

A qualitative exploration of HIV-positive pregnant women's decision-making regarding abortion in Cape Town, South Africa

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Abstract

HIV-positive women's abortion decisions were explored by: (i) investigating influencing factors; (ii) determining knowledge of abortion policy and public health services; and (iii) exploring abortion experiences. In-depth interviews were held with 24 HIV-positive women (15 had an abortion; 9 did not), recruited at public health facilities in Cape Town, South Africa. Negative perceptions towards HIV-positive pregnant women were reported. Women wanted abortions due to socio-economic hardship in conjunction with HIV-positive status. Respondents were generally aware that women in South Africa had a right to free abortions in public health facilities. Both positive and negative abortion experiences were described. Respondents reported no discrimination by providers due to their HIV-positive status. Most respondents reported not using contraceptives, while describing their pregnancies as 'unexpected'. The majority of women who had abortions wanted to avoid another one, and would encourage other HIV-positive women to try to avoid abortion. However, most felt abortions were acceptable for HIV-positive women in some circumstances. Data suggested that stigma and discrimination affect connections between abortion, pregnancy and HIV/AIDS, and that abortion may be more stigmatised than HIV/AIDS. Study results provide important insights, and any revision of reproductive health policy, services, counselling for abortion and HIV/AIDS care should address these issues.

Keywords: HIV/AIDS, HIV-positive pregnant women, abortion, gender, South Africa.

Résumé

La décision d'avorter des femmes séropositives ont été étudiées: (i) en enquêtant sur les facteurs d'influence; (ii) en déterminant les connaissances de la politique en matière d'avortement et des services de santé publique; et (iii) en étudiant les expériences d'avortement. Des entretiens approfondis ont été réalisés auprès de 24 femmes séropositives (dont 15 avaient subi un avortement et 9 non), recrutées dans des structures de santé publique du Cap, en Afrique du Sud. Des perceptions négatives des femmes enceintes séropositives ont été rapportées. Les femmes souhaitaient avoir recours à l'avortement du fait de leurs difficultés socioéconomiques doublées de leur statut sérologique positif. Les interrogées savaient généralement qu'en Afrique du Sud, les femmes avaient le droit de se faire avorter gratuitement dans les structures de santé publique. Des expériences d'avortement aussi bien positives que négatives ont été décrites. Les interrogées ont indiqué que les prestataires de services ne les discriminaient pas du fait de leur statut sérologique positif. La plupart des interrogées ont indiqué ne pas utiliser de contraception, mais décrivaient leurs grossesses comme 'non prévues'. La majorité des femmes ayant subi un avortement souhaitaient en éviter un autre, et affirmaient souhaiter encourager les autres femmes séropositives à essayer d'éviter de se faire avorter. Cependant, la majorité d'entre elles considéraient que les avortements étaient acceptables pour les femmes séropositives dans certaines circonstances. Les données enregistrées indiquaient que la stigmatisation et la discrimination affectaient les liens entre avortement, grossesse et VIH/SIDA, et que l'avortement pouvait être davantage stigmatisé que le VIH/SIDA. Les résultats de l'étude fournissent des informations importantes, et toute révision des politiques de santé génésique et des services et conseils relatifs à l'avortement et à la prise en charge du VIH/SIDA devraient aborder ces questions.

Mots clés: VIH/SIDA, femmes enceintes séropositives, avortement, genre, Afrique du Sud.

Introduction

The HIV/AIDS epidemic in South Africa features distinctive age and gender distributions. Women bear the burden of the epidemic, particularly women in their reproductive years (Shisana *et al.*, 2009). Moreover, gender inequities in South Africa underpin women's greater risk of HIV infection (Orner *et al.*, 2008; Cooper *et al.*, 2007a;

Orner *et al.*, 2006). Ensuring access to effective reproductive health services, including improved access to safe abortion for HIV-positive women, could reduce unintended pregnancies, births, maternal ill health and mortality, and reduce HIV infections in infants. Prior research suggests that HIV-positive women and men do not have sufficient information about abortion options (Cooper *et al.*, 2007a).

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Among women in HIV/AIDS care (non-HAART – highly-active antiretroviral therapy), 11% reported becoming unintentionally pregnant after being aware of their HIV-positive status. Only half of these women had entered a perinatal transmission prevention programme during this pregnancy. Among women on HAART, 9% reported having been pregnant since commencing HAART; 30% of these pregnancies were reportedly unintentional (Cooper *et al.*, 2009). Further, general population data from the 1998 South African Demographic and Health Survey showed that up to 53% of pregnancies were either unplanned (36%) or unwanted (17%) (Cooper *et al.*, 2004).

Studies addressing abortion among HIV-positive women generally do so in the context of a wider investigation of sexual and reproductive health rights and services. Findings from several of these studies have suggested that the likelihood of becoming pregnant and of terminating a pregnancy are the same or similar for HIV-positive and HIV-negative women (Berer, 2004; Hebling & Hardy, 2007). Internationally, there has been little work on policy and programmes designed to meet HIV-positive women's specific needs, including access to abortion (de Bruyn, 2005; de Bruyn, 2004; de Bruyn, 2003). Research on reproductive intentions among HIV-positive women has been done, but a focus on unwanted pregnancies and abortion intentions is rare. One study conducted in KwaZulu-Natal, South Africa, indicated that HIV-positive women experienced discrimination at abortion services (Gender AIDS Forum, 2005). Additionally, the International Community of Women Living with HIV/AIDS (ICW) has documented instances of HIV-positive women in South Africa being pressured to undergo sterilisation after abortion in order to access safe abortion care (ICW, 2004).

In South Africa, the 1996 Choice on Termination of Pregnancy Act (CTOP) affords women relatively progressive rights towards accessing abortions. The Act allows for termination on request for pregnancies of 12 weeks or less gestation; pregnancies of 13 - 20 weeks may be terminated when continuation of the pregnancy poses a risk to the woman's social, economic or psychological well-being (Cooper *et al.*, 2004). Prior to the introduction of the CTOP Act, approximately 425 women died each year from complications of abortions, and some 14 000 or more women per year attended hospitals for treatment of complications (Dickson-Tetteh & Rees, 1997). Those most affected by illegal backstreet abortions were black women (Gabriel, 2008). Following the legalisation of abortion in 1996, morbidity from abortion complications declined by almost 50% and mortality by 91% (Gabriel, 2008).

However, barriers to safe abortion still exist for women (Harries, Stinson, & Orner, 2009; Molosankwe & Skade, 2007; Steele, 2007). These barriers are particularly pervasive for impoverished women, many of whom are HIV-positive, and exploration in this area is urgently needed. While research has been conducted on reproductive intentions among HIV-positive women in South Africa (Cooper *et al.*, 2009; Cooper *et al.*, 2007a; Orner *et al.*, 2008), little attention has been given to HIV-positive women's intentions and experiences of abortion. One study reported that an HIV-positive status prompted a participant to seek an abortion (Harries, Orner, Gabriel & Mitchell, 2007); however, the extent to which this is a determinant for abortion more generally has not been fully

established. Specific focus on this issue would yield richer and more reliable data.

The research project reported on here was conceptualised within an analytical framework that highlights the social construction of gender relations, roles and identities, and was informed by literature encompassing a multilevel conceptualisation of sexual and reproductive decision-making. As with other areas of sexual and reproductive health decision-making, individual behaviours related to managing unwanted or unintended pregnancies are shaped by a range of different interrelated psychosocial and contextual factors (Gage, 1998). Individual-level factors include women's perceptions of the future and their current well-being, counterbalanced by the role of childbearing in identity formation and maintenance. Immediate social influences include partners, family members and communities. Structural conditions include types and quality of available health care, providers' attitudes and values, and broader sociopolitical and economic determinants. This framework underpins established approaches to understanding fertility intentions and contraceptive decision-making and other aspects of health-related behaviour in both developed and developing countries (Delbanco & Daley, 1996; Hardee, Ulin, Pfannenschmidt & Visness, 1996; Oppong, 1980). Given the dearth of information available in this regard, exploration of HIV-positive women's decisions regarding terminating or continuing a pregnancy, abortion experiences, and knowledge of abortion policy and public health abortion services would potentially provide insights to inform not only South African policy and service provision, but may also be valuable internationally, especially in developing country contexts.

Methods

Study site

The study was conducted over a 13-month period in 2007/2008 at three public sector health facilities located in Cape Town municipality. The facilities serve predominantly peri-urban working-class communities, and are broadly representative of the types of HIV/AIDS and abortion services in the area. Initially, the study site consisted of just the high-volume antiretroviral/infectious diseases (ARV/ID) clinics located at a public health hospital. However, recruiting constraints emerged as the study progressed (e.g. restructuring of the ARV/ID clinic services), and additional study sites were thus required. Approval was granted by the provincial Department of Health to expand the study site to two community health centres in the area, both of which have busy ARV clinics and abortion services. Many of the HIV-positive primary care clients originally seen at the initial study site had been redirected to one of these sites for care and treatment.

Study design

In-depth interviews were conducted with HIV-positive women primarily attending ARV/ID clinics at the study sites. Grounded theory informed development of study tools and informed consent forms, which were reviewed by all co-investigators. Interview guides were semi-structured, open-ended and probing, and explored the following areas: perceptions and beliefs about HIV-positive pregnant women, abortion, unplanned pregnancy, and contraceptive practices; reasons for wanting an abortion and factors that influenced abortion decision-making; knowledge of

abortion policy/access to abortion services and how this impacted on abortion decision-making; experiences of terminating a pregnancy at a public health facility; and experiences of stigma and discrimination.

Study tools were piloted with HIV-positive women to refine language and adapt questions and probes accordingly. An experienced qualitative research interviewer conducted the interviews in isiXhosa (first language of respondents and interviewer). The principal investigator (PI) trained the interviewer on the study tools, and was involved in field supervision. The sensitive nature of the study's topic and appropriate handling of any feelings of discomfort were discussed in training sessions. The interviews lasted approximately one hour, and were held in a private room at the health facility, or at another private venue if requested by a participant. Interviews were digitally recorded, transcribed verbatim and translated into English by bilingual isiXhosa- and English-speaking staff. All interview recordings were downloaded to the PI's computer (which is password protected) to be stored for two years before they are destroyed. Recordings on the digital recorder were deleted after downloading to the PI's computer.

Only women who provided written informed consent were interviewed, and confidentiality and anonymity were ensured for all phases of the research. Participants were compensated R50 (approximately \$5.00) towards costs incurred due to study participation. Ethical approval for the study was granted by the Health Sciences Research Ethics Committee, University of Cape Town (UCT), and the Western Cape Department of Health granted approval to conduct the study at their facilities.

Study respondents

Participant selection was purposive and recruitment occurred in two stages: First, the interviewer approached individual clients attending study site services to inform them about the study. Approximately 20 women declined to participate after being briefed on the study. Reasons most often cited were: (i) not becoming pregnant since knowing their HIV-positive status; and (ii) knowing HIV-positive status before becoming pregnant or discovering it when pregnant but not considering an abortion.

The interviewer explained that the research was being conducted by UCT and was not part of the care provided by the health facility. Individuals willing to be considered possible participants signed consent for review of their clinic records to determine study eligibility and to be contacted (usually preferring by cell phone) for an in-depth interview if deemed eligible. Eligibility criteria included: (a) being HIV-positive; (b) aged 18 years old or older; (c) currently pregnant or had been pregnant during the past two years, knowing HIV-positive status; and (d) had an abortion at a public health facility, or had been referred to a public health facility for abortion but did not have one. Fifty-four women (out of the 410 who consented to record review) met eligibility criteria (48 recruited from the ARV/ID clinics; six recruited from the abortion services).

The second stage involved contacting and inviting eligible women to participate in the study. Of the 54 women who met study eligibility, 30 were not interviewed mainly due to incorrect or

non-functioning telephone numbers, after initial agreement to return calls, failing to do so and being non-contactable (e.g. phones put on voice mail), cancelling scheduled interviews due to illness, work commitments, and household problems. None of the women said that they were no longer interested in being a participant, or refused participation due to the study topic.

A total of 24 in-depth interviews were therefore held with HIV-positive women, comprising women who had an abortion ($N=15$), and women who did not ($N=9$). Women were interviewed subsequent to an abortion or to a pregnancy. The mean age of women who had an abortion was 30.2 years (range 22 - 36). All were single, 13 women had children, 12 had secondary school education and 13 women were unemployed. The mean age of women who had not terminated a pregnancy was 29 years (range 22 - 36), three women were married, all had children, eight had secondary school education, and eight women were unemployed. The data for one participant were missing.

Data analysis

Data were analysed using grounded theory techniques. Initial categories for analysis were drawn from the interview guides (Carey, 1994), and themes and patterns emerged after reviewing the data within and across respondent groups (Charmaz, 1990). Transcripts were reviewed by the co-investigators and a preliminary list of codes and code definitions was developed and subsequently refined through discussion. Data were collaboratively coded and reviewed, major trends and cross-cutting themes were identified and issues for further exploration were prioritised for final analysis. Coding discrepancies were resolved through co-investigator discussion and consensus.

Results

Themes emerging from perceptions and insights expressed by respondents illustrate the complexity of the decision-making process and challenges faced by HIV-positive women seeking abortions, and are highlighted below.

Community perceptions of HIV-positive pregnant women

Discussion of the broader community's stance on pregnant HIV-positive women yielded general agreement that communities as a whole deemed HIV-positive pregnant women irresponsible, especially given 'easy access' to contraceptive methods (e.g. male condoms) to prevent unwanted pregnancies. Pregnancy in conjunction with HIV/AIDS was seen to irreversibly worsen a woman's health, and likely to lead to postnatal death. Community members also believed that HIV-positive women's babies would be HIV-infected:

People don't believe that an HIV-positive person can give birth to an HIV-negative child. According to people if a person is HIV-positive and pregnant the baby is going to be HIV-positive because the mother's blood has a virus – so how [could a baby be] HIV-negative while the mother of the baby is HIV-positive? [Woman 30 years, no termination of pregnancy (TOP)].

Reasons for TOP

Reasons for wanting an abortion were discussed through reflection on factors that influenced women's decisions. Key issues to emerge

were socio-economic hardship concomitant with concerns that pregnancy would undermine health, and fear of inflicting suffering on the baby and on other dependent children.

Women repeatedly raised socio-economic hardship as a prime reason for wanting an abortion. Twenty-two of the 24 respondents were unemployed yet often the sole family breadwinner. Having a child or another child under these circumstances was a bleak prospect, and outweighed doubts for many about having an abortion:

The reason I thought about abortion is because I have too many children already so who was going to support this baby? Even the father has nothing. He comes empty-handed all the time. I was struggling already so I thought [no] I will struggle more. [Woman 36 years, had TOP].

I have two children already. I am a burden myself. So I decided to terminate that pregnancy because I am mother and father for my children. They look up to me for everything. I cannot afford to have a third one. [Woman 28 years, had TOP].

Grave concerns were articulated about the possible negative health impact of pregnancy and birth – abortion was seen as a means to avert this. For example, one respondent had regained her health and feared another pregnancy would cause her to ‘go back to square one’. Reflection on carrying a pregnancy to term made another respondent ‘think of death’, whereas abortion afforded hope. Similarly, abortion had ‘opened an opportunity’ for another respondent who had been suicidal and anxious about her children’s future if she died giving birth. Family members were already unsupportive and critical towards her for having a child while HIV-positive, but ‘It was going to be worse if there were two. No one was going to help me.’

For some women, feelings of responsibility and ‘guilt’ appeared to outweigh other considerations:

I didn't have a problem because I know my status. I didn't want to create problems for my child. If my baby was HIV-positive I would end up dying ... because that is a pain, I cannot watch my child suffering from HIV. That would hurt me for the rest of my life. [Woman 26 years, had TOP].

Respondents who did not terminate pregnancies similarly had considered abortion due to fears that pregnancy and birth would deepen their health problems, coupled with fears of having HIV-positive babies. Several women who were ‘ready to abort’ decided against it after being counselled on prevention of perinatal HIV transmission.

Knowledge of abortion policy and services

Most respondents knew about abortion policy, generally via the local media or from clinic posters promoting free abortions. Respondents typically commended government for legalising abortion, deeming it far superior to former policies. The policy was valued for abortions being free, and for offering a safer alternative to more dubious options:

I think this policy is right. It helps people not to do backstreet abortion because that is too dangerous, it creates problems because women do not get cleaned by the hospital, they just

do things on their own. But now that the government has allowed [abortion], it is going to be fine. [Woman 26 years, had TOP].

Women were afforded greater choice regarding unwanted pregnancies, which occurred for diverse reasons including rape, male partners denying paternity and abandoning pregnant women, male condoms breaking during sex, and ‘falling pregnant by mistake’. Women, who otherwise may have remained pregnant, benefited from access to free and safer abortions.

However, ambivalent feelings toward the policy were also expressed. Many women acknowledged that it had helped them resolve an untenable situation in their own lives; nevertheless, some had problems accepting a policy perceived to condone ‘murder’ or that ‘allowed’ young girls (11 - 16 years) to have legal abortions, deeming this to have fertility, parity and ethical implications.

While conceding that there were compelling reasons for wanting an abortion, respondents believed women would continue to be secretive about it, underscoring that despite South Africa’s liberal policy, abortion is still highly stigmatised. Respondents’ own perceptions, such as believing abortion inappropriate for married women living with their husbands, or unjustified in situations seen to be economically stable further illustrated this:

On the one hand it [abortion policy] is good, like when you and your husband don't work and there are lots of children in the house, and you are poor. The bad thing is when a person does TOP but she has money, she needs nothing. [Woman 35 years, had TOP].

Regarding abortion services, generally respondents knew that they could access free abortions at local public health clinics. As mentioned earlier, they had gained this knowledge through national and local media, via posters displayed at clinics, or knowing other women who had used the services. For some, knowledge of abortion services coincided with first use of the services. Only a few respondents were knowledgeable about the intricacies of abortion procedure; depending on their knowledge or what they had heard, they either had no fears or some uncertainty:

We were told that these tablets they give to us ... the foetus can come out at home or on your way to hospital. It did happen to others but not to me. With me everything went well. That was the major thing that I was afraid of, something happening at home or in the train. [Woman 28 years, had TOP].

Regarding accessibility, respondents appreciated abortion services that were ‘nearby’ and free, citing that this was especially important for impoverished women unable to afford private services. However, ‘accessibility’ had broader implications. For instance, restriction on the number of women able to obtain abortions on a particular day meant that one respondent eventually had an abortion in her second trimester because ‘we were many and they were taking a limited number’. Falsifying her home address was the only way a respondent could obtain an abortion in one facility. Further difficulties included jeopardising her employment due to excessive absence from work:

I went to xxx about three weeks without receiving any help. The doctor referring me to [another clinic] advised me not to

mention where I live because they might turn me back, so I used a [false] address to access xxx and finish this whole business. I almost lost my job because I didn't go to work for about a month. I was trying to solve this once and for all. [Woman 33 years, had TOP].

Several women who ultimately did not terminate their pregnancies commented that a family member or health care provider had said it was probably too late for an abortion:

When I came back from the Eastern Cape, I was told that I'm five months pregnant and cannot do abortion because I am too advanced. [Woman 34 years, no TOP].

Abortion experiences

Respondents articulated a diversity in abortion experiences at the study sites. Both positive and negative experiences were described, including how abortion providers impacted experiences.

Descriptions of overall abortion experiences underscored that women received mixed messages from health care providers. Respondents were asked by pre-abortion counsellors why they wanted an abortion. One woman explained that once the counsellor understood her situation she was told 'you can do abortion but don't come again'. Women were counselled to use contraceptives to prevent unwanted pregnancies and not to come for a second abortion. A respondent was informed that 'abortion is good if you are done with children'. In one instance, the counsellor's role was described bluntly as:

You meet with the counsellor and she explains that as you are doing this, you are murdering because this is a human being. They don't support that you must do TOP but the choice is yours. [Woman 32 years, had TOP].

A participant felt 'insulted' by the lack of care received immediately post-abortion, expecting to be washed and her pain attended to, not 'chased out of the room because other people must come in'. Another woman was scandalised because:

The baby comes out of your vagina while sitting on the chair and you will push in the toilet alone. After everything comes out you wrap the whole thing and they show you where to put it and you will go inside for cleaning. [Woman 33 years, had TOP].

Echoing this, a respondent was repulsed by 'the placenta com[ing] out' while waiting for the doctor to arrive. Providers reportedly refused to replace linen savers that were full of blood clots. A participant started to reconsider abortion upon realising 'a pipe' would be inserted into her vagina, but was influenced by a supportive provider to continue.

Positive abortion experiences often starkly contrasted with the above comments. Abortions were deemed safe and uncomplicated. Abortion staff were considered welcoming, helpful and professional in their approach. They were described as 'very cool, very generous', informative about what women should do during the procedure, and were commended for providing information on post-abortion contraceptive methods. One woman who had an abortion even commented that she would:

...use them [TOP providers] for contraception because where I go for family planning the nurses are always shouting. But their

services are very good; you are not scared of the nurses; they make you feel comfortable. [Woman 30 years, had TOP].

Significantly, while disclosing HIV status was not a prerequisite for obtaining an abortion, 'self-disclosure' did occur. Some women assumed their HIV-positive status was known through their health record. Nevertheless, these women concurred that they received the same level of care as other women. As one such respondent explained: 'Everyone was rushed... if they call your name you have to speed to go there'. Another participant had told providers that she was HIV-positive in order to receive treatment commensurate with her status. Her abortion went well, and post-abortion she still felt fine.

Unplanned pregnancy

Pregnancies generally were described as unexpected and inexplicable, despite inconsistent or non-contraceptive use. One woman shouted in disbelief at clinic nurses when told she was pregnant. Another participant 'came from the doctor very shocked' upon being informed she was pregnant. Contraceptive failure was considered one possibility for unwanted pregnancies. Women reported problems associated with male condoms, such as breaking during sex or migrating to 'inside my womb'. Women also attributed unplanned pregnancies to non-contraceptive use combined with ARV treatment:

We had sex without a condom, at the same time I'm not using any contraception method, I'm only relying on condoms. I have one boyfriend only, the father of my baby who knows my status and I know his, so we do not have a choice we do sex with condoms. So I don't know what happened on that day, and these ARVs are cleaning because once you do a mistake just for once you fall pregnant there and then. [Woman 26 years, had TOP].

Ambivalence and indecision appeared to underlie some women's unplanned pregnancies. One woman had used contraceptives, but she 'lost my family planning card and after that I did not care that my card was lost'. Another participant thought that she had made a crucial mistake by having sex with someone knowing her HIV status and at the same time not using contraceptives or condoms. Describing herself as 'desperate' when she met a man who refused to use a condom and simultaneously not on family planning, the participant 'fell pregnant there and then'.

Respondents who had abortions and those who did not both reported sometimes being coerced into unprotected sex with male partners. Notwithstanding the above, most women reported that they would not want to become pregnant in future.

Future TOPs

Most women who had an abortion would want to avoid future abortions. Comments made included women proposing to 'prevent [pregnancy] with injection' rather than 'risk death' by having another abortion; or only having another abortion if the intention was that 'I want to die'. Regardless of knowing what to expect, one woman would not 'aim to do it again'. Conversely, if confronted with another unwanted pregnancy, another participant would not hesitate to have another abortion. Several women who did not terminate pregnancies would consider future abortions.

One woman had gained enough knowledge to pursue abortion with more confidence if she became pregnant again, especially given that she *'didn't need a second baby'*.

Respondents offered a broad range of advice to other HIV-positive women seeking abortions. Women not experiencing any problems were advised to remain pregnant, because *'you won't be right after the abortion'*. It was advisable either to use male condoms to prevent pregnancy, or not to date. Women who were *'clear'* about abortion should proceed, but to be prepared for ill-effects:

Because you bleed too much and you take tablets while you are already taking [ARVs] so you mix things that don't go together. Something's going to happen, maybe your CD4 count will go down. I am waiting for whatever, even if it's in the coming months. [Woman 28 years, had TOP].

Contrasting advice was that CD4 count post-abortion would not necessarily decrease, and that women should not be deterred by misinformation:

Women living with HIV who want to do abortion must not be afraid. They must come to the clinic to do abortion before it's too late. [Post-abortion] she must take good care of herself by eating healthy food to quickly gain her weight back. [Woman 30 years, had TOP].

Stigma and discrimination

Women made disclosure decisions based on their personal situations and broader social realities. For instance, women often told no one that they were pregnant. One woman disclosed to her family and male partner that she was HIV-positive, but not that she was pregnant and was going to have an abortion. Another woman did not tell family or friends that she was pregnant or about her subsequent abortion, citing that they would think her *'very cruel ... and they'd dislike me'*. She further noted that people talked about HIV/AIDS, but not about abortion. Seemingly, disclosing abortion intentions could engender a 'Catch-22' situation:

They [family] knew nothing. I noticed [pregnancy] very early and if they had noticed, I was going to keep the baby because they would not allow me to do abortion. It is because I have not yet disclosed my [HIV positive] status to them. I would have been forced to do so in order to do abortion because they would not allow it. [Woman 26 years, had TOP].

Similarly, disclosing abortion intentions to neighbours or other community members was complex. While abortion was certainly a taboo subject, the combined stigma of abortion and HIV/AIDS was reflected in this comment:

It's not easy to tell [neighbours] that your health is in a mess or this is what you're thinking of doing because you're not sure after you told who she'll tell next. You tell her because you trust her, and she will do the same and the next person will do the same, so it's going to be a chain. [Woman 33 years, had TOP].

Respondents generally did not inform or were ambivalent about informing male partners regarding pregnancy, abortion intentions, or having an abortion. Inadequate or non-existent male support appeared to underpin these decisions.

One participant knew her partner would not condone abortion, but given that *'women suffer alone if they took their men's decision'* stuck to her decision. Abortion was the best option for a respondent who *'needed to be looked after'* herself, and who doubted being able to do so while simultaneously the sole caregiver of three children:

Like some of us, if your boyfriend runs away once you're pregnant, you decide to abort the baby in those situations. [Woman 33 years, had TOP].

Discussion

Although limited in scope, this study suggests that a broad range of complex interrelated factors both facilitate and hinder HIV-positive women's decisions regarding abortions in this setting. This complex matrix of individual, interpersonal, social and health-related factors play out in diverse ways, and women engage in 'weighing-up' the different decision options in their lives. For instance, the broader community was perceived to judge HIV-positive women harshly who wanted to have children knowing their HIV-positive status. Simultaneously, widespread stigma was evident in respondents' accounts of people's attitudes towards abortion. Moreover, most respondents held similar attitudes, evidenced by repeated reference to abortions as 'scandalous', 'disgraceful' and 'sinful'. Respondents' realities, however, compelled them to find solutions to unwanted pregnancies, although social conditions were deeply complex and mostly unsupportive. For example, socio-cultural expectations in effect 'demanded' that people have children (Cooper *et al.*, 2007a; London, Orner, & Myer, 2008), yet HIV-positive women were discouraged from having children because it was believed that they would be HIV-infected, and this would be unfair to the child.

Respondents' reasons for wanting abortions were underpinned by interrelated factors. Many felt that their health was already compromised and feared the consequences of a pregnancy, often coupled with fears of being too ill to care for an additional, possibly HIV-positive child. Some of these fears are based on well-founded evidence regarding pregnancy, HIV and abortion, others not (de Bruyn, 2007). For instance, while pregnancy is considered an immunosuppressant, to what extent it affects CD4 count is open to debate, as this depends on the health of the woman – in a healthy woman it may not make much difference (personal communication, M Besser, 10 June 2008). However, a perception among many HIV/AIDS clients and health service providers is that pregnancy makes HIV 'grow' (Cooper *et al.*, 2007a).

Comments on ARV treatment increasing fertility may also be based on some knowledge of decreased fertility in HIV-infected women and men and an increased return to fertility when on ARVs (Coll *et al.*, 2007; Gilling-Smith, Nicopoullou, Semprini & Fordsham, 2006). Moreover, HIV-positive women were clear that they did not want to cause further suffering. This is consistent with other studies suggesting that not wanting to risk perinatal HIV transmission or to compromise one's own health were important reasons for seeking an abortion (Berer, 2004). Social support for HIV-positive women to terminate a pregnancy nevertheless appeared elusive. Women spoke about having to cope with all of this *'with nobody to help'*

them, and were reluctant to disclose to others HIV-positive status, pregnancy and, notably, abortion-related intentions.

Respondents were generally aware that all women in South Africa had a legal right to safe, free abortions in public health facilities. Women largely concurred that abortion policy was beneficial, especially for poor women, and considered it greatly superior to former policy. Women were also clear that the policy provided them with safer alternatives to abortions performed by poorly trained community or township doctors in cash-only practices. Yet, many respondents expressed unease with the policy's underlying principles. Both women who had abortions and those who had not supported abortion and women's right to choose in certain circumstances, but most remained wedded to the notion that abortion was equivalent to 'murder'.

While respondents' reasons for wanting abortions could be unique to their HIV-positive status, they also faced the same socio-economic hardships as other impoverished women in this setting, which created barriers to obtaining abortions. For example, overstretched public health resources, unhappiness regarding aborting while sitting in the waiting area, and disposing of own products of conception. Also mentioned were long waiting times, restriction on the number of women who could obtain abortions at any one time, being too rushed, fears of unknown instruments (e.g. references to vacuum aspiration syringes as 'pipes'), pain, sickness and weakness post abortion.

Women also spoke about mixed messages from abortion staff. Notably, there was a mixed response regarding whether providers had a caring attitude or were confrontational and judgemental. Examples include counsellors advising women on their abortion rights simultaneously framing abortion as 'murder', and assuring women abortion was safe, but also intimating that it made one infertile. In other instances, women were not provided with clear information to distinguish the difference between medical and surgical abortions, causing confusion and anxiety for affected women. Nevertheless, positive abortion experiences were reported. Women who expressed satisfaction noted being treated well, including not being shouted at, and not being treated differently as HIV-positive women.

Women seeking abortions at public health facilities are not required to disclose their HIV-positive status beforehand; however, a number of women spontaneously self-disclosed or assumed providers knew their status. Self-disclosure occurred in various ways, such as relating HIV as a reason for wanting an abortion or informing providers they were on ARV treatment. Respondents who believed providers knew their status felt that they received the same care as other women. These findings stand in contrast to discussions in the literature on the potential for overt or covert discriminatory attitudes by health care providers to partly shape women's reproductive choices (London *et al.*, 2008). Unlike identified in other studies (Cooper *et al.*, 2007b; Harries, Orner, Gabriel & Mitchell, 2007; Meel, 2005), this study suggested that healthcare workers did not hold HIV-specific judgmental and discriminatory attitudes regarding HIV-positive women's reproductive intentions. This is not to say that providers were

not discriminatory towards respondents – they were, signified by repeated references to providers' judgemental attitudes towards women seeking an abortion.

Respondents' ability to hold simultaneously contradictory views emerged throughout the interviews in response to a range of issues. For example, when asked to reflect on unplanned pregnancies, women acknowledged non- or ineffective contraceptive use, yet many professed 'shock' upon confirming a pregnancy. Women's responses may have been a form of 'denial' or possibly their way of coping with not feeling in control of means to prevent pregnancy. There were obviously social and other reasons for poor contraceptive uptake; however, given that most respondents strongly desired no more pregnancies, it would seem critical to unravel this conundrum.

Most respondents indicated that they hoped never to become pregnant again. It is not clear how, if at all, this might be related to a 'bad' abortion experience. Similarly, most women who had an abortion would want to avoid another one and would advise other HIV-positive women to take measures to avoid having to terminate a pregnancy. However, abortion was deemed acceptable for HIV-positive women in some circumstances. Some women thought it advisable that HIV-positive women avoid getting pregnant, regarding pregnancy as too risky for their health. For women determined to have an abortion, respondents advised them to consult a doctor beforehand.

Disclosure of seeking or having an abortion to male partners, family, friends, community members and structures was complex and often fraught for participants, and non-disclosure was often women's preference. Disclosure of abortion intentions frequently presupposed disclosure of pregnancy and sometimes HIV-positive status. The data suggested, however, that abortion rather than HIV was perceived to engender deeper censure overall. Respondents also appeared to be sources of stigma, seemingly themselves viewing abortion as the greater 'sin'.

Conclusion

The HIV-positive women in this study represent a triple-bind situation. They experience social disapproval if they become pregnant after knowing their HIV-positive status; they are often impeded in attempts to prevent pregnancy by unco-operative partners or experience difficulties in using contraception; they feel even stronger social and internalised disapproval when they consider or have an abortion. While many of their reasons for wanting an abortion were similar to those of the general population of women, some were specifically HIV-related concerns about the impact of pregnancy on their health or the possibility of having an HIV-positive child. Experiences related to poor quality of care during an abortion were similar to those reported elsewhere by women in the general population. Addressing these issues should be incorporated into revision of policy, services and counselling guidance for abortion and HIV/AIDS care and treatment.

Another recommendation for strengthening health systems to emerge from this study is the need to improve integration of services, specifically the links between abortion and HIV/AIDS

services. Further, HIV/AIDS services/organisations should provide more information about legal abortion (and the risks of unsafe abortion) for women who are facing unwanted pregnancies.

Organisations working on HIV/AIDS can also contribute to destigmatisation of abortion by dealing with pregnancy termination within education and counselling, particularly in 'normalising' it by discussing abortion in a matter-of-fact way, as is currently done for prevention of perinatal transmission and voluntary counselling and testing. Similarly, human rights education and advocacy in the area of HIV/AIDS should also address abortion access.

Lastly, further research should specifically address topics to generate factual data which women can use when making decisions to abort or not (e.g. disease progression and pregnancy, effects of pregnancy or abortion on CD4 counts).

The study findings reflect specifically the local South African setting, particularly given that the legality of abortion varies widely on the African continent and elsewhere. Nonetheless, findings relating to the stigma associated with abortion among HIV-positive women and the pattern of reasons for seeking an abortion may provide useful insights for high prevalence HIV/AIDS settings in other developing countries.

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