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Es el derecho de la mujer:

A Qualitative Review of Abortion Care Quality in Bogotá, Colombia

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Bachelor of Arts
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2012

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An abstract of
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Rollins School of Public Health of Emory University
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Abstract

Es el derecho de la mujer:
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By Nassira Marissa Bougrab

Background. Despite the decriminalization of abortion in Colombia, women continue to seek out abortions outside the law. The clandestine nature of these abortions has raised a serious public health concern because "illegal abortion" is often synonymous with "unsafe abortion". It is unclear why women continue to get illegal abortions years after the procedure had been decriminalized. In an effort to answer this question, a student research team from the Rollins School of Public Health at Emory University traveled to Bogotá, Colombia in the summer of 2015 to assess the quality of abortion care. Although there is a dearth of research on how quality of care standards are followed in medical practice, the literature suggests there is a need to improve the implementation of the law and the quality of abortion care.
Objectives. We conducted a qualitative study of physicians and medical school faculty to explore their experiences providing abortions or training others to provide abortions.
Methods. We conducted structured in depth interviews with nine physicians and 14 medical school faculty. We addressed these questions: 1) to explore the perceptions of doctors about the quality of abortion care currently provided; and, 2) to describe the current medical education curriculum on abortion care in medical schools.
Results. Overall, many participants agreed that the quality of legal abortion care in Bogotá is of good quality, but that there are problems with the application of the law and the structure of the health and education system. Most of these issues are present in the form of barriers to care for the patient.
Conclusions. In conjunction with the Socio Ecological Model and the Organizational Stage Theory of Change, our findings show that there is an interaction across various levels that can impact the quality of care for a patient seeking an elective abortion. These findings have implications for individual provider outcomes as well as for larger institutions of care.

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Chapter I. Introduction

Abortion in Colombia

Globally, many women die from unsafe and illegal abortion practices. Although global rates of maternal deaths from abortion have been on the decline for the past 20 years, nearly all abortions performed in Central and South America continue to be carried out in unsafe conditions (Snow, Laski, & Mutumba, 2015). This region has some of the most restrictive abortion laws and, despite what policy makers may believe, the literature shows that intensive legal restrictions on abortion do not actually lower the number of abortions or increase the number of live births that occur (Snow et al., 2015; WHO, 2014). This same literature also demonstrates that areas where abortion is a legal and easy to access procedure do not experience an increase in the number of abortions taking place (WHO, 2014). The criminalization of abortion fosters a fear of the legal and penal repercussions that could result from a woman seeking this service or a doctor providing an illegal procedure.

In 2006, however, Colombia departed from the norm and issued Decision C-355/06. With this policy the Constitutional Court decriminalized Colombia's position on abortion, thus making the procedure legal and more accessible to women. This legislation was progressive due to its focus on upholding rights on equality grounds and ruling on abortion in the context of human rights (Ruibal, 2014). The court's decision was argued based on four points of support: upholding internationally recognized human rights treatises, a balance of legal rights and values, equality, and proportionality (Amado, Calderon Garcia, Cristancho, Salas, & Hauzeur, 2010; Gisez, 1983). Colombia's constitution allocates finances to ratify and uphold international treaties on human rights, and in the case of abortion rights the court found the right to life was not an absolute. Specifically, the court found that the legal protection of the "unborn" should be

balanced by other rights and values in the constitution (Amado et al., 2010). Women's rights and gender equality are also constitutionally protected, in addition to that of the right to life. Finally, the court also upheld the principle of proportionality (or the notion that a moral judgment is a comparative evaluation of the possibilities available for choice) imposes limits on legislation regarding the criminalization of abortion (Amado et al., 2010; Gisez, 1983). This new legislation allowed for abortions to be performed under three circumstances: endangerment of the health or life of the woman, severe malformation of the fetus such that it is expected to die after birth, or pregnancies resulting from rape, incest or other non-consensual insemination (McDermott, 2006). Prior to this change it had been completely illegal under any circumstance and could result in severe penal repercussions for both the woman seeking the abortion and the physicians providing them.

Most recently, Attorney General Eduardo Montealegre proposed a bill to legalize abortion under any circumstance during the first 12 weeks of pregnancy (AAEA, 2015). In response, the Minister of Health, Alejandro Gaviria, supports the effort of fully legalizing abortion but refutes this bill as the best tool to achieve this. Gaviria claims, instead, that the most important barriers to access are "campaigns of disinformation" ("Del caso Carolina Sabino a la despenalización del aborto," 2015).

The Problem

Despite the decriminalization of abortion in Colombia, women continue to seek abortions outside the law (E. Prada, Maddow-Zimet, & Juarez, 2013). The clandestine nature of these abortions has raised a serious public health concern because "illegal abortion" is often synonymous with "unsafe abortion" (Cohen, 2009). It is unclear why women continue to get illegal abortions years after the procedure had been decriminalized. In an effort to explore this

issue further, a student research team from the Rollins School of Public Health at Emory University traveled to Bogotá, Colombia in the summer of 2014 to assess potential barriers and facilitators women experience in accessing abortion care. The arm of their study that focused on physicians who conscientiously object to providing abortions identified some areas where further research was needed; especially in regards to abortion care quality (Brack, Stanhope, Fink, & Richardson, 2014). Although there is a dearth of research on how quality of care standards are followed in medical practice, the literature suggests there is a need to improve the implementation of the law and the quality of abortion care (E. Prada et al., 2013).

Purpose and Aims

This study used qualitative methodology to explore the experiences and perspectives of doctors and medical educators on abortion care quality and training in Bogotá, Colombia. Based on the recommendations from findings of the previous student team and the literature there were two major aims: 1) to explore the perceptions of doctors about the quality of abortion care currently provided; and, 2) to describe the current medical education curriculum on abortion care in medical schools. This study also relied heavily on the guidance of in-country advisors at Fundación Oriéntame to provide the researchers with appropriate cultural context. Oriéntame has been providing quality reproductive health services to women for over 35 years with an emphasis on unwanted pregnancy (Acosta de Hart, Umana, & Villarreal, 2002). This organization has directly contributed to the reduction in maternal mortality from abortion (Acosta de Hart et al., 2002). Within the literature, Fundación Oriéntame has been shown to provide a level of abortion care that leaves the majority of women satisfied with the care they received and likely to recommend the services to a friend in the same situation (DePineres, Baum, & Grossman, 2014).

As advisors to this research team, Oriéntame provided assistance throughout the methodology and planning of the data collection.

Qualitative methods were used to interview physicians who currently perform abortions and explore their experiences, opinions, and knowledge of standards of abortion care in order to identify areas of improvement, and to make recommendations to current procedures. Additionally, this study examined the medical training and education that is currently provided through medical school curricula by interviewing relevant faculty at both public and private medical schools.

Significance

In addition to improving health outcomes, legal access to abortion also has broader economic and policy ramifications for Colombia. A study in 2013 assessed the health care costs of post abortion care complications resulting from illegal abortions (E. Prada et al., 2013). Care for post abortion complications from illegal procedures costs the health system approximately $14 million (in U.S. dollars) per annum. They also found that legal abortions performed at higher-level facilities resulted in high health care costs to the system. They concluded that these costs could be reduced through changes in procedure and policy (E. Prada et al., 2013).

The findings from this current study had implications for current health practices and identified clear areas for improvement in quality care. In looking at quality of care from the perspective of the institution and the provider, a better understanding of what is happening at these big picture levels can help identify areas for improvement in quality. In citing both the previous team's work and the extant literature to be found, this research aims to focus on the physicians that perform the abortions or have knowledge about abortion training and their

perspectives on the quality of care in Colombia. With the literature not only scarce but inconclusive, there is more to discover about the quality of care.

Terms

In this report, the term "abortion" refers to a medical procedure resulting in the intentional removal of a fetus or embryo from the uterus before the 24th gestational week. For the purposes of this study, this includes all methods of medical and surgical abortion procedures. Quality of care is defined here as the "characteristics and degrees of excellence, with standards referring to a general agreement of how things should be (to be considered of high quality)" (Mitchell, 2008). This general definition will be further outlined and explored later during the literature review.

The final concept that must be defined in more detail is "conscientious objection." Conscientious objection is defined as an allowance for someone to exempt himself or herself from an act that threatens their sense of integrity. In this case, physicians in Colombia are protected by the law and allowed to conscientiously object to providing abortion care on the grounds of their religious faith. This provision, however, is not extended to other healthcare workers, like nurses, and can create a tension among healthcare workers and result in lowered quality of abortion care provided to patients by unwilling staff (Amado et al., 2010).

Chapter II. Review of the Literature

Since the passing of the legislation that partially decriminalized abortion in Colombia (Decision C-355/06), the proportion of women seeking legal abortions remains quite low while the number of "backstreet abortions" remains high at an estimated 320,000-450,000 per year (Amado et al., 2010; Moloney, 2009). In 2011, 93,000 women presented with post-abortion care complications and only 9 per 1,000 women received post abortion contraceptive care, which is a staple of quality abortion care (Elena Prada, Singh, Remez, & Villarreal, 2011). Over a third of all abortions performed in Colombia are unsafe and result in complications from the clandestine nature of their illegal setting, such as a lack of provider training or insufficient tools and materials (Elena Prada et al., 2011). The number of women hospitalized for post abortion complications increased from 57,679 cases in 1989 to 93,336 in 2008 (E. Prada, Singh, & Villarreal, 2012).

Many physicians and pro-choice activists support broadening the criteria by which a woman is entitled to an abortion by examining socio-economic factors (Moloney, 2009). These factors could help identify avenues by which to provide access to more women who need it (Moloney, 2009). Socio-economic factors can include dimensions such as level of education, income level, and occupation (Winkleby, Jatulis, Frank, & Fortmann, 1992).

Only a third of gynecologists are in support of the law and are prepared to perform a legal abortion which can greatly impact quality of care (Moloney, 2009). Additionally, there is currently a dearth of literature on how doctors in Colombia are trained or otherwise prepared to provide abortion care services. While Fundación Oriéntame is known to provide on site training, there is little documentation about Medical Schools and their trainings (Acosta de Hart et al., 2002). The combination of this new law and physician's historic unwillingness and potential

unpreparedness to provide abortion care have created subpar abortion care that does not meet the accepted clinical standards set by the Secreteria de Salud (Department of Health) in Colombia. The following review of the literature highlights the existing research on the quality of abortion care, abortion care training, and organizational level theories that relate to understanding abortion practices in Bogotá.

Quality of Abortion Care

The World Health Organization defines "quality of care" based on six separate dimensions. Care should be effective, efficient, accessible, acceptable/patient-centered, equitable, and safe. Physicians are in a prime position to influence most if not all of these levels in the type of care they provide their patients (WHO, 2006). There is currently a paucity of research on the quality of abortion care in Colombia. For the purposes of this investigation, *high* quality healthcare is defined as procedures that are safe, legal, and follow standardized recommendations as dictated by national publications and mandates (WHO, 2014). The Ministry of Social Protection in Colombia has published several documents outlining the appropriate clinical standards for legal abortion services. These standards cover proper health care service methods for providing abortions, outlining who can conscientiously object, and underline the importance of keeping abortion services covered under basic healthcare plans (Amado et al., 2010). However, there are currently no records of whether these guidelines are being followed or if health services are being monitored. Quality of care is critical in providing women with services that are both safe and satisfactory. In Colombia, however, many women continue to experience negative outcomes when they seek out legal abortions (Brack et al., 2014).

Quality of care can be a barrier to accessing services when the care provided is suboptimal and low quality. Furthermore, a lack of quality of care can be a barrier to accessing

family planning services (Bertrand, Hardee, Magnani, & Angle, 1991). There are clear recommendations for the improvement of the patient experience of abortion care. For example, research shows that changes should focus on client-staff interaction, information provision, service accessibility, technical competence and the facility environment (Becker et al., 2011). These are all areas in which the physician, as the provider of care, can impact health outcomes.

Thus far the definition of "quality of care" in the literature has always been quite general and all encompassing. Some concrete aspects of quality of care discussed in the literature included timeliness of care, safety of the procedures, safety of the facility and overall respect for the patient. In the literature, certain clients experience longer waits to receive care. Second-trimester patients are expected to experience longer delays in each step of the abortion process when compared to their first-trimester counterparts (Baum, DePineres, & Grossman, 2015). This includes the time it takes the client to suspect she is pregnant. Financial barriers are also the most common deterrent clients face (Baum et al., 2015).

Recent studies in the literature address concerns surrounding the procedures and the environment in which the abortion would occur. In a study of the relative costs and safety of legal and illegal abortion conditions, less than 1% of legal abortion cases experienced a complication during the procedure (Rodriguez, Mendoza, Guerra-Palacio, Guzman, & Tolosa, 2015). Additionally, the growing role of misoprostol has resulted in an often incorrect usage and replaced the use of surgical abortion by doctors (E. Prada et al., 2012).

The iconic story of Monica Roa, a legal champion of abortion rights, also points towards some indicators that may be a part of the quality of care in the healthcare setting. Since 2004, Roa has been the Program Director for Women's Link Worldwide – an international organization of human rights. In 2005, Roa filed the constitutional lawsuit that later led to the

2006 liberalization of Colombia's ban on abortion (Mohammadi, 2015). Culturally, this decision was rife with passionate political and civil response. The resulting anger and heated debate came to a head in 2012 with death threats and an armed attempt on Roa's life (Mohammadi, 2015). Although the law had been passed, there still remained a largely aggressive sentiment towards proponents and supporters of abortion.

Curriculum and Medical Education

There is sparse literature on abortion training in Colombia curricula and universities. There is, however, some literature on abortion training and education in other countries, which we explore here. In a study on medical students in Argentina, researchers evaluated a group of students for their understanding and perspectives on the abortion law (Provenzano-Castro, Oizerovich, & Stray-Pedersen, 2016). All of the students were in the first year of their medical, nursing, midwife, or other healthcare program. For some context, the law on abortion in Argentina is almost 100 years old and restricts the procedure to cases in which the woman's life or health is in danger or if pregnancy is the result of rape or assault to a developmentally disabled woman. The study found that about half of the students did not know the current regulations and were unable to recognize the cases in which abortion is legal. However, three-quarters of the students reported being supportive of abortion, especially if they had sexual experience themselves. This is the first study of its kind to occur in Argentina, underlining the need for more information on students' knowledge and attitudes around this issue.

The implications of this study are troubling when one considers the effect the students' knowledge can have on their personal lives and on their future career as a healthcare practitioner. This lack of knowledge may cause them to deny a woman an abortion to which she may be legally entitled, thus resulting in her seeking an unsafe, illegal procedure. The researchers

conclude that there is an urgent need to raise awareness among these medical students such that they recognize the risks and implications of unsafe abortion and the barriers that exist to women. They also recommended that medical schools include sexual and reproductive health topics in heir curricula. Although this study was conducted in Argentina, it has important implications for countries like Colombia because they share many of the same cultural and regional contexts.

Organizational Theory

Using a theory-based approach to research can help guide the methodology and formation of a research question for the project. In this study, higher-level theories are used to explore the organizational and contextual levels of abortion care among physicians in Bogotá. Understanding the processes of organizational change is crucial to developing strong health promotion initiatives and provides strategies for the best ways to promote change at the organizational level (Batras, Duff, & Smith, 2014). Theories of organizational change define an organization as a larger entity composed of smaller units (Glanz, Rimer, & Viswanath, 2008). In order to create change in organizations, health promoters and educators use theories to understand how organizations may actually discourage positive health behaviors or negatively impact public health promotion. Subsequently, organizational change theory can illustrate how to change or avert negative outcomes and create positive change (Glanz et al., 2008). Although individual level theories are quite reliable, theories of organizational change account for influences at both the individual and the team level because it is important to acknowledge these different factors and how they interact with each other. For example the use of Social Ecological Model (SEM) in conjunction with organizational theories (Glanz et al., 2008) can track both the inner developments of an organization as well as how the organization exists in relation to the larger

socio-ecological environment. This union allows us to examine the changing cultural dynamics around a controversial issue like abortion.

There is very little research on organizational theory, specifically the Stage Theory of Organizational Change (STOC), and reproductive healthcare. One study discussed the theoretical and organizational structure of carrying out manual vacuum aspiration (MVA) for miscarriages, a procedure used in abortions in Colombia (Darney, Weaver, VanDerhei, Stevens, & Prager, 2013). However, this paper focused on the diffusion of an innovation and a new skill rather than procedures doctors were trained to practice (Darney et al., 2013). The specific literature on the application of these theories to abortion providers remains sparse. However, the larger body of literature on SEM and STOC are well documented.

The application of the SEM allows health promoters to navigate the complex changes an organization experiences and the translation of the constructs to the organizational level. SEM acknowledges the different levels at which each individual of the organization interacts with is surroundings and that this interaction occurs at multiple levels (Glanz et al., 2008). For example, in focusing on the physician role in providing quality of care, using SEM notes that their role in the organization occurs at the individual, interpersonal, organizational, community, and policy levels. For example, a physician may have his or her own personal beliefs about providing abortions and their own internal reasoning for deciding to exercise their right to conscientiously object. At the interpersonal level, a physician may be particularly influenced by the support he or she feels from their colleagues or care team of nurses. According to the model, if a physician doesn’t feel supported by their team, they may not provide the best level of care. Additionally, the issue of conscientious objection and who is impacted by this provision may create tense team dynamics if a willing physician is leading a team of conscientious objectors. For example, the

attending staff who are do not support abortion may take out their frustrations on the patient and provide inadequate care because they are required to participate in a procedure that they don't believe is right or moral.

At the organizationally level, physicians are part of a larger health system and are heavily influenced by internal policies and standards. The extent to which they are trained and provided with guidance when navigating this relatively new post-legalization of abortion can greatly influence the level of care quality they provide to patients. Finally, at the larger cultural context level, physicians interact with the new law such that it directly affects their practice and the larger cultural acceptability of abortion. More specifically, physicians entering the workforce or getting retrained are beginning their work in an era where abortion provision is a given right protected by the law. Abortion becomes the "norm" or standard of practice for which physicians train.

The field of organizational development has four main dimensions within which change can occur (Glanz et al., 2008). This study will be focusing on "reactive versus proactive change" and its effects on the current organization. Reactive change occurs when there is a sudden event change throughout the organization that causes the member and subgroups to respond in a way that is unplanned and chaotic (Glanz et al., 2008). Within the scope of this study, that change came in the form of Decision C-355/06 which suddenly allowed abortions to be performed legally and without criminal consequence. STOC helps to identify the different steps and stages needed to create a lasting change or adoption of a new convention by the organization. In particular this study will mainly be exploring the constructs surrounding the first stage known as the "Define the Problem" or "Awareness" stage (Glanz et al., 2008).

The "awareness stage" has four main constructs: sensing unsatisfied demands, searching for possible responses, evaluating the alternative, and deciding to adopt a course of action (Glanz et al., 2008). In assessing the first construct the physicians would need to identify whether or not they perceive abortion care as an area for quality improvement. If they don't sense this as an area for improvement, this would be the first level for the organization to get involved in and foster buy in to the issue. Searching for possible responses would involve including the physicians in the problem solving process and ascertaining the kinds of changes they would make and recommend the organization make in order to meet those unsatisfied demands. In evaluating the alternative, physicians would compare the current situation with what it could be according to external standards of practice that are viable alternatives. It would be important here, to see if they feel that these kinds of expectations are realistic and practical. Finally, at the end of this first stage is where physicians would decide to adopt a course of action. This is a critical point in the progression of organizational change because if the physicians do not feel the call to action and need for change, then these changes will never occur.

Figure 1: Socio Ecological Model and Stage Theory of Organizational Change (Awareness Stage)

The above model demonstrates the interaction between the Socio Ecological Model and the Awareness Stage of the Stage Theory of Organizational Change. Because the researchers focused on quality of care and standards of care, the organizational level is of particular interest and where the Awareness stage of the STOC model comes in to play.

The findings based on these theories have implications for current health practices and identify clear areas for improvement in care quality, thus moving the hospitals and clinics on to the Initiate Action (Adoption Stage) of organizational change. Additionally this study examined the medical training and education that is provided through the current medical school curricula by interviewing relevant staff and faculty at different institutions. In looking at quality of care from the perspective of the institution and the provider, a better understanding of what is happening at this level helps identify areas for improvement in quality.

Chapter III. Methods

This study used qualitative methodology to explore the perspectives of doctors and medical educators on the quality of abortion care. This methodology had two components: (1) interviews with physicians on their experiences providing abortions, and (2) interviews with medical faculty members on their experiences with the curriculum and trainings surrounding abortion care. Qualitative research methods were used due to the explorative nature of this project and the focus on the physician experience and the "emic" perspective (Hennink, Hutter, & Bailey, 2011). These various measures will be used to create a picture and provide information for our research aims. As described earlier, this project collaborated with Fundación Oriéntame, who acted as the "gatekeeper" throughout recruitment and an advisor to the research process. Their involvement is further detailed in each arm below.

Interviews

This study population for the physician interviews consisted of all physicians in Bogotá who are currently in practice, and have provided abortion care since the 2006 law change. Participants were recruited via a convenience sampling methodology. Fundación Oriéntame and the previous student research team acted as gatekeepers and introduced the research team to potential physicians who could participate in the study. After contacting potential participants via a combination of phone, email, and social media (specifically, the texting app WhatsApp) we continued to snowball sample through multiple points of contact or "snowballs". We also cold called and cold emailed participants who fit our criteria based on information that was publicly available on hospital and university websites. We aimed for 10 physician participants (5 participants from public hospitals and 5 participants from private clinics) or until saturation was reached and no new themes were being presented in the data. For the medical school educator

interviews, we had aimed for 20 participants (10 from public and 10 from private schools) or until saturation was reached.

As a qualitative study, the measures and operationalized theoretical constructs were the basis for the interview domains. The interview guide for the physicians had five sections including the introduction and close out. The interview guide was developed based on the theoretical constructs from the Socio Ecological Model and the Stage Theory of Organizational Change as well as with contextual information based on the literature review. The first section established trust and built rapport with some opening questions about the interviewee and their career. Sections two through four included questions from each construct from SEM and STOC. The second section included general questions on the physician's role in providing an abortion and the methods and procedures associated with that role. The third section contained questions about the quality of care patients receive, how doctors define good quality care, and the standards of care they follow. The fourth section guided a discussion about abortion law in Colombia. The fifth and final section had a closing question in which the participant was invited to say anything else on the topic. After that there was a short demographic questionnaire to collect more discrete data for our records (such as gender, years in practice, etc.). The interview guide for the medical school educators had 4 sections including the introduction and closing. The first section established trust and built rapport with some general questions about the interviewee and their career. The second section had general questions on what the interviewee's knowledge of the medical curriculum and education around abortion training. The third section covered the interviewee's perceptions of quality of care and how this concept was integrated into the medical curriculum, if at all. Throughout the interviewing process, probes were used at the interviewers discretion. The researchers were able to pilot the interview guides with physicians at Fundación

Oriéntame who then also helped to revise the interview guides. Additional changes were made to the phrasing of some questions as we began the interview process.

Each interview began with the signing of a consent form and verbal affirmation of consent to participate. Consent forms and documents were approved by both the IRB at Emory University and Fundación Oriéntame (See Appendix A). Consent forms were kept on file and separate from the recordings and transcripts of the interviews. Additionally, interview transcripts and fieldnotes were demarcated by numbers and letter codes (a combination of participant and interviewer initials and the order in which the interviews were conducted). Two researchers were present at all interviews, one to conduct the interview and the other to take notes. The interviews were conducted in Spanish. A brief introduction to project was provided as well as information on how the data will be used. Each interview lasted about 30 minutes and was structured by following an Interview Guide (See Appendices B and C). Each interview ended with the researcher thanking the participant for their time and asking for recommendations for any additional potential participants to interview for the study. After each interview was analyzed, the recordings were deleted.

Analysis

Interviews were analyzed through thematically analyzing field notes and transcripts. All of the physician interviews were transcribed. The educator interviews were analyzed using both the field notes from the researchers and the recordings – many of the educator interview recordings were incomplete and fragmented and several did not have full recordings. All analysis was performed by one researcher. Materials coded inductively and deductively without the use of software. Inductive codes were created by one researcher based on what was found in the data as outlined in qualitative theory (Hennink et al., 2011). Deductive codes were created through a

combination of the theoretical applications of the SEM and STOC. Some deductive codes were pulled from the preliminary analysis the original interviewing researchers performed immediately after the conclusion of this research project. The researcher independently coded and reviewed the notes and transcripts without the use of a beta coder.

These methods had some strengths and weaknesses. The method of creating our research focus based on a previous team's findings lent the data some credibility and was a strength. We worked closely with the Colombian collaborators, which allowed rich context to come through with qualitative methods. They provided us with great support in understanding cultural contexts and updating our interview guides to reflect appropriate conventions with vocabulary and phrasing. However, there were several limitations with the data. There was only one researcher that transcribed, coded and analyzed the data. This resulted in some data quality limitations. Data was analyzed manually and without the use of computer software. To ensure consistency and quality, the coder read each interview three times and thematically analyzed the codes twice. Not all the interviews had been recorded fully, so in lieu of transcripts the researcher used a combination field notes and incomplete recordings to understand the findings from each interview. Additionally, two of the three interviews were not native Spanish speakers and none of the interviewers were well versed in Colombian Spanish. The interviewers relied on the in-country mentors to help adjust the language in the interview guides. However, there were still some challenges in grasping some of the clinical terms used to refer to certain procedures – for example, "el Pomeroy" was often used to refer to the Pomeroy technique of tubal ligation. These terms were easily researched after the interviews but at the time may have posed a challenge in the interviewer probing properly. Data was analyzed using a combination of inductive and deductive coding.

Chapter IV. Results

Physician Interviews

In total, nine physicians were interviewed who were OB-GYN's currently in practice at hospitals throughout Bogotá. Four participants worked at private institutions and the remaining five worked at public hospitals. The gender distribution was fairly even (4 women, 5 men). The years of experience providing abortions ranged from eight months to 24 years (median years of experience = 2 years; mean years of experience = 6.9 years). The typical number of abortion procedures that these doctors provided in the six months prior to the interview was between 20-30 but ranged from less than ten to 340 procedures per participant. Only three of the participants provided abortions prior to the law changed with Decision C-355/06. The following main themes emerged in the data.

Medical Training and Education

All of the respondents attained their medical degree in Colombia. Most participants received their training to perform abortion care services outside of their medical degree program either with the Secretaria de Salud or on the job. All doctors were familiar with the provisions of the law, however they felt that there were providers out there who provide services without such familiarity of the law and subsequently impart incorrect information to their patients. One participant noted that her training on the job was much more than what she had received in her residency. Overall, there didn't seem to be one strict path for learning how to perform an abortion. Each participant had a slightly different experience.

Standardized Procedures

Along the lines of fluctuations in educational experiences, the researcher noticed fluctuations amongst the clinical procedures. Participants were asked about the general steps of

an abortion procedure, the methods and services offered and any other standards that structured their care. Across all participants, there were some slight variations in what protocols they followed, the gestational limits, and the family planning options available.

All of the doctors reported following some standardized protocol. The guidelines they referred to varied however. Some used the protocols set out by the Secretaria de Salud, others used the protocols set by the World Health Organization, and finally others used recommendations set out by the National Abortion Federation (NAF). One doctor even reported that his hospital was visited by NAF every so often for quality checks – their last visit was in 2014. This kind of quality control did not come up in other interviews.

Although the abortion law in Colombia does not specify any gestational limit, doctors reported different conventions that they followed with regards to gestational limits and abortion methods they used. Participants performed abortions up to anywhere between 15 and 22 weeks. Among these variations, some doctors only performed manual vacuum aspiration while others would offer medication abortions and surgical. Every doctor interviewed followed slightly different conventions.

Additionally, the doctors reported being able to provide only certain forms of family planning options to the patient. This varied by medical site and seemed to depend on what tier the hospital or clinic was categorized as. Hospitals and clinics could be ranked as primary, secondary or tertiary level facilities that were able to provide different types of care based on their designation. A higher ranking indicated it could treat more complicated cases. One doctor explained, that this system does not allow his hospital to always guarantee that they have every method of family planning available because they are a third tier facility and often have to refer the woman to a primary care facility that handles primary care and low complexity cases.

Additionally this same doctor explained that even if they do have the method of family planning available it is not always certain that the insurance will cover it.

Professional Support

All doctors expressed feeling supported by their colleagues and coworkers during an abortion procedure. There were some nuances however in the way that these physicians spoke about that support. Most participants highlighted that their coworkers were conscientious objectors but that in general they felt a good amount of support. They did not report feeling rejection from coworkers and underlined how much involvement and support they receive from people in other departments who are needed during the process (such as psychiatry and social work offices).

One issue arose, however, around the nurses. More female doctors seemed to notice issues with the nurses – all the male doctors reported good support from the nurses and even one said that the "nurses can't object so there aren't any problems. Female doctors appeared to have the opposite opinion. One doctor described the level of support she receives from the nurses as "good" but went on to describe situations where it appeared she received the bare minimum of support. She said, "In the hospital I am at, I get good support… they help me during the procedure… But if I'm not attentive that they (the nurses) change the sheets because they are full of blood or something like that, they won't do it as quickly as they would for a pregnancy patient. They don't pay the same attention, so I feel like I have a bit less support." She further described how responsible she felt and the level of ownership she took with respect to her job. She expressed worries about the care provided by the nurses – that they would show her the fetus or judge her. "Those patients are my responsibility because none of the gynecologists there deal with the abortions. It's me. The work is mine.

Another doctor reflected that the nurses always seemed “a little more distant” with the patients. A third female gynecologist said that the nurses need clarification on the values and norms after their trainings – “you can’t ask her [the patient] about her decision, you can't call her "mom" you can't show her the baby, you can't ask her what she is going to do with the fetus or make her look at it,” she said.

Quality Care as a Right

Participants were asked about the importance of quality of care both at their organization and for them personally. Responses varied by institution but in general, those who worked at a private clinic spoke highly of the quality of care while those who worked at a public hospital reported it was of moderate importance. One doctor who worked at a public hospital said that his institution “they are concerned with the mortality and morbidity and the literature shows that access to safe abortion minimizes the morbidity and mortality.” By the same token however, this same physician personally holds quality of care very highly, a sentiment shared by all the physicians. For him, providing good quality of care is the “minimum we can offer them to respect and guarantee the respect of their rights.” All respondents indicated that the quality of care they provide is of utmost importance to them. Overall they defined good quality care as a service that is timely, confidential, and respectful.

Most of the doctors (eight of the nine) believed that abortion and other reproductive healthcare is a fundamental right of the woman and carried out this passion into upholding high standards of care in their own work. One doctor reflected on the need to “become a world where a woman can request an abortion without needing to show proof or get paperwork but where it is her right.”

One participant who worked as a gynecologist in a public was adamant that although he followed the law, he did not believe that abortion was a right. This particular interview was unique in that he was accompanied by a legal representative of the clinic and we were not allowed to record the interview. This participant seemed to be in direct contrast to the observation of different participant, who had stated in his interview that many doctors do not support abortion and simply end up just not providing them.

Recommendations

Respondents identified several areas for improvement throughout the continuum of care. Many respondents mentioned the lack of education and information available to both medical staff and patients. To better the quality of care, respondents said, there must be a better level of information that the public has access to – such as a complete understanding of the law and its provisions and their options for family planning. On the provider side, many participants indicated that there should be a sensibility training and further education for medical staff treating abortion patients. This would improve the handling and care of these patients. A couple participants highlighted specific parts of training that should be improved in the traiings such as a better explanation of how to interpret the abortion law.

Respondents also mentioned the time it took for patients to find a provider and make an appointment for their abortion. This was due to the delays on the side of the health insurance companies. These delays created more barriers as the pregnancy advanced. Because of this situation, some respondents went on to suggest that more providers should be willing and able to provide abortions at more advanced stages of pregnancy because there are no gestational limits according to the law.

Participants also had recommendations for changes at the system level and how it is structured. All doctors had various recommendations, but the most common suggestion for improvement was to change the logistics of abortion provision. One common suggestion was to provide all of family planning options to abortion patients after the procedure, which doesn't seem to be happening currently based on the above findings. Overall, the participants named various areas that could also be changed. Infrastructure concerns were raised, as a couple doctors discussed how abortion services should occur in a different area of the hospital than the maternity ward. Several mentioned that they should be able to care for women seeking abortions at more advanced stages of pregnancy, especially since the law does not provide a gestational limit for the procedure. One doctor noted that patients often find her through the connection their insurance provider has with her clinic as a preferred provider. She suggested that this kind of connection should be made for all providers so that women can seek services more quickly and without delay. Another doctor who worked at a public hospital summed up his suggestions by saying, "yes, they say it is decriminalized but they don't give us the help or tools to provide these services."

Medical Educator Interviews

In total, we interviewed 13 medical educators and staff. Nine of these participants were from private institutions while 4 worked at public universities.

University Curricula

Every medical program represented by the participants taught quality of care in general, covered Decision C-355/06 and the abortion methods/techniques in theory, and discussed conscientious objection - the right of a doctor to not perform an abortion for personal religious, moral, or philosophical reasons. At times, some programs taught bioethics and law classes. Much

of the teaching about abortion and quality of care services occurs in the clinic or on the job, especially during residency.

The theme of “university autonomy” surfaced several times. According to respondents, the universities throughout the country can create their own curriculum surrounding medical training. There are areas where this is not an issue. For example, the university will train people in the same way for procedures that have medical standards put forth by the medical association such as dilation and curettage. One respondent, however, did mention how problems arise when there are varied interpretations for less defined issues, such as the mental health of the woman.

All respondents stated that there weren’t explicit classes on quality of care or abortion procedures but that this typically came up peripherally throughout their instruction. Two staff members noted the lack of guidelines on medical school curricula. In several interviews, it was noted that the universities have “autonomy” over their curriculum. One interviewee noted that this autonomy “prevents important things lie women's sexual and reproductive rights, contraception, and abortion from being taught in some schools.

Respondents discussed the level of training provided in the schools. In general, the schools covered the law and the basic theory of how to perform an abortion but the practical knowledge came to many during residency or on the job. A couple respondents also noted that students were taught specifically about conscientious objection and the process for legally objecting. One of these interviewees further stated that “You can train students to do the abortion but then they don’t want to.” Interviewees identified some aspects of the curriculum that presented challenges to providing good care. A few faculty members discusses gaps in training when transitioning from the knowledge in theory to putting it into practice.

"Civilized Care"

Participants were asked about how they defined quality of care in theory. Most participants defined good quality care as medical care that followed protocols and in which the patient is well informed and the doctor is well trained. Several participants also raised an issue of *atencion humana* or "civilized care" in which the patients' rights, privacy and dignity are respected. One participant said that "civilized treatment of women needs to be a priority."

Humanistic care or, "patient-centered" care, arose as a particularly important issue to the participants. Respondents discussed how doctors must be supported when they perform or are deciding to perform an abortion. Patients must also be provided treatment that considers their physical, emotional, and social well-being. Respondents discussed the need for more resources for doctors who are still deciding whether or not they want to be a conscientious objector and perform abortions or not. One respondent mentioned the need to make sure that there is a social network supporting the patient after she leaves the clinic. Participants also recommended that doctors must be trained to keep their personal biases out of conversations with patients. The ethics of patient-doctor confidentiality should keep doctors from reporting women who solicit abortion care. In reality, some doctors will report women to the police as trying to access an abortion outside of the three proscribed conditions.

Interpreting the Law

By the same token of the mental health issue raised above, many participants discussed problems with the flexibility of the law. Many respondents discussed the need for strict guidance on how to interpret the law and determine whether an abortion can be performed. This is a specific problem with the causality that allows abortions to be carried out if the pregnancy is a danger to the woman's mental health. Of interest, one respondent also raised the concern that

doctors are now required to tell all pregnant patients that abortion is an option. We were unable to confirm whether or not this was a regulation, but this was also an issue of concern for one participant in particular who believed that offering an abortion unsolicited might encourage more women to abort. He said, “They don’t tell women of the risks associated with an abortion, they simply say a woman hast the right to her body and that’s it.”

One respondent mentioned that all human rights are covered by the constitution but that this is not always carried out in practice. This family practice doctor and faculty member also suggested that “Patients have a right to confidentiality but don’t have the information about their rights” – an issue that came up in other respondents’ interviews. Only two respondent mentioned being trained about women’s rights and how to respect those rights and a third suggested that this was missing in her education as well.

Recommendations

Respondents would like to see changes in various levels – at the health systems level, the provider level, and the public level. At the system level, two participants suggested specifically that there be some sort of follow up after the procedure. At the level of the provider, several participants had recommendations for the trainings and curriculum. Together, most participants recommended that the curriculum needs an ethics component to discuss the law and conscientious objection with students. Interviewees also suggested changes need to be made to the curriculum such as improving the quality in the theoretical and practical trainings. A specific problem on participant highlighted was the flexibility of the curriculum that was discussed further above and recommended that this flexibility be reduced such that curricula require abortion and contraception and women's sexual and reproductive rights to be taught. One participant said that they “need to train doctors to be sensitive and tolerant” and that at their own

institution they "need people in leadership to be involved" in making these changes. For the broader population, there were three participants who had suggestions that public education efforts focus on making sure the law is known, focus on prevention, to provide more access to health care, especially to family planning materials. One interviewee highlighted how "the most important thing is he information available" and that the "worst is when someone makes a decision that is misinformed."

Chapter V. Discussion

Findings and Conclusions

This study aimed to explore the perceptions of doctors about the quality of abortion care currently provided and to describe the current medical education curriculum on abortion care and in medical schools. Based on our findings, doctors and medical educators had clear areas where they felt the quality of abortion care could be improved. We conclude that next steps in improving abortion care involve standardizing the curricula and training of staff and overall improvement of access to methods of family planning.

To better understand the findings, the theoretical model discussed above in the literature was used to contextualize the themes and results from the interviews (See Figure 2). Each them can be categorized into the different levels of this model. At the policy level, we have the findings from the physicians in which good quality care and access to abortion was considered to be the woman's right. This finding is reflected in the legislature which support's women's access to abortion and even regulates the amount of time a woman should wait before receiving care. However, as was noted in the results, regulations do not always get translated into practice and women seem to experience delays before receiving care.

At the community level the themes that cover norms and standards appear. The data showed some interesting findings in how the law was being implemented among the physicians and the discrepancies amongst different procedures. Additionally, amongst the educators, there were also differences and confusion about how to implement the law and apply it in practice. These community level issues identify areas to focus on when thinking about the messaging and bigger picture aspects of interventions that may target these clinicians and educators.

At the organizational level, the themes of the university curricula, education and training of the physicians, and the quality of care provided to patients all came up. Findings at this level indicate that many of the issues presented as barriers to providing good quality of care appear to be systematized. Participants identified several issues in the curricula and the training of physicians.

At the interpersonal level and the Individual level, multiple themes start to overlap. Findings suggest that the professional support that physicians receive at work can impact how they personally view and carry out their own care that they provide patients. It seems as though these two levels might feedback on each other – the less supported they feel by their peers, the more seriously and independently they may take their work and, by extension, receive less help and support.

In addition to the SEM model levels is the Awareness Stage in the STOC model, which ties into the Organization Level of the SEM. Here is where the data notes the actual recommendations made by the participants. Amongst every participant, the feedback and response indicates that they have sensed areas in which there are unmet demands and are aware of ways that these can be addressed. Both physicians and physician educators indicated that further or modified trainings should be held with physicians and/or other clinical staff. The most opportune time to make these changes would be to start incorporating abortion training and teachings more fully into the gynecological curricula of medical schools. Additional sensitivity trainings could also be helpful.

Recommendations were also made for changes at the health systems and infrastructure levels. Physicians suggested that the tiered hospital model and current triaging of abortion cases was inefficient and costly, which is supported by the literature (E. Prada et al., 2013; Rodriguez

et al., 2015). Making changes at these levels can begin with changes made within the physician's local area – their hospital or clinic. A few physicians identified that the practice of treating an abortion patient in a maternity ward was an area for improvement and could be addressed by re-organizing what rooms abortion patients are viewed in and treated. These small-scale changes in the immediate surroundings can lead to larger systematic changes.

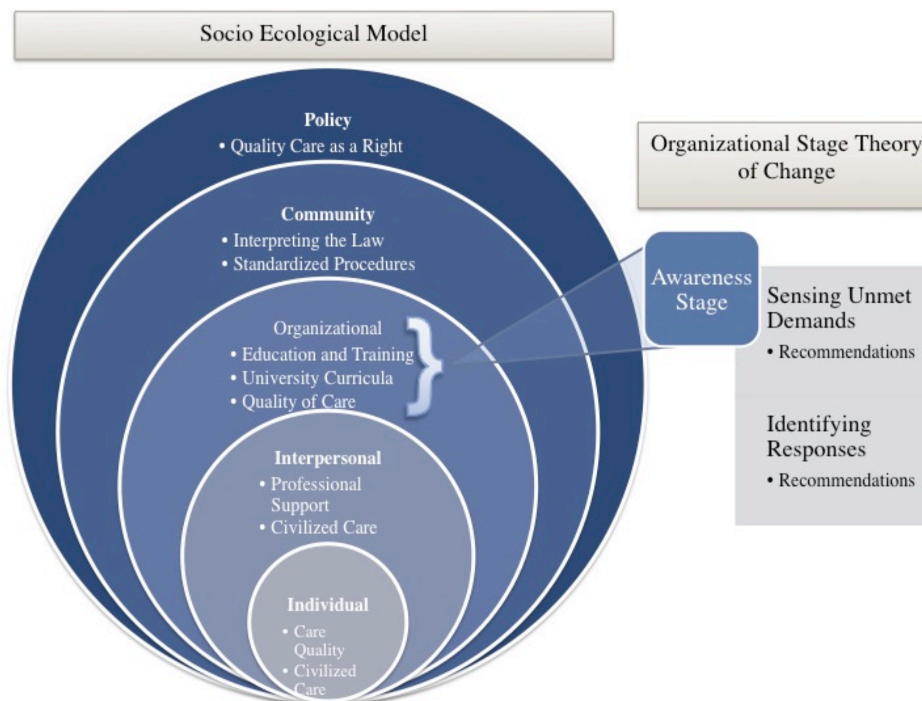

Figure 2: SEM and STOC Awareness stage with Themes

Data quality limitations

Interviews with physicians who are currently in practice and performing abortions were conducted in Spanish by the first author, a female graduate student in public health. This interviewer has a high proficiency in Spanish and her native language is English however [add the limitation]. The interviews with medical school educators were conducted in Spanish by the first author's two teammates. One - a female graduate student in a doctoral medical anthropology program – had intermediate Spanish skills but had fluency in Italian which lent itself to an

improved proficiency throughout the project. The other interviewer, a female undergraduate, was fluent in Spanish, which was also her native language. The two interviewers alternated between the roles of conducting the interviews or taking notes which, may have limited the quality of the field notes since the two interviewers had different levels of Spanish fluency. The language of medical professionals in Colombia often includes some words and phrases specific to their profession. Although most of these terms were understandable there were some abbreviations and colloquialisms that had to be clarified during the transcription process. Subsequently, some nuances in these responses may have been missed and some comments that should have been probed were not.

A major limitation of this study was the professional network we used to recruit respondents. Based on our experiences being referred to the same participants over and over, it's clear that we found ourselves in a small network of professionals. The sampling strategy was such that we kept getting referred back into this network. This could be avoided in the future by allocating more time in country and perhaps even prior to the project start to allow for establishing broader professional networks. In general, however, it did appear that the population of doctors providing legal abortions in Bogotá was fairly small. We also were unable to reach our sampling goals.

Implications

Within the realm of Behavioral Science and Health Education, this study has implications for how healthcare systems and providers are monitored. Through this process we gained some insights into the varied levels of experience and training that providers receive in Colombia surrounding abortion. Additionally, our findings have implications for broader public health and policy implementation. As was discussed by the medical educators and reinforced in the literature, it is imperative that governments should increase the level of transparency in their

policies. In this case, the government should be encouraged to publicize the regulations and produce guidelines on when an abortion procedure will not attract police or any other legal scrutiny (Cook, Erdman, & Dickens, 2007). This will help reduce the number of obstacles barring women from seeking abortion care by eliminating the misunderstandings around the ethical, legal, and medical requirements stipulated in Decision C-355/06 (Amado et al., 2010).

Future Research

Should future studies wish to expand on the research presented above, they would need to address the aforementioned limitations. Conducting a similar study over a longer period of time could establish a wider network could yield more in-depth results. Additionally, more formally trained interviewers and researchers who are more familiar with cultural contexts may lead to richer results as well.

Possible areas of research include looking outside of Bogotá to the quality of abortion care in other cities and rural areas to see how the decriminalization of abortion has impacted other regions of Colombia. Within Bogotá and other areas, it would be interesting to look into providers of clandestine abortions and their experience providing abortion care. Given the decriminalization of abortion, probing into the factors behind the continued existence of illicit abortion providers may prove fruitful. Additionally, it would be interesting to conduct a quantitative study of abortion care quality based on areas of concern mentioned above. Factors such as the length of time until an appointment is made and professional support scales could be used to assess quality of care in quantitative way.

More research is particularly needed in two areas: medical education and the patient experience. Next steps in this area of research would greatly benefit from explorative studies and a more thorough review of the medical schools in Colombia and how the curriculums might vary

between institutions. Finally, giving the women seeking these abortions a voice to tell their stories and experiences would also provide a lot of valuable information to the body of research. Learning more about their reasons for seeking abortion services – legal or otherwise – and their experiences getting these services would provide a necessary perspective on how these services work in practice.

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Appendix A: Consent Form

nu. de estudio.: **IRB00081604** **Emory University IRB** IRB uso solo Doc aprobado: 06/17/2015

Universidad de Emory
Formato de Consentimiento Informado

Título de la Investigación: Investigación cualitativa sobre la Calidad de las interrupciones voluntarias del embarazo
Investigador Principal: Adriana Bracho
Fuente de Financiamiento: Instituto de Salud Global de Emory

Introducción y Visión General de Estudio

Gracias por su interés en nuestro estudio. Nos gustaría comentarle más sobre la entrevista y nuestro estudio antes de que usted decida si quiere participar o no. Su participación es totalmente voluntaria y puede interrumpir la entrevista en cualquier momento.

1) El propósito de nuestro estudio es aprender más sobre las perspectivas de calidad de servicios de los proveedores de interrupciones voluntarias del embarazo
2) Esta investigación se lleva a cabo en nombre de la Universidad de Emory en el departamento de Rollins Escuela de la Salud Pública en los EEUU.
3) Esta entrevista tendrá una duración aproximada de 45 a 60 minutos.
4) Si decide participar puede contestar las preguntas como usted quiera, completas o breves.
5) No hay riesgos conocidos por participar en esta entrevista. Toda la conversación y la información que nos dé será anónima.
6) Debido a que el propósito de la investigación es comprender las perspectivas de los proveedores sobre la calidad de servicio de las interrupciones legales, beneficiará a las personas quienes están interesadas en esta información porque toda la información que coleccionamos añadirá al cuerpo de conocimiento.
7) Su privacidad es importante para nosotros. No le pediremos información personal de ningún tipo.

Información de Contacto
Si usted tiene preguntas sobre esta investigación, su participación, sus derechos como participante, o si tiene preocupaciones o quejas, puede comunicarse con:

- Nassira Bougrab, Co-Investigadora y Entrevistadora, nassira.bougrab@emory.edu
- Emory Institutional Review Board: +1 (404) 712-0720, +1 (877) 503-9797 o con correo electrónico irb@emory.edu

Identificación del Participante:

Tiene alguna pregunta sobre la investigación? SI NO

Tiene alguna duda de participar en esta investigación? SI NO

Voluntariamente desea participar en esta entrevista? SI NO

Si la repuesta es afirmativa:

____
Nombre del Participante

____
Firma del Participante

____
Fecha

____
Nombre de La Persona Encargada de la Discusión de Consentimiento Informado

Appendix B: Physician Interview Guide

Médicos: Guía de Entrevista

Introducción:

Gracias por su participación en esta entrevista. Mi nombre es Nassira Bougrab y soy estudiante del programa de Maestría de Salud Pública en la Universidad de Emory - Rollins en Atlanta, Georgia en los Estados Unidos. Estoy haciendo esta entrevista para un proyecto sobre la calidad de los servicios de interrupción voluntaria del embarazo en Bogotá. Estamos explorando las experiencias de médicos que hacen las IVEs. Estoy aquí hoy día para hablar con usted sobre sus conocimientos y experiencias. Su participación en esta entrevista es completamente voluntaria y usted puede desistir de contestar cualquier pregunta o terminar la entrevista en el momento en que así lo prefiera. Esta entrevista va a tomar 30 minutos de su tiempo.
Me gustaría grabar nuestra conversación para documentar sus respuestas si esto está bien con usted. Yo no puedo escribir tan rápido como hablamos y el español no es mi primera lengua. También, me quiero enfocar sobre nuestra conversación y no en lo que estoy escribiendo. Nuestra conversación de hoy es completamente confidencial. Nadie afuera de nuestro proyecto va a escuchar sus respuestas. Su jefe o supervisor no va a ver o escuchar sus respuestas. No le voy a preguntar a usted información personal. Después de que la grabación sea transcrita y traducida, será destruida.

Usted tiene algunas preguntas para mí?
Me da permiso para grabar nuestra conversación ahora?
Está listo/a para empezar?

Sección 1: Preguntas de Apertura

1. ¿Cuántos años lleva practicando medicina?
2. ¿En su mayoría, usted ha trabajado en instituciones públicas o privadas?
   (Indagar: Me puede contar más sobre eso?)
3. ¿Cuales servicios provee usted?
4. ¿Cuántos años lleva proveyendo estos servicios?
5. Que entrenamiento recibió usted para proveer servicios de interrupción de embarazo?
   En dónde recibió esta capacitación?
   (indagar: en la universidad?, en el servicio de la clínica u hospital donde trabaja?)

Sección 2: Preguntas Generales sobre IVE

Ahora vamos a hablar sobre su experiencia general con la interrupción del embarazo.

1. ¿Qué tipo de cuidados relacionados con el aborto ofrece?
   Por ejemplo: aborto inducido, servicio post aborto
      ¿Hasta cuantas sems ofrece las interrupciones?
2. ¿Qué métodos de IVE provee usted en su práctica?
      a. Por ejemplo el aborto médico, curatage, aspiración, etc.
      b. Qué métodos de planificación familiar ofrece?

3. De su perspectiva, ¿me puede contar el proceso de una interrupción típica?
      (Indagar: ¿Cómo empieza el proceso? ¿Cuáles son las etapas del procedimiento?)
4. Durante el procedimiento, ¿cuánto apoyo siente usted de los otros empleados que trabajan con usted?
a. ¿Quien le ayuda durante el procedimiento? ¿Cómo le ayudan?
5. ¿Qué tanto apoyo siente que le dan sus compañeras de trabajo en el momento de realizar una IVE?
6. ¿Qué tanto rechazo ha sentido de parte de sus compañeras de trabajo por efectuar interrupciones de embarazo?

Sección 3: La Calidad de los Servicios de Interrupción

Ahora vamos a hablar sobre la calidad de los servicios de interrupción basado en sus experiencias.

1. ¿Usted cómo definiría la calidad en los servicios de interrupción voluntaria del embarazo?
   (Indagar: Como llega a esta definición?)
2. Cuáles estándares sigue usted para hacer las interrupciones?
3. Qué importancia tiene para usted proveer un servicio de IVE de calidad?
4. Qué importancia tiene a para su organización/hospital/clínica proveer un servicio de excelente calidad?

Sección 4: La Legislación de la Interrupción del Embarazo

Ahora vamos hablar sobre la situación legal de la interrupción del embarazo en Colombia.

1. ¿Qué conoce sobre la legislación de la Interrupción Voluntaria del Embarazo?
   Indagar: ¿Qué es la causal salud?
2. ¿Piensa que hay médicos que prestan servicios del aborto y no conozcan la legislación?
3. Si ya era médico/a en ejercicio cuando la ley cambió, cómo éste influyó en su trabajo?

Preguntas de cierre:

1. Qué cambios pueden hacerse en los servicios de la interrupción en general?
   a. (Indagar: Lo pueden mejorar? Está bien como están ahora?)
2. Cómo puede mejorar la calidad el hospital/la clínica donde trabaja?
3. Hay algo más que usted quiera discutir sobre este tema?

Muchísimas gracias por tomarse el tiempo de hablar conmigo. Espero que usted haya tenido una buena experiencia durante esta entrevista.

Preguntas Demográficas

Estas preguntas están aquí para categorizar las entrevistas más fácilmente. Es posible que ya hayamos hablado sobre estos temas y yo pueda llenar las respuestas.

1. Usted se identifica como: Hombre Mujer Intersexual Otro

2. Hace cuantos años que usted provee las interrupciones de embarazo:_______

O

Usted estaba proveyendo las interrupciones antes de la despenalización? SÍ NO

3. Usted trabaja en una institución pública o privada? PÚBLICA PRIVADO OTRO

4. Se graduó como médico/a aquí en Colombia? SÍ NO

5. Aproximadamente cuántas interrupciones hizo usted durante los últimos 6 meses?

<10 10-20 20-30 >30 OTRO ________

Appendix C: Medical Educator Interview Guide

Profesor de Medicina: Guía de Entrevista

Introducción:
Gracias por tomar el tiempo de entrevistarse con nosotras. Nuestros nombres son Wendy Avila y Sarah Whitaker y somos estudiantes de la Universidad de Emory en Georgia, EE.UU. Estamos realizando esta entrevista como parte de un proyecto que tiene como propósito indagar sobre el concepto de calidad entre trabajadores de la salud en Bogotá. Esta entrevista se realiza con el fin de conocer sus puntos de vista, como director de una facultad de medicina o profesor, sobre la forma en que la calidad de la atención en salud se enseña generalmente y cómo se relaciona con el aborto. Hoy estamos aquí para hablar con usted acerca de su conocimiento y experiencias. Su participación en esta entrevista es completamente voluntaria, y puede detener la entrevista en cualquier momento. Esta entrevista tendrá una duración aproximada de 50 minutos. Nos gustaría grabar nuestra conversación para poder transcribir las respuestas después, si usted está de acuerdo. La conversación entre nosotros es completamente confidencial; nadie más que las personas asociadas con el proyecto escucharán la grabación. Solo estas personas tendrán acceso a lo que decida compartir con nosotras durante este proceso. Su supervisor no podrá escuchar o leer sus respuestas. Cuando se transcriban estas respuestas su nombre será excluido. Para mantener esta información confidencial, no le pediremos información personal. Después de que transcribimos la grabación, la eliminaremos.

¿Tiene preguntas para nosotras?
¿Tenemos permiso para grabar nuestra conversación?
¿Está listo(a) para comenzar?

Sección 1a: Preguntas Generales:
1. ¿Asistió la escuela de medicina?
2. ¿Ha trabajado en hospitales o clínicas?
3. ¿Cómo se convirtió en un director/profesor de medicina?
4. ¿Cuánto tiempo ha estado en su posición actual?
5. ¿Cuánto años lleva enseñando?
6. ¿En qué universidades ha enseñado?
7. ¿Qué materias enseña? ¿O ha enseñado?

(Solo para los que se han ingresado en la escuela de medicina)
Sección 1b: Su Educación Médica:
Ahora vamos a hablar acerca de la educación médica en su universidad.
La universidad que asistió

8. ¿A qué universidad asistió?
9. ¿Puede describirnos el plan general de estudios de medicina en su escuela?
10. ¿Cómo se incluyó la calidad de atención en su plan de estudios?
(Pregunte: ¿Cómo se define? ¿En qué clases lo enseñaron?)

Sección 2: La Educación Médica
Ahora hablaremos de la educación en medicina en la universidad donde trabaja.

11. ¿En relación con el aborto, qué tipo de entrenamiento reciben los estudiantes en la escuela de medicina?
(Pregunte: ¿En qué grado se enseña: en el pregrado y/o en el posgrado?)
12. A partir de la despenalización parcial de la IVE en el 2006, ¿se realizaron cambios en el plan de estudios de medicina? ¿Por qué sí? O ¿Por qué no?
13. ¿Cómo y que tanto prepara esta facultad de medicina a sus egresados para prestar servicios de aborto?

(Pregunte: ¿Prepara a los doctores para proveer abortos? ****En este punto sería importante diferenciar los pregrados de los posgrados.)

Sección 3: Preguntas generales sobre la Calidad de la Atención:
Ahora vamos a hablar acerca de los elementos centrales que usted cree que debe tener un servicio de IVE de calidad.

14. ¿Qué significa el término "alta calidad de la atención" para usted?
(Pregunte: ¿Cómo llegó a esta definición?)
15. ¿Hay clases que recalcan esta definición de la calidad de la atención?
(Pregunte: Si es así, ¿cuáles son?)
16. ¿Qué es lo que usted considera alta calidad de la atención en relación a los abortos?
17. ¿Qué clases enseñan acerca de la alta calidad de la atención en relación a los abortos?

Sección 4: Últimas Preguntas:

18. ¿Qué cambios le gustaría ver en el plan de estudio de medicina con relación al aborto y la calidad?
19. ¿Qué cambios se podría hacer para cambiar la calidad de la atención en abortos desde la universidad?
20. ¿Hay algo más relacionado con la calidad de la atención que le gustaría discutir?

En adición a estas preguntas, estamos estudiando textos y libros de medicina. ¿En general, qué textos se usan para enseñar en la facultad de medicina que aborden la calidad y la prestación de servicios de aborto?

Una vez más, muchas gracias por tomar el tiempo de su día para entrevistarse con nosotras. Esperamos que haya tenido una buena experiencia durante la entrevista.