our members have felt that sometimes health-care workers present abortion as the only option once a positive woman becomes pregnant. Yet HIV positive women have the right to have children and, given the right care, treatment and support, they generally can have healthy pregnancies and babies. Positive women should never be pressured by their partners, families or

Health-care workers to have abortions — that is also a violation of our human rights.

Another point of concern is related to the increasing tendency to criminalize HIV transmission. So far, most legislative initiatives have concerned transmission by sexual or blood-borne routes, but this does not rule out that perinatal transmission might be included in such laws (despite the fact that antiretroviral treatment is not 100% effective for prevention). Women should not be avoiding voluntary HIV counselling and testing (VCT) or choose to end a pregnancy simply due to fear of being punished for transmission [7].

Why we need safe abortion services

A 2007 review of abortion worldwide noted that criminalizing pregnancy termination is not associated with a low incidence of abortion; in addition, most unsafe abortions occur where abortion is highly restricted [8].

“Ensuring that safe abortion is available and accessible to the full extent allowed by law to women living with HIV/AIDS who do not want to carry a pregnancy to term is essential to preserving their reproductive health.” WHO [4]

HIV positive women are prone to septicaemia and may be especially at risk of complications following unsafe abortions. The range of needed sexual and reproductive health services — such as family planning, maternal and child health care, sex education and safer sex counselling, marital, family and individual counselling — should include both postabortion care for miscarriages and unsafe abortions, as well as safe abortion counselling and care [3].

What could abortion services offer HIV-positive women?

Abortion should not be the recommended option for HIV positive pregnant women. Rather, information about safe abortion should form part of a holistic package of information and advice that includes prevention of perinatal transmission (PMTCT). Unfortunately, comprehensive PMTCT services that focus on the health both of the mother and the health of the child in equal balance before, during and beyond pregnancy and birth are still rare. Sexual and reproductive health services need to provide: Improved information about, and access to, preferably free, unbiased, legal, safe and confidential pregnancy, childbirth, and/or abortion services for HIV-positive women. Better training and awareness-raising for health workers to reduce the frequency of forced abortion and forced sterilization of HIV-positive women.

Abortion-care providers should provide:

- Non-discriminatory, non-judgemental advice and counselling pre- and post-abortion
- Further information and counselling about family-planning methods, including emergency contraception
- Referrals to post-rape services (PEP for HIV negative women, legal assistance, shelter, protection)
- Information and advice about sexual and reproductive health and rights, including gender-based violence
- Information about HIV care, treatment and support services
- Referral to relevant HIV and SRH services.

Should abortion services also provide testing services?

Abortion services can be one entry point for VCT. In fact, in some countries, HIV rates are higher among women attending abortion services than at antenatal care. However, going through an abortion can be very emotional for a woman, particularly if she became pregnant as the result of sexual

coercion. Imagine learning you are also HIV positive immediately after an abortion? Service providers should be aware that if a woman tests HIV positive, she is more likely to experience abandonment, discrimination and violence (including sexual violence). Moreover, the family member or partner who tests HIV positive first is more likely to be blamed for bringing HIV into the family. It also cannot be assumed that a woman who may have very limited ability to negotiate, who has been subjected to subordination all her life, and who may have very limited self-esteem can meaningfully decide on short notice whether she should be tested or not. Let's not assume that a 'yes' answer to a question posed by a person in a position of authority (for example, a health worker) constitutes voluntary consent.

All of this may mean a referral is preferable to on-the-spot VCT. It is important that abortion providers who refer women to VCT services do so only if comprehensive counselling and support services are available. But establishing mutual referral links between VCT, abortion and other sexual and reproductive health services is needed for women to fully enjoy sexual and reproductive health.

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