‘It hurts, but I don't have a choice, I’m not working and I’m sick’: decisions and experiences regarding abortion of women living with HIV in Cape Town, South Africa

Phyllis Orner a, Maria de Bruyn b & Diane Cooper a

a Women's Health Research Unit, School of Public Health and Family Medicine, University of Cape Town, Cape Town, South Africa
b Ipas, Chapel Hill, NC, USA

Available online: 09 Jun 2011

To cite this article: Phyllis Orner, Maria de Bruyn & Diane Cooper (2011): ‘It hurts, but I don't have a choice, I’m not working and I’m sick’: decisions and experiences regarding abortion of women living with HIV in Cape Town, South Africa, Culture, Health & Sexuality, 13:7, 781-795

To link to this article: http://dx.doi.org/10.1080/13691058.2011.577907

PLEASE SCROLL DOWN FOR ARTICLE
‘It hurts, but I don’t have a choice, I’m not working and I’m sick’: decisions and experiences regarding abortion of women living with HIV in Cape Town, South Africa

Phyllis Orner*, Maria de Bruynb and Diane Coopera

aWomen’s Health Research Unit, School of Public Health and Family Medicine, University of Cape Town, Cape Town, South Africa; bIpas, Chapel Hill, NC, USA

Research was conducted with 36 women living with HIV in Cape Town, South Africa, regarding their decision-making about, and experiences with, abortion of unwanted pregnancies in the public health sector. Abortion intentions and decisions were explored by investigating influencing factors; knowledge of abortion policy and public health sector services; and abortion perceptions and experiences. Findings reveal that many women face censure both for becoming pregnant and terminating a pregnancy, including by family, partners, community members and healthcare providers. Data suggest that abortion may be more stigmatised than HIV despite South Africa’s liberal abortion law. Generally, however, study participants were satisfied with the abortion care received. Most would advise women living with HIV to think carefully about abortion, but to make a decision in their own best interests, including only seeking care early in pregnancy from an accredited clinic. Study implications include a need to integrate information and counselling on safe legal abortion within sexual and reproductive health services, especially in efforts to integrate sexual and reproductive health into HIV care, and to forge greater linkages between HIV and abortion services more generally to ensure continuity in follow-up of care for women.

Keywords: abortion; HIV/AIDS; living with HIV; South Africa

Introduction

Investigation of decisions about and experiences with abortion among pregnant women living with HIV is critical for fully understanding the sexual and reproductive health (SRH) challenges faced by people living with HIV in South Africa. South Africa has one of the severest HIV epidemics in the world. Among the approximately 5.6 million South Africans living with HIV (UNAIDS 2010), women are disproportionately affected, particularly women in their early reproductive years. For instance, in 2008, among 15–19-year-olds, HIV prevalence was approximately 2.7 times higher in women than men. The peak prevalence among women of almost 33% was in the age group 25–29 years, compared to the equivalent peak of 25.8% in men aged 30–34 years (Shisana et al. 2009). Women’s greater risk for HIV infection is underpinned by inequitable gender relations and sociocultural norms. Reproductive decision-making is a particularly fraught situation for women living with HIV attempting to balance their own needs against both social childbearing expectations and...

Concurrently, with a generalised and advanced HIV epidemic, unintended pregnancies constitute a major problem in the general population of women, with approximately 53% of pregnancies reported as either unplanned (36%) or unwanted (17%) (Cooper et al. 2004). While data on unintended pregnancies among women living with HIV in South Africa is relatively sparse (Laher et al. 2009; Rochat et al. 2006), one recent study found that among women not on highly active anti-retroviral treatment (HAART), 11% became pregnant after knowing their HIV status and all their pregnancies were unintended. Among women on HAART, 9% of women had become pregnant since commencing HAART, yet a third of those pregnancies was unintended (Cooper et al. 2009).

Although some women living with HIV may want to become pregnant, research suggests that women and men living with HIV in South Africa do not have sufficient information about abortion options as one way of coping with unwanted pregnancies (Cooper et al. 2009). This is despite South Africa’s liberal abortion law that allows for free legal termination of pregnancy (TOP) up until 20 weeks of gestation under a broad set of circumstances, including for woman experiencing difficult socioeconomic circumstances (Department of Health 1996). Prior to this law, up to 425 women died annually from illegal abortion complications and approximately 14,000 women were treated in hospital for abortion-related complications (Dickson-Tetteh and Rees 1999). Poor and marginalised black women were most adversely affected by unsafe abortion. After liberalisation of the law, morbidity from abortion complications declined by almost 50% and mortality by 91% (Gabriel 2008). Nevertheless, women in South Africa continue to abort outside designated facilities, signifying that not all risk has been removed simply by passing the law (Jewkes et al. 2005).

Although research into the sexual and reproductive intentions and rights of people living with HIV has been conducted in South Africa (Cooper et al. 2007; Kaida et al. 2010; Orner et al. 2008; Ramkussoon et al. 2006) and elsewhere (Kaida et al. 2009; Kisakye et al. 2010) and a few studies have explored abortion intentions among women living with HIV (Chi et al. 2010; Floridia et al. 2010), minimal attention has been given overall to unwanted pregnancy and abortion in the context of HIV, especially in countries in sub-Saharan Africa, where the majority of women living with HIV reside (de Bruyn 2007; Kaida et al. 2009; Orner et al. 2010).

In South Africa, women and men living with HIV have reported judgemental and/or discriminatory attitudes by healthcare workers regarding reproductive intentions (Harries, Cooper et al. 2007; Orner et al. 2010). Negative experiences for women living with HIV seeking safe legal abortions may be compounded when HIV/AIDS services do not address abortion issues, for instance, because abortion services are separate from both SRH and HIV care services and counselling specifically on abortion is not included in in-service training for healthcare providers of SRH and HIV care (rendering them ill-equipped to counsel women on abortion). The unavailability or inaccessibility of abortion services at many public health sector facilities, lack of client-centred abortion information at numerous clinics and not offering integrated SRH and HIV services may further impede HIV-positive women’s decision-making about abortion (de Bruyn 2004; Magome 2010).

Given that both HIV/AIDS and abortion are stigmatised in most societies, understanding the context and factors that facilitate or hinder abortion decisions and experiences of women living with HIV is of central importance. Documentation of their decisions regarding terminating or continuing a pregnancy, abortion experiences and knowledge of abortion policy and public health sector abortion services can inform not
only South African policy and service provision, but also be valuable for other developing countries. Personal accounts of decision-making can contribute insights to help ensure access to effective, acceptable and safe SRH services, including abortion care for women living with HIV.

Methods
This study built on the formative qualitative research we conducted on abortion decisions and experiences of women living with HIV in Cape Town, South Africa. The aim of the study was to gain an understanding of the main factors that facilitated or hindered the abortion intentions and experiences of women living with HIV in Cape Town.

Study site
The study was conducted in 2008–2009 at three public health sector facilities in Cape Town municipality. The facilities serve predominantly peri-urban working-class communities and are broadly representative of the types of HIV and abortion services prevailing in the area, namely, high patient loads for HIV (comparable to the national prevalence of 29%) and for first- and second-trimester abortion services.

Study design
In-depth, semi-structured interviews were held with 36 women attending HIV or abortion services at the study sites. The study tools were piloted among women living with HIV to refine language and adapt questions and probes. Interview guides were open-ended and explored the women’s perceptions/beliefs about becoming pregnant, abortion, unplanned pregnancy and contraception; reasons for wanting abortions and factors that influenced decision-making; knowledge of abortion policy/access to abortion services; experiences of abortion at public health sector facilities; and experiences of stigma and discrimination.

Interviews were conducted by an experienced qualitative researcher in isiXhosa (respondents’ and interviewer’s first language), who was trained on study tools and supervised by the principal investigator (PI). Given the sensitivity of the subject matter, the interviewer was provided with handouts listing local support services to be given to respondents if deemed necessary. The interviews lasted approximately one hour, were held in privacy at the health facility, digitally recorded and subsequently transcribed verbatim and translated into English. Any lack of clarity through translation was verified with the interviewer/transcriber. Recordings and transcripts are stored on the PI’s password-protected computer and will be destroyed after two years. Recorder interviews were deleted. Participant/facility identifiers were removed from the data before data analysis commenced.

Respondents
Participant selection was purposive and recruitment occurred in two stages. First, the interviewer approached female clients attending study site services to inform them about the study – that it was to be conducted by the University of Cape Town and that it was not part of the health facility’s care. Individuals willing to be considered possible participants signed consent for the interviewer to review their clinic records to determine study eligibility and to be contacted for an interview if deemed eligible. Eligibility criteria included: (1) knowledge of HIV-positive status; (2) 18 years or older; (3) had an abortion
or been referred to abortion services at a public health sector facility but did not have one within the past two years, or currently pregnant/planning to have an abortion; (4) willing to discuss abortion decisions related to the study topic and objectives; and (5) willing to have the interview taped and transcribed, on the understanding that names would be excluded in any record of the discussion. Eligible women were then invited to participate in the study.

Forty-three interviews were held with 36 respondents. One group comprised 23 women who were no longer pregnant and had intended to have an abortion. Of these, 15 women had an abortion and 8 did not (interviews were held subsequent to an abortion or pregnancy). A second group comprised 13 currently pregnant women intending to have an abortion. Of these women, 7 were interviewed prior to and after their abortion. In this group, 6 were lost to follow-up and we were unable to ascertain whether they continued or terminated the pregnancy; data from those women are not included in this paper.

Sociodemographic data were collected prior to the interviews. One woman did not provide sociodemographic information. Fifteen women were aged 20–29 years, 16 were 30–39 years, and four were 40–49 years of age. Twenty-six women reported having a male partner or being married, but only four lived with them. Almost equal numbers were employed (17) and unemployed (18); only eight women reported receiving HAART (six who had an abortion and two who did not).

Data analysis
Data were analysed using grounded theory techniques, which are based on systematic coding and categorising of raw data into manageable units of analysis in order to ‘discover’ categories, themes and patterns that emerge from the data (Strauss and Corbin 1998). Initial categories for analysis were drawn from the interview guides and themes and patterns emerged after reviewing the data within and across respondent categories (Charmaz 1990). Transcripts were reviewed by the co-investigators. A preliminary list of codes and definitions was developed by the PI and subsequently refined through discussion. Data were collaboratively coded and reviewed, major trends and crosscutting themes were identified and issues for further exploration were prioritised for final analysis. Coding discrepancies were resolved through co-investigator discussion and consensus. Quotes were extracted from the transcripts to illustrate themes. Atlas.ti was used to facilitate management and sorting of the data.

Ethical considerations
Only women who provided written informed consent were interviewed and confidentiality and anonymity were ensured for all phases of the research. Participants were reimbursed approximately US$5.00 per interview towards costs incurred (the standard rate of compensation in this context). Ethical approval for the study was granted by the University of Cape Town’s Faculty of Health Sciences Research Ethics Committee and the Ethical Review Committee of the World Health Organization. The Western Cape Department of Health granted approval to conduct the study at their facilities.

Results
Themes emerging from respondents’ perceptions and insights illustrate the complexity of both decision-making and the challenges faced by pregnant women living with HIV who seek abortions.
**Little support for pregnancy or abortion**

Respondents generally acknowledged that there was little community support for pregnant women living with HIV, largely due to a perception that they risk infirmity or death by becoming pregnant. Another widespread perception is that their babies would inevitably be infected with HIV and as a consequence the ‘sick’ and likely motherless child would become somebody else’s ‘burden’:

In the area where I live people say if you are HIV-positive you are not supposed to have children; maybe you are going to die earlier, leave a child behind and make trouble for other people. (Busisiwe, 24 years, had TOP)

While most respondents suggested there is widespread disapproval of women living with HIV becoming pregnant, most also said they were unlikely to get support for an abortion from family or community members. For instance:

They were going to think I am a bad person who has done the worst thing ever, and they would say that not knowing my reason for doing abortion. (Thandi, 44 years, had TOP)

**Reasons for unplanned pregnancy**

Unplanned pregnancy was associated with non-contraceptive or erratic contraceptive use, partners refusing to use male condoms regularly or at all, condom breakages and providers refusing to sterilise two women who sought it to prevent pregnancy. As one woman put it:

I wanted to sterilise because I’m HIV-positive but they said I’m still young, I cannot sterilise. They said I might get a husband and what will I do if he wants to have a baby. They said you cannot sterilise because it’s going to be a problem once you get married. (Pearl, 31 years, had TOP)

Women reported having unprotected sex and subsequent unwanted pregnancies because of difficulties in negotiating male condom use, unavailability of condoms or because ‘poor quality’ government-issued condoms broke during sex. Unplanned pregnancies were also attributed to limited contraceptive choice with respondents remarking, for example, about their reluctance to use hormonal injectables due to possible side-effects, including a loss of interest in sex. Unwanted pregnancy further occurred when, after a period of abstinence, women embarked on a sexual relationship coinciding with non-contraceptive use. Some women believed that pregnancy would not occur if they had infrequent sex or occasionally skipped using condoms. Not having money for transport to the clinic was also mentioned as a factor underlying erratic contraceptive use.

**Reasons for abortion**

Some of the reasons why respondents wanted an abortion were similar to those commonly expressed by women in general, namely: not ready to have a child; had the number of children desired; and being too poor to support a child or another child.

I have a two-year-old daughter; she is in crèche so I thought I’m going to struggle because their father isn’t working. So I thought I will struggle with another child. Buying nappies, clothes and I must also pay the crèche. I cried and cried when the doctor told me that I cannot have an abortion. (Ida, 29 years, no TOP because pregnancy too far advanced for a legal abortion)

For women who had many children but were uncertain about sterilisation, abortion could be an intermediate option. Abortion was also sought due to pregnancy occurring through rape or an abusive relationship, or due to fears of social stigma such as towards single...
women having a child with an already married partner or having a baby at an older age (in their 40s).

**HIV/AIDS impact**

A key issue to emerge was a concern that pregnancy would undermine already compromised health, along with fear of inflicting suffering on the baby or on other dependent children:

> What pushed me to do abortion is my health. I know that I am not healthy and cannot have children while I am HIV-positive, because having children would affect my health. (Mandisa, 38 years, had TOP)

Women living with HIV and very ill during or following a previous pregnancy dreaded repeating the experience. One woman reported having never regained her health after her child’s birth and, although on HAART, was determined not to have another child. Similarly, some women who knew about preventing perinatal-HIV transmission still wanted an abortion due to uncertainty about its effectiveness:

> I did get treatment while I was pregnant; I don’t know where it went wrong. Although I was taking medication for prevention until I gave birth, still my baby was infected with HIV. (Gloria, 36 years, had TOP)

**Socioeconomic hardship deepened by HIV**

Socioeconomic hardship was repeatedly raised as a prime reason for abortion. Women without jobs or earning irregular and/or little income felt compelled to seek abortions. There was reluctance to bring children into already overburdened households and risk arousing family anger. Socioeconomic hardship on its own presented most respondents with serious challenges regarding an unwanted pregnancy, but these challenges were often deepened and more complex when coupled with HIV:

> When I knew my status, I was not ready to have this child. When you are HIV-positive you are told to eat healthy which is difficult, so how much more now that I’m pregnant. I was jobless and I’m HIV and unable to eat healthy, so I was just confused. (Nora, 21 years, no TOP because pregnancy too far advanced for a legal abortion)

**Gender norms**

Inequitable gender norms influenced respondents’ abortion decisions in numerous ways. Women spoke about the difficulties and possible risks of abuse if they refused sex with partners who insisted on unprotected sex. They raised the conundrum of being in relationships with men not prepared to support children, but who also refused to support abortion. One woman associated pregnancy with men’s greater power over women, suggesting that a non-pregnant state was more favourable for women. Concurrently, the need to assert their rights in relationships was raised, often reflected by the fact that they did not inform their partners about their abortion intentions or ignored their wishes.

**Good knowledge of law**

Virtually all respondents were aware of South Africa’s abortion law, typically through the local media or clinic promotion efforts. Most respondents felt that the law made abortion safer. Access to free abortions ameliorated the stress of an unwanted pregnancy and,
although abortion could be painful, ‘it was pain you could live with’. The policy was valued for easing women’s reproductive difficulties:

The policy is good. Some people fall pregnant by mistake, but they won’t be asked why they didn’t use contraception. That won’t help the person who is already pregnant. In difficult situations for raising the baby or if they are too young to have a baby, abortion is good then. (Nomzi, 25 years, had TOP)

Ambivalent feelings toward the policy were also expressed. For some, it was only ‘good’ in certain situations, such as a difficult pregnancy or cases of rape. Some did not accept women terminating a first pregnancy or not wanting a baby coupled with non-contraceptive use during sex. A few women felt the law encouraged unsafe sex, allowed women to ‘become killers’ and thought it wrongfully allowed girls as young as 14 years to have abortions.

Awareness about public health sector abortion services
There was general awareness that free abortions were available in public health sector facilities, again gained mostly from local media and clinic posters, but also from knowing other women who had used the services. Interestingly, while respondents knew about the services, many said they did not take much notice because, as one woman put it, ‘I never thought I would do abortion’. However, most women generally knew very little or nothing about abortion procedures:

I knew nothing [and] arrived at the clinic without knowing what is going to happen. You get an explanation when you are here to abort. (Thumeka, 31 years, had TOP)

I got tablets from the hospital and I was told to take it at home and come the following day. I didn’t know that I was going into the theatre where the doctor will drain you from the womb. (Lungelwa, 24 years, had TOP)

Abortion experiences
Respondents described both positive and negative abortion experiences. Key themes included staff incorrectly informing women that repeat abortions were not allowed and women receiving a contraceptive injection immediately post-abortion without appropriate counselling or consent. Yet, discussion on quality of care was largely dominated by perceptions that providers ‘care too much’ (meant in a positive sense).

Only one abortion allowed
Despite this being at variance with the law, some respondents reported being told that they could only have one abortion. A woman who was refused a second abortion explained that:

At reception, your folder is checked to see if you’re there for a second abortion. If you are, you are turned away and told that a second abortion is not allowed at government hospitals in South Africa. I was unsatisfied and very shocked. I didn’t know there’s a policy saying I must only abort once. It would be much better if nurses asked you the reasons for repeating abortion and to hear the reasons before chasing you away. (Patricia, 33 years, had TOP)

A woman reported being warned they were being ‘remembered’ to ensure that ‘no-one from us will go there and ask for another abortion’. Respondents were also informed post-abortion that they would not be welcomed a second time. According to one respondent this contributes to continuation of widespread unsafe abortions. Pre-abortion counseling was also seen by some as judgemental rather than informative:
We need abortion counselors who will talk to you and explain what’s going to happen, to make sure you want to continue with your decision or not. Not counselors that will tell you not to terminate your pregnancy. (Vuyiswa, 31 years, had TOP)

Contraceptive injection

Some respondents were reportedly given hormonal injectables without prior consent or adequate counselling. They described this as comparable to being given contraceptive injections postnatal, suggesting that it was non-negotiable in both instances. A respondent explained:

After abortion you are given [Petogen], which we’re told about before the abortion. They say everyone will have an injection. They ask our problems about injections, which we explain. Then they say, ‘You are going to have it, if the problem persists, report it to your clinic.’ But the injection was by force because I don’t like it. But I was doing abortion, so I was forced to have it. (Lucy, 30 years, had TOP)

Satisfaction with care

Notwithstanding the above, most respondents expressed satisfaction with the quality of care they received once they had arrived for the actual procedure, signified by comments that abortion providers ‘care too much’, often counterpoised against anticipation of substandard care. Contrary to expectations, many women said that abortion providers did not question them on why they were pregnant and did not harangue them for not preventing a pregnancy. Providers reportedly did not shout, swear or ‘beat people on their thighs’, all of which were expected, but instead treated women respectfully:

We did not feel like we came for abortion, it felt as if we were there for any disease or illness, there was no problem. (Ndubela, 38 years, had TOP)

HIV status disclosed

It is not mandatory to disclose HIV status to abortion providers and providers reportedly did not ask about or discuss HIV status. Women associated this with HIV status being a non-issue for providers. Some respondents voluntarily disclosed that they wanted an abortion due to being HIV-positive; others assumed that providers knew their status through clinic records. Respondents who said that providers knew or assumed that they knew their status reported no discrimination on that basis:

Yes, they knew, I told all of them. We were all treated very nice. We weren’t aware of each other’s HIV status, but the treatment was the same. You could not say this one is positive and this one is negative, we were treated equally. (Jo, 34 years, had TOP)

Women who did not terminate a pregnancy

Of the eight women who carried their pregnancies to term, four did not have an abortion because they were told their pregnancies were too far advanced for a legal termination. One woman heard from a friend that abortion could not be done after three months’ gestation, so she stopped seeking such care. Another woman changed her mind after being told to return to the service later:

They told us loudly they wouldn’t take us all, we were too many. We begged them but they said they can only take a limited number, so we went home. If I had been taken on that day, I was going to do abortion. Because I was not taken, I changed my mind. (Zizo, 29 years, no TOP)
Some women decided not to go through with an abortion as they feared it might negatively impact on their health. Other factors named by the women who changed their minds included male partner influence, antipathy towards abortion and religious beliefs.

**Willingness to consider future abortions**

Respondents’ contemplation on future abortions underscored the complexity of both abortion and pregnancy decisions. Several women reported that they would have another abortion if necessary, primarily because they did not want more children. Others were resolute about not considering any further abortions, due to having previously experienced severe physical pain, concerns that another abortion would harm their health or cause death or feeling that if they became pregnant again they would continue with the pregnancy because they now knew ways to prevent perinatal-HIV transmission. The importance of getting appropriate support for preventing pregnancy was mentioned, as was an inability to envisage having another abortion, often associated with a desire for no more pregnancies:

If I fall pregnant by mistake, I’m going to raise the baby. I don’t see myself aborting again. I’m saying if it happens again, but I don’t have any plans of falling pregnant again. (Thembela, 33 years, had TOP)

**Advice to others about abortion**

When asked how they would advise other pregnant women living with HIV seeking an abortion, the women’s responses were wide-ranging, often pragmatic, but above all thoughtful in tone. A few women highlighted the need to seek abortion early in pregnancy at accredited facilities and not to resort to popularised ‘remedies’ or unsafe abortions. Overall, abortion was seen as a deeply personal decision and women were advised to base their decisions on their own individual needs:

I don’t see anything difficult, but it must come from you because you know yourself. You know that you are HIV-positive so it must come from your heart whether to do it or not. You must not be told by someone to do it, it must come from you. (Linda, 25 years, had TOP)

**Stigma**

Stigma towards abortion was associated with issues of disclosure and entangled with disclosing pregnancy and/or HIV-positive status to a range of people. Whether or not pregnancy was disclosed, myriad obstacles hindered abortion disclosure for most respondents. Family were not told, partly because disclosing abortion intentions could precipitate emotionally constraining pleadings not to ‘kill the baby’. Women anticipated disapproval or anger from their mothers or did not want to hurt them by disclosing abortion intentions. For example, one woman who could not have a legal termination because of advanced pregnancy had already tried unsuccessfully to self-induce an abortion at three months using chemical substances. Confiding in sisters and friends did occur and they were often supportive.

Disclosure to male partners had a mixed response: acceptance and support for abortion was reported by a few women, but unfavourable responses were more commonly reported. Women felt that as men were removed from directly experiencing the pain of an unwanted pregnancy, they were likely to rebuke women for having abortions or object if they wanted children. Hence women tended not to disclose abortion intentions to a partner when they saw little to gain by it. One respondent was afraid her partner would stop loving her and
think her ‘a killer’ if he knew. A contrasting perception was that a partner’s view was irrelevant given that abortion ‘is not about him, it is about me’.

**TOP more taboo than HIV**

Data strongly suggested that abortion is more taboo than HIV. Many respondents interviewed had disclosed their HIV-positive status to others yet kept quiet about abortion:

I’m not scared to tell people about my HIV. I tell them that if you talk bad about HIV, you are hurting me because I am HIV-positive. But abortion is funny as compared to HIV. (Nothando, 27 years, had TOP)

Moreover, while HIV/AIDS was reportedly openly discussed at clinics, nobody talked about abortion nor was it addressed in any serious way. Both clinic users and providers purportedly shied away from even mentioning abortion:

When you come for abortion you don’t see anything about it, you’re just told ‘Go to that room’. There is no abortion sign to those rooms. Knowing that abortion is done here is hearsay. I never saw a thing about it. (Nomsa, 21 years, no TOP)

People are scared to ask nurses where to go for abortion. The nurses are afraid to talk about abortion. If they freely talked about abortion services, people won’t be terrified and could feel free to request abortion without fear. (Thelma, 31 years, had TOP)

**Discussion**

Exceptionally complex interrelated factors both facilitate and hinder HIV-positive women’s abortion decisions. Generally, respondents were forced into a delicate balancing act when faced with reproductive health decisions. For example, they were harshly judged or blamed for becoming pregnant, whether planned or not. These findings are supported by other studies conducted in South Africa (Cooper et al. 2009), Viet Nam (Chi et al. 2010) and Argentina (Gogna et al. 2009).

Data from this study additionally suggested that despite this criticism, respondents were unlikely to get support for abortion given that it is deeply stigmatised regardless of HIV status; indeed, abortion is seemingly even more stigmatised than HIV/AIDS. For example, respondents repeatedly used terms such as ‘killing’, ‘disgrace’ and ‘murderers’ to describe normative perceptions of abortion and women who had abortions. Fear of community censure was conspicuous and could compel women to continue an unwanted pregnancy, with possible tragic consequences for mother and baby (e.g. abandonment). That HIV-related services in South Africa do not include specific attention to abortion as a valid part of SRH care can only serve to reinforce the experienced abortion stigma.

Respondents’ abortion perceptions often echoed community perceptions with many believing abortion is essentially wrong (see also Kumar, Hessina, and Mitchell 2009). For some, abortion was acceptable only in certain situations, including rape or dire socioeconomic conditions. Despite this complex and often unsupportive social context, women’s realities compelled them to find solutions to unwanted pregnancy and access to safe abortion was critically important to them in this regard.

Women’s reasons for wanting abortions were underscored by interrelated factors. Some are not necessarily specific to women living with HIV, including: low contraceptive use or failed contraception (Dahllööck et al. 2010; Shah and Ahman 2009); perceived completion of family size (Oye-Aderniran et al. 2004); social stigma, such as pregnancy while at school, at an older age or outside of marriage (Orner et al. 2010; Shah and Ahman 2009); and pregnancy due to rape or with an abusive partner (Ashenafi 2004;
Harries, Orner et al. 2007; Orner et al. 2010). Issues specific to study respondents included fearing pregnancy would cause illness progression, often coupled with fear of having an infected baby and being too ill to care for the infant. These concerns usually coincided with socioeconomic hardship (a common reason for abortion among South African women generally and provided for in the abortion law) and were underpinned by inequitable gender norms and problematic partner relations.

Respondents generally knew women could access free abortions in public health sector facilities and commended the law for affording safer abortions and greater choice regarding unwanted pregnancies. Awareness of abortion law, however, did not preclude confusion around the legal limits regarding pregnancy gestational age, so that five respondents did not have desired abortions because they were unclear about these provisions in the law. Unsurprisingly, some respondents noted that if abortion was not legal, women would continue resorting to illegal unsafe abortion. Indeed, research in Cape Town suggests that illegal abortions are not uncommon and may be partly driven by misinformation given to women regarding repeat abortions (Orner et al. 2010).

Abortion experiences in South Africa are importantly shaped by healthcare providers opposed to abortion, often creating barriers to service accessibility and availability (Hall and Roberts 2006; Harries, Stinson, and Orner 2009; Mhlanga 2003; Ngwena 2003; Orner et al. 2010). Data from this study suggested that staff often functioned as ‘gatekeepers’ by attempting to influence or control women’s decisions. Particularly disturbing is that, despite no mention in the law of number of permissible abortions, women reported being informed that they could not have another abortion. An account of a particularly inhospitable scenario suggested women felt scrutinised by abortion staff seemingly attempting to identify ‘repeat abortion offenders’. Respondents were also informed they were too young or too old to have an abortion or it was not a good idea if it was a first pregnancy. One respondent was told that living with HIV was not a valid reason for having an abortion, concurring with findings in Brazil (Barbosa et al. 2009) and Namibia (J. Gatsi-Mallet, personal communication).

Access to safe abortion is deeply questionable if women are routinely turned away, warned not to return for another abortion or faced with other obstacles. While providers may at times act out of frustration and concern for a woman’s health, an authoritarian approach to care cannot be condoned, especially when it is accompanied by messages or unofficial ‘rulings’ that leave women feeling they have no alternative but unsafe abortions.

Nonetheless, the complexities of abortion experiences in this setting are underscored by somewhat disjunctive respondent conceptions regarding quality of care issues. In the above mentioned formative study (Orner et al. 2010), dissatisfaction with the quality of care in the abortion services was often graphically described. Yet in this study, conducted at the same facilities, few respondents bemoaned their care, but rather tended to praise it. In light of numerous studies highlighting poor quality of care in the South African public health sector, this finding appears unique. Moreover, given the challenges faced by respondents regarding repeat abortions and other obstacles to abortion, the finding appears contradictory. Respondents’ characterisation of received care as good may be partially explained by the notion that once patients are in care, healthcare providers will provide optimal care. Respondents may have appreciated unexpected levels of not only ‘good’ care, but care that felt truly ‘caring’.

Some women’s descriptions of care also implied that their threshold for measuring quality may be low – likely to be the norm for users of public health sector services faced with deep challenges. Thus, a professional rendering of care may elicit a powerful emotional response, perhaps mixed with feelings of appreciation and relief. For women
living with HIV who face often challenging situations daily, the care they received may have had particularly important personal implications, including the fact that HIV status appeared not to provoke discriminatory behaviour towards them.

The study’s overall results should be interpreted in light of some limitations. The findings are specific to one setting, although it is broadly representative of other urban and peri-urban primary healthcare settings in South Africa. Further research is needed in rural areas with poorer healthcare infrastructure and potentially different client and provider attitudes and profiles. Moreover, the findings reflect the views and experiences of women living with HIV wanting abortions who attend public health sector services, which may differ from those individuals attending private services or who are outside of the healthcare system. The strengths of this study are that it is only the second study, to our knowledge, providing qualitative insights into the main factors facilitating or hindering the abortion intentions and experiences of women living with HIV in this region.

These findings may prove relevant to other settings, including high HIV prevalence situations where abortion remains illegal, by highlighting that while liberalisation of abortion law is critical to making access to safe abortion easier for all women, on its own it is not enough. Equally important is to transform the socioeconomic, gender and health service-related factors that hinder both implementation and development of liberalised abortion law and consequently women’s access to safe legal abortion.

Conclusion
The women in this study faced multifaceted challenges in terms of their SRH decisions and rights. Respondents contended with social discrimination towards women living with HIV becoming pregnant within a context of multiple barriers to preventing pregnancy, yet were often simultaneously hindered in their attempts to access safe abortions for unwanted pregnancies. For many, this hindrance included their personal dislike of abortion. It is obvious that the women were strongly motivated to seek and have abortions in the face of such evident adversity.

Similar to most women accessing abortions in South Africa’s public health sector, a key issue for those seeking abortions was socioeconomic hardship. This concern often intersected with fears that pregnancy in the context of HIV would worsen their health and possibly cause suffering for children and others. Respondents did not primarily criticise the services, even when they faced deeply problematic and contentious provider practices. It is unclear how they were able to hold apparently contradictory views, but perhaps a partial explanation could be that their expectations for good care were extremely low, so that any ‘good’ service was perceived as far outweighing the ‘bad’.

Important policy implications from this and the previous formative study include a need to re-educate abortion providers in terms of non-discriminatory practices and to prevent abortion access being arbitrarily denied, so that women do not possibly seek unsafe abortions as a solution. There is a need for an explicit policy statement explaining that more than one abortion is allowed. As many of the abortion experiences of women living with HIV are similar to those of the general population, it is imperative to address their negative experiences and obstacles in access in relation to all women in South Africa. Additionally, there is an urgent need to include information and counselling on the dangers of clandestine abortions and the option of safe legal abortion within the broader integration of SRH into HIV care. Given that living with HIV did not appear an issue for providers when women sought abortions and that disclosure appeared fairly common, there is a need
for greater linkages between HIV and abortion services more generally to ensure continuity in follow-up of care for women.

Acknowledgements
The study was supported by the World Health Organisation. The authors thank the women living with HIV who participated in the study, Nomfuneko Konzaphi, the Western Cape Department of Health and study site staff.

Note
1. All participant names attached to quotes are pseudonyms.

References


Résumé

Une recherche a été conduite avec 36 femmes séropositives au VIH vivant au Cap, en Afrique du Sud, sur leur prise de décision et leurs expériences concernant l'interruption volontaire de grossesse (IVG) dans le secteur de santé publique. Les intentions et les décisions d’avoir recours à l’IVG ont été explorées grâce à une enquête sur: les facteurs d’influence; les connaissances des politiques en matière d’avortement et des services pertinents dans le secteur de santé publique; et les perceptions et les expériences en ce qui concerne l’IVG. Les résultats révèlent que de nombreuses femmes sont confrontées à l’exclusion, de la part de la famille, des partenaires, des autres membres de leurs communautés et des prestataires de soins, aussi bien lorsqu’elles deviennent enceintes que lorsqu’elles ont recours à l’IVG. Les données suggèrent que l’IVG pourrait être la source de plus de stigmatisation que le VIH, malgré les lois libérales sur l’avortement en Afrique du Sud. Cependant, d’une manière générale, les participantes ont exprimé leur satisfaction quant aux soins dont elles ont bénéficié lors des avortements. La plupart d’entre elles conseilleraient aux femmes vivant avec le VIH de réfléchir attentivement avant de décider d’avorter, mais de faire un choix qui réponde le mieux à leurs besoins, ne serait-ce que la recherche de soins précoces pour la grossesse dans un centre de soins accrédité. Les implications de l’étude incluent la nécessité d’intégrer l’information et le conseil (counselling) sur l’avortement légal et à moindre risque dans les services de santé sexuelle et reproductive, en particulier à travers les efforts d’intégration de la santé sexuelle et reproductive dans les services de soins du VIH; et de renforcer les liens entre les services de soins du VIH et ceux dédiés à l’avortement d’une manière plus générale, pour garantir la continuité du suivi médical pour les femmes.

Resumen

Se llevó a cabo un estudio con 36 mujeres seropositivas en Ciudad del Cabo, Sudáfrica, para conocer qué poder de decisión y experiencias tenían en el sector sanitario público con respecto al aborto de embarazos no deseados. En este estudio se analizaron las intenciones y decisiones del aborto examinando los siguientes puntos: factores de influencia; conocimiento de la política del aborto y los servicios sanitarios de carácter público; y las percepciones y experiencias con el aborto. Los resultados indican que muchas mujeres son censuradas por parte de familiares, parejas, miembros de la comunidad y proveedores de servicios de asistencia sanitaria tanto por quedarse embarazadas como por interrumpir el embarazo. Los datos indican que el aborto podría estar más estigmatizado que el virus del sida pese a la liberal ley del aborto en Sudáfrica. Sin embargo, las participantes de este estudio estaban en general satisfechas con la atención sanitaria que recibieron en casos de aborto. La mayoría de ellas aconsejarían a las mujeres seropositivas que se pensasen detenidamente la opción de abortar pero que tomaran una decisión en virtud de sus intereses y que solo buscasen asistencia en una clínica acreditada y en una fase temprana del embarazo. Este estudio ha servido para saber que es necesario integrar la información y el asesoramiento para practicar el aborto legal en condiciones seguras en el marco de los servicios sanitarios en el campo sexual y reproductivo, y especialmente, aunar esfuerzos para integrar la salud sexual y reproductiva en la atención del sida y, en general, forjar vínculos más sólidos entre los servicios de asistencia al sida y al aborto con el fin de asegurar un seguimiento continuo de asistencia para las mujeres.