Invited Viewpoint

# Reversal of Roe VS Wade – Implications on Women's Health in Malawi

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The United States Supreme Court in on 24th June, 2022 reversed the Abortion Law enacted in 1973 which made safe abortion available to women in that country. It now depends on the individual States to decide which way to go. Almost immediately, 22 of the 50 States reversed the law and outlawed abortion. The argument for the reversal is largely religious describing abortion as egregiously wrong. This has huge implications on many low and middle-income countries (LMIC) such as Malawi which depend on American aid to develop their Safe Motherhood programs. To understand the issue, we need to first understand why, in the first place, abortion was legalised in the United States of America in 1973. In the 50 States of America at that time 40-50% of the maternal deaths were due to complications of abortion outside the medical system. For this reason it was permitted by law to introduce safe abortion to save women's lives.

## Impacts on women's health in Malawi

As a graduate student in Obstetrics and Gynaecology, I spent a year at the US Federal Center for Disease Control and Prevention (CDC) in Atlanta-Georgia in 1980/81 operating from the Center's Abortion Surveillance Branch which was monitoring abortion mortality nationwide. At that time America had a population of about 200 million people and their women were procuring 2 million abortions[1] each year. This resulted in 0-3 abortion deaths each year; as a percent of the 2 million abortions this is practically zero deaths from abortion complications. In contrast in Malawi, out of 141,000 abortions each year, based on the last study in 2015[2], there resulted 500 deaths each year based on the fact that one in 5 of the 2,500 maternal deaths each year were due to complications of abortion. The reason why women in America did not die from abortion is that practically all the abortions in that country were procured in the medical care system while those in Malawi are procured outside the medical care system.

Malawi allows abortion only where there is evidence that the continuation of the pregnancy threatens the woman's life. The rationale for this is that the condition that threatens the woman's life also threatens the life of the unborn child. If the woman dies so does the baby; on the other hand if the pregnancy is terminated, only the baby dies, the woman survives. This is not to say there was a deliberate attempt to the unborn baby's right to life but that that the baby's survival was not guaranteed if the pregnancy continued. The majority of the 500 women who die from complications of unsafe abortion in Malawi are those who carry pregnancies with no known threat to their lives and therefore did not qualify for the safe abortion in the health care system under Malawi's law.

Globally nations have agreed to eliminate deaths due to pregnancy and childbirth; towards achieving this goal, no country is to have a maternal death ratio of more than 70 pregnancy-related deaths for every 100,000 livebirths by the year 2030. The dilemma for Malawi is that of its 439 maternal deaths per 100,000 livebirths abortion alone currently accounts for 80 of the deaths[3]. This means that unless the currently abortion law extends the exceptions to allow more women to qualify for safe abortion; Malawi will not attain the SDG 3 goal. Although Malawi is a sovereign State it will risk reducing its funding for Safe Motherhood directly and indirectly; directly because USAID (United States Agency for International Development) will likely cut off any funds it provides to the country. This may be indirectly, because USAID has in the past cut off funding to UNFPA because the latter financed family planning programs in countries which provided abortion services, such as China. Withdrawal of USAID funding and reduced funding from other development partners such as UNFPA will strangle the already underfunded Malawi National Safe Motherhood program.

## Ethical considerations

Since the 5th century, upon graduation from medical school, and before practicing medicine independent of their teachers, doctors /were required to take an ethics oath. Authored in 400 BC this Hippocratic Oath is one of the oldest binding documents in history. It has been modified over the years to "First do no harm" to the sick, but the text of the original oath is revealing.

Among the things the doctors had to swear in the original oath is the following: "*I swear by Apollo the Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgment this oath and this covenant: ..... I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art. .....*[4]".

There are two messages here, the first is that at that time, even when performed by doctors, abortion was fatal and the medical profession could not allow doctors to kill women through abortion; doctors were there to save lives irrespective of their religious affiliations. This ban however did not stop women procuring abortion outside the health care service and abortion deaths continued to mount. The second message is that 400 years before Christ came to this world abortion was already a public health issue that needed to be addressed. For this reason when the abortion procedures were made safer doctors were once again allowed to save women's lives through induced abortion.

## To what extent should abortion be liberalised?

The United States Supreme Court ruling raises the question as to what extent should abortion be liberalised? This



https://dx.doi.org/10.4314/mmj.v34i2.14

depends on whether the objective of the nation is to reduce abortion deaths or eliminate abortion deaths altogether. The rationale for supplementing family planning with a less restrictive abortion law is to eliminate abortion deaths. The practice in Malawi is that when women present for prenatal care following a previous pregnancy, a series of questions including the following are asked: How many times have you been pregnant and how many children do you have? If the response reveals that there are fewer children than the number of children the doctor will want to ensure that he was not dealing with a woman who had miscarriages, stillbirths or early infant deaths which should be prevented in the current pregnancy. The next question therefore is what happened to the other pregnancies? In the private hospital I worked, it was not uncommon for women to respond that those extra pregnancies were terminated. The doctor now wants to know whether or not the woman underwent a safe procedure and that there are no complications such as cervical incompetence so the next question is about how the pregnancy was terminated. The response may be that she procured the abortion at such and such a clinic. Knowing that the law permits termination of pregnancy only when the pregnancy threatened the woman's life, the doctor will want to know whether he was dealing with a woman with some serious medical problem that s/he needs to address so the next question is to geared to know the reason given for the termination of her pregnancy. It's not common to be told that she just told the clinicians that she did not want the pregnancy.

In our studies therefore we found that women in the rural Malawi believe that abortion on demand is legal in Malawi, but only for the rich. When discussing abortion deaths with them their observation was *"This problem is just for us the poor, the rich are sorted out by their money."*[5] One of the arguments for advocating for the liberalisation of the abortion law is to bring equity for the right to life between the rich and the poor.

## Social implications

Abortion has both health and social implications to women in Malawi. Working at Queen Elizabeth Central Hospital in Blantyre, I received a very sick woman from a Lower Shire hospital. When her labour commenced, she went to the nearest midwife in her community – the Traditional Birth Attendant (TBA). She laboured there for two days but the baby did not come out. After many internal examinations to assess the opening of the mouth of the womb and descent of the baby, the TBA manipulated the womb repeatedly in an attempt to put the baby in a plane that would encourage descent without success. By the time the TBA referred the mother to the hospital, the womb had been twisted on itself 180 degrees, thereby obstructing its blood supply. This process killed the unborn child and the womb also due to lack of blood supply. Meanwhile infection due to the inadequate sterility during the internal examinations ascended into her womb which then became gangrenous. The solution was to remove the womb which was now the nidus of infection to all her body and was in septic shock when she arrived at my hospital.

After the surgery she was admitted in the Intensive Care Unit where she remained unconscious for three days. All this time her dutiful husband was by her bedside. When she came round I heard her ask her husband the question – "*Now that I have lost my womb, you will leave me won't you?*" The response of the husband was "*Yes I will, but we shall discuss this at home not here in the hospital".* This sums up the plight of the woman who loses her womb in Malawi; she loses her right to marriage also as is the custom.

Unsafe abortion is also a common cause of loss wombs; here is the supporting evidence. A woman with three children from a district in Central Region had unwanted pregnancy and she and her husband decided to seek an abortion. A neighbour told the woman that she too was in a similar situation and procured an abortion at a named clinic. The couple went to that clinic but they could not afford the fee. They together then procured an abortion from a traditional healer in her community. She suffered a complication ending in having her womb being removed at the local district hospital; soon after the husband divorced his wife because "she was no longer a woman".

For girls in Malawi, unplanned pregnancy is also the commonest cause of school dropout. In a small village North of Mangochi, the headmaster for the local primary school reported that in the 12 months of 2009, 56 girls were expelled from school due to pregnancy; some of these girls went on to procure unsafe abortions. Extrapolating this to the whole country of Malawi tells us that a lot of girls miss out on education because of unwanted pregnancy. The message is that while we know that pregnancy is common in schools in Malawi, young women have no access to contraceptive services. Compare this to The Netherlands where the age of consent to sex had been dropped to 12 years, girls there hardly experience unwanted pregnancy nor get HIV infection because the school system has provided them with knowledge on how to protect themselves and all they need for protection was made available to them. The outcome is that teenage fertility in Malawi is 131 births per 1,000 women 15-19 years old against The Netherland's 4 births per 1,000 women of the same age group. The message is that for as long as girls in Malawi are not protected from unwanted pregnancy the country will continue to develop a large pool of poor women further stunting the development of education in the country. The potential reduction of funding from the USAID would lead to a cycle of poverty and therefore diseases of poverty will be more endemic.

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