EXPANDING
REPRODUCTIVE RIGHTS
KNOWLEDGE AMONG HIV-POSITIVE
WOMEN AND GIRLS

TACKLING THE PROBLEM OF UNSAFE ABORTION IN MALAWI
Maria de Bruyn and Marie Khudzani Banda
Final project report
September 2010
Acknowledgment

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Foreword

This project report summarizes the development and implementation of a project carried out in 2009 by ICW Malawi and Ipas to destigmatize unwanted pregnancy and abortion among women living with HIV in Malawi and to expand ICW Malawi’s partnerships with other organizations in order to undertake reproductive rights advocacy.

The report was written by Maria de Bruyn, based on reports submitted by Marie Khudzani Banda, ICW Malawi facilitators and conversations and written communications with ICW members.
1. Introduction

1.1. Background to the project
In September 2007, Ipas and the International Community of Women Living with HIV/AIDS (ICW) collaborated to enhance the training and advocacy capacities of ICW members from seven African countries including Malawi. The aim was to work on issues of gender, violence, HIV/AIDS and reproductive health and rights.

The ICW members participated in a two-week training-of-trainers (TOT) workshop in Namibia, during which they learned to facilitate two workshops developed by Ipas: Gender or sex: who cares? and Understanding and claiming reproductive rights.

Participants were trained to offer skills-building workshops in their own countries; learned about their reproductive rights, especially regarding unwanted pregnancy and abortion; and developed ideas for possible reproductive rights advocacy actions that could be carried out with local ICW and community members.

In Malawi, Marie Khudzani Banda, an ICW member who attended the TOT in Namibia, followed up by organizing two workshops in December 2007 and July 2008. The December workshop involved women living with HIV from community-based organizations (CBOs) and home-based care groups. This workshop was also attended by women teachers living with HIV, who formed a group called Teachers Living Positively, T'lipo. It was important to include them because they can share information and messages with fellow teachers and learners.

The 2008 workshop included HIV-positive women from all three regions of Malawi. It was similar in content to the first workshop, but featured guest speakers from the Nurses and Midwives Council of Malawi and The Malawi Human Rights Commission.
1.2. Project objectives and activities

In 2009, ICW Malawi and Ipas agreed to carry out one more follow-up project to the original 2007 TOT. The project leaders in Malawi were Marie Khudzani Banda, Joyce Kamwana, Deidre Madise and Miriam Nyoni, all members of ICW Malawi. Maria de Bruyn was the project manager for Ipas.

IPAS and the ICW leaders collaborated in developing the project proposal. Ipas supported the project through the creation of a community discussion curriculum, sample group discussion and interview guides on pregnancy and abortion among HIV-positive women, a glossary explaining key sexual and reproductive health terms, a sample PowerPoint presentation on abortion for educational purposes, evaluation forms for facilitators and participants in monthly meetings, and a monthly monitoring form. Ipas also committed to update ICW leaders on new developments regarding abortion and reproductive rights.

ICW Malawi was responsible for the project implementation and reporting. Phone conferences were held between Ipas and ICW Malawi to discuss the project’s progress and necessary changes to the original proposal as a result of unexpected delays. Feedback and support were further carried out through e-mail.

The project, scheduled to run from February to June 2009, had three main objectives, divided into several activities:

1. **Contribute to awareness-raising around, and de-stigmatization of, the topics of unwanted pregnancy, HIV and reproductive rights, and unsafe abortion in three selected communities, one in each region of the country.**

ICW members who had participated in previous workshops agreed to carry out awareness-raising and educational activities with women living with HIV in three selected communities where there were active ICW members. The monthly sessions would be both informative and participatory, with a focus on unwanted pregnancy, unsafe abortion and safe abortion care. By organizing these community discussions, ICW aimed to destigmatize unwanted pregnancy and abortion.
Ipas provided a curriculum of exercises and activities to structure the discussions in the months of March to July 2009. The topics covered were:

- Making decisions about pregnancy
- Man-to-man letter (about gender equity)
- Problem tree about unwanted pregnancy
- Ideas and facts about contraception/emergency contraception
- Recognizing early pregnancy
- Coping with teenage pregnancy
- Abortion-related exercise: What would you do?
- Abortion-related exercise: Should we let them die?
- Putting abortion in context
- Safe abortion: facts or fiction?
- Who does my body belong to?
- Addressing stigma
- The story of a T-shirt (wearing a shirt saying “I had an abortion” to evoke discussions)
- Closing discussion on unwanted pregnancy and abortion

Methods included role play, group discussions, question-and-answer segments, viewing of photos (e.g., of objects used in unsafe abortions) and demonstrations (e.g., of an MVA instrument). The ICW project leaders were able to participate in some sessions, while others were carried out by local ICW facilitators.

2. **Gather information regarding experiences of HIV-positive women with abortion that could be used in advocacy with civil society, legislators and the media to promote the reproductive rights of women living with HIV/AIDS.**

During the discussion meetings, women were invited to relate stories about women (themselves, friends or relatives) who had experience with an unwanted pregnancy and abortion. The facilitators explained that these stories were a way to give a “voice” to women who have terminated a pregnancy secretly because access to safe, legal abortion has not been available in Malawi. This activity was meant to show that these are common experiences, thereby contributing to destigmatization among the participants, and to collect the testimonies for inclusion in a booklet that could be used as an advocacy tool with policymakers. In addition, women were invited to speak with ICW facilitators privately if they wished to share a story that could be included in the booklet.

3. **Establish closer links with organizations and groups that are willing to advocate and support work on sexual and reproductive rights in Malawi.**

The original plan for the project was that ICW would organize a meeting to “launch” the booklet of stories to which policymakers and civil-society organizations would be invited. We felt that this would be a means to initiate and/or strengthen ICW Malawi’s connections and relationships with other people and groups who can advocate for sexual and reproductive rights in the country.
2. Context for the project

2.1. HIV situation in Malawi
In 2009, Malawi’s HIV epidemic was classified as generalized, with an adult national HIV prevalence (15-49 years) of 12.1 percent overall, and 12.6 percent in pregnant women. A majority of transmissions were attributed to unprotected heterosexual intercourse. An estimated 930,000 people were living with HIV in Malawi, 60 percent of them women and girls (UNAIDS 2008).

The HIV epidemic in Malawi affects women and girls differently compared to men and boys, because women and girls have higher prevalence rates and are more likely burdened than their male counterparts due to their primary role as caregivers to the sick. According to the Malawi HIV Situation Analysis (UNAIDS 2008), women who no longer had steady partners (widowed and divorced or separated) had significantly higher rates of infection (37 percent and 26 percent, respectively) than women who had never been in a stable union (5 percent) or were currently in a union (13 percent).

2.2. Gender dynamics
As many as 64 percent of women in rural areas of Malawi are illiterate and only 58 percent of girls reach grade eight of school, many of them leaving school due to teenage pregnancy and forced marriage (Ratsma and Malongo 2009).

Gender dynamics in Malawian society confer major decisionmaking powers on men. Sexual matters are paramount among these. In addition, inequality and stigma are major barriers to women’s health and livelihood. Overall, condom use is low and some women’s and girls’ male partners prevent them from using contraceptives, as evidenced by the following remarks made during a study of perinatal transmission prevention programs (Chinkonde et al. 2009):

“Even when I tell my husband about HIV risks, he does not listen to me. As you know, men do not listen to what women say. If my husband had agreed to use condoms, maybe I would be protected, but as things are, it is difficult.”

“My husband refuses condoms. He says he is already dead. I may be against having unprotected sex, but as a woman, this does not carry any weight.”

These socio-demographic issues intersect with stigma and discrimination against those living with HIV/AIDS, especially for women and girls. Women and girls who reveal their HIV-positive status often risk abandonment by their partners and families. In addition, when a husband dies from HIV-related diseases, the wife is normally blamed for having infected the husband, which can lead to further stigma and discrimination.

Gender-based violence exacerbates women and girls’ susceptibility to contracting HIV and STIs and having unwanted pregnancies, challenges that could be addressed through information, efforts to influence policymaking and capacity development of relevant grassroots structures. As a government representative stated in October 2008: “Gender-based violence is a persistent problem for women and girls in Malawi. It reinforces
subordination of women and further promotes sexual abuse which leads to injury, HIV infection and unwanted pregnancies” (Makhumula 2008). Surprisingly, 46 percent of Malawian women perceive gender-based violence to be normal and acceptable. This is worrying because of its implications for women’s health, their ability and willingness to access services and their vulnerability to HIV infection.

2.3. Sexual and reproductive rights and abortion

In Malawi, instances of child dumping (abandonment of newborns and infants) and unsafe abortion are increasing, according to the Family Planning Research Centre of Malawi (Gama 2008). Their study, carried out in four districts, indicated that unsafe abortions are responsible for 16-40 percent of admissions to public hospital gynecology wards for school-aged girls.

"Most abortions in Malawi are not safe, leading to complications such as hemorrhage, infection, infertility and death,’ said Gama. Overdosing on drugs such as quinine, drinking powdered soaps and using herbs from traditional healers were cited as the most common methods of illegal abortion in Malawi.’” (Davis 2008).

In August 2010, Health Minister David Mphande confirmed this problem, stating: “It is obvious that we cannot achieve our MDG 5 target of 155 [maternal deaths] per 100,000 if abortion deaths alone are responsible for 200 deaths per 100,000 live births on our current maternal mortality rate of 807 per 100,000” (Ligomeka 2010). This indicates that women and girls are not always able to exercise their reproductive rights, such as their rights to health (being able to access and use modern contraceptives, freedom from domestic and sexual violence) and the right to decide the number and spacing of their children (e.g. being able to negotiate the circumstances of protected sex, having access to family planning information, emergency contraception and safe, legal abortion).

Modern contraceptive use rates in Malawi are 22.4 percent for all women and 17 percent for adolescents 15-19 years old, with 68 percent of girls having begun childbearing by the age of 19. However, it is common knowledge that many women, including young women, terminate unwanted pregnancies. Girls and women in Malawi, including those living with HIV, have limited options for deciding how to deal with unintended and unwanted pregnancies. A lack of access to emergency contraception means that they either must carry the pregnancy to term, which may place them in very difficult and challenging life circumstances, try to obtain a safe abortion (which may involve great expense) or have an unsafe abortion. One health-care worker interviewed in a 2009 study reported meeting an HIV-positive woman during her seventh unplanned pregnancy; the health-care provider remarked that neither the woman nor her seven children are alive today (Stefiszyn 2009).

Malawi has ratified several international human rights treaties; UN Committees that monitor State compliance with the treaties have recommended revision of the country’s abortion law. In 2010, the CEDAW Committee recommended: “that the State party review the laws relating to abortion with a view to removing the punitive provisions imposed on women who undergo an abortion, providing them with access to quality services for the management of
complications arising from unsafe abortion and reducing maternal mortality rates, in accordance with the Committee's general recommendation No. 24.” In 2009, the Committee on the Rights of the Child had already expressed its concern to the government, saying: “The Committee notes with appreciation the improvements made in the area of adolescent reproductive health and voluntary counselling and testing for HIV/AIDS. However, the Committee notes with concern the high levels of early pregnancy in the State party and unsafe abortions and STIs.”

Malawi has also ratified the Protocol on the Rights of Women for the African Charter on Human and People’s Rights in 2005, which states that women should have access to safe legal abortion. However, current legislation only permits abortion in order to save a woman’s life; other abortions are punishable by up to 14 years of imprisonment. In November 1997, the government developed a plan to follow up on recommendations from the Beijing Platform for Action, which included a call to: “review and repeal the abortion laws to provide women their reproductive health rights” (Jamieson 2009). The Executive Director of the Malawi Human Rights Commission (MHRC), Dr. Aubrey Mvula, has stated: “This is part of addressing reproductive and sexual health rights of all Malawians. This is important, because there is overwhelming evidence of dangerous termination of pregnancies among women and girl children of Malawi” (Semu-Banda 2009).

The government has now worked with the World Health Organization (WHO) and Ipas to conduct a situation assessment of maternal morbidity and mortality related to unsafe abortion in the country (Reproductive Health Unit 2009). The preliminary report, issued in June 2009, stated that Malawi’s maternal mortality ratio had scarcely declined since the early 1990s, with 807 women dying per 100,000 live births. As many as 24 percent of the deaths were due to unsafe abortions: an average of three to four deaths per day. The final report from the strategic assessment was disseminated in August 2010 to government and civil society representatives to discuss the implications for government policy.
3. Project outcomes

3.1. Challenges and implementation details
Logistically, a few problems arose during the project. Meetings at one venue had to be postponed because of a lack of equipment, so the project began later than envisioned, resulting in the combination of the March-April meetings. Some costs were higher than originally budgeted, and Ipas took on some tasks originally assigned to ICW Malawi. In addition, some of the session evaluation forms were completed in Chichewa by the women and ICW Malawi did not have the time and resources to provide translations; those comments could not be incorporated into the final report. In addition, some feedback forms did not include key information (number of participants, age range).

The project officially began on 11 April 2009 with a planning meeting for 17 ICW members who were to act as facilitators for the community meetings. Most of the women felt that this was an important project to participate in because of the high numbers of unwanted pregnancies in their country. One participant, for example, shared the ordeal of her teenage niece who inserted sticks into her cervix and ended up injuring her reproductive organs.

Together, they agreed on a set of guiding principles to facilitate the community meetings:

- Use familiar and non-technical language
- Be mindful in dressing appropriately
- Do not criticize someone in front of participants
- Identify each other's talents
- Share responsibilities

3.2. Community-based awareness-raising and education
The communities for the project were chosen during a one-day planning session with ICW members in Lilongwe and included: Lilongwe (with one meeting being held in Dowa, 50 km from Lilongwe), Mzuzu and Blantyre.

In March 2009, ICW invited 15 to 20 HIV-positive women in each community to an introductory meeting which described the project and explained the topic of sexual and reproductive rights. From April to June 2009, meetings were held with the women where information was given and discussions were held about contraception, pregnancy, abortion, and sexual and reproductive rights (Appendix 1).

The age range and number of participants varied at the meetings:

- Mzuzu: 15 women aged 25-47 years at the first meeting; 15 women and 1 man, aged 23-60 years, at the second meeting
- Blantyre: 16 women aged 20-35 years at the first meeting
- Lilongwe: 24 women at the first meeting

The duration of the meetings varied considerably. In Mzuzu, for example, the meetings were only about two and a half hours long, while in Blantyre and Lilongwe meetings took a whole day (eight and seven hours, respectively). Guest facilitators were invited to some sessions,
such as Ms. Orace Valani of Banja la Mtsogolo (a family planning association) and Dr. Fannie Kachale, Deputy Director of the Reproductive Health Unit of the Ministry of Health. During two of the sessions, participants who were nurses participated in some of the facilitation.

During the discussions, women in the different communities shared ideas about what they could do personally to resolve problems that contribute to gender inequalities and situations that lead to unwanted pregnancies. The following table gives some examples.

<table>
<thead>
<tr>
<th>Exercise/activity/topic</th>
<th>Women's comments/suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decisionmaking about pregnancy</td>
<td>▪ Know your HIV status before becoming pregnant in order to use appropriate procedures.</td>
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<td></td>
<td>▪ Be financially able to support the intended pregnancy; plan to have a reasonable number of children considering your financial situation.</td>
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<td>▪ Be sure to immunize your children.</td>
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<td>▪ The PMTCT program is encouraging HIV-positive women to become pregnant.</td>
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<td></td>
<td>▪ What happened in the role plays is exactly what happens in our communities because of different cultures; women/men in most families are not friendly with their children because they feel it’s a taboo to talk about sex education with the young girls and boys.</td>
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<td>Man-to-man letter (a letter directed toward men to encourage gender equality and eliminate violence against women)</td>
<td>▪ Discourage the use of drugs.</td>
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<td>▪ Respect one another, institute mutual caring and consent.</td>
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<td>▪ Be open with your partner.</td>
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<td>▪ People seldom lie about abuse but seldom talk about it.</td>
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<td>▪ We had no men in the group but we knew that most of them feel it would be difficult to live up to the ideals expressed in the letter because of peer pressure in the communities and because they think they are superior to women.</td>
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<td>▪ “There are men out there who just want to satisfy their needs when it comes to sleeping with their wives even if their wives are not ready.”</td>
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<td>Problem tree on unwanted pregnancies</td>
<td>▪ Women and girls develop stress and there is poor personal care.</td>
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<td>▪ Girls are abandoned by their parents and the father of the child.</td>
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<td>▪ Some die from unsafe abortions so safe abortion is needed.</td>
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<td>▪ Recommended age for childbearing was said to be 20-35 years.</td>
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<td>▪ This is happening in our community because of the culture that says you cannot be free with your daughter to talk about these sexual issues.</td>
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<td>▪ Women and girls drink surf [detergent] and quinine to abort. Other people go to […] to abort and are charged a fee of K3000. But the pregnancy has to be 12 weeks or less, otherwise they refuse.</td>
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<tr>
<td>Exercise/activity/topic</td>
<td>Women's comments/suggestions</td>
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<td>▪ There is a need to legalize safe abortion in this country so that girls/mothers can freely ask for these services.</td>
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<td>▪ A woman shared a story about her grand-daughter who is lame because her hip bone was destroyed when she gave birth at 13 years old.</td>
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<td>Ideas and facts about contraception</td>
<td>▪ Young girls and boys want to prove their maturity.</td>
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<td></td>
<td>▪ If a condom breaks or there is rape, women should go to the hospital for emergency contraception.</td>
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<td>What would you do?</td>
<td>▪ You may have to beg your relatives for money to remove your pregnancy.</td>
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<td></td>
<td>▪ Approach the traditional birth attendant and exchange chickens for an abortion.</td>
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<td>Coping with teenage pregnancy (having an abortion, raising the child as a single mother, giving the child to family, giving the child up for adoption or to an orphanage, raising the child as a couple)</td>
<td>▪ One participant talked about looking after her baby as a single mother. She said she had a lot of problems with her parents, and that the father of the child was not giving her any help. Now she wants to go back to school but her parents refuse to pay for her school fees. She is looking for well-wishers to help her go back to school.</td>
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<td>▪ It was noted that women who are very desperate not to have a baby... or who do not terminate the pregnancy might end up baby dumping or committing suicide like the stories which we see in local newspapers.</td>
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<td>▪ We need to think carefully about advantages and disadvantages of these choices from the point of view of our own lives, health, values and that of the baby.</td>
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<td>Putting abortion in context</td>
<td>▪ People have different reasons for why they choose to have an abortion; let’s not have negative attitudes toward the people that choose to have an abortion.</td>
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<td>▪ It was noted that it’s not always that someone opts for abortion; sometimes it’s a miscarriage that occurs between 26-28 weeks.</td>
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<td>▪ Though we have negative reactions to some women’s reasons for choosing abortion, we should not judge them because we are not in their circumstances; we may not have all the relevant information and must respect their right to make their own decisions; we cannot impose our beliefs on them and, lastly, it is God’s role to judge and not human beings.</td>
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<td>Should we let them die?</td>
<td>▪ It’s better to have an abortion with a trained person to prevent complications and unnecessary deaths.</td>
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<td>▪ If you want to terminate the pregnancy, it’s better if it’s done before 12 weeks, not after 12 weeks.</td>
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<td>▪ It would be a good idea to show this to policymakers in Malawi; maybe it can help change their attitudes towards abortions.</td>
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<td>What would you do?</td>
<td>▪ All the small groups agreed that the person who should be told about the pregnancy is the one who has given you the pregnancy; from there it’s where you look for solutions and all agreed that it’s better to have a safe abortion.</td>
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</table>
| Safe abortion: facts or fiction? | ▪ All agreed that they didn't know that there is a law that
<table>
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<tr>
<th>Exercise/activity/topic</th>
<th>Women’s comments/suggestions</th>
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<td>allows abortion to save a woman’s life.</td>
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<td></td>
<td>- All agreed that abortion should be legalized in Malawi so that every woman can access it freely.</td>
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<td></td>
<td>- At one session, we saw the MVA instrument and the cannula; it gave us a positive attitude that a baby cannot fit, though many activists say abortion is killing full-grown babies.</td>
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<td>Who does my body belong to?</td>
<td>- It is different for women following the death of a spouse; men stay [alone] for a short period and remarry, while women can stay [alone] longer.</td>
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<td>- Come rain, come sunshine, I can be in a position to say NO or use female condoms.</td>
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<td>- A woman is able to control her feelings, whereby most men cannot hold themselves as we do. It is important for women to own themselves because they are the ones who experience a lot of challenges in the communities as mothers, people living with HIV/AIDS, as caregivers and as wives.</td>
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<td></td>
<td>- They also felt that owning and controlling oneself is important as we have only one life so it is important to look after our health. It goes with a saying in our local language meaning “you cannot give your life to someone to keep or look after it.”</td>
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<td></td>
<td>- In most cases, some women would agree to have sex even if they don’t want to because they want to keep the marriage/cultural norms and faithfulness.</td>
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<tr>
<td>Addressing stigma</td>
<td>- To solve the problem of stigma we need to place God first to guide us, in order to love one another.</td>
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<td></td>
<td>- [With] abortion you can be laughed at for a short period, while HIV/AIDS is a life-long thing and you are laughed at for a long period.</td>
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<td></td>
<td>- Avoid stigma because WE are affected directly or indirectly.</td>
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<td></td>
<td>- It's not easy to reduce stigma attached to HIV/AIDS because it is associated with a lot of myths and misconceptions. The stigma attached to abortion doesn’t matter so much; people can talk about it and forget.</td>
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<td>The story of a T-shirt</td>
<td>- She was a voice for the voiceless in order to legalize abortion.</td>
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<td>(about a girl in Brazil who wore a T-shirt for one day saying “I had an abortion”)</td>
<td>- In Malawi, abortion is committing sin; we can talk openly due to the effects of abortion.</td>
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<td></td>
<td>- Malawians would react negatively because they think abortion is killing. They consider the abortion issue as taboo and they will think you are mad and a big sinner.</td>
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<td>- The women felt they would do a similar action to wearing such a T-shirt but with words such as “Is baby dumping good?” so as not to directly address the heavy topic of abortion.</td>
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<td>- We thought we would be willing to wear a different T-shirt with “I was fired because I told my boss to keep his hands off me” or “I was raped and am living as a...”</td>
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</table>
In many of the sessions, women said that abortion should be legalized to prevent death and injuries from unsafe abortion.

Overall, the women said they benefited greatly from the sessions, in particular that they learned about new reproductive resources with which they were unfamiliar (emergency contraception, manual vacuum aspiration [MVA]). Their verbal comments and responses on evaluation forms indicated that the sessions had indeed helped make the topics of unwanted pregnancy and abortion easier to discuss (Appendix).

Issues that the women felt were particularly important included:

- Development and distribution of more materials on contraception.
- Education and sensitization of community members, especially young girls and boys, about emergency contraception so that unwanted pregnancies can be prevented more often.
- Increasing the number of women receiving information and education about the differences between unsafe abortion and safe abortion care.
- A need to provide sexuality education to young people, both in and outside schools. Parents often find this difficult but it is something that is sorely needed so they must learn to discuss such topics with their children.
- “If this [abortion] will be legalized, then women/girls will not look for traditional methods which are commonly used. As a result, we will avoid the unnecessary deaths.”
- “Child dumping could be avoided if women have early pregnancy termination and if the law permits women to do so under some circumstances. These circumstances could be: to protect her physical health; to protect her mental health in cases of rape and incest; socioeconomic reasons if a woman has already several others and cannot afford another child; if she is living in a situation of ongoing violence; if the pregnant girl is not yet mature and able to raise a child.”
- Holding more community dialogues/education sessions, including in schools, on topics like safer sex, pregnancy, contraception and abortion so that women become more
knowledgeable and are better able to contribute to community discussions, advocacy and policymaking regarding reproductive health.

- Ensuring that hospitals have a client-friendly atmosphere so that girls and women feel comfortable asking for reproductive health services.

### 3.3. Collection of information on abortion-related experiences

During each community session, women were invited to share information about abortion cases they knew, either during the group meetings or in private interviews. Women also brought up examples of cases they had heard during group discussions. For example, when discussing unwanted pregnancies in Mzuzu, they spoke about unwanted babies being killed or dumped in their own town; at various meetings, women also described abortion cases with which they were familiar (although these were not recorded).

In one region, the women’s personal stories were discussed in the group but not recorded because the facilitators could not stay long enough to transcribe the testimonies. However, several testimonies were given in other regions. Ultimately, the booklet included 11 stories about abortion and three stories about women who had unintended pregnancies and carried them to term.

The facilitators were able to purchase a tape-recorder and tapes, but this was only used for one session; notes on the discussions and stories were usually recorded manually. Marie Khudzani Banda edited the stories, sometimes after speaking with the women involved; Maria de Bruyn prepared the final booklet. The budget proved insufficient to cover editing and printing or photocopying of the booklet, so Ipas took on dissemination of the publication for ICW.

Copies were shipped to Malawi and some were shared with the ICW facilitators in the communities so they could in turn share the booklets with local women. ICW did not organize a launch meeting as representatives of other NGOs recommended that they first be registered as an official NGO in order to have more official standing vis-à-vis other partner organizations. Unfortunately, the ICW members did not receive much support from international ICW offices to register the group as an NGO, so Ms. Banda, as ICW Malawi coordinator, liaised with an NGO known as Group Ideas for Community Development.
ICW Malawi and GICOD are in the process of registering together as a group so that they can work collaboratively on HIV/AIDS as it affects women and girls, as well as other issues that affect women. In the future, ICW Malawi members and GICOD can seek funds together to carry out activities.

Ultimately, copies of the booklet were disseminated to stakeholders at a meeting in August 2010 organized by the Ministry of Health to present initial results of the strategic assessment conducted with WHO.

3.4. Collaboration to build ICW Malawi’s advocacy network

ICW initiated more intensive contacts with colleague organizations by inviting guest speakers/facilitators to the April and June meetings. In April 2010, collaboration was sought with Banja la Mtsogolo, a Marie Stopes International affiliate, and with the Family Planning Association of Malawi. In June 2010, a representative of the Reproductive Health Unit of the Ministry of Health was invited to a session that focused on abortion-related issues.

At the time of the project, Ipas was working with the World Health Organization and the Malawi Ministry of Health to carry out a strategic assessment of abortion and abortion-related services in the country. Part of this work involved holding capacity-building workshops with members of civil society organizations and the formation of a coalition to advocate for reproductive rights. ICW was invited to send participants to these workshops and meetings, thereby strengthening their visibility and recognition as a sexual and reproductive rights advocacy organization. Members of ICW Malawi have also joined the newly-formed Coalition for the Prevention of Unsafe Abortion.

Ms. Banda participated in a panel at the 2010 UN Commission on the Status of Women, co-sponsored by Ipas, the Government of The Netherlands and IPPF. She highlighted the outcomes of the project and the recommendations made by the community members. This led to contacts with other representatives of the Malawian government, who commended her on the work being done in this regard by ICW.

Other ICW members have since been invited to regional meetings on issues such as cervical cancer care and the group has been invited to join a new network, the Southern and Eastern Africa Positive Women Human Rights Network. Ms. Kamwana spoke about the project for participants at the 2010 UN High-level Plenary Meeting on the Millennium Development Goals (MDG Summit) and other interested parties in September 2010.

Photo: Maria de Bruyn
Ipas shared information about the project during the first panel to address HIV and abortion at an International AIDS Conference in 2010 in Vienna, Austria, and will also be submitting articles on this work to journals.

4. Concluding observations
With only a limited budget and considerable volunteer time, ICW Malawi carried out a successful project that contributed to the empowerment and reproductive rights knowledge of women living with HIV in Malawi. The enthusiastic response of the community meeting participants and their numerous comments testifying to positive changes in attitude towards women who terminate an unwanted pregnancy provided further evidence that abortion and HIV were somewhat destigmatized.

Policymakers at the national and international levels are often reluctant to address the issue of unsafe abortion and the need for legal reform to enable women to terminate pregnancies safely. Indeed, while representatives of UN agencies and international NGOs call for law reform with regard to criminalization of people living with HIV, sex work, substance use and different sexual orientations, they continue to refer to “abortion where legal.” This project showed that women at the community level, who are directly affected by gender inequality, unwanted pregnancy and unsafe abortion, are much more willing to examine and discuss the issues, particularly when they are provided with a “safe space” where they can share their own experiences.

Although ICW did not disseminate the booklet with stories within the envisioned time frame, the project did open up venues for them to liaise with a greater number of national and international partners. We hope that the group’s upcoming official registration will enable them to continue their educational and advocacy work on reproductive health and rights for women living with HIV in Malawi.
Appendix: Comments from meeting evaluation forms

In many cases, participants in the meetings made similar comments, so the repetitions have been eliminated.

1. What part of today’s meeting did you find most interesting and why?
   - Making decisions about pregnancy because I have learnt experiences of others. It was educative and I have learnt to be friendly to my own children.
   - Making decisions about pregnancy because we have learnt to be closer to our children.
   - Early signs of pregnancies and safe abortion because we can use them to sensitize and educate our young girls and boys.
   - Recognizing pregnancy because it is telling us what happened when someone have lengthy labor, e.g. which results in fistula
   - Problem tree was found interesting because it has enlightened the consequences of unwanted pregnancy and what to do that the situations can be reduced
   - Problem tree analysis – it teaches us to tell our children how they can prevent unwanted pregnancy
   - Problem tree – it’s very educative to our children. It tackles us to be close to our children
   - Ideas and facts about sex and contraception, because I have learnt more about unwanted sex and their consequences.
   - Safe and unsafe abortion; learned the advantages and disadvantages of this. (Very many participants mentioned this.)
   - Unsafe abortion because people should not die where there is a way to save their lives
   - Safe abortion discussions and the sharing of experiences
   - Safe abortion leads to no sepsis or no complications
   - Having safe abortion because it saves the life of a woman
   - Safe abortion was interesting; if safe abortion can be legalized and practiced, it will reduce risks of several complications.
   - Should we late them die? This is because many women are still behind, so it’s me today to give them orientations.
   - Stories by different people and their experiences.
   - Guest speaker’s presentation was done in a lay man’s language, it wasn’t rushed. Participation was great!
   - The story of a T-shirt. The girl spoke for the voiceless. (Numerous participants liked this.)
   - Who does my body belong to? Because I have the authority over my own body. (Numerous participants liked this.)
   - Why does my body belong to? It taught me that I can control it the way I like.
   - You have to take pregnancy by choice not by force.
• The most interesting was apart of stigma because patient comes for a help but a nurse and doctor ignore to assist a patient.
• Addressing stigma because in most places people with HIV/AIDS are being stigmatized.
• Addressing abortion because it is better for the government to legalize safe abortion in order to reduce maternal death.
• Topic of laws of Malawi because most women did not know that abortion is illegal in some circumstances.

2. **What part of today's meeting did you find least interesting and why?**
• All parts were interesting. (Many participants)
• Discussing “man to man letter” because our group had no male participants. (Several participants commented on this)
• Sex and contraceptives – most of us are not sexually active, hence we do not need the contraceptives.
• Unsafe abortion and safe abortion.
• Coping with pregnancy. (Several participants mentioned this)
• The unwanted pregnancy because in most cases the pregnancy should be by choice not by chance.

3. **If you were to tell a friend or neighbor about one useful piece of information or skill that you learned today, what would it be?**
• By using the sample [problem] tree, the badness of unwanted pregnancies. (Several participants mentioned this.)
• The best way is to use a sample tree for easy explanation about the causes and consequences of unwanted pregnancy.
• It is good to have safe abortion because it is good for our health.
• I would tell the friend/neighbor to be open and discuss freely with our adolescent kids to avoid unwanted pregnancy.
• I would tell them about EC.
• The skill of how to use condom and the hours when emergency contraception should be taken.
• The dangers of unsafe abortion.
• How to avoid unwanted pregnancies.
• It would be signs of pregnancy.
• I would advice a friend the use of MVA.
• It is a procedure done at the hospital is known as manual vacuum aspiration done by a trained physician.
• If a person wants to abort, it’s good to follow safe abortion, seeking medical personal, especially when below 12 weeks to use MVA instrument.
• I would tell my friend that it is good to have safe abortion.
• Safe abortion done in a hospital is a very simple procedure using an MVA.
• We have to control our bodies.
• We all have responsibility to fight stigma.
• I could tell him/her that everyone has the responsibility to fight stigma and discrimination.
• To start advocating for the legalizing of safe abortion.
• I would have to tell her or him everything what I have learnt.
• I should tell my neighbor if she wants to be pregnant she go for a test to know her status.

4. Did you change your thinking in any way because of the discussion today?
• Yes, because I’ll start loving my children and be open to them.
• Yes, because we have made the decision to have safe abortion.
• Yes. It’s not good to have unsafe abortion because it can lead to death.
• Have changed my mind because of the helpful things learnt.
• Yes, I have changed because I was of the people who was unable to discuss issues with my kids.
• No (three participants)
• Yes, I have changed my thinking because I have discovered so many things, like we should be close with our children at home.
• Yes, it made me have the feeling of helping the girls at home the early signs of pregnancy.
• Yes, because it is good to have an abortion which is safe.
• Yes, because I was thinking that once I became pregnant, the best way is just to commit suicide but with the knowledge gained, I have really changed.
• Yes, because I want my children to disclose their problems to me.
• No, there was no need.
• Yes, because we have enlightened some other issues which [we] didn’t know and [it] will also help to teach relatives and neighbors.
• Yes, as a woman and a mother.
• I have a changed mind set.
• Yes, we have known disadvantages of unsafe abortion and advantages of safe abortion, more especially below 12 weeks where MVA is used.
• Yes, we have known disadvantages of unsafe abortion and advantages of safe abortion.
• I have now changed my mind because I have learnt a lot.
• Yes, because I have full knowledge of safe abortion and should we let them die also (it was so good).
• Yes, at first I was feeling somehow but after discussion I was so happy to see people giving testimonies.
• Yes, I have completely changed my thinking capacity over those that go for abortions.
• Yes, some of the items discussed have touched and changed me.
• No, it was a good meeting.
• Yes, I have gained skills on safe abortion.
• Yes, because my mindset has changed concerning safe abortion
• Initially I though abortion was dangerous and unsafe but have realized that there’s safe abortion done by medical practitioners.
• Yes, there were some demonstrations.
• I was thinking that abortion was dangerous and evil and am now fully equipped to tell people how safe it is.
• Yes, because in the past I thought it was difficult to come out in the open and discuss something that concerns my life.
• Yes, because I have learned how to own my body.
• Yes, because I have learned why it is important to legalize safe abortion.
• Yes, because men always think that they are the controller of everything.
• Yes, we should support safe abortion.
• Yes, I have learned a lot and I will help others if they happen to be pregnant when they do not want it, so that they go for safe abortion.
• Yes, we encouraged each other on how to fight stigma and discrimination
• Yes, I have changed because I have learnt some lessons which I didn’t have in my mind.
• Yes, I have noticed that I have to take care of my body.
• Yes, because I know that my body belongs to me.
• To be able to make a decision.
• Yes. Women who were doing abortion we were stigmatizing them. But now we will not do it again.
References


