# A Qualitative Investigation Conducted in Cape Town, South Africa of the Influence of Male Partners on HIV-Positive Pregnant Women's Decisions Regarding Abortion

**by**

**Mayra Lourenco de Melo**

**MLXMAY001**



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**Supervisor: Ms Phyllis Orner**

**Women's Health Research Unit, Department of Public Health and Family Medicine**

# Declaration

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# Acknowledgements

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# Contents

# 1. Protocol

## 1.1 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 (HSRC, 2006). Moreover, gender inequities in South Africa strongly underpin women's greater risk to HIV infection (Cooper et al., 2004). Ensuring access to effective reproductive health services, including improved access to abortion for HIV-positive women, could reduce unintended pregnancies and births, simultaneously reducing HIV infections in infants. Prior research suggests that HIV-positive women and men do not have sufficient information about abortion options.

To date, there has been little work on policy and programmes designed to meet HIV-positive women's specific needs, including access to abortion (de Bruyn, 2004 a; de Bruyn, 2004 b; de Bruyn, 2005). Some research has been done on reproductive intentions among HIV-positive women, but a focus on unwanted pregnancies and intentions to terminate them has been largely absent in the literature. One study in KwaZulu Natal did indicate that HIV-positive women experience stigma and discrimination at abortion services (Gender AIDS Forum, 2005) and the International Community of Women Living with HIV/AIDS has documented instances of HIV-positive women being pressured to undergo sterilization in order to access safe abortion care (ICW, 2004).

In most countries gender roles can be rigid, for example, the husband or male partner is seen as head of household and main provider for the family, whereas wives or female partners are seen as the main caregivers and homemakers. Although women may express anger and resentment at the control exercised by their husbands, marriage is one of the few ways through which

women can ensure their social status and economic security (Feldman & Maposhere. 2003, p.164). There is some flexibility, however, to the extent that it might allow the discussion of problems together but the husband/male partner usually has the final word when it comes to decision making as it is assumed that he "knows best" (Meursing & Sibindi, 1995).

Given that women's desire for having children is largely socially constructed and often related to economic dependence on male partners, HIV-positive women may suffer a great deal of pressure from husbands and families as well as other forms of social pressure to have children (Aka-Dago, Desgrees, Msellati, & Welfens-Ekra, 1997). At the same time, the sexual and reproductive rights of HIV positive women are restricted by stigma and women's subordinate position either economically or socially (Feldman & Maposhere. 2003, p.171). Such dependence makes maintaining the relationship a priority, and many women consent to the demands of their partners disregarding their health and reproductive choices (Feldman & Maposhere. 2003).

Thus, due to social and cultural values, it is difficult for women to make their own sexual and reproductive choices, and may be especially so when HIV-positive. Contrarily, men appear to be less pressured by cultural expectations regarding parenthood. These facts highlight the power imbalances between men and women in intimate partner relationships, as well as women's "under-powered" position (Cooper et al. 2007).

While South African abortion legislation affords women relatively progressive rights, important barriers to safe abortion continue to exist for women in South Africa; recent journalistic investigations have given some evidence of this (Molosankwe & Skade, 2007; "Call for," 2007; Steele, 2007). These barriers are particularly pervasive for impoverished women, many of whom are HIV-positive.

Coercion has never been considered appropriate for determining decisions. This is particularly valid when regarding choices of reproductive health and sexuality. People living with HIV/AIDS rely on health care systems for access to information, counselling and relevant guidance adapted to their needs. HIV-positive people, as any other healthcare user, are entitled to confidentiality, and full informed consent must be given for all service provisions. Involving their partners should always be encouraged in the decision-making process especially when regarding sexuality, reproductive health and childcare choices (Gruskin, 2007).

The literature on sexual and reproductive health has suggested that reproductive health choice in general is greatly influenced by the desires of the male partner, and that often women are restricted from expressing their own desires and needs. However, not enough research has been conducted regarding those influences when it comes to abortion. There is need to investigate how gender roles play out in this specific situation.

The proposed study emerges from a broader research project which was a collaborative study conducted over a period of 12 months (December 2008 to December 2009) involving the Women's Health Research Unit (WHRU) in the School Public Health and Family Medicine at University of cape Town (UCT) and Ipas, USA to address HIV-positive women's decisions-making process with regard to terminating a pregnancy.



## 1.2 Aim and Objectives

### *1.2.1 Aim*

To explore, using the data from a larger study, how male partners influence HIV-positive women's decisions with regard to terminating a pregnancy.

### *1.2.2 Objectives*

- To explore gender factors that may impact on HIV-positive women's decisions to terminate a pregnancy
- To understand the impact of gender, sexual relations and male partner influence on the decision-making process of HIV-positive women regarding abortion

## 1.3 Methods

Qualitative research methods were used to collect data. In-depth interviews were conducted with HIV-positive women, tape-recorded, transcribed verbatim and, where necessary, translated. The present author was not involved in the data collection of the larger study, but rather conducted an analysis of the qualitative in-depth interview data from this study.



### *1.3.1 Study site, population and selection*

The study sites included the ARV/ID clinics at G F Jooste Hospital, Michael Mapongwana CHC in Khayelitsha and Heideveld CHC in Heideveld. Women accessing the abortion services are not required to disclose HIV status to health care providers, and for this reason the ARV/ID clinics rather than the abortion services were preferentially target for participant recruitment.

Participants were recruited in two stages: First, the selected interviewer explained the purpose of the study to female clients, emphasising that it was a study of the WHRU at UCT and that it was conducted by the Unit and not by hospital staff. Clients were asked for consent for a WHRU fieldworker/interviewer to access their clinic records to identify their suitability for inclusion in the study and, if found eligible, their consent was contacted regarding possible participation in the study. Suitability for inclusion in the study was based on identifying:

- Clients who were 18 years or older

- Clients who, at the time, were currently pregnant or had been pregnant in the past two years - knowing their HIV-status
- Clients who were referred for an abortion and terminated their pregnancy at a public health facility
- Clients who were referred for an abortion but did not terminate their pregnancy

The collated information was then used to purposively select 40 potential participants, including women who were referred and had an abortion and women who were referred but did not have an abortion. Out of this pool of 40, two pilot in-depth interviews, and 24 in-depth interviews were conducted.

Second, potential participants were contacted by the fieldworker/interviewer and asked if they would be willing to meet to discuss participation in the study. For those who agreed, the interviewer organized suitable meeting times to explain the study's purpose and sought interview consent. The in-depth interviews took place in a private office at the health facility or at another private venue, if participants were not comfortable with this arrangement. The interview was conducted in the client's first-language or in the language of her choice. The reasons given by those who declined to participate were noted.



All participants were reimbursed R50 (US$ 6.50) towards costs incurred due to participating in the study. This modest amount of money compensated them for possible travel and child-care services.

### *1.3.2 Data collection*

The fieldworker/interviewer was trained to abstract the relevant information from the clinic records. Service providers indicated at the end of the week which clients agreed to have their

records reviewed and the interviewer spent 5 to 8 hours each week identifying eligible women from the records. Identification of eligible women ran concurrently with conducting the in-depth interviews. Depending on the volume of records that required review, the same researcher recruited for interviewing may have conducted the record review.

An interviewer experienced in conducting in-depth interviews was recruited, and was trained on the study instruments. During this training, particular attention was paid to the sensitive nature of the issues to be discussed and how to handle any possible feelings of discomfort appropriately. The South African site Principal Investigator did additional training and role-playing with the field staff, using a manual developed by the WHRU. The in-depth interviews were conducted in the respondents' preferred language - most likely to be Xhosa.

Research tools, including informed consent forms and the interview guides were piloted after initial review by co-investigators, an experienced abortion provider from the community (Dr Marijke Alblas), and one or two representatives of women living with HIV (e.g., from the local branch of the International Community of Women Living with HIV/AIDS (ICW), the Treatment Action Campaign (TAC), Wolanani or a student from the University of Cape Town's HIV/AIDS support group.)



An in-depth interview guide was developed and piloted. Pilot data was transcribed and translated, and the tool amended if necessary. Thereafter, 20 in-depth interviews were held with women.

### *1.3.3 Data analysis*

Data from the larger study will be analyzed using a grounded theory approach. Grounded theory is based on a process that helps the researcher to systematically "discover" categories,

themes and patterns that emerge from the data through coding and categorizing the raw data into manageable units of analysis (Strauss & Corbin, 1998). Initial categories for analysis will be drawn from the interview guides (Carey, 1994); thereafter, coding of transcripts will be refined to explore emergence of themes or patterns (Charmaz, 1990).

For this specific study, data will be analyzed using a thematic analysis approach. Thematic analysis is a process for encoding qualitative data (Boyatzis, 1998). Themes, which are a specific pattern found in the data collected, are identified. In thematic analysis, themes are developed straight from the collected data (Joffe & Yardley, 2004), which in this case will be the interview transcripts from the larger study. Deductive coding will be used, where themes and codes will develop from existing theoretical ideas (Boyatzis, 1998), drawn from the literature review. Codes developed allow for later retrieval of valid information and analysis of the data (Joffe & Yardley, 2004).



## 1.4 Ethical Issues

Ethics approval for this study was obtained from the University of Cape Town's Faculty of Health Sciences Research Ethics Committee (REC REF #502/2007), and permission to conduct the study at the health facilities from the Western Cape Provincial Department of Health.

Client consent was sought at two points in the study: (1) to review records and to be contacted regarding possible participation in a study, and (2) to participate in in-depth interviews. The first consent was taken by the interviewer in the clinic in the client's preferred language. It explained the purpose of the study, why records would be reviewed, ensure confidentiality of record data, and emphasised that women were free to decide whether to participate in the study or not, and that their routine clinical treatment would not be affected by their decision to

participate or not. Care was be taken by the WHRU to ensure that the service providers were well trained in administering this consent form to avoid any elements of coercion.

The second consent was also taken by a WHRU interviewer. It explained the purpose of the study, what would be asked of participants and would confirm the confidentiality of data collected. It explained that participation is voluntary, that they have the right to refuse to answer any questions or to withdraw from the interview. Interviews proceeded only if the participant understood the content of the consent form and agreed to sign it. For people who couldn't read, the consent form was read out to them. All consent forms included contact information for the South African site Principal Investigator to facilitate communication by participants who wished to ask a question or register a complaint.

Confidentiality was ensured during all phases of the research, and only the researchers had access to the data. Reports of the findings will not identify individual participants, i.e., interviews were coded and any direct citations in reports/articles/ presentations, etc. guarantee participants' anonymity. All forms, tapes and lists held by the researchers are kept in a locked cupboard in the WHRU at UCT for a maximum period of one year after the study report is finalised and then destroyed.

Participants in the study may not directly benefit from the study, but may indirectly benefit by providing information that could contribute to improving the quality of sexual and reproductive health care for HIV-positive persons accessing treatment. Women who participate in the in-depth interviews may also benefit by sharing their thoughts and feelings about their experiences.

The compensation offered to participants was not considered undue inducement since it was not high enough to be seen as a motivational factor for participating in the study; however, such compensation was necessary to ensure that the goal was achieved.

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# 2. Literature Review

Patriarchy as an ideology predominates in most cultures, societies and communities worldwide with men playing a significant adversarial role in decisions regarding many aspects of women's sexual and reproductive lives. Within this framework, this literature review will discuss pertinent issues that importantly contribute to an analysis of the role of male partners regarding HIV-positive women's abortion decisions in Cape Town, South Africa.

Much research has been carried out in sub-Saharan Africa on gender relations, gender power imbalances and women's disempowerment regarding family planning, contraceptive use and reproductive choice in general. Little attention, however, has been placed on the role that male partners play in relation to women's decisions to carry a pregnancy to term or not, particularly among HIV-positive women (Puri, Ingham, Phil & Matthews, 2007).

Many studies have been carried out about the importance of safe abortions or relating to how healthcare professionals are often judgmental towards women seeking abortions (Gruskin, Ferguson, O'Malley, 2007; Harrison, Montgomery, Lurie & Wilkinson, 2000; Harries, Stinson & Orner, 2009). In contrast, there is little that examines women's decision-making regarding abortion when their HIV-positive status is known prior to the pregnancy or becomes known during the pregnancy. What influences and eventually determines their decision to have or not have an abortion? Do male partners influence the abortion decisions made by HIV-positive women? How do they affect these decisions?

One study in Nepal looking at factors affecting abortion decisions among young couples (regardless of serostatus) mentioned that interpersonal relationships played an important part in

abortion decision-making (Puri et al., 2007). This study reported that husbands play a dominant role in making the final decision, not only in Nepal but in other Asian countries such as India and Bangladesh. In Nepal, the study also showed that the final decision to end or continue a pregnancy was generally the husband's. In addition, husbands would provide the necessary financial aid for post-abortion care. As such, husbands were considered the major decision-makers (Puri et al., 2007).

Research has suggested that the sexual and reproductive health needs of HIV-positive men and women do not differ much from those of people not living with HIV (Gruskin et al., 2007; Krishenbaum et al., 2004). Populations with a high HIV prevalence may require the prioritization of certain services. Addressing societal factors such as stigma, privacy and confidentiality are also of great importance.

More than 15 years into the AIDS pandemic, stigma and discrimination are still present in the lives of South Africa's HIV-positive women. This discrimination is evident in their communities, in health care facilities, in their families and is sometimes practiced by their partners. Having access to legal abortion through the public health system and to information regarding their sexual and reproductive rights and choices is of the utmost importance and should not be compromised by the prejudice, opinions and pressure of friends, family and partners (De Bruyn, 2004; London, Orner & Myer, 2008).

There is an ongoing need to investigate and study the factors contributing to and aggravating the suffering and lack of support for sexual and reproductive choice, decision-making, and rights, particularly among marginalised social groups. This includes impoverished HIV-positive women who often have difficulty accessing public health services that provide support in the areas of family planning and reproductive health.

## 2.1 HIV-Positive Women, Society and Reproductive Choice

Women are more vulnerable to HIV infection than men owing to being physiologically and biologically more likely to be infected through unprotected sex in addition to not being able to insist on monogamous relationships and male condom use due to gender inequality prevalent in most societies (De Bruyn, 2006). Most of the women affected by HIV/AIDS in sub-Saharan Africa are of reproductive age (Thoronton, Romanelli & Collins, 2004) and many desire to have children despite the difficulties arising from doing so in the context of being HIV-positive.

In most countries, societies and cultures, having a child means achieving a certain social status desired by most men and women (Aka-Dago, Desgrees, Msellati, & Welfens-Ekra, 1997) and these beliefs do not change when one or both partners are HIV-positive. London et al. (2008, p. 17) noted that "Social expectations regarding women's child bearing role are tremendously powerful forces influencing women's and men's decisions." As such, women and men's desire to have children is significantly socially constructed. In socioeconomic settings where women are economically dependent on male partners and where communities and family groups have great influence on individual choices, HIV-positive women experience pressure regarding reproductive behavior (Aka-Dago et al., 1997).

In many social environments, having children and obeying the husband are common expectations of marriage:

> *Although women often express anger and resentment at the control exercised by their husbands, marriage is one of the few ways through which women can ensure their social status and economic security.* (Feldman & Maposhere, 2003, p.164)

In addition, the sexual and reproductive rights of HIV-positive women are restricted by stigma and women's socioeconomic subordinate position (Feldman & Maposhere, 2003). This means that poverty and women's economic dependence on their husbands or partners constrains women's reproductive rights and increases their susceptibility to HIV (Feldman & Maposhere, 2003). As De Bruyn (2006) has reported, this reflects the conditions that underpin inequitable gender relations.

Female dependence on male partners may make maintaining a relationship a priority and women in these situations often "consent" to their partner's demands, disregarding their health and reproductive choices and making their lives even harder (Feldman & Maposhere, 2003). Employment and the integration of women into the economic sector have resulted in their greater empowerment, autonomy and authority, substantially improving health outcomes (Gruskin et al., 2007).

Gender power imbalances occur for women regardless of their serostatus but HIV-positive women suffer even greater adversity. People living with HIV often deal with increasing pressure regarding their reproductive choices (Gruskin et al., 2007). In effect, women living with HIV often have limited ability to control their reproductive decision-making.

Informed choices of seropositive women regarding having more children or not requires the support of the whole community (Aka-Dago et al., 1997). For this to happen, a collective knowledge and conscience has to be built, integrating the seropositive women into a community that allows "free" and "open" choices. According to Meursing and Sibindi: "A married person with HIV needs full support of their spouse to initiate new measures of family planning" (1995, p. 61).

## 2.2 HIV-Positive Women, Human Rights and Reproductive Choice

Pressuring HIV-positive women not to have children or forcing those already pregnant to have an abortion is a violation of human rights. It is important to provide appropriate services to which these women can look for support and on which they can rely to make informed choices (Berer, 2004). According to Delvaux and Nostlinger:

> *HIV-positive women and men should be empowered to take informed choices relating to their reproductive lives, free of coercion. Their specific health condition and their socio-economic situation may render them vulnerable in this regard, however, which makes support for their reproductive rights a priority*. (2007, p. 46)

It has been argued that any approach that prevents HIV-positive men and women from making free choices about their desire to have children violates their rights to reproductive autonomy and control over their own bodies, ultimately causing a loss of confidence in their health care provider (London et al., 2008). Furthermore, the World Health Organization supports providing information and free choices:

> *Where termination of pregnancy is both legal and acceptable, the HIV-positive woman can be offered this option. 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* (WHO, 2002 as cited in De Bruyn, 2003, p. 153)

For this to occur, measures need to be taken so that these women are free to exercise their right to decide whether or not to have children (De Bruyn, 2003).

### *2.2.1 Termination of Pregnancy in South Africa*

In 1996, South Africa enacted the Choice on Termination of Pregnancy Act (CTOP), which provides for abortion on request up to 12 weeks of gestation. In cases of socio-economic hardship, incest, rape and for reasons related to the health of the pregnant woman and the foetus, terminations can be performed up to 20 weeks. In subsequent weeks, it can only be done to save the life of the mother. Surgical terminations (i.e., mechanical uterine evacuation) can only be performed by a doctor or a trained midwife in facilities designated for the purpose by the Provincial Department of Health. (Jewkes, 2005, p.1236)

Research that monitored the impact of the new Act showed a significant decrease in abortion-related mortality but no decrease in incomplete abortions, suggesting that women were using safer methods but still having abortions outside designated facilities (Jewkes, 2005). The findings of this study suggest multiple explanations for this, including lack of information on abortion rights and the unavailability of or lack of access to abortion services.

Somewhat contrary to Jewkes' findings, Harrison et al. (2000) found that knowledge regarding the CTOP was widespread and that abortion evoked strong opposition from communities and health care workers, except in situations such as incest, rape or when the pregnancy was a threat to the mother's life. Opposition to abortion originates from both personal (including moral and religious beliefs) and sociocultural perceptions. Public education and widespread discussion before the Act was implemented could have addressed some of these issues, but little occurred. This may have affected the views of younger women, who in some instances feel intimidated even to ask for any extra information on abortion (Harrison et al., 2000).

## 2.3 HIV-Positive Women, Gender Inequality and Reproductive Choice

Gender roles and relations play a major part in determining the difficulties women living with HIV may experience regarding motherhood and reproductive choice. Women, in general, have been considered to be subordinate to their families and male partners and this often results in their reproductive choice commonly being restricted by and dependent on that of their husband and family. Concluding from the literature reviewed here, this does not change for HIV-positive women.

In most contexts, gender roles are often inflexible and change is slow or relatively non-existent. For instance, married men are seen as the heads of their respective households and providers for the families, whereas married women's principal role is to care for the home and children. Where flexibility in gender roles does exist, problems may be discussed but husbands usually have the final word when it comes to decision making as it is assumed that the husband "knows best" (Meursing & Sibindi, 1995). Moreover, Meursing and Sibindi emphasize that "a wife who challenges her husband's acts and decisions, ventures into a risky area, and may get a beating" (1995, p. 58).



For a woman to reveal her HIV status to her partner is often difficult and many women fear that their partners will abandon them when they say they are HIV-positive (Feldman & Maposhere, 2003). As a result, these women go through an emotional roller-coaster, trying to adapt to the new aspects of their relationship while concentrating on the needs of a better future represented by having a healthy child (Aka-Dago et al., 1997).

Becoming a mother is often of great importance. It is not only a defining biological feature of most women's adult life but also a social and cultural one. In many countries in Southern

Africa, infertile women have difficulty being accepted in their marriages and may be returned to the woman's family and have their lobola[1] claimed back. Some of these women continue to "search" for a pregnancy to fulfil cultural and social expectations, leading to situations where some women have multiple sequential partners (I. Lourenco, personal communication, April 16, 2009).

Due to social and cultural values, it is difficult for women to make their own sexual and reproductive decisions and this may be particularly the case for HIV-positive women. These facts highlight the power imbalances between men and women in intimate partner relationships as well as women's inequitable position in these relationships (Cooper et al., 2007). In Feldman and Maposhere's (2003) study, most women perceived that the sexual rights of marriage were held by men and that it was male partners who decided when to have sex. Sexual coercion was common and women would have sex with their partners even if they did not want to (Feldman & Maposhere, 2003).



### *2.3.1 Male Condom Use, Contraception and Family Planning*

Male condom use is an important aspect when addressing gender and power relations. Men's and women's approaches to the use of male condoms illustrate the gender power imbalance in sexual relations (Feldman & Maposhere, 2003; Meursing & Sibindi, 1995). Women often insist on condom use but most men are reluctant or refuse to use a condom, arguing that it affects their pleasure and undermines their manhood (Meursing & Sibindi, 1995; Santos, Ventura-Filipe & Paiva, 1998; Feldman & Maposhere, 2003).

[1] Lobolo or lobola is the provision of gifts to the parents of a bride, usually in the form of cash or livestock. It is an entrenched part of marriage in parts of Southern Africa. It can be translated as "bride price." This system requires that a price be paid for the right to marry a woman (Ansell, 2001).

According to Gruskin et al. “Cultural expectations regarding male behaviour in most parts of the world have been seen to encourage risk-taking and discourage protective behaviour” (2007, p.12). Male partners are usually responsible for making decisions concerning the number of children a couple have, condom use and family planning (Meursing & Sibindi, 1995).

Studies show that women who have steady partners report less consistent use of male condoms (Santos et al., 1998). Women report that men most commonly insist on the non-use of condoms, even when knowing their partner’s serostatus (Santos et al., 1998; Feldman & Maposhere, 2003). In contrast, some women hold the belief that if a man has sex with his wife without a condom, she is more valued than a sex worker or a temporary partner. On the rare occasions that a husband would propose to use a male condom, these women would refuse (Feldman & Maposhere, 2003).

A study of contraceptive choice among HIV-positive women worldwide (Mitchell & Stephens, 2004) and a North American study regarding reproductive choice among HIV-positive women (Kirshenbaum et al., 2004) showed that consistent male condom use was associated with having a single partner and a higher income. Women who use effective or long term methods of contraception, such as intrauterine devices, oral contraceptives, and female sterilization, are less likely to report consistent condom use. Less consistent use is also reported by concordant couples while consistent condom use within discordant partnerships is reported by approximately 50% of the couples (Mitchell & Stephens, 2004). Obstacles to greater use of male condoms include lack of availability, fear of being perceived as having multiple partners and being unfaithful to a regular partner and male dominance in decision making (Mitchell & Stephens, 2004). Condom use is also related to whether the woman has informed her partner of her status. Women living with HIV infection may feel unable to disclose their HIV status and

negotiate condom use with new sexual partners for fear of abandonment, domestic violence, loss of economic support, and social isolation (Mitchell & Stephens, 2004).

The literature thus strongly suggests that decision-making regarding reproductive choice is unequal and that male partners often make the final decision. However, as a study carried out in Uganda suggested, there is a simultaneous lack of involvement of male partners in family planning discussions (Kaida, Kipp, Hessel & Konde-Lule, 2005). In addition to the cultural, social and economic factors that underscore unequal gender relations already mentioned, there is also a lack of involvement of male partners in sexual and reproductive health services, where historically women have shown greater participation. A study conducted in Cape Town, South Africa suggested that clients attending an HIV/AIDS clinic strongly desired to increase male involvement in HIV/AIDS and sexual and reproductive health services, perceiving that by doing so would possibly improve female, male and child health outcome and women's and men's sexual relationships (Orner et al., 2008).



## 2.4 HIV-Positive Women, Desire for Children and Reproductive Choice

For reasons discussed above, it is important for women in all contexts to have the right to have children and they often state their wish to do so. Seropositive women in South Africa express the desire for children from an individual and social point of view (Cooper et al., 2007; London et al., 2008; Orner et al., 2008). The desire to have children has an impact on people's behaviour and this can be intensified with the knowledge that one is HIV-positive (Aka-Dago et al., 1997). In the course of deciding to have a child or not, women undergo a number of processes in order to help them cope with their decision. Some are processes of defence that help them deal with the situation and include compensation, denial, rationalization and projection (Hebling & Hardy, 2007).

Compensation is a psychological process in which an individual self-compensates for some shortcoming through another aspect that is considered positive (Zimbardo & Ruch as cited in Hebling & Hardy, 2007); denial is a tendency to deny painful sensations and disagreeable realities in an attempt not to consciously accept any fact that disturbs the ego (Laplanche & Pontalis, 1998); rationalization is a process through which an individual offers an explanation that is logically consistent or ethically acceptable for an attitude, action, idea or feeling that causes anguish (Laplanche & Pontalis, 1998); and projection is defined as an operation by which a person attributes their own qualities, feelings and desires, of which they are unaware or which they refuses to accept, and projects them onto another individual (Laplanche & Pontalis, 1998).

These processes are implemented by both seropositive and seronegative women and there appears to be little difference between them. Nevertheless, Cooper et al. (2007) found that the choice to have a child was often not up to the women alone but also reflected strong partner expectations. As such, child bearing as part of family formation was seen as a "natural and necessary" part of marriage. As mentioned earlier, many women, in spite of their HIV status, faced demands from their husbands to have children and feared infidelity or abandonment if they did not comply (Meursing & Sibindi, 1995; Feldman & Maposhere, 2003).

For some HIV-positive woman, pregnancy represents a time of elevated self-esteem and motivation to live a closer to "normal life" (Chen, Philips, Kanouse, Collins & Miu, 2001). This is applicable not only to a South African context but also to HIV-positive women in general. However, it has been shown by studies worldwide over the last 20 years, that HIV-positive women and men want and have children as often as their HIV-negative counterparts, despite concerns about the future and not wanting to pass on the infection (Berer, 2004). Often, HIV-positive women's decisions not to have children are determined by having the desired

number of children and not by their HIV status (Gruskin et al., 2007). Other factors that influence women's decisions regarding child bearing are age and social and family pressures (Cooper et al., 2007).

With regard to abortion decisions, a diverse number of factors influence women's decisions. In the USA, women were more likely to terminate a pregnancy if they were married or living with a partner (Bedimo, Bessinger & Kissinger, 1998). On the other hand, unmarried women in South Africa showed greater autonomy in their decisions regarding reproductive choice (Cooper et al., 2007). A study in Nigeria, which did not account for HIV status, showed that a significant characteristic of women seeking an abortion after the first trimester of pregnancy was that they were not married. They also sought the abortion without the partner's consent and nearly half these women stated that either their single status or not being out of school were the primary reasons for having their abortion (Bankole et al., 2008).

Being HIV-positive may disrupt one's sexual life but most men and women resume their sexual activity despite infection. Ignoring their sexuality and desire for children contributes to inequitable relations between women and men (Santos et al., 1998). Having open discussions regarding HIV-positive men and women's desires helps reduce stigma and helps couples make informed decisions. As previously mentioned, integrating and involving men in sexual and reproductive health services may contribute towards more equitable sexual relationships (Orner et al., 2008).

## 2.5 HIV-Positive Women, Health Care Services and Reproductive Choice

Greater access to information, better education and open discussions within peer groups and in different communities concerning the topics mentioned above should be incorporated as part of

national health programs to help reduce the stigma attached to HIV/AIDS. This often does not happen and as a result women who are HIV-positive and pregnant or wishing to have a child, do not have access to information providing viable options (Feldman & Maposhere, 2003; Berer, 2004; De Bruyn, 2006; De Bruyn, 2007).

A vital role is played by health service providers in stimulating and shaping access to and quality of sexual and reproductive health services. In addition, some providers promote specific services such as sterilization or abortion only, which compromise or limit women's reproductive choices (Cooper et al., 2007). Related to these limitations are reported instances of staff rudeness and patients generally (i.e., not necessarily HIV-positive) complaining about health care providers attitudes in South Africa and Zambia (Jewkes, 2005). These situations illustrate the increasing need for a functioning health system that can deliver both HIV and sexual and reproductive health services (Gruskin et al., 2007). A study in Cape Town, which was analyzed using a human rights framework, suggested that health care providers' attitudes played a key role in enhancing or obstructing access to abortion services (London et al., 2008).

HIV-positive men and women rely on health systems for information, counselling and guidance adapted to their needs. HIV-positive people, like any healthcare users, are entitled to confidentiality and full informed consent must be given for all services rendered. Involving partners should always be encouraged, especially regarding sexual activity, reproductive health and childcare choices (Gruskin et al., 2007). Orner et al. (2008) suggested that the integration of HIV/AIDS and sexual and reproductive health services is likely to be beneficial to the quality of care provided and more broadly to quality of life for people living with HIV/AIDS.

Regarding abortion services, studies conducted in KwaZulu Natal and in the Western Cape, South Africa revealed that health care providers in many facilities responded adversely to new

abortion legislation by evading training and refusing to provide abortions, delaying the successful implementation of the Act (Harrison et al., 2000; Harries et al., 2009). In principle, legislation and its implementation will help reduce all the difficulties encountered by HIV-positive women and men regarding reproductive choice. However in practice, legislation alone is not sufficient. It is important that health care providers understand the importance of sexual and reproductive services, including abortion services, as a measure to improve women's health and as social services that could aid women's empowerment and the possibility to make choices free of coercion.

It is important to address issues such as HIV-positive women wanting to terminate a pregnancy and making these services available. Integrating such services into family planning programs would improve health care for women with HIV (De Bruyn, 2006). Having adequate services ensures that women have access to pertinent and correct information and allows informed decision-making regarding family planning and abortion. If this were the norm, women would have access to all the information needed to guide them through their choices (Berer, 2004). Harrison et al. (2000, p. 429) make a similar point:

> *It is of vital importance that, all women and men, be they general members of the community or health care providers, understand the importance of abortion services and how these can improve women's sexual and reproductive health and choices, taking into account the role HIV plays in these choices*.

In conclusion, this literature review highlights critical issues related to the topic at hand. For instance, it illustrates that an inequitable distribution of power underpins gender relations. Patriarchy underscores male and female behaviour, and men often make critical unilateral decisions regarding the sexual and reproductive aspects of women's lives**.** Critically, the number of children that women have or desire and condom use are among these aspects. Many

studies suggest that when women insist on male condom use, it is frequently male partners who decide whether or not to use them. Thus, women are frequently coerced into having unprotected sex.

Male domination is also applicable to women's desire to have children, which is a complex mesh of subjective and objective influences. The combination of societal and male partner pressures makes it difficult for women to differentiate between their individual desire and the desires of those around them. Even though many women express an individual desire for children, external factors are a great influence and women frequently subordinate individual desire when making decisions.

Being HIV-positive doesn't suppress women's desire for children and as with seronegative couples, social and family pressures apply and are strong components affecting sexual and reproductive health choices. Such pressures and influences put women's empowerment in jeopardy, as independent and objective decision-making that is free of pressure and interference is compromised. This lack of autonomy is enhanced when women are economically dependent on their male partner and many HIV-positive women fit into this context. Deciding about their reproductive options, they have to cope with economic difficulties while managing a disease that carries a stigma in their social environments.

Sexual and reproductive health services are potentially an important arena for redressing critical gender issues. Women and men should be able to rely on sexual and reproductive health services that empower them to make informed decisions and allow them to discuss sexuality and reproductive issues that might be affecting them on equal terms. Service providers need to be equipped to support HIV-positive men and women in making the best choices for their reproductive health rather then dictating such choices. More men need to take part and be

proactive in the area of sexual and reproductive health in order to promote better services and practices.

The provision of sexual and reproductive health information devoid of health providers' personal, moral or religious beliefs should be available to enable women and their partners to make informed decisions. South Africa's abortion policy is liberal, affording women access to free and safe abortion, but there is still strong resistance among the general population and health service providers regarding termination of pregnancies. Pregnant women, including HIV-positive pregnant women, should be able to access these services freely and in a non-coerced manner.

Reproductive health choices in general are influenced by the desires of the male partners and women are often restricted from expressing their own needs. As such, research and investigation is required in order to identify and respond to the causes of gender inequality. Despite suffering prejudice and requiring special health care needs, HIV-positive women participate in society and contribute to the economy. As such, there is an urgent need to redress society's perceptions of them and the stigma attached to HIV infection.



HIV-positive women's decision-making regarding abortion and male partner's influence in this process requires urgent attention. The literature reviewed indicates women's subordinate position in relation to male partners, particularly concerning sexual and reproductive choices. Research should engage the factors that affect HIV-positive women's decisions while encouraging decisions based on sexual and reproductive health rather than patriarchy and societal pressure. Health services need to empower HIV-positive women to embrace the right to make their own decisions. This has critical implications for HIV-positive women in terms of their choices regarding abortion.

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# 3. Journal Manuscript

A Qualitative Investigation Conducted in Cape Town, South Africa of the Influence of Male Partners on HIV-Positive Pregnant Women's Decisions Regarding Abortion

## 3.1 Abstract

This study investigated the influence of male partners on HIV-positive women's decisions regarding abortion in Cape Town, South Africa. Twenty-four in-depth interviews were conducted with HIV-positive women, recruited at local public health facilities. Fifteen had an abortion and 9 did not. The major themes that emerged from the study were: (1) Pregnancy and abortion disclosures, (2) Partner support and non-support, (3) Financial support, (4) Disclosure of HIV status and (5) Condom use. Directly or indirectly, participants engaged their male partners in the decision-making process. Results suggest that male partners' reactions towards abortion were mostly adverse and possibly influenced women in their decisions. Personal and social factors such as stigma and financial constraints played an important role regarding whether or not to terminate pregnancies. Power and gender-related inequities emerged from the data and were reinforced by the participants' HIV-positive status. Despite abortion legalization in South Africa, abortions are still stigmatized. As such, HIV-positive women still undergo pressure, stigma and prejudice regarding the reproductive choices they make. Such paradoxes create a need for public awareness and empowerment of HIV-positive women regarding abortion and other sexual and reproductive choices. Ensuring access to effective reproductive health services, including improved access to abortion services for HIV-positive women, and attempting to reduce these gender imbalances could reduce unintended pregnancies and births, simultaneously reducing HIV infections in infants.

*Keywords: Abortion, HIV-Positive Women, Male Partners*

## 3.2 Introduction

Patriarchy predominates in most cultures, societies and communities, with men often playing a significant adversarial role in decisions regarding aspects of women's sexual and reproductive lives. Little attention, however, has been placed on the role that male partners play in relation to women's decisions to carry a pregnancy to term or not, and this is particularly notable among HIV-positive women (Puri, Ingham, Phil & Matthews, 2007). There is also little discussion in literature that examines women's decision-making regarding abortion when their HIV-positive status is known.

The literature regarding the influence of male partners on women's sexual and reproductive health indicates that the sexual and reproductive health choices of women (including HIV-positive women) are greatly influenced by the desires of their male partners and that women often face barriers in expressing their own desires and needs. Sexual and reproductive rights of HIV-positive women are restricted both by women's socioeconomic subordinate position to men in relationships and by HIV/AIDS-related stigma (Feldman & Maposhere, 2003).

In fact, HIV-positive women often feel pressurised by their male partners to have children (Aka-Dago, Desgrees, Msellati, & Welfens-Ekra, et al., 1997). Such dependence on male partners make maintaining the relationship a priority and women often consent to the sexual demands of their partners to do so, disregarding their health and reproductive choice (Feldman & Maposhere, 2003). These factors highlight the power imbalances between men and women in intimate partner relationships, as well as women's "under-powered" position (Cooper et al., 2007).

Having access to legal abortion through the public health system and to information regarding sexual and reproductive rights and choices is of the utmost importance and should not be compromised by prejudice, opinions and pressure of friends, family and partners (De Bruyn, 2004; London, Orner & Myer, 2008).

The following study emerged from a broader research project which was a collaborative study conducted over a period of 13 months (December 2008 to December 2009) involving the Women's Health Research Unit (WHRU) in the School of Public Health and Family Medicine at the University of Cape Town (UCT), South Africa and Ipas (USA) to address HIV-positive women's decision-making process with regard to terminating a pregnancy.

## 3.3 Methods

### *3.3.1 Study Site*

The study was conducted over 13-months in 2007/2008 at the Antiretroviral/Infectious Diseases (ARV/ID) clinics and abortion services of three public health facilities located in the greater Cape Town area.

### *3.3.2 Study Design*

In-depth interviews were conducted with HIV-positive women. The interviewer was trained on the study instruments and trained to extract the relevant information from the clinic records of HIV-positive women. Research tools were piloted amongst HIV-positive women. Pilot data was transcribed and translated and the interview guide amended accordingly. In-depth interviews took place in a private office at the health facility and lasted approximately one hour. The interview was conducted in Xhosa, transcribed verbatim and translated into English. Participants were reimbursed R50 (US$ 6.50) towards study-related costs incurred. The University of Cape Town's Research

Ethics Committee granted approval for the larger study and for the study under discussion. Approval from the Western Cape Department of Health was also obtained for use of the study sites.

### *3.3.3 Study Respondents*

Of a total of 40 potential participants, twenty-four in-depth interviews were held with HIV-positive women who had an abortion (N=15), and women who did not (N=9). Participants were recruited in two stages. The interviewer explained the purpose of the study to women attending study site services. Women who were interested in study participation were asked for consent for record review and contact if deemed eligible for the study. Eligibility criteria included: (a) HIV-positive status, (b) 18 years or older, (c) had been pregnant in the past two years knowing their HIV-positive status, (d) had an abortion at a public health facility or had been referred for or sought an abortion in a public health facility but did not have one. The collected information was then used to select potential participants. Eligible participants were then contacted and those who provided written consent were interviewed.



### *3.3.4 Data Analysis*

For this specific study, data was analyzed using a thematic analysis approach. Thematic analysis is a process for encoding qualitative data (Boyatzis, 1998). Themes, which are a specific pattern found in the data collected, are identified. In thematic analysis, themes are developed straight from the collected data (Joffe & Yardley, 2004), which in this case were the interview transcripts. Deductive coding was used, where themes and codes were developed from existing theoretical ideas (Boyatzis, 1998), drawn from the literature review. Codes developed allow for later retrieval of valid information and analysis of the data (Joffe & Yardley, 2004). The present author was not involved in the data collection of the larger study, but rather conducted an analysis of the qualitative in-depth interview data from this study.

## 3.4 Results

Interview results revealed a variety of experiences concerning male partner influence on HIV-positive women's decisions regarding abortion. Most participants engaged their partners about being pregnant. Others did not disclose their pregnancy, their intention to have an abortion, the abortion itself or their HIV-positive status to their male partners. Key themes that emerged from the interviews are highlighted below.

### *3.4.1 Pregnancy and abortion disclosures*

Pregnancy disclosures were not always done with the intention of informing partners of their pregnancy and/or of their abortion intentions. Several participants expressed that the decision to have an abortion was not under discussion as an abortion was often seen as the only option:

> The results were that I was pregnant so I told my boyfriend that I have no choice but to terminate. [Woman, had TOP]

Some women expressed that it was important to communicate their pregnancy to a member of their family in addition to their partner, possibly due to lack of emotional and financial support from their partners. Despite disclosing their pregnancy, some women avoided disclosing the abortion to their partners or found other ways to explain the interruption of their pregnancy:

> I came without informing him and I only told him two weeks after that I had a miscarriage. [Woman, had TOP]

Some participants reported that male partners supported their abortion intentions while others spoke about anxieties associated with disclosing their abortion to their partners and described

being reprimanded and how the partner reacted negatively. Most participants did not state whether they informed their partner about their final decision or the abortion itself:

> My family or relatives had not heard that I was going to have an abortion, it was my decision and my boyfriend allows me. [Woman, no TOP]

> [He said] I have done something that I should have discussed with him before doing it. [Woman, had TOP]

> He was very shocked he did not speak nicely. [Woman, had TOP]

### *3.4.2 Partner Support*

Only a few participants who had an abortion reported if male partners directly influenced their choice to abort or not. This was more frequently described by those that did not have an abortion. For example, a participant affirmed that she did not carry out her intention to abort owing to her partner's opinion regarding abortion:

> During our counselling session I noticed that my husband did not want me to do abortion so I told the counsellor that I am no longer doing abortion, I have changed my mind. [Woman, no TOP]

A few women who had an abortion reported the support of partners regarding their intention to abort. Others reported being influenced by the fact that their partners were not present or that they were abandoned as a result of communicating their intention:

> He said [...] if I want to do TOP he is allowing me to do TOP, if there is a need for money where I am going for TOP, he will give me the money. [Woman, had TOP]

> My partner left me, I told myself that there is nothing I can do I must go for an abortion because I do not have money I am not working. [Woman, had TOP]

> I told him that I was thinking about doing an abortion and that was the end of us. [Woman, had TOP]

### *3.4.3 Financial Support*

For some participants, financial support from a male partner was described as being decisive when it came to carrying a pregnancy to term. This was reported by women who had an abortion as well as those who did not.

> What played a role in my decision is that fact that my partner left me. I told myself that there is nothing I can do I must go for an abortion because I do not have money I am not working and I have children that look up on me and there is no one helping me. [Woman, had TOP]

> I asked him if he is going to afford this child, he said he has no problem, so I gave up. [Woman, no TOP]

### *3.4.4 Condom Use and Disclosing HIV Status*

Most women not using any type of contraceptive had abortions when they fell pregnant. Male refusal to use condoms was frequently reported:

> So I struggle, I must beg him so that we can use condoms, otherwise he doesn't want it. [Woman, had TOP]

Few participants mentioned whether their partners knew about their HIV-positive status. One woman stated that even though her partner knew her HIV-positive status, he refused to use condoms. Most respondents that did not disclose their HIV-positive status knew about the importance of condom use. Despite this, they were unable to successfully negotiate the use of condoms with their partners. For some participants, condom use even influenced whether pregnancy was disclosed:

> The person that made me pregnant I didn't tell him that I am HIV-positive, I said to him when were about to have sex we must use condoms, he said he doesn't want to use it. [Woman, had TOP]

> I didn't tell him because we were using condoms so he was going to say I had an affair. [Woman, no TOP]

Being married or having a permanent partner was seen by some participants as a disadvantage for negotiating condom use and some women feared that if they insisted on condom use, their partners might abandon them.

> I had stopped using contraception as I was married. My husband didn't want me to use contraception. [Woman, had TOP]

## 3.5 Discussion

Despite the limits of its scope, this study suggests that HIV-positive women's abortion decisions are influenced by a variety of factors, including gender relations via male partner influence. Results suggest that, in contrast to the ideal of women's empowerment, autonomy regarding sexual and reproductive choice may be compromised during the decision-making process.

A limitation of this study may be the lack of sufficient evidence regarding the nature of the intimate partner relationships between the women and their male partners. This was partly due to this not being included as a focus in the larger study.

For most of the women who disclosed pregnancy to male partners, disclosure was framed by the need for financial support from their partners. Some respondents also sought the stability of having someone who would participate in the pregnancy and recognize the child as their own. Often, it was hoped that male partners would assume key roles as financial supporters (as suggested in Puri et al., 2007).

According to some of the participants, non-disclosure of pregnancy, abortion intentions and/or abortion was linked to a concern centred on the possible negative reactions of male partners if they discovered that abortion was being considered. Most of the women in the study encountered many difficulties when it came to reaching a decision regarding their pregnancy. These difficulties were not only due to male partner pressure but also to economic constraints and factors such as cultural beliefs and social expectations (Aka-Dago et al., 1997; London et al., 2008).

Disclosure of pregnancy and disclosure of abortion intentions were intimately related. Many women only disclosed their pregnancy because of their intention to abort or only disclosed abortion intentions because their partners knew about the pregnancy. Interviewees were generally weary of disclosing their abortion intentions to their partners due to not expecting financial and emotional support to be forthcoming and/or potentially judgmental reactions. This latter point suggests an opposition to abortion that could be accounted for by lack of knowledge (Jewkes, 2005; Harrison, Montgomery, Lurie & Wilkinson, 2000) or personal and cultural beliefs (Harrison et al., 2000).

Reactions towards abortion by the partners of the women in the study were diverse. Influence of male partners appeared to carry greater weight when they were against abortion. The majority of the women who did not have an abortion emphasized that their partners were against their abortion intentions and some women mentioned how this affected their decision. On the other hand, a minority of participants mentioned support from their partners towards their intention to abort. However, in some of these instances, support appeared contradictory. For example, some partners suggested the abortion as the only alternative, going so far as to demand it and provide the financial aid needed. Reactions from male partners that saw women being rejected, indifference or the absence of the male partner were only reported by women that had an abortion. Such events seemed to have had a strong influence on the decision to have an abortion but were reported by a small number of participants.

The economic status of partners and/or potential fathers is mentioned throughout the interviews and is a factor taken into consideration in the abortion decision-making process for the participants. In an ideal situation, male partners would contribute economically to child maintenance (Aka-Dago et al., 1997; Feldman & Maposhere, 2003; Cooper et al., 2007; Puri et al., 2007). However, in this study, considerable numbers of women stated that abortion was a

consequence of lack of funds to sustain a child suggesting that, if desired, participants could not count on their male partners to contribute to the economic needs of their children.

As previously mentioned, most participants who disclosed their pregnancies expected financial and emotional support. If this support was not forthcoming from their male partners, they often turned to their families or even their partners' families. This underlines women's subordinate position and economic dependence on male partners and families (Aka-Dago et al., 1997; Feldman & Maposhere, 2003; Cooper et al., 2007).

Statements made by many participants (refer to 'condom use and disclosing HIV' in resluts) suggest that they perceived their partners as having a sense of ownership over them, as also reflected in other studies (Feldman & Maposhere, 2003). This perception may lead to fear when disclosing abortion intentions or negotiating condom use (De Bruyn, 2006). In an attempt to avoid adverse reactions, including gender-based violence and stigma, some women opted not to disclose abortion decisions to their partners and families. Many participants thought that if no one else knew about the pregnancy they would not have to disclose the abortion or even their abortion intentions. In the absence of an environment that allowed making a joint decision with their partners regarding abortion (Meursing & Sibindi, 1995), many women were driven to conceal their intention to abort.

Most of the women in this study reported that their partners systematically rejected the use of male condoms. The desire not to use condoms among male partners appeared to be greater than the men's fear of acquiring HIV (Meursing & Sibindi, 1995; Santos, Ventura-Filipe & Paiva, 1998; Feldman & Maposhere, 2003). This suggests that male partners of most of the women in this study did not associate condom-use with the prevention of disease transmission and the prevention of unwanted pregnancies. As such, sociocultural expectations of male conduct have

been perceived to encourage risk taking behaviours (Gruskin, 2007). Some women attributed unwanted pregnancies to the lack of condom use, which in turn depended on male partner decisions. These findings were consonant with results from other reproductive choice studies (Santos et al., 1998; Feldman & Maposhere, 2003; Meursing & Sibindi, 1995).

Unwanted pregnancies forced study participants to face stressful decisions regarding what action to take. Moreover, women were burdened by stigma when considering whether to have an abortion or not. Male partner influence in this process often impaired the ability to make appropriate decisions and cast a shadow over women's constitutionally-entrenched right to equality.

## 3.6 Conclusion

The HIV-positive women in this study face a complex mesh of personal and social factors that play an important role in their decisions regarding abortion. Besides being HIV-positive, they suffer even greater stigma when they consider having an abortion. Aggravating this situation is the fact that they are often unable to prevent pregnancy and lack financial independence, which for the women of this study is often a factor taken into account when deciding whether to carry a pregnancy to term or not.

Partners often play a role in the decision-making process of women's abortion decisions either directly, by actively communicating their desires, or indirectly, where the participants choose not to communicate their pregnancy or their intentions to abort due to perceptions of probable non-support (both financial and emotional) and fear of adverse partner reactions. From the data, issues of power and gender-related imbalances emerge. Additionally, respondents live in a judgmental society which discriminates against women who are HIV-positive becoming

pregnant and having abortions. All these factors markedly influence decision-making by hindering the process in which HIV-positive women are legally empowered to make independent choices and decisions.

Although HIV-positive women's attempts to negotiate condom-use were often related to their HIV-status or a means to prevent unwanted pregnancies, condom-use was rarely practiced and perceived by partners as undesirable. Besides this, when condom use was insisted upon by the women, it often created issues of distrust given that condom use is often associated with casual sex, mostly by male partners. In addition, it has been suggested that despite TOP legalization in South Africa, abortions are still stigmatized and there is strong opposition from many, if not most, male partners, health care providers, family members and often from women themselves, including HIV-positive women. Both the participants of the study and their male partners often demonstrated their negative views towards abortion.

Despite national public health policies and legislation that exist to support HIV-positive women who choose to have an abortion, public awareness, knowledge and support have not been effectively and sufficiently promoted. HIV-positive women still endure great amounts of pressure, stigma and prejudice, which in turn make it difficult for them to make a conscious and coercion-free decision with regard to their sexual and reproductive health. The paradoxes that HIV-positive women encounter, such as having legislative support to terminate a pregnancy but still being stigmatised by their communities, families, healthcare providers and male partners underscores the importance to attempt to create the kind of public awareness that empowers HIV-positive women and, indeed, all women to make better decisions regarding their sexual and reproductive health to allow for a better quality of life.

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# Appendix 1: AIDS Care - Psychological and Socio-medical Aspects of AIDS/HIV

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# Appendix 2: Ethics Approval Letter

UNIVERSITY OF CAPE TOWN

**Health Sciences Faculty**
**Research Ethics Committee**
**Room E52-24 Groote Schuur Hospital Old Main Building**
**Observatory 7925**
**Telephone** [021] 406 6338 • **Facsimile** [021] 406 6411
**e-mail:** sumayah.ariefdien@uct.ac.za

**08 May 2009**

**REC REF: 201/2009**

**Miss ML Melo**
**Public Health & Family Medicine**
**OMB**

Dear Miss Melo

**PROJECT TITLE: A QUALITATIVE EXPLORATION ON THE INFLUENCE OF MALE PARTNERS ON HIV-POSITIVE PREGNANT WOMEN'S DECISION-MAKING REGARDING ABORTION IN SOUTH AFRICA.**

Thank you for submitting your study to the Research Ethics Committee for review.

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above-mentioned study.

**Approval is granted for one year till the 12th May 2010.**

Please submit an annual progress report if the research continues beyond the expiry date. Please submit a brief summary of findings if you complete the study within the approval period so that we can close our file.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

**Please quote the REC. REF in all your correspondence.**

Yours sincerely

Wesley Brierley

**PROFESSOR M BLOCKMAN**
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