SOCIAL CONSEQUENCES

Investigating social consequences of unwanted pregnancy and unsafe abortion in Malawi: The role of stigma

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Malawian women in all sectors of society are suffering from social implications of unwanted pregnancy and unsafe abortion. Unwanted pregnancies occur among women who have limited access to family planning and safe abortion. A legally restrictive setting for safe abortion services leads many women to unsafe abortion, which has consequences for them and their families. In-depth interviews were conducted with 483 Malawian stakeholders belonging to different political and social structures. Interviewees identified the impact of unwanted pregnancy and unsafe abortion to be the greatest on young women. Premarital and extramarital pregnancies were highly stigmatized; stigma directly related to abortion was also found. Community-level discussions need to focus on reduction of stigma.

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1. Introduction

Demographic indicators shed light on the context in which unwanted pregnancy and abortion occur in Malawi. The 2008 Census reports a population size of 13 million people, the majority (84.7%) of whom live in rural areas. The average age of the general population is 17 years [1]. While the 2010 Demographic and Health Survey reported that women in Malawi desired a family size of 4 children, Malawian women have a total fertility rate of 5.7 (4.0 for urban women and 6.1 for rural women) [2]. The 2010 contraceptive prevalence rate for currently married women was 46.1% for all methods and 42.2% for modern methods [2]. A sizeable proportion of births (44.3%) were unplanned, of which 18.8% were mistimed and 25.5% were reported as unwanted at the time of interview [2]. This demographic evidence reveals a context wherein birth rates and the proportion of unwanted pregnancies are both high.

Induced abortion is restricted by law in Malawi to circumstances perceived to preserve the pregnant woman's life (Cap. 7:01, Laws of Malawi). Despite restrictions on induced abortion, a study by the Family Planning Association of Malawi revealed that women in the country continue to seek induced abortion for various reasons, including poverty, unplanned pregnancy, fear of being forced out of school, and shame [3]. Compared with countries having less restrictive abortion laws, countries having more restrictive abortion laws have higher rates of induced unsafe abortion [4].

Unsafe abortion, performed by an unlicensed medical provider, in unhygienic conditions, or both [5], can result in serious medical complications, including death. Africa has the highest maternal mortality ratio in the world of about 1000 deaths per 100 000 live births of which 13% are due to induced abortion complications [6]. The maternal mortality ratio (MMR) in Malawi is 675 (range, 570–780) deaths per 100 000 births, which is quite high [2,7]. Of 6 studies on maternal mortality in Malawi, 5 revealed that postabortion complications are between the first and second highest cause of death, ranging from 6%–23.5% of women presenting for care [8,9]. Evidence of these demographic, legal, and health factors yields a context in which more information is desired concerning community-level impressions of the impact of unwanted pregnancies and unsafe abortion in Malawi. This study investigated community-level opinions on the social consequences of unwanted pregnancy and unsafe abortion in Malawi.

2. Methods

The study collected qualitative data in 2009 from initiation of the World Health Organization (WHO) Strategic Approach to Strengthening Sexual and Reproductive Health Policies and Programs in Malawi [10,11]. Based on a foundation of country ownership, this methodology is used to explore sensitive reproductive health topics in a country in a participatory manner. The 3-stage process mobilizes citizenry to identify health priorities through a strategic
assessments, pilot tests interventions, and replicates and expands effective interventions [11]. Further information on the methodology and main findings of the Malawi strategic assessment are available [10].

In-depth interviews were conducted in 10 districts with 485 Malawian policymakers, governmental employees, educators, healthcare providers, religious leaders, nongovernmental organization members, and community members. Sampling of initial interviewees was purposive, and the snowball technique was used to identify subsequent interviewees. The interviews were conducted consecutively by a team of lay interviewers in each of the Northern, Central, and Southern regions of Malawi. Following the methodology of WHO Strategic Assessments, demographic information on research participants was not captured and interviews were not taped; instead, interviewers took notes on the conversations. Teams met at the end of the day to review dominant and emerging themes in the day's discussions and to synthesize data. Emerging themes were followed up in more depth with subsequent interviewees.

Findings reported here are based on notes from the 485 interviews, which were coded using an inductive approach. Thematic analyses were used to manage and analyze the data [12]. Interview notes were read and items were attributed to 4 initial categories or themes of social and economic consequences of both unwanted pregnancies and unsafe abortion. As interviews were read, 3 additional major themes emerged: determinants of unwanted pregnancies, barriers to contraceptive use, and recommendations as to how the country should address unwanted pregnancy and unsafe abortion. Interviews were analyzed for each of these 7 themes. Within these 7 major themes, minor themes emerged, such as cross-cutting themes of stigma and the impact on youth, and more limited themes such as those addressing marital status and legal consequences of engaging in an illegal act. Ethical approval for this study was obtained from the Malawi National Health Sciences Committee and the WHO Institutional Review Board.

3. Results

Findings are reported for 4 of the major themes that emerged from the interviews: barriers to contraceptive access and use. Consequences of both unwanted pregnancies and unsafe abortion, and recommendations as to how the country should address unwanted pregnancy and unsafe abortion. Key findings revealed that primary reasons for unsafe abortion included contraceptive failure, having an unwanted pregnancy outside of marriage, and young people fearing their parents' reaction. In-depth interviews revealed the impact of unwanted pregnancy on young women and the stigma associated with obtaining an unsafe abortion.

3.1. Barriers to contraceptive access and use

The cultural context surrounding contraception is critical to set the stage for understanding how unwanted pregnancies occur in Malawi. Respondents articulated a lack of knowledge concerning contraception for both married and unmarried women and men, and barriers to obtaining contraception, especially among young people. Although health workers noted that young people tend to learn about contraception from their friends, health workers, and medical staff, they also recognized that the information young people have is quite limited. Teachers and school administrators noted that life skills classes should include topics on family planning and sexual and reproductive health, but rarely do. A combination of factors lead to the exclusion of these topics, including teachers not being trained on these topics or having the skills to teach them, teachers not feeling comfortable teaching the topics, and conflicts over having enough class time to adequately cover other topics examined in standardized tests. Parents indicated that they do not discuss sexuality with their children because they feel ashamed to discuss a taboo topic.

Problems with access to correct information are not limited to young people. As men are often seen as decision makers in the household, women often seek their husband's consent to obtain and use a contraceptive method. However, men have even less information than women and often fear that contraception will interfere with the timing and pleasure of sexual relations. Discouraging myths surround contraceptive methods, such as dangerous side effects. Pamphlets explaining methods or dispelling myths are of limited use because of illiteracy. These factors impact contraceptive uptake among older women.

Among those couples who have enough information to make an informed choice about family planning, access becomes a barrier. Contraception is available at health clinics, but access and availability vary, especially for young people. Several health workers reported feeling personal discomfort discussing contraceptive use with unmarried young people. In contrast, a nurse in a Health Center in the Central region noted that single 18–20-year-old men often ask for condoms for protection in extramarital relationships, whereas young married women about 17 years or older ask for other typical contraceptives. She distributed contraceptives regardless of a patient's marital status. However, a young man from a rural village said that his peers were denied condoms because workers at health centers felt the young men would sell them rather than use them. Certainly these conflicting messages and access issues lead to poor uptake. Within a culture of low contraceptive use, unplanned pregnancy is common.

3.2. Social consequences of unwanted pregnancy

Interviewees identified the impact of unwanted pregnancy and unsafe abortion to be greatest on young women, with social consequences including early marriage and expulsion from school. Rural areas have retained the traditions of initiation ceremonies, which begin a series of events leading to some unwanted pregnancies among young women. During womanhood initiation, young women learn information about expectations of women in the community, are introduced to information about sexuality, and often experience coital debut with older men chosen for this role. As they begin to enter into sexual relationships in the absence of contraception, unwanted pregnancies occur.

Thus, traditions encourage some types of sexual relationships before marriage. Due to the high stigmatization of pregnancy outside of marriage, the consequences of unprotected sex and the potential for unwanted pregnancy can have severe social costs for these young women. Respondents of all ages and professions noted that young unmarried women would fear telling their partner they were pregnant because the partner might deny responsibility, and would fear telling their parents because of their reaction. Teenage pregnancies are stigmatized in the community, especially among unmarried women. When pregnancies among unmarried young people are discovered, discussions occur between the youths' families, often leading to an early marriage that will save the social status of the young woman and her family.

Once young women are found to be pregnant, they are asked to leave school and have a decreased chance to return. In the Southern region of Malawi, the headmaster of a primary school in a small village reported 56 expulsions due to pregnancy in 1 academic year, a primary school headmaster reported 55 pregnancies during an academic year, and a secondary school administrator reported 3–5 pregnancy-related dropouts in 2008. Although the governmental Re-Admission Policy of 1990 allows for young women to apply to return to school 2 years after pregnancy, young mothers rarely do so, either because they do not apply for readmission because
of the time elapsed or they are denied readmission. Others may elect to attend a different school on return to escape stigma from their peers. If an abortion is discovered, the community labels these women as sinners and as evil, and asserted that communities become “infected” by women aborting. They also described such women as prostitutes, affecting their quality of life. Unfortunately, stigmatizing behavior continues to exist, even if the woman ends up aborting the unwanted pregnancy.

3.3. Social consequences of unsafe abortion

Many cultural barriers to obtaining an abortion were reported, including country-wide myths about abortion. Among them, there was a local perception that if a woman aborts, she will be unable to bear children thereafter, owing to widespread belief that infertility is a common outcome of unsafe abortion. Interviewees reported that men will die if they sleep with a woman who has had an abortion. They also described such women as sinners and as evil, and asserted that communities become “infected” by women who have had an abortion. In addition, marriage opportunities for siblings of a young woman who has aborted may be compromised if the community finds out about the procedure. All of these beliefs help to cultivate and perpetuate the stigma that a woman may experience in the community if it becomes known she had an abortion. Stigma leads women to access unsafe abortion, which is more secretive and allows her to maintain confidentiality around the event.

Although anti-abortion sentiments and myths surrounding unsafe abortion were identified in the interviews, it is important to note that interviewees were also aware that unsafe abortion occurs in their communities. Many community members could note which homes in their neighborhoods contained women who had had abortions. It was not clear if this was because of knowledge that a woman had sought assistance with her termination or because she had suffered from postabortion complications.

Malawian society values women who have many children. Therefore, health consequences of unsafe abortion, such as sterility, may prevent women from participating as full members of their community, losing their standing in their community. Evidence of this was found in the example given by a healthcare provider of an unmarried woman younger than 20 years old who presented at a hospital with a septic abortion. She was treated with uterine evacuation and antibiotics, but providers had to remove her perforated uterus. At such a young age, her sterility reduced her marriage ability.

Stigmatizing behavior at the level of the family or community may extend to the healthcare system as well, thereby increasing the risk of morbidity and mortality among those who have obtained an unsafe abortion and had complications. Women often suffer postabortion complications silently in their homes, leading to delayed care and potentially more severe complications, including death. Once they arrive at a healthcare facility, they may be subjected to stigmatizing health worker attitudes and resultant negligence. A registered nurse-midwife reported that patients needing postabortion care (PAC) “are looked at as having done a bad thing and may be neglected”. Although this sentiment was echoed by other interviewees, it was clearly not a feeling of all respondents. Other health workers reported that PAC patients are treated like patients experiencing any other medical condition. Several health workers reported that they felt their colleagues’ treatment of PAC patients had improved after facility training and sensitization.

Although abortion is legal in Malawi only to save the life of a woman, it was interesting to note that interviews with police departments yielded very few cases brought against women who had procured abortions and none against those who had provided illegal abortions. Cases that were reported were usually brought by a partner – either the husband who learned the wife had aborted or a wife claiming her husband forced her to abort – or between parents and their daughters in which cases the parents claimed the daughter aborted or the daughter claimed the parents forced her to abort. One interview with police station workers revealed only two complaints concerning abortion in the past 7 months, and others facilities noted even fewer cases in the same time period. Healthcare providers reported that their facilities did not have a policy of reporting cases of induced abortion to the police. They mentioned that this was partially because it can be difficult to definitively determine whether an abortion was induced versus spontaneous, especially as women do not disclose whether they induced the abortion.

3.4. In-country recommendations for change

Along with thoughts on social consequences of unsafe abortion, interviewees were also asked what could be done to improve the situation surrounding unsafe abortion in their country. Responses included the involvement of men in family planning, wide implementation of a comprehensive school-based sexuality curriculum, and upgrading PAC facilities. Many of the participants felt that programs that include men and husbands in discussions about family planning would be helpful to curb unwanted pregnancy. Traditionally in Malawi and most of Africa, men are the decision makers on the use of contraception and family size. Consensus was not reached that this decision-making structure should change and that women should have complete control over their fertility. Instead, it was more often expressed that men should be included in the social dialogue, potentially accompanying women to the clinic under certain circumstances. As dialogue concerning family planning and contraception increases, more information about reproductive health becomes available in the community overall, and among males specifically. This could reduce the number of unwanted pregnancies overall and perhaps change the dialogue from perpetuating stigmatizing attitudes toward those that have an unwanted pregnancy to one focused on taking responsibility for prevention of unwanted pregnancy.

Institutional measures, through schools and health facilities, were proposed. Many respondents felt that sexual and reproductive health, including family planning and choices of contraceptive methods, should be taught in schools. The current life skills class mainly focuses on HIV/AIDS prevention and is not widely available. Again, dialogue surrounding contraception will ideally lead to behavior change and the reduction of unwanted pregnancies.

In addition, respondents felt that general care for treatment of PAC could be improved, through increased training of providers, strengthened supply systems of manual vacuum aspiration equipment and contraceptive options, upgraded facilities, increased number of facilities in both private and public sectors and in rural areas, and integration of PAC services into other reproductive health services, including family planning. As indicated by a nurse-midwife, training and sensitization for health workers could reduce enacted stigma by improving the way that PAC patients are treated when they arrive for services at a facility.

4. Discussion

This study yielded evidence of stigma surrounding unwanted pregnancy, especially among women who were unmarried or whose husbands were away. In response to fears of parental reaction, fears
their partner would deny responsibility, and/or desires to continue schooling, women, especially young women, resort to abortion to keep the premarital and extramarital relationships and subsequent pregnancies secret. Stigma related to unwanted pregnancy is quite common and has been found among Malawian adolescents in other studies [13,14], as well as among adolescents studied in Zambia, South Africa, and Indonesia [15–17]. When faced with scenarios of pregnancy among unmarried teens, one-quarter of South African youth reported that if the partner denied paternity, the pregnancy would be aborted [16].

One factor linked to unwanted pregnancy among young people was the role of initiation ceremonies in introducing sexuality education to young people in rural areas. The Malawi Census identified about 85% of Malawi as rural [1], demonstrating the importance of initiation ceremonies on adolescents throughout the country. An in-depth look at cultural practices regarding rites of passage revealed geographical differences in initiation ceremonies by region in Malawi [13]. In the North, initiation ceremonies included instruction on adult behavior, emphasizing avoidance of premarital sex. In the Central and Southern regions, however, greater emphasis is given to young women about how to please their husbands sexually, with encouragement for young women to experience coital debut after initiation ends. Young men in the Central and Southern regions are encouraged to have sex “often to release some ‘energy’” [13]. These messages of engaging in sexual practices after initiation conflict with cultural taboos of pregnancy outside of marriage, creating a difficult landscape for young people to negotiate as they explore their new roles as adults in the community. Initiation ceremonies are designed to prepare young women for womanhood, and are therefore an important component of Malawian culture. What is needed is additional education on prevention of unwanted pregnancy and increased access to and use of contraception.

Although induced abortion was cited as a common solution to avoiding the stigma associated with an unwanted pregnancy, especially those pregnancies outside of marriage, this study also identified stigma related to abortion. Abortion stigma was identified at multiple levels: toward young unmarried women, toward married women, within health facilities, and within communities. Abortion stigma has been defined as “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood” [18]. Abortion stigma is generated and perpetuated by the process of identifying women who have aborted as a group that exists apart from the general population, and different from the rest of the community [18]. One approach to destigmatizing abortion is to educate people to the commonality of the event; there is evidence of this in Malawi. A study of Malawian adolescents aged 12–19 years showed that more than one-third of 15–19-year-olds and about 1 in 5 young people aged 12–14 years reported having a close friend or friends who had ever tried to end a pregnancy [19]. Studies have indicated that abortion is recognized as a common occurrence in other developing countries as well [16,17,20]. To counteract the context for maintaining abortion stigma, information about the frequency of induced abortion could be used.

In addition to addressing unwanted pregnancy-related and abortion-related stigma, greater access to youth-focused reproductive health services is needed in Malawi. The median age at first intercourse among 20–24-year-olds is 17.4 years. Forty-four percent of young women aged 15–19 years reported ever being sexually active, with 20.5% of this group currently sexually active. One-quarter of young women aged 15–19 years reported an unmet need for family planning [2]. These statistics indicate the lack of contraception services among young people in Malawi that must be prioritized. This study suggests that services inclusive of the special needs of young people would be well received in Malawi, ranging from prevention of unwanted pregnancy to use of PAC services.

In the event that contraception fails, young women need improved access to comprehensive PAC services, including postabortion family planning. One study found that Malawian youth did not know how to access PAC and experienced poor health worker attitudes during the process [21]. The need for youth-focused services has been found in other studies, as 12.6% of South African health workers who were surveyed reported that they felt that young people did not attend health clinics for fear of health worker attitudes [16]. To ensure uptake of services, the importance of addressing stigmatizing attitudes among health workers cannot be underestimated.

One of the limitations of this study is that the interviews were not tape-recorded or transcribed verbatim. Very few quotes were directly written down. This could have resulted in interviewer bias, as interviewers may have highlighted items of interest to them personally or neglected to write down ideas that could be important perspectives of the interviewee. Further research may include more rigorous data collection and should address how accessible Malawian women find family planning services in general and their thoughts about contraceptive choices they have been offered at visits. Programmatic interventions should include sexuality education in schools, sensitization of health workers, and increased knowledge and access to contraception among young people. Further discussion needs to occur in communities to reduce the stigma associated with unwanted pregnancy and abortion.

5. Conclusion

Malawian women from all walks of life are suffering from the health and psychosocial consequences of unwanted pregnancy and unsafe abortion, perpetuated and reinforced by community-level and institutionalized stigma. They are faced with few options to manage an unwanted pregnancy, as is common in countries such as Malawi where abortion is legally restricted. Lack of access to safe, legal abortions leads many women to undergo unsafe abortion, which has both health and economic security consequences for the woman and her family. It also indicates a social sanction on women’s sexuality, in that women’s sexuality is specifically tied exclusively to childbearing. If abortion was legalized and safe services were available, then hopefully more women would know how to access safe abortion. This may lead to breaking down barriers and destigmatizing abortion.

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Conflict of interest

The authors declare that they have no conflicts of interest.

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