

# Reproductive choice and women living with HIV/AIDS

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December 2002

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## Preface

The World AIDS Campaign for 2002–2003, "Live and let live", is focused on eliminating stigma and discrimination against people living with HIV/AIDS. The Campaign, coordinated by UNAIDS, is encouraging people to speak out and break the silence surrounding barriers to prevention and care for people living with the virus.

One area in which stigma and discrimination affect women living with HIV/AIDS (WHA) is reproductive health. This report summarizes available information concerning barriers and discrimination that WHA face in exercising their full sexual and reproductive rights concerning pregnancy. It is based on an extensive review of the literature and interviews with key informants in Australia, India, Kenya, South Africa and Thailand.

The literature review covered reports in scientific journals, as well as gray and popular literature, produced mostly from 1998 to July 2002. Searches were done using the MEDLINE, POPLINE, SOCIOFILE and PSYCHINFO databases and through Internet searches at key websites. Further information was obtained from abstracts and presentations at the Fifth and Sixth International Congresses on AIDS in Asia and the Pacific and the XIII and XIV International Conferences on AIDS. Information from informal reports and personal communications to e-mail forums was also included.

The interviews aimed to elicit information and ideas about the difficulties that WHA may face in preventing and dealing with both planned and unwanted pregnancies. Four WHA from Argentina, Australia, Kenya and South Africa reviewed the study design and interview guide. The WHA from Australia, Kenya and South Africa subsequently carried out confidential interviews with 36 key informants in Australia (3 persons), India (6 persons), Kenya (11 persons), South Africa (8 persons) and Thailand (8 persons). Thirty-one informants were women and 12 were persons living with HIV/AIDS. All of the informants gave written informed consent for the study and requested a copy of the interview report.

Representatives of the public health sector participated in all countries, including physicians and/or nurses in Australia, India, Kenya and Thailand. Other types of agencies represented by key informants included associations of people living with HIV/AIDS, AIDS Service Organizations, family planning providers, and NGOs.

Interested readers can request full copies of the literature review and interview study reports from the author ([debruynm@ipas.org](mailto:debruynm@ipas.org)).

## Introduction

UNAIDS estimated that by December 2002, 42 million people worldwide were living with HIV/AIDS; 19.2 million were women aged 15–49 years. Two million of these women were newly infected with HIV in 2002 and 1.2 million died of AIDS that year [1]. UNAIDS further estimated that about 2.5 million of the 200 million women who become pregnant each year are HIV–positive [2]. Of the 14,000 new daily HIV infections each year, more than 1600 occur among children during pregnancy, childbirth and the postnatal period [3].

Sentinel surveillance of women attending prenatal clinics is widespread as a means of tracking the HIV/AIDS epidemic's evolution. HIV prevalence rates vary widely among these patients, ranging from current lows of 1–3% in cities and districts of India to 20–36% in parts of Africa. Such statistics do not include all pregnant women in a given area; in many developing countries large numbers of poor and rural women do not receive prenatal care. Where programs exist to prevent mother–to–child transmission of HIV through the administration of antiretroviral therapy (ART), women are also being offered the chance to undergo voluntary HIV counseling and testing (VCT); this is increasing data on HIV/AIDS in relation to pregnancy. However, many women who choose to terminate pregnancies do not seek prenatal care and are therefore not included in the statistics.

Approximately 19 million unsafe abortions take place each year, most of them in developing countries. In Africa 4.2 million and in Asia 10.5 million unsafe abortions occur annually. Given the high and still increasing rates of HIV prevalence among women of reproductive age in these regions, it may be assumed that WHA are among the women affected and the health consequences may be even more serious for them than for other women [4].

### Important statistics

- By December 2002, 19.2 million women aged 15–49 years were living with HIV/AIDS.
- 2 million women were newly infected with HIV in 2002.
- 1.2 million women died of AIDS in 2002.
- 2.5 million of the 200 million women who become pregnant each year are HIV–positive.
- Approximately 19 million unsafe abortions take place each year, most of them in developing countries.
- 4.2 million unsafe abortions take place in Africa each year.
- 10.5 million unsafe abortions take place in Asia each year.

The context in which WHA make decisions regarding pregnancy and childbearing is often characterized by a number of negative factors:

- obstacles to pregnancy prevention: lack of contraceptive information, particularly about how contraceptives may interact with ART and medications taken to treat opportunistic infections; an inability to use condoms and contraception consistently, partly due to gender-based factors; pregnancies resulting from sexual violence
- lack of knowledge about their HIV status when they become pregnant
- lack of access to measures that can prevent mother-to-child transmission of HIV (PMCT), especially for WHA in developing countries
- lack of knowledge about and access to means to terminate unwanted pregnancies safely.

## **Strategies for dealing with HIV/AIDS and pregnancy**

Many UN agencies are now promoting a three-pronged strategy to address the intersection between HIV/AIDS and pregnancy: 1) prevent HIV infection in young people and women of childbearing age, 2) prevent unwanted pregnancy among women with HIV infection and 3) prevent transmission of HIV from an infected mother to her infant [2].

Despite widespread educational programs focused on the first strategy, large numbers of youth and women worldwide continue to contract HIV because of factors outside their control (inability to negotiate condom use, lack of access to condoms, infection due to sexual violence). In comparison, measures to prevent perinatal transmission (HIV infection of an infant during childbirth or the pre- and postpartum periods) have proved more effective, partly because they are shorter-term and partly because health-care providers can control the circumstances in which they are implemented. Prevention of mother-to-child transmission (PMCT) has thus become a major element of many governmental HIV/AIDS programs and donors have greatly increased funding to implement this strategy.

An unfortunate consequence of the focus on PMCT is that women have been approached mainly as vectors of HIV transmission. WHA have either been told that they should not have children or they should take ART to prevent infection of their babies. In response, policy advocates are focusing on ensuring that the right of WHA to bear children is respected and they are calling for more holistic approaches to managing pregnancy for HIV-positive women.

The strategy that has received the least attention is prevention of unwanted pregnancy among WHA. There are three ways of achieving this: promotion of effective contraceptive use, ending sexual violence against WHA, and enabling WHA to prevent

unwanted pregnancies through emergency contraception or to terminate them through safe abortion.

WHO recognizes that some WHA do not wish to have (more) children and that pregnancy termination should be an option for them. The WHO Making Pregnancy Safer Initiative requires: "Access to safe abortion (where this is legal) and counselling to ensure informed decision making and consent by the woman, should be part of the services" [5]. Nevertheless, advocacy efforts often neglect the right of WHA to have access to safe abortion. The strategy of preventing unwanted pregnancy among WHA has focused almost entirely on urging them to use contraceptives, despite knowledge that many WHA have little control over whether they become pregnant or not.

This gap is of particular concern because the consequences of incomplete and unsafe abortions may adversely affect the health of WHA even more than that of HIV-negative women. Postabortion care interventions should take this into account as an important part of providing WHA with comprehensive care. Extra measures to prevent complications after induced abortions may also be needed for WHA.

## **The context of reproductive decision-making**

To understand the factors that may influence decision-making by WHA regarding pregnancy, it is useful to review the context in which that decision-making takes place. Four areas are of particular interest here: contraceptive use by WHA, the relationship between HIV/AIDS and pregnancy outcomes, available means to prevent perinatal transmission, and stigma and discrimination affecting WHA.

### **Contraceptive use**

It appears that many WHA do not receive comprehensive information about their contraceptive options; in addition, using contraceptives consistently may be difficult.

Most contraceptive methods are said to be appropriate for WHA but some do have side-effects that should be considered. No increases in infectious complications have been noted for IUD use by WHA but such devices can lead to increased menstrual flow and anemia. IUDs are further contraindicated for women at increased risk of STIs because they contribute to increased risk of pelvic inflammatory disease [6]. Hormonal contraceptive methods have been shown to increase or decrease concentrations of ART drugs, which could affect therapy; conversely, some ART medications may decrease the effectiveness of oral contraceptives. Many WHA in developing countries do not yet have access to ART, but drugs used to treat opportunistic infections such as penicillin, tetracyclines and rifampin also interact with oral contraceptives, particularly progestin-only products [6].

The key informants in all countries of the Ipas study agreed that contraceptives are generally available through clinics, hospitals, pharmacies and/or community-based distributors. However, they noted that adolescents may have problems obtaining them; many informants in the developing countries also felt that rural women may have little or no access to most contraceptive methods. In all countries, informants said that emergency contraception was a little known option to prevent pregnancy for the large majority of women. However, informants in Australia, South Africa and Thailand said some women do access it, in particular adolescents and more educated women.

Some key informants did not feel that WHA have particular problems regarding contraceptives but many did note barriers to use. These included:

- Male partners' refusal to use condoms because: 1) they simply do not wish to use them; 2) both partners are seropositive and they do not consider it urgent to prevent reinfection; 3) they are unaware of their female partners' serostatus and the women fear requesting condom use because then they would have to reveal their serostatus.
- Reports that some ART drugs can reduce the efficacy of hormonal contraceptives and the possibility that IUDs can cause pelvic infections, which means that this option may be inadvisable for WHA.
- Health-care provider fears of infection: one informant in India noted that some providers refuse to insert IUDs for WHA because they do not want to come into contact with vaginal fluids.

Key informants in Australia and South Africa remarked that some people, including health-care providers, assume WHA do not have sexual lives and this can restrict the information they are given. One WHA in Australia commented: "...as a positive woman myself, I don't think I've ever had a doctor talk to me, since I've been diagnosed, about contraception....I've never had it mentioned to me...It's like something that doesn't even enter their minds."

When WHA seek contraceptives, counselors' preferences may determine the kind and amount of information they receive. Many AIDS programs promote condoms rather than other contraceptive methods. Research involving nine family planning clinics in New York City showed that 86% of providers would recommend the male condom to all clients but 64% would not recommend it as a primary contraceptive method; 70% had negative attitudes towards female condoms and 52% would not recommend them as a primary method. Most of the providers felt that promotion of condom use instead of hormonal methods would increase pregnancy rates and favored dual use of condoms and another method [7]. A study in 2000 using 146 simulated client visits to 31 public sector facilities in two provinces of South Africa found that barrier methods were offered to only 39% of clients, while 12% of clients were told about dual protection (condoms and another contraceptive method). Only 12% of the clients received counseling on

HIV/STIs [8]. WHA interviewed for a study in Zimbabwe said that family planning providers did not mention HIV to them [9].

Even when contraceptive information and methods are available, WHA are affected by gender biases and social norms that restrict their ability to avoid unplanned and unwanted pregnancies. For example, in many communities, women are supposed to use contraceptives only with their partners' permission and some partners may prevent them from using contraceptives at all [10]. The European Commission/UNFPA Initiative for Reproductive Health in Asia has stressed that discussion about sex-related matters is often taboo before marriage, condom use is often associated with sex work, and many women are unable to demand safer sex precautions within relationships [11]. Most women and men who participated in 12 focus groups in Nakuru District, Kenya, said that they could not refuse sex with their partners, even though they considered unwanted pregnancy and HIV/AIDS serious problems; both the women's and men's groups also rejected the idea that a woman could suggest condom use to her partner [12]. A study among WHA in Rwanda in the early 1990s found that among 45% who gave birth during a three-year period, just under half were planned pregnancies [13]. Among 52 WHA interviewed in Zimbabwe, 16 became pregnant after diagnosis, only seven intentionally so [14].

### **HIV/AIDS and pregnancy outcomes**

Few key informants felt that sufficient information is available to the general population regarding HIV and pregnancy. Most felt that if WHA wish information, they need to seek it specifically; they also generally believed that the information provided is best for those women who are fortunate enough to have access to PMCT programs.

### **Pregnancy complications**

Pregnancy in itself does not accelerate HIV progression in women who are in the earlier and asymptomatic stages of infection; the situation may be different for women with high viral loads and diagnoses of AIDS [3, 15]. Pregnancy complications that have been observed more frequently among pregnant WHA than HIV-negative women include genital and urinary tract infections, more frequent and severe blood loss, anemia, bacterial pneumonia, intrauterine growth retardation, preterm labor and premature rupture of membranes, premature delivery and low birth weights [3, 6]. Co-infection with other diseases, such as hepatitis, and complications related to drug abuse appear to also increase the risk of complications for WHA during pregnancy [16, 17].

HIV may be transmitted to a fetus at any time during pregnancy, during delivery and during the postpartum period through breastfeeding. It is estimated that 25–40% of transmission occurs during the prenatal period and 60–75% during labor and delivery

when no breastfeeding takes place. There are indications that the presence of various factors during pregnancy may increase risks of perinatal infection; these include becoming infected with HIV after conception, STI infection, maternal injecting drug use, smoking, vitamin A deficiency, and unprotected sex with multiple partners [18, 19]. High viral loads and advanced HIV infection, preterm delivery, membrane rupture more than four hours before delivery and breastfeeding have also been linked to greater chances of perinatal transmission [18, 20].

### **Miscarriage and complications of induced abortions**

It has been noted that fertility appears to be lower among people living with HIV/AIDS than in the general population. The lower fertility rate has been linked to co-infection with other sexually transmitted infections (STIs), decreased production of spermatozoa and less sexual activity among WHA – particularly those who have more advanced infections. The UN Population Division has stated that another factor has failed to be taken into account: fertility rates among WHA are probably also lower because of the number of miscarriages, stillbirths and induced abortions they have [21].

Much data on HIV and pregnancy comes from research on PMCT; very few of these studies address the topic of pregnancy termination, either among women who declined to participate in PMCT programs or as part of the reproductive history of the study participants. Many reports on HIV and pregnancy outcomes also do not distinguish between spontaneous and induced abortions, making it difficult to assess whether WHA do indeed suffer more fetal loss than HIV-negative women. Because abortion is often clandestine and unsafe, it is conceivable that some women present for treatment of miscarriages after having had an unsafe abortion.

Data on the incidence of spontaneous abortions among WHA in industrialized countries conflict; more studies seem to indicate that they do not have significantly more miscarriages than other women. According to research thus far, however, WHA in developing countries appear to have higher risks of miscarriage and stillbirths; this may be related to a higher prevalence of co-infection with other diseases [3, 6, 22]. In a few reviewed study reports that compared WHA with HIV-negative women, the WHA had higher rates of pregnancy termination than the other women. Most of these studies took place before the introduction of ART, however. It would be of interest to learn whether pregnancy termination rates have become more similar among HIV-positive and HIV-negative women in places where PMCT programs are easily accessible to WHA.

No research studies were found that specifically investigated the effects of unsafe abortions on WHA, but it can be assumed that considerable numbers of WHA in countries with high HIV prevalence and numerous restrictions on legal abortion are terminating pregnancies unsafely. A study carried out by the International Community of Women Living with HIV/AIDS (ICW) in Zimbabwe found that 2 of 59 interviewed women

had had unsafe abortions requiring hospitalization [9]. The health of WHA may be dramatically affected when they suffer complications such as sepsis, hemorrhage or a perforated uterus.

There is also little information available about whether complications following safely induced abortions are more common among WHA than other women. A few studies have indicated that this may be the case; in a German study, the odds ratio for WHA suffering postoperative complications after abortion and curettage compared to HIV-negative women was 7.7 [23]. Another study stated that the number of prior abortions had by WHA was associated with an increased risk of cervical cytological complications [24].

Because there are indications that complications may be higher following sharp curettage or dilatation and curettage for WHA than HIV-negative women, research is needed to determine which types of abortion procedures would be safest for WHA. For example, studies should be done comparing complications for WHA and HIV-negative women who receive abortions involving vacuum aspiration rather than curettage. Because surgical abortions might pose increased health risks for WHA, it has been suggested that medical abortion might be a preferable alternative for them [25]. This recommendation would require further research, however, since the consequences of bleeding for WHA who are sent home after taking a pharmaceutical product to terminate pregnancy are largely unknown. This would be of particular concern for women living in low resource areas and for persons who care for WHA at home since they could be exposed unnecessarily to HIV-infected blood.

## **Means to prevent perinatal transmission**

### **Voluntary counseling and testing**

In many countries, voluntary HIV counseling and testing (VCT) are now offered to pregnant women, though this may not be systematic and can depend on the availability of HIV test supplies and the success of counseling training for health-care providers. Though increasing numbers of women are beginning to accept offers of VCT when they attend prenatal clinics, considerable numbers in developing countries still decline VCT or do not return for their test results, even when they could have access to ART for PMCT. A frequently-cited reason for this is their fear of being stigmatized if their test were to turn out positive.

Almost all of the key informants favored HIV testing of women in prenatal care, provided that the testing was voluntary, with the woman's informed consent and accompanied by good-quality pre- and post-test counseling. The rationale for testing given by most of them was that this would enable women to possibly take advantage of PMCT measures

and manage their pregnancies better. Two informants in South Africa, however, felt that women should not be singled out for HIV testing because this may increase stigmatization of WHA.

Counseling and testing is supposed to be voluntary in all the key informants' countries; however, the Thai informants noted that testing is simply done routinely for all prenatal clinic attendees, often without pre-test counseling. Key informants in India also cited instances where this happens. A literature report concerning Bangalore and Mumbai stated that test results are sometimes not given to pregnant women but to their husbands or other family members instead because it is assumed that their spouses will make decisions about whether or not to continue the pregnancy. As one gynecologist in a private Mumbai hospital stated: "When a young woman who is first time pregnant is found to be HIV-positive, we ask her to call her mother-in-law. We explain the report to the mother-in-law. These patients who come here are from low-income group, and if the girls are newly married, they are really dumb and don't understand anything, so the mother-in-law is called to explain" [26]. A recent report in the literature also stated that routine testing without consent is occurring in Canada [27].

UNAIDS' 2002 global report on the HIV/AIDS epidemic states: "Preventing mother-to-child transmission and providing treatment and care to mothers and their infants can best be achieved by greatly increasing the access of women of childbearing age and their partners to HIV prevention services, reproductive health and family planning services, and antenatal/maternity clinics. Such services should ensure that women can choose whether or not to know their HIV status; to control their fertility; to terminate a pregnancy, where this is safe and legal; and to take advantage of MTCT drugs and other interventions if HIV-positive and having a child." The chapter does not recommend HIV testing for women who present for abortion-related care, however [2].

Even where laws, regulations and policy recommendations advise or require health-care providers to offer VCT to prenatal clinic attenders, there is often no requirement to also offer VCT to women who seek postabortion care or induced abortions. Added to the fact that ART is withdrawn from most PMCT participants after delivery, this could be taken as evidence that the main purpose of VCT is not related to the women's health. Rather, VCT is offered to women who are expected to carry pregnancies to term so that they can take ART to prevent the birth of babies with HIV infection.

Few researchers appear to have investigated HIV prevalence among women seeking abortion. It has been speculated that HIV prevalence rates may be higher among women seeking pregnancy terminations than among prenatal clinic attenders but the literature offers no conclusive evidence for this. If this were the case, however, more attention should be given to offering VCT to women who seek abortion-related care so that those who test HIV-positive have more options for seeking care and prolonging their lives.

### **Antiretroviral therapy**

Perinatal transmission can be greatly reduced with administration of antiretroviral drugs to the mother and infant just after the birth. Many PMCT programs use zidovudine but other drugs are also used; in developing countries, regimens involving nevirapine are finding favor because the drug only needs to be administered during labor and to the infant after delivery.

Most of the key informants favored prenatal VCT because they felt it would enable women to possibly take advantage of PMCT measures and manage their pregnancies better. However, it was noted in India, Kenya and South Africa that access to ART for PMCT is very limited so that it is not an option for the majority of WHA. This is also the case in many other developing countries though the number of PMCT programs is expanding with donor support.

ART has reduced perinatal transmission considerably in industrialized countries. In Europe, the rate fell to 2.6% after 1998; it has been reported that fewer children are infected perinatally in the USA in one year than in one morning for the rest of the world [28]. The Centers for Disease Control and Prevention (CDC) in the USA reported that ART reduced the number of perinatal infections diagnosed in 1999 by 83%; for the years 2000–2001, perinatal transmission was reduced to less than 2% with ART or zidovudine administration combined with cesarean section [18].

There are no conclusive indications that ART used to prevent perinatal transmission produces serious short- or long-term adverse effects for mothers and children, but there have been incidental reports of maternal deaths and DNA mutations among children whose mothers received PMCT drugs. The US-based Antiretroviral Pregnancy Registry, sponsored by several pharmaceutical companies that produce ART medications, follows up pregnancies among WHA. A review of 2174 pregnancies reported up to July 2001 concluded that birth defects were no more common among babies whose mothers took ART for PMCT than among babies born to the general HIV-negative population. Lynne Mofenson, of the National Institute of Child Health and Human Development, stated that although the Registry has drawbacks (e.g., reliance on voluntary reporting and lack of follow-up to detect defects not immediately apparent at birth), "It provides us with some information regarding the potential for birth defects. We can say with some certainty that the rate of birth defects does not increase with exposure to zidovudine, and with a little less certainty, with zidovudine and lamivudine. But there are insufficient data to make that claim about combination therapy, nor about the long-term effects of therapy" [29].

Relatively little time has passed to assess the effects of ART for PMCT, particularly in developing countries. Concerns continue to be raised about possible longer-term effects for mothers and children, as well as the possibility of drug resistance for women,

whereby the effectiveness of ART drugs for future pregnancies or the women's own treatment could be compromised. A study among 322 WHA contacted through 12 clinics and AIDS Service Organizations in Georgia, North and South Carolina in the USA, reported that 23 women (7.2%) were unlikely to take ART for PMCT because of fears of harm to themselves or the infants or because of their past experiences with medications; 62 women (19.4%) were undecided [30]. A representative of the self-help group Life Strength in Thailand commented in 2000 that some women did not wish to take ART because of side-effects they believed could ensue, such as nausea and bone problems; she also pointed out that if women were to take the drugs irregularly because of side effects, the efficacy of a PMCT intervention would diminish while drug resistance could increase [31].

### **Cesarean sections**

Some concerns have been raised that WHA might suffer increased morbidity and mortality with cesarean sections such as delayed wound healing, high fevers, severe anemia, infections and a need for additional surgery. Studies in industrialized countries have shown complication rates for WHA that are both similar to and greater than those for HIV-negative women.

The US Public Health Service's 2001 guidelines for managing pregnancy in WHA states that cesarean sections should only be considered for women with viral loads above 1000 cells/ml, citing a study that showed a three- to four-fold increase in fever, urinary tract infections and postpartum morbidity for WHA undergoing cesareans compared to WHA delivering vaginally [32].

### **Breastfeeding measures**

Another major measure recommended to reduce perinatal transmission rates is replacement of breast milk with other feeding substitutes or, if this is not possible, exclusive breastfeeding. Women who do breastfeed are advised to seek treatment for mastitis and other lesions on the breast [19].

The literature review indicated that when women want to keep their serostatus secret, it can be difficult for them to comply with PMCT regimens. In communities where breastfeeding is a norm, they may fear that avoidance of breastfeeding will lead others to assume that they are HIV-positive. Key informants in India, Kenya, South Africa and Thailand confirmed the literature findings by stating that it can be very difficult for WHA not to breastfeed. They believed this was due to two reasons: 1) this departure from standard practice can be interpreted to signify that a woman is HIV-positive and many women wish to keep their positive HIV status private; 2) many WHA do not have access to breast milk substitutes. On the other hand, in Australia – where almost no WHA breastfeed and this is strongly advised by health-care providers – one WHA informant

stated that more needs to be done to investigate ways in which WHA can breastfeed safely so that they do not miss out on this aspect of motherhood.

## **Stigma and discrimination**

In all countries, the key informants indicated that stigma and discrimination towards people living with HIV/AIDS still exist, although often this may not be expressed openly in Australia and Thailand. In India, Kenya, South Africa and Thailand, informants noted that women often suffer greater stigma and discrimination than men, with women often being blamed for "bringing AIDS into the family". As a result, it was said that many women are reluctant to inform their partners and families about their positive HIV status because they fear abandonment. The expressions of discrimination they mentioned included:

- HIV testing of people without their knowledge or consent
- gossip and negative remarks being made about PHA, including the idea that they became HIV-positive because of immoral behavior
- dismissal from jobs and stigmatization of children at schools
- avoidance and isolation by family, friends and health-care workers.

Reports in the literature confirmed the existence of such discrimination:

- "Married women with HIV do not reveal their positive serostatus to their spouses for fear their husbands would say 'You got it first ... you are the one who brought it in the family.' Therefore often when you ask them what they will tell their husbands, or what they are going to do [they say] 'I will keep quiet.' 'Why?' 'He will say I have brought it and he will send me away.'" (female counselor in Uganda [33])
- "My in-laws do not have good opinion about me. They say that my husband got this disease from me. I sometimes feel 'Why should I live with this insult? It is better to die.' But I am living for the sake of my children." (40-year-old WHA in India [26])
- "My mother-in-law tells everybody, 'Because of her, my son got this disease. My son is a simple boy as good as gold - but she brought him this disease.'" (26-year-old WHA in India [26]).

Many informants felt that most people generally do not believe that WHA should become pregnant and have children. This was mainly for two reasons: the risk of perinatal transmission (even in the presence of ART, which was felt not to guarantee a seronegative child by some informants in developing countries) and the risk that the mother will die, leaving behind orphaned children who will become a burden to families and communities.

- "My God. Are you kidding? 'How can a woman with HIV be so irresponsible so as to have a child? Doesn't she know that it's one of the worst things you can do, to bring a baby with HIV into the world? How are you going to help that baby to live? And the child will fall ill and anyway it will die. So what's the whole point?' That [type of thinking] is pervasive. I can't think of any view that might be contrary to that. And I think that deep in their hearts, even activists might say politically correct things but a lot of the time, in private conversations, admit to having a lot of doubts about the advisability of a woman with HIV having a child." (key informant in India)
- "Look, from my own personal experience, there is even amongst AIDS activists, there is this condemnation for someone who knows her status and had a child and would think of having another child. Now I know of couples who have children, consciously chosen to have children knowing they are HIV-positive. I am telling you honestly that is not a very conducive environment for that." (key informant in South Africa)

In addition, although many health professionals will not openly say that WHA should not become pregnant, both research studies and anecdotal reports indicate that such attitudes may still be widespread. One researcher recently reported that staff at a clinic in the USA did not want to participate in a study on pregnancy and ART because they thought some of their patients might become pregnant as a result and they did not want this to happen [30]. In October 1998, the *South African Medical Journal* published a letter from a hospital staff-member which included the following points [34]:

- "The availability of antiretroviral treatment should be conditional on voluntary or enforced sterilisation after the present pregnancy.
- ...termination of pregnancy should be considered in HIV-infected pregnant women, either voluntarily or by law.
- An Act of Parliament should be considered to the effect that all HIV-infected women in their reproductive years should be sterilised."

In all countries, key informants noted that many health-care providers, particularly outside specialized HIV/AIDS services, share negative judgmental community attitudes toward WHA. In some cases, they felt that care could be influenced by providers' fears of infection and this was said to result in unnecessary precautions, which many WHA feel are stigmatizing and discriminatory. Examples given in Australia included assigning pregnant WHA to separate rooms or a drug dependency ward and asking a WHA to disinfect herself after delivery. In Kenya, it was said that some health-care providers use double or even triple gloves during delivery or abortion-related care, a procedure which not only shows WHA are treated differently but which also contravenes standards for universal precautions. A survey of 1 500 primary care physicians in the USA found that they were generally less willing to provide gynecological, contraceptive and pregnancy care to WHA than to HIV-negative women [14].

When asked whether the introduction of ART for PMCT had changed attitudes concerning HIV and pregnancy, many informants felt that this was not the case. They noted that some health-care workers involved in PMCT programs now feel encouraged because they have something concrete to offer WHA in the way of assistance and this has led to better treatment. However, they believed that other health-care providers often remain judgmental and that much more training is needed to change attitudes. The types of discrimination noted included the following examples:

- Providers make judgmental remarks and ask unnecessary intrusive questions.
- Providers fail to keep a woman's HIV status confidential.
- Providers deny or delay care for WHA.
- Providers pressure WHA to utilize some PMCT measures (ART, cesarean sections and avoidance of breastfeeding); this was particularly the case in Australia and Thailand.

Literature reports confirmed such cases of discrimination in Australia, Brazil, India, The Netherlands and Thailand. Individual stories were also included:

- “I was working as a nurse in a reputed Mumbai hospital and came to know about being HIV-positive when I miscarried. I was bleeding profusely, but the gynaecologist refused to even touch me. I was shifted to a municipal hospital, but had a similar experience there...” (woman in India [35])
- “I was pregnant. It was my third month I remember well. I went a check up. The doctor said they would check my blood. Next time when I went to the doctor she said the hospital would not take me for delivery. 'There is mistake in the blood, bring your husband.' Then they checked his blood also and said 'It is AIDS. We cannot take you here for delivery.' For the next three months I cried. Then with the help of a doctor in that hospital, they agreed to admit me.” (woman in India [26])
- A woman in Zambia said: “I was refused admission for delivery because of my HIV status. Finally I delivered at home.” A traditional birth attendant in the same region stated that hospitals discharge very ill pregnant WHA and tell them to deliver their babies at home [36].
- The NGO WOFAK (Women Fighting AIDS in Kenya) began offering information and training to health-care providers after one WHA asked for help in finding someone to help during the delivery of her baby – she had been refused assistance due to her HIV-positive status until WOFAK found a doctor to assist at the birth [37].

One result of the idea that WHA should not have children has been coercion on them to have abortions. Pregnant WHA in various countries have reported being pressured by health-care providers to terminate their pregnancies. A health worker may not consider his/her advice to be coercive, but it may be perceived that way, especially by women who are accustomed to relying on health workers' expertise and by women who are not accustomed to challenging persons in positions of authority. Such reports have come from India, France, Russia, Sweden, Thailand, the Ukraine and the USA [36, 38–43]. Key informants in India and Thailand knew of women who had been pressured or coerced

into having abortions, either by family members or health-care providers. Some Thai informants also commented on the fact that WHA are pressured to undergo sterilization after a delivery, a miscarriage or an abortion.

In this context, WHO has stated: "Where termination of pregnancy is both legal and acceptable, the HIV-positive woman can be offered this option. However, many women learn of their HIV status during pregnancy, and will not be diagnosed in time to be offered termination. If termination is an option, the woman, or preferably the couple, should be provided with the information to make an informed decision without undue influence from health care workers and counsellors" [44].

## **Decision-making about pregnancy**

Decision-making regarding pregnancy can be a complex process for any woman; for WHA, HIV infection becomes one more factor to consider. Quantitative studies have provided information on which characteristics may be more associated with decisions to carry pregnancies to term or terminate them (e.g., age, ethnicity, marital status, prior reproductive history), but have not elicited how various factors are mediated by one another during the decision-making process. Qualitative studies centering on interviews and focus groups have provided more information in this regard.

## **Decisions to begin or continue childbearing**

WHA who choose to continue – but especially begin – childbearing seem to focus most on positive factors during their decision-making process; the relative influence of HIV infection is thereby diminished. These often younger women appear to be most motivated by a desire for motherhood and the idea that having a child will give them more hope. In a few cases, personal convictions that abortion is wrong may prevent them from seeking terminations, so that they end up having children “by default”. Other factors that emerged from the literature as having a bearing on decisions to continue pregnancies were the pressure of gender-based norms regarding desired family size and the unacceptability of childlessness, seeing childbearing as a means of obtaining or ensuring economic support from partners, failure of induced abortion attempts and refusals by health-care providers to provide abortion assistance.

These points were borne out as well in the interviews. Many key informants felt that WHA often do wish to have children and that other factors besides HIV status are more important in such decision-making. The reasons cited varied: WHA do not want to miss out on the experience of motherhood, social norms dictate that women are not truly adult unless they have children, the women wish to leave something of themselves behind, the women know that their children will receive care even if they die.

When asked whether the availability of PMCT would influence women's decisions to have children, many key informants felt that this is the case for women who have access to ART because they know that the risks of having seropositive children are greatly diminished. However, it was often noted that few women have access to ART. Studies in Canada and the USA, where ART is widely available, showed that fewer women were terminating pregnancies after PMCT programs were introduced [45, 46].

### **Decisions to terminate unwanted pregnancies**

When asked why WHA may have unwanted pregnancies, many key informants felt that it was for the same reasons as seronegative women: failure to use contraceptives (often related to their lack of decision-making power), incorrect use of contraceptives, not thinking about the possibility of pregnancy, and forced sex or rape. For example, a few key informants knew of WHA who had become pregnant due to rape, including forced sex within marriage. An Australian informant knew a WHA who had terminated the pregnancy; two Kenyan informants knew of women who had considered abortions but carried the pregnancies to term because they could not find services or their partner opposed the termination.

The one reason cited that would distinguish the situation of WHA from other women was the fear of disclosing serostatus to partners, whereby a mutual decision to avoid pregnancy is prevented.

Based on the literature, it appears that negative considerations seem to predominate in the decision-making of WHA who choose not to become pregnant or to terminate pregnancies; HIV infection then appears to play a greater role in that process. Such women may tend to be older, already have children, have lived for a longer period of time with the disease and have more advanced infection. They consequently may already be facing numerous problems and challenging situations (care of several children, widowhood, a need to spend economic resources on their own health and the care of living children, etc.). Adding another child to the family could be seen as a burden in such circumstances and may predispose women to pay more attention to their concerns about the effects of pregnancy on their own health, concerns about perinatal transmission, and worries about the efficacy and effects of ART. WHA who are drug users, partners of drug users, immigrant women and sex workers may similarly be facing difficult life circumstances; when these women have had a history of prior abortions, they may choose pregnancy termination more easily as an option.

There appears to be some evidence that WHA who learn of their HIV diagnosis early during pregnancy may be more prone to termination; this does not mean that they will avoid future pregnancies, however. Another factor that appears to influence decisions by WHA not to have more children or carry pregnancies to term is their fear of leaving their

children orphaned or anxiety about the stigma and discrimination that their children may face:

- “My father when he was distributing his estate he said ...'Eeh! Do you count Namuli as a human being? She is going to die!'...On the side of my husband, they were allocating his estate, they said 'Eeh! Why give Namuli's children...they are also going to die because they have 'slim.' [AIDS]...Those children do not have any future.” (WHA in Uganda [33])
- “I feel the two children I have are enough. If I continue to give birth, I will have no energy to take care of those many children. If I get more children, maybe I will die and leave them suffering. Also, if my husband goes first and I be rendered a widow, I will have no way of taking care of them.” (WHA in Zimbabwe [14])
- “Nobody in the family is willing to take care of these children even while we are around doing the rounds of hospitals. The fact that no one will even look at them, let alone feed them or take care of them once the parents perish, is quite clear. They will be reduced to mere nothings awaiting their death – surely no parent wants this kind of a life for their children, if this can be called a living.” (person living with HIV in India [47])
- “I have no right to bring an innocent one into this world knowing well that he will have to undergo the pain of living as I am suffering. When nobody wants to know you, meet you, talk to you and is mortally scared of sharing space with you – one knows what social ostracism is. The baby will always be an unwanted one by the society, will have no happy future whatsoever – health, academics, growth, social life all this will be non-existent for him. I think it is a crime to give birth in such a miserable existence.” (WHA in India [47]).

## **Obstacles to terminating unwanted pregnancies**

The main obstacles to safe abortions for WHA that emerged from the literature included: lack of information about abortion safety and availability, learning an HIV-positive diagnosis during a late stage of pregnancy, costs of abortion, and negative attitudes and discrimination.

### **Lack of information**

In many countries, the majority of women do not have access to safe, legal abortion. The Botswana Network on Ethics, Law and HIV/AIDS recently pointed out that legislation penalizing abortion in that country eliminates a woman's right to choose what to do with her body [48]. In yet other countries, women may be unaware that they are entitled to terminate a pregnancy or may not know how to obtain a safe legal abortion.

The subject of pregnancy termination seems to be largely avoided in information, education and counseling programs for WHA and women attending VCT centers.

UNFPA's 2001 Programme Brief on preventing HIV infection in pregnant women states that: "As some pregnant HIV positive women may wish to terminate their pregnancy due to fear of HIV transmission to their child, consideration should also be given to inform them of the actual risk of HIV transmission to offspring...and the options available to them (e.g. ARV [ART], elective cesarean section in some settings, termination of pregnancy). The aim is for pregnant women to make their own informed decisions. Termination of pregnancy should not be promoted as part of routine ANC recommendations" [49].

Because recommendations issued by US agencies are often followed in developing countries, it is important to consider the kind of guidance they give regarding abortion. In the early days of the epidemic, the CDC failed to mention that options for pregnancy termination should be included in counseling for pregnant WHA. The 1995 US Public Health Service Recommendations on VCT for pregnant women only mentioned pregnancy termination as follows: "Uncertainties regarding HIV infection status, including laboratory test results, should be resolved before final decisions are made concerning pregnancy termination, ZDV [zidovudine] therapy, or other interventions" [50]. The CDC's 2001 revised guidelines for HIV screening of pregnant women did not mention pregnancy termination specifically, alluding to it as follows: "HIV-infected pregnant women should receive information regarding all reproductive options. Reproductive counseling should be nondirective. Health-care providers should be aware of the complex concerns that HIV-infected women must consider when making decisions regarding their reproductive options and should be supportive of any decision" [18].

Many materials produced by NGOs that receive funding from the US government omit the topic of abortion or how women can deal with contraceptive failure and unwanted pregnancies. For example, one resource developed for programs in developing countries, *HIV/AIDS prevention and care in resource-constrained settings: a handbook for the design and management of programs*, points out which contraceptive methods might pose problems for WHA and women with STIs but makes no mention of what they should do in cases of contraceptive failure [51].

Some NGOs in other countries where abortion is permitted by law do broach the topic in IEC materials concerning pregnancy and HIV [52–56]. Even when pregnancy termination is mentioned, however, this may be only in very cursory terms.

When information and access to legal pregnancy termination are lacking, WHA are prevented from ending unwanted pregnancies safely. Researchers who interviewed 52 WHA in Zimbabwe stated: "long-term married women...may be ready to terminate childbearing, but often cannot put that decision into practice because they lack control over contraception and access to abortion" [14]. When WHA lack factual information on

the low risks of safe abortion, their fears may also prevent them from having a termination; as one woman in India explained: "[My second pregnancy] was an accident. I did not want another child because already I have HIV. I did not want. But then I think to abort. But then I am worried. Many women, they get very sick or they die after abortion. What if I do abortion and then I die? Then my daughter will not have a mother. And again, if the people, my community, if they know I do abortion it will not be good. So I decide to have the child" [57].

### **Diagnosis during a late stage of pregnancy**

Among 36 intravenous drug users interviewed in New York City during a study on HIV and pregnancy in 1985, termination of pregnancy was more common among both WHA and seronegative women when they had been tested before or early during pregnancy [58]. Choosing termination of pregnancy becomes more difficult as pregnancy progresses and late-stage abortions might entail more risks, so women may find it more difficult to access services then. Questionnaire interviews with 264 women attending prenatal clinics in eight provinces of Thailand found that while half of the WHA had wanted to terminate their pregnancies, two-thirds only learned of their HIV status after three months of pregnancy and only 10% were able to have an abortion [59].

### **Costs of abortion**

Key informants in the interview study believed that health-care providers refuse to perform pregnancy terminations or charge very high fees. In Kenya, this was felt to be because abortion is illegal. In South Africa the problem cited was long waiting lists at public hospitals. Informants in India said that high fees were related to health-care providers' desire to avoid WHA. One key informant in India, a nurse living with HIV, related her own experience in this regard: "I did it myself. I was not admitted into the hospital [where she worked]...they were not willing to admit me, so myself I did it in the home. I induced tablets through the vagina...It is an international tablet. In total I paid about...2000 rupees for that tablet. It was very painful so I took pain-killing tablets also...Our doctor went to England and from there she brought the sample and she sold it to me. I paid and after that I came to know it was a sample." (She was not admitted to the hospital because of her HIV infection.)

There were also indications in the literature review that the costs of abortion might pose obstacles to WHA who wish to terminate pregnancies. Where abortion fees are high, women living in low-income situations may be unable to afford the procedure; for example, women in some US states cannot obtain abortions with Medicaid funding (a federal health insurance scheme for poor people) [60]. A researcher commenting on the situation in New York City in 1990 stated: "HIV-infected women...are now being encouraged to limit reproduction to prevent transmission of disease to their children and on grounds of costs to society. However, at the same time their options for making

this choice independently are being restricted. Women placed in this no-win situation, not surprisingly, cannot win" [60].

In a Zimbabwe study, five interviewed WHA considered terminating their pregnancies but did not do so because it was unavailable; in at least one case this was related to cost: "When I found I was pregnant I tried to terminate it but it was not easy. The doctors refused to terminate my pregnancy even though I told them about my HIV status. Another doctor told me to give her Z\$3,000, which I did not have at the time. I tried to look for it to no avail. Seeing that I had failed to have an abortion from the specialist, I looked for traditional medicine. I used it and I had an incomplete abortion. I was very sick and was taken to the hospital" [9].

In Phayao Province, Thailand, three WHA participants in a PMCT program abandoned their attempts to obtain a termination because of the costs involved. One woman only did so after considerable effort: she first tried to self-induce an abortion with medicines; next she sought a termination at a private clinic but was refused because she was already four months pregnant. Then she visited a private hospital to which the clinic referred her. The hospital staff asked her to pay 7500 Baht but she only had 6500 Baht; the hospital would not provide the procedure [61].

## Negative attitudes and discrimination

The literature review did not find research evidence concerning stigma and discrimination against WHA who seek abortion-related care. This should not be taken as evidence that it does not exist; rather, it does not seem to have been a subject of research.

A few key informants in Australia, India and South Africa commented that some people may be more accepting of abortion for WHA because they do not think they should have children in the first place. The Australian informants did not think that termination of pregnancy was generally stigmatized. In all the other countries, the key informants felt that abortion is highly stigmatized, with women being labeled murderers and sinners if they have a termination. A few informants in Kenya and South Africa felt that women who have HIV and have an abortion would be doubly stigmatized.

- "Women who choose to terminate their pregnancies, even if they don't have HIV, are stigmatized because it is not actually accepted in most African societies. Termination of pregnancies are immoral, not very accepted. But if you also have HIV, you are now doubling the evils, termination or abortion is evil in itself, having HIV is even worse but if now you have two, your situation is worsened."  
(key informant in Kenya)

- "I think that's the thing, mixed messages, where other people are saying that you are bringing an innocent child into [an] HIV world, better to just terminate. And on the other level, morally you can't do that. I think it is there; unfortunately quite a bit of it comes from health professionals." (key informant in South Africa)

In Zimbabwe, where abortion is permitted for WHA, fears associated with disclosing HIV status can be obstacle; one woman interviewed there in 1999 said: "Personally I did not want a child but I wanted to please him [boyfriend]. I later on decided to abort, but I feared because I did not have the right place to do it successfully since I did not want anyone to know that I was HIV positive" [9].

In Thailand, key informants – including a physician and WHA – said that physicians were refusing to provide pregnancy terminations because of the health-care providers' desire to obtain large samples for research studies on the efficacy of ART for PMCT.

### **HIV/AIDS as an indication for legal abortion**

Some advocates are now calling for designation of HIV/AIDS as a specific indication for abortion permitted by law. Some key informants in the interview study believed naming HIV infection as a legal indication for abortion could be useful because it would increase women's access to safe termination of pregnancy. However, 23 informants believed that decisions about abortion should be the woman's choice, indicating that WHA should have access to it under the current provisions in their countries' laws (Australia, India, South Africa), that advocacy should be done to ensure every woman's right to legal abortion, or that HIV/AIDS should be included a general indication for health or other reasons.

Four key informants in Kenya were against abortion under any circumstances and did not feel an exception should be made for WHA. However, it was noteworthy that three of them did advocate strongly that WHA should be enabled to avoid unwanted pregnancies through empowerment for decision-making about reproductive issues.

When asked what effects there might be for WHA if HIV/AIDS were made a specific indication for legal abortion, a variety of responses were given. On the positive side, some informants said that this could increase women's willingness to be tested for HIV and decrease the number of unsafe abortions. On the negative side, several informants felt that this could create the possibility of coercion on WHA to terminate pregnancies or possible increases in stigmatization of WHA.

Those considering advocating that HIV/AIDS be named specifically by law as an indication for legal abortion should consider the possible disadvantages of this strategy:

- ◆ It might imply that pregnancy in itself is dangerous for the health of WHA and lead to continued pressure on WHA to avoid childbearing.
- ◆ It could be used as a means of pressuring or coercing some WHA into having abortions.
- ◆ If HIV/AIDS is the only health condition named specifically for legal abortion, WHA may become doubly stigmatized within their communities if it becomes known that they had an abortion.
- ◆ If only women living with HIV/AIDS are enabled to access a health service that remains illegal for other women (e.g., those with cardiomyopathy, tuberculosis, cancer or other chronic illnesses), accusations of unfair treatment and resentment towards WHA could arise. Women who do not have HIV or who are unaware of their HIV status could rightly complain that all women are entitled to safe, legal abortions.

It could be better to advocate for the full reproductive rights of WHA and to advocate for the passage and implementation of laws that permit abortion for "chronic conditions that may endanger a woman's health", without naming HIV/AIDS specifically. It is important, however, to ensure that regularly updated medical protocols issued by Ministries of Health and medical associations provide guidance on how to interpret the health indications for legal abortion so that WHA are guaranteed access to this medical procedure. In any case, associations of WHA should be consulted on the pros and cons of including HIV/AIDS as an indication for legal abortion so that policy- and lawmakers can also consider potential unexpected negative consequences.

## Recommendations

The majority of key informants in the interview study said that more needs to be done to advocate for the reproductive rights of WHA. Most of them indicated that their organizations had not yet addressed HIV/AIDS, pregnancy and reproductive rights specifically and said that they would appreciate guidance and technical support in addressing these issues. Recommendations are presented below that have incorporated the key informants' suggestions, as well as suggestions for research, program implementation, policy and advocacy that emerged from analysis of the literature review.

### Research – conduct studies on:

- The prevalence of HIV among women who seek abortions compared to women who carry pregnancies to term in order to determine whether women who terminate pregnancies are at greater risk of HIV infection because of difficult life circumstances.

- The health effects of incomplete miscarriages and unsafe abortions in WHA compared to HIV-negative women in order to determine whether special measures are needed for postabortion care.
- The prevalence and types of complications of induced abortions seen in WHA in order to determine whether special measures are needed to guarantee safety and reduce post-procedure sequelae.
- The comparative advantages of surgical versus medical abortion for WHA.
- The type of counseling given by health-care providers and counselors regarding pregnancy termination in order to determine whether they advise WHA and other women differently (issues of coercion or discouragement rather than neutral informative counseling; refusals to perform procedures or provide referrals, etc.).
- The efficacy of including WHA as counselors in contraceptive counseling following abortion-related care.

The key informants also stressed that WHA should be involved in research on the above-mentioned topics and that associations of women living with HIV/AIDS should be informed about the results of research done with their cooperation.

### **Health service implementation**

- Ensure that contraceptive information given to WHA is comprehensive, including discussion of the advantages and disadvantages of various methods.
- Advocate for and help produce guidance documents on contraceptive use for WHA that can be used in VCT programs as well as in contraceptive counseling following abortion-related care.
- Provide counselors with checklists of issues to be covered in relation to pregnancy and abortion-related care for WHA.
- Establish clear policies regarding pre- and post-test HIV counseling, including discussion of options to prevent and terminate pregnancies and measures to ensure that abortions are performed only with the woman's voluntary and informed consent.
- Integrate comprehensive counseling on HIV/AIDS and pregnancy into nursing and medical school curricula.
- Provide more education for health-care providers, in particular general practitioners and those working on maternal-child care, regarding HIV/AIDS and pregnancy. This could include outreach programs, such as door-to-door campaigns.
- Carry out values clarification interventions with AIDS and family planning counselors on the rights of WHA to have children and to prevent or terminate pregnancy (implying that WHA should be well informed about contraceptive options, including emergency contraception and abortion) in order to create more favorable health-care provider attitudes towards WHA.
- Ensure that health-care providers have up-to-date information on the effects of unsafe and induced abortion for WHA.

- Provide health-care workers with opportunities to see hands-on high-quality care for WHA as one step towards changing negative attitudes.
- Ensure that WHA can act as counselors through initial and refresher training and by creating support mechanisms for their employment.

### **Policy and advocacy related to HIV/AIDS**

- Increase efforts to reduce stigmatization and discrimination of people living with HIV/AIDS.
- Carry out advocacy with parliamentarians, health planners and bureaucrats regarding the problems of WHA in general.
- Encourage WHA to speak out publicly to bridge the gap between the women and civil society organizations and encourage women's organizations to take up WHA issues.
- Designate WHA and other women to advocate on issues related to lower prices for antiretroviral therapy (ART), wider availability of essential medicines, and HIV and pregnancy-related issues. This includes appointing more WHA to policy and decision-making bodies.
- Establish support groups for persons carrying out advocacy on behalf of WHA.

### **Policy and advocacy related to reproductive health and rights**

- Carry out education programs at the grassroots level to educate women regarding their anatomy, biology and reproductive functioning; HIV testing; gynecological care; perinatal transmission of HIV and PMCT and their rights regarding abortion.
- Increase education on sexuality and contraception for young people and people living with HIV/AIDS, including the issue of unprotected sex between discordant couples.
- Carry out more gender-sensitization programs at the grassroots level that help empower women, make them more aware of their sexual and reproductive rights and improve respect for women's reproductive rights and their access to reproductive health services (using seminars, workshops and newsletters).
- Establish umbrella organizations where WHA organizations, AIDS Service Organizations, NGOs and health workers can debate and work on issues related to wanted and unwanted pregnancy, unsafe abortion, abortion and HIV/AIDS.
- Ensure that NGOs, associations of people living with HIV/AIDS and feminist/women's movement groups include all elements of reproductive rights in their advocacy concerning health care for WHA; this includes promoting access of WHA to safe abortion services, while combating coercion and pressure on WHA to undergo abortions.
- Provide more education for the general community on PMCT.
- Work with the media on pregnancy and HIV issues, including more exposure for HIV-positive parents.

- Carry out sensitization of and advocacy toward community leaders, policy-makers and parliamentarians on the effects of unsafe abortion.
- Educate men specifically about the effects of unsafe abortion.
- Advocate for full implementation of laws regarding conditions under which abortion is allowed.
- Advocate that governments promoting the offer of VCT for prenatal clinic attenders also make the same recommendation for clinics and hospitals that treat women for unsafe abortions and provide induced abortion care.

## Conclusion

In 1994, the AIDSCAP Project published a paper discussing the implications of AIDS for maternal health in developing countries, mentioning that “The potential impact of HIV/AIDS on demand for abortion has not been systematically explored,” and noting further that “an increased demand for abortions would lead to more septic abortions and risks of HIV transmission to health-care providers who treat unsafe abortions without observing universal precautions” [62]. Since that time, however, it appears that safe motherhood interventions for WHA have tended to leave aside the issue of miscarriage and abortion, and research studies have given relatively little attention to the part played by miscarriage and the complications of unsafe abortions in the overall maternal morbidity and mortality of WHA.

From a public health perspective, it is important to focus attention on combating the effects of unsafe abortions for WHA. The more than 525,000 women who die due to pregnancy and childbirth complications each year include women living with HIV/AIDS, particularly in countries with high levels of HIV prevalence. The proportion of WHA dying or suffering significant morbidity due to unsafe abortions is likely to be relatively high in these countries as well.

Like other women, WHA should have the right to choose whether or not to carry pregnancies to term. This has been confirmed by international guidelines on HIV/AIDS and human rights issued by UNAIDS and the Office of the United Nations High Commissioner for Human Rights: “Laws should also be enacted to ensure women’s reproductive and sexual rights, including the right of independent access to reproductive and STD health information and services and means of contraception, including safe and legal abortion and the freedom to choose among these, the right to determine number and spacing of children, the right to demand safer sex practices and the right to legal protection from sexual violence, outside and inside marriage, including legal provisions for marital rape” [63].

From a human rights perspective, it is essential that measures be taken to ensure that WHA are able to exercise their right to decide whether and when to have children. This means that they must have control over their reproductive decisions and be enabled to carry out their decisions voluntarily and safely.

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