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Unwanted Pregnancy and Induced Abortion among Women in the Amazon Region of Colombia

By

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Unwanted Pregnancy and Induced Abortion among Women in the Amazon Region of Colombia

By

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B.A University of California at Los Angeles, 2009

Thesis Committee Chair: Monique Hennink, Ph.D

An abstract submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health in
Global Health
2011

Abstract

Unwanted Pregnancy and Induced Abortion among Women in the Amazon Region of Colombia

By Ryan Woodson

Background: Three years after the partial decriminalization of abortion in Colombia in 2006, less than 3,000 legal abortions have occurred, while 320,000 - 450,000 unsafe abortions continue to occur annually. National data shows that 27% of pregnancies are unwanted. Unsafe abortions caused 28% of all maternal deaths in Colombia, of which rural, poor and indigenous women were disproportionately affected. Yet, little data on unwanted pregnancy and induced abortion decision-making exists since this change in the law among women in the Amazon region.

Objectives: To understand the social and cultural perceptions, and individual experiences of unwanted pregnancy and induced abortion among residents in the Amazon Region of Colombia. To elucidate the process by which women decide to abort or continue an unwanted pregnancy.

Methods: 6 focus group discussions, which included ranking activities, were conducted separately among males and females. 13 in-depth interviews were conducted with women between 15-44 years of age, who had at least one unwanted pregnancy in their lifetime.

Results: Regardless of their decision, all women experienced the same stages in their decision-making process: knowledge, social and economic concerns, disclosure, contemplation of pregnancy outcomes, decision, and acceptance. A woman's decision was indirectly influenced by the advice provided by the maternal confidant and directly influenced by her relationship status at the disclosure stage. Women who decided to continue the pregnancy did so because they disclosed the pregnancy to a partner who desired the pregnancy. Women with less supportive partners, decided to continue the pregnancy in hopes that it would strengthen their current relationship. Women who did not have a partner at the time of disclosure decided to abort the pregnancy, in addition to other factors, which varied by age. Younger women's abortion decision was directly related to being single and a desire to continue school. Older women tended to abort due to marital problems.

Discussion: Decision making processes relative to unwanted pregnancy and abortion are intrinsically bound to socioeconomic and relationship factors. There is a need for future research in the Amazon region of Colombia that emphasizes the roles of the partner and maternal confidant at pregnancy disclosure.

Unwanted Pregnancy and Induced Abortion among Women in the Amazon Region of Colombia

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A thesis submitted to the Faculty of the
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Master of Public Health in
Global Health
2011

ACKNOWLEDGEMENTS

THIS THESIS WOULD NOT BE POSSIBLE WITHOUT THE INVITATION FROM DRS. JAVIER AND GLORIA GUTIERREZ, THE FOUNDERS OF FUNDACIÓN CLÍNICA LETICIA. I AM GRATEFUL FOR THEIR SUPPORT AND HOSPITALITY. MANY THANKS TO FRANCISCO PALOMEQUE FOR SERVING AS THE PRIMARY LIASON FOR THE DEVELOPMENT OF THIS STUDY.

I AM INDEBTED TO THE MEN AND WOMEN OF LETICIA, COLOMBIA WHO OPENLY SHARED THEIR TRADITIONS, CULTURE, AND PERSPECTIVES ON UNWANTED PREGNANCY AND INDUCED ABORTION. OPENING THEIR HEARTS AND HOMES, IT IS BECAUSE OF THEM THAT I TRULY UNDERSTAND WHAT IT MEANS TO BE "TRANQUILA". AND FOR THIS, I AM FOREVER THANKFUL.

I WOULD LIKE TO THANK DR. ROGER ROCHAT AND SUSAN ROCHAT FOR THEIR UNWAVERING SUPPORT AND DEDICATION TO THE GLOBAL ELIMINATION OF MATERNAL MORTALITY FROM ABORTION. THE ROCHAT'S CREATED AN ENVIRONMENT WHERE ABORTION RESEARCH IS ACCEPTED, ENCOURAGED, AND SUPPORTED, RATHER THAN STIGMATIZED. THE AMOUNT OF CARE AND SUPPORT THEY PROVIDED ME, NOT ONLY DURING THIS STUDY, BUT ALSO THROUGHOUT MY TIME AT ROLLINS HAS BEEN HEARTWARMING, MOTIVATING, AND TRULY INSPIRATIONAL.

THE GUIDANCE I RECEIVED FROM DR. MONIQUE HENNINK THROUGHOUT THIS PROCESS WAS INVALUABLE. HAVING THE OPPORTUNITY TO WORK WITH AND LEARN FROM SUCH A CARING AND REVERED PROFESSIONAL IN THE FIELD OF QUALITATIVE RESEARCH WAS TRULY GRATIFYING.

I WOULD NOT BE WHERE I AM TODAY WITHOUT MY FAMILY. MY MOTHER, FATHER, AUNTS, GRANDMOTHERS, SISTER, AND BROTHER-IN-LAW HAVE ALWAYS PROVIDED UNCONDITIONAL LOVE AND GUIDANCE. I AM FOREVER GRATEFUL FOR HAVING SUCH A WONDERFUL AND SUPPORTIVE FAMILY. I WOULD ALSO LIKE TO THANK MY BOYFRIEND AND MY FRIENDS FOR THEIR LOVE AND ENCOURAGEMENT.

ALSO SPECIAL THANKS TO MY COLLEAGUE AND FELLOW LETICIANA, SHREYA RAO. SHE WAS MY MAIN SUPPORT SYSTEM IN LETICIA AND I AM SO GRATEFUL FOR THE EXPERIENCES WE SHARED.

FINALLY, I LIKE TO EXPRESS MY SINCERE GRATITUDE TO THE GLOBAL FIELD EXPERIENCE AND THE GLOBAL ELIMINATION OF MATERNAL MORTALITY FROM ABORTION (GEMMA) FUNDS FOR SUPPORTING THIS STUDY.

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CHAPTER ONE: INTRODUCTION

In Colombia, preventing unwanted pregnancy and access to safe abortions are significant human rights and public health concerns, especially among women in indigenous populations. From a human rights perspective reducing unwanted pregnancy and access to safe abortion are two indicators of women's reproductive health, and of the level of autonomy women have in reproductive decision-making (Eggleston 1999). From a public health perspective, unwanted pregnancy that leads to abortion may increase a woman's risk of abortion related maternal morbidity and mortality (Glasier et al 2006); additionally, abortion is the leading cause of maternal morbidity and mortality in regions where abortion is legally restrictive, which is the case in most Latin American countries (Singh 2006), specifically Colombia. A recent study shows that unsafe abortions caused 28% of all maternal deaths in Colombia, of which rural, poor and indigenous women were disproportionately affected (Ceaser 2006). Other studies show that women residing in indigenous populations are at greater risk for unwanted pregnancy, and consequently resort to unsafe abortion. However, few studies examine the process by which and the context in which at-risk women in indigenous regions decide to abort or continue an unwanted pregnancy (Singh 2006; Goicolea 2010). Thus, the purpose of this study is to elucidate the process by which women in the Amazon region of Colombia decide to abort or continue an unwanted pregnancy by shedding light on the individual experiences, and cultural and societal factors that potentially influence a woman's decision.

CHAPTER TWO: COMPREHENSIVE REVIEW OF THE LITERATURE

The goal of this literature review is to synthesize existing research on unwanted pregnancy and abortion decision-making. Given that literature on the target population, women in the Amazon region of Colombia, is limited, the included studies examine unwanted pregnancy and abortion among similar populations and in similar contexts, in hopes of providing context for the study. Four primary criteria were used to select relevant studies for this literature review:

- Study documents incidence of unwanted pregnancy and abortion in the context of Latin America, Colombia, and/or among other Amazon populations in Latin America
- Study uses quantitative or qualitative methods to identify determinants or influences of unwanted pregnancy and or abortion among poor, rural, and/or indigenous populations
- Study examines social, health, and economic effects of unwanted pregnancy and abortion among poor, rural, and/or indigenous populations
- Study elucidates unwanted pregnancy and abortion decision-making process among poor, rural, and/or indigenous women.

The literature review is divided into five sections. The first provides an overview of unwanted pregnancy and abortion terminology. The second section elucidates the global burden of unwanted pregnancy and abortion, with a focus on Colombia. The third section discusses the legality of abortion in Colombia. The fourth section provides an overview of relevant research on the topic. In this section research is categorized by study topic and

the nature of the findings. And lastly, the fifth section identifies gaps in the literature, and expresses the need for more research in the topic area.

Definitions

The term unwanted pregnancy is categorized as a type of unintended pregnancy. Unintended pregnancies are pregnancies that are reported as unwanted or mistimed (Santelli, Rochat et al. 2003). For the purposes of this literature review, I included studies that distinguished between unwanted and mistimed pregnancies. Abortion is defined as removal of a fetus or embryo from the uterus prior to the stage of viability. An induced abortion is characterized by deliberate interference with the pregnancy, either by the woman herself or by another individual, with the aim of terminating the pregnancy (Royston and Armstrong 1989). When carried out by trained professionals and under recommended clinical guidelines, abortion carries the lowest physical risk for women of any significant medical procedure (Daulaire and Leidl 2002). In regions where abortions are performed in safe conditions, maternal morbidity and mortality rates are low (AGI 1999). Contrastingly, where abortions are performed by untrained professionals, and or in non-sterile environment, rates of deaths due to abortion tend to be high. In such cases induced abortions become unsafe. The World Health Organization (WHO) defined an unsafe abortion as "a procedure for terminating pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both" (WHO 1993). Unsafe abortion is the leading cause of maternal morbidity and mortality in regions where abortion laws are highly restrictive, which is the case in most Latin American countries (Singh 2006). Other abortion terminology includes: abortion rate,

which is defined as "the number of abortions per 1,000 women of reproductive age"; abortion ratio, "the number of induced abortions per 1,000 live births"; and, abortion mortality ratio, "the number of abortion deaths per 100,000 live births" (WHO 1993).

The Global Burden of Unwanted Pregnancy and Induced Abortion

Unwanted pregnancy and abortion are common phenomena that occur throughout the world. Recent reports from the Guttmacher Institute show that of the 210 million pregnancies occurring worldwide each year, about 38% are unplanned and 22% end in abortion (AGI 1999). Maternal deaths due to unintended pregnancies are highest in developing countries with highly restrictive abortion laws (Table 1). Illustrating the annual incidence of unsafe abortion among women of reproductive age, Table 1 shows that the incidence of unsafe abortion is highest in Latin America and Eastern Africa.

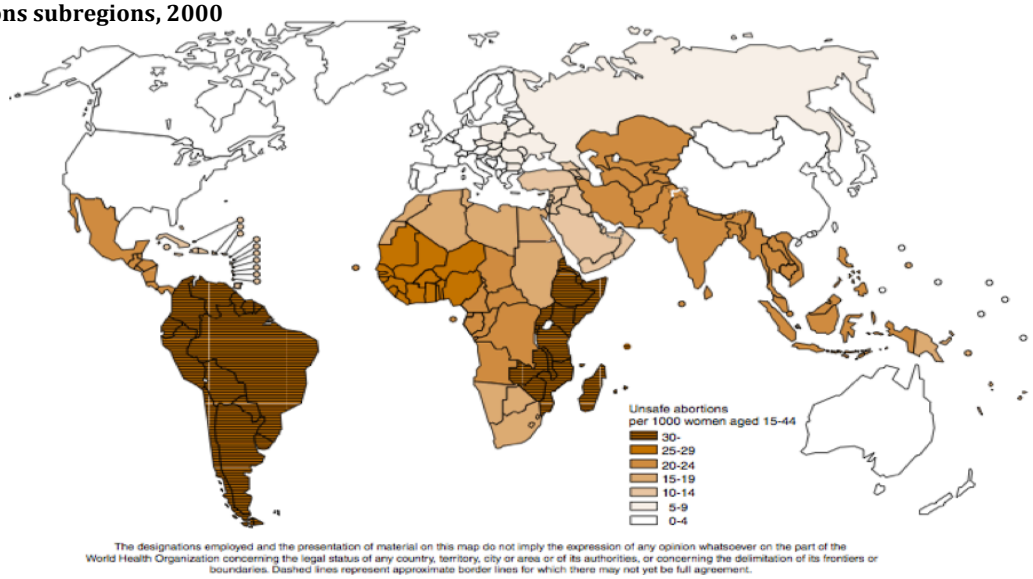
Table 1: Regional estimates of maternal deaths due to unintended pregnancies from 1995-2000

Time Period: 1995-2000	Maternal deaths	Deaths from unintended Pregnancies	Proportion of maternal deaths due to unintended pregnancies
Africa	1,731,000	282,100	16.3%
Latin America/Caribbean	129,000	51,300	39.7%
North America	3,000	400	12.5%
Near East	110,000	29,300	26.7%
Europe	24,000	13,900	57.8%
Asia	1,234,000	25,100	25.1%
Developed Pacific	2,000	200	11.8%
TOTAL	**3,233,000**	**687,600**	**21.3%**

Source: Global Health Council, 2006

Unintended pregnancies place women at a high risk for abortion, and in countries where abortion law are restrictive; it is extremely difficult for women, particularly poor and rural women to access safe abortions. Unsafe abortion is defined as "a procedure for terminating pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both" (WHO 1993), and is the leading cause of maternal morbidity and mortality in regions where abortion laws are highly restrictive, which is the case in most Latin American countries (Singh 2006). The high incidence of unsafe abortions in Latin America is linked to women's need to space births before having a sterilization procedure (Shah and Ahman 2010). Compared with developed countries, abortion related deaths are one hundred times more common in Latin America (AGI, 1999). Latin America and the Caribbean rank as the second highest regions in the world in the proportion of maternal death due to unintended pregnancies at 39.7% (Figure 1)

Figure 1: Estimated annual incidence of unsafe abortion per 1000 women aged 15-44 years, by United Nations subregions, 2000



Source: World Health Organization

Given the aforementioned relationship between unwanted pregnancy and abortion, it is unfortunate, yet apropos that Latin America has an unintended pregnancy rate (72 per 1000 women aged 15-44) that is higher than the world average (55 per 1,000 women aged 15-44) (AGI 2009).

Legality of Abortion in Colombia

Prior to 2006, Colombia was one of three countries in Latin America that contributed to the 0.4% of the world population where abortion is prohibited by law. On March 14th, 2005, Women's Link Worldwide, an international human rights non-profit organization aimed at improving women's rights globally, challenged the Colombian Constitutional Court to liberalize the country's abortion law. The campaign focused on the adverse effects that criminalization of abortion had on poor and rural women in the country, particularly women in the Amazon region.

"The women who live in rural areas are the ones who pay the cost in health, or even with their lives, because abortions are illegal." (Monica Roa, Director of Women's Link Worldwide 2006)

After a highly contested process the court ruled that abortion is a constitutional right for women and should not be considered a crime under the following three circumstances:

- When the life or health (physical and mental) of the woman is in danger
- When pregnancy is a result of rape or incest
- When grave fetal malformations make life outside the uterus unviable

Before the partial decriminalization of abortion in Colombia, estimates from hospital admissions for abortion related complications showed that 250,000 - 350,000 abortions

occurred annually (Singh and Wolf 1991). Three years after the legalization of abortion, less than 3,000 legal abortions have occurred, while 320,000 - 450,000 unsafe abortions continue to take place every year (Amado, Calderon Garcia et al. 2010). While, measuring the effect of the recent policy change remains an immense challenge due to the scarcity and incomplete nature of official abortion statistics, the available estimates demonstrate the modest impact legalization of abortion has made in reducing the incidence of unsafe abortion in the region. Studies attribute the low of number of legal abortions to the following obstacles (Roa 2008):

- Lack of knowledge regarding the new abortion laws
- Abuse of conscientious objection by physicians, judges, and the healthcare system
- Deliberate interference or obstruction of women's consent process
- Request of additional requirements or postponement of medical board approvals
- Discrimination against physicians and women who practice legal abortions

While the navigation of such roadblocks requires a system of resources unavailable even to the most affluent women in the region, one study shows that the aforementioned obstacles are more commonly experienced among women of low socioeconomic status (Amado, Calderon Garcia et al. 2010). Given that these women do not have the means to navigate the legal system, it can be suggested that the incidence of unsafe abortion remains an undocumented and salient issue among marginalized populations in Colombia, particularly among women in the Amazon region. The effects of the partial decriminalization of abortion have yet to be explored among poor, rural, and indigenous populations, who are undoubtedly at greater risk for unwanted pregnancy, and consequently, unsafe abortion.

Incidence of Unwanted Pregnancy and Abortion in Latin America and Colombia

"More is known today about the epidemiology of legally induced abortion than any other operation. In contrast, huge gaps persist in our understanding of the incidence, morbidity and mortality of unsafe abortion. Because of stigma or fear of legal reprisals, unsafe abortions are grossly under-reported, and the complications thereafter are often concealed or attributed to spontaneous miscarriage" (Grimes 2003).

Research on unwanted pregnancy and abortion has followed several avenues. The incidence of unwanted pregnancy and abortion has been estimated globally, regionally, and among specific populations. International organizations, such as the Guttmacher Institute, the World Health Organization, and the Global Health Council, released world reports documenting the incidence of unwanted pregnancy and abortion worldwide. Notable studies by Henshaw (Henshaw, Singh et al. 1999) and Singh (Singh 2006) documented the incidence of unsafe abortion from a global perspective. Such studies indicated that Latin America has the highest incidence of unsafe abortion worldwide. These findings are supported by other empirical research. (Paxman, Rizo et al. 1993; Henshaw, Singh et al. 1999; Grimes, Benson et al. 2006; Singh 2006). Such studies indicated that unsafe abortion is more common in Latin America, because most in most countries abortion commonly criminalized except in the cases rape or incest, fetal malformations, and when the life of the mother is at risk. The aforementioned studies used hospital admission records to measure the incidence of unsafe abortion and have the limitations such measurement methods entail. Paxman (1993) noted that surveys based on hospital data produce under estimates of induced abortion largely because of the social stigma and fear surrounding the issue that permits most women from seeking care, and therefore being included in the hospital data.

In Colombia, measuring the incidence of abortion is particularly difficult due to illegality of abortion and the numerous obstacles that impede women from seeking abortion services. The scarcity of abortion data in the region is due largely to the fact that abortion statistics are not collected where abortion in prohibited (AGI 1999). Available data, gathered from random response technique (RRT) and hospital admissions from pregnancy related complications, is scarce and incomplete due to social stigma and illegality of abortion- both of which lead to underreporting and ultimately prohibit women from seeking abortion services.

A recent study showed that unsafe abortions caused 28% of all maternal deaths in Colombia, of which rural, poor, and indigenous women were disproportionately affected (Ceaser 2006). Furthermore, in 2005, national estimates show that 27% of births were reported as unwanted (Colombia 2005 Demographic Health Survey). Low income women, especially women in indigenous regions, have limited access to qualified service providers, especially for stigmatized health issues related to unwanted pregnancy and abortion (Acosta de Hart, Umana et al. 2002). According to the 2005 Colombia Demographic Health Survey, rural populations, primarily composed of indigenous persons, compared to their urban counterparts, have first sexual intercourse at younger ages (18.2% versus. 12.3% respectively); higher fertility rates (3.4 per 1,000 live births versus. 2.4 per 1000 live births respectively); earlier onset of teenage pregnancy (2.9 versus. 1.4 percent of women giving birth between 15-19 year of age respectively); and higher use of traditional methods of contraception (11.1 versus. 9.7 respectively) among married women. The Guttmacher Institute characterizes sexual intercourse, desire for children and contraceptive use as determining factors of unwanted pregnancy (AGI

1999). From these statistics, women residing in primarily indigenous regions are disproportionally represented in each of the aforementioned factors. These women are therefore at higher risk for unwanted pregnancy, and consequently unsafe abortion.

Influences of Unwanted Pregnancy and Abortion among Indigenous Populations

While few studies on the topic exists for Colombia, the work of Goicolea (Goicolea 2010), Singh (Singh 2006), and Mora and Villarreal (Mora and Villarreal 1993), demonstrated that parity, rural residence, and education level are primary factors in increasing the risk for unwanted pregnancy among women in developing countries. Unlike the work of Eggleston (1999), whose multivariate analysis showed that rural residence lowered probability of unintended pregnancy, the aforementioned studies showed lack of education, rural residence, and parity were risk factors for unintended pregnancy. Eggleston's bivariate analysis of the 2004 Ecuadorian Demographic Health Survey data demonstrated that by area of residence, unwanted pregnancies were more common among rural women (24%) compared to their non-metropolitan (16%) and metropolitan counterparts (20%) (n=4,534). Eggleston also found that by socioeconomic status, women in poor households were most likely to report their pregnancy as unwanted (26%), compared to women of higher socioeconomic status (14%). Eggleston's research still supports the current study because although the results showed that unintended pregnancy decreased with rural residence, unintended pregnancy did not decrease among indigenous groups. In fact, Eggleston noted unwanted pregnancy was far more likely to occur among women from the predominantly indigenous region, the Sierra region, than those from the coast. She further highlighted that regional differences in unwanted

pregnancy are largely due to the majority of the countries' indigenous Quichua populations residing in the Sierra region.

Furthermore, several studies conducted within the Amazon region of Ecuador, shed light on the determinants of unintended pregnancy and the factors that increase a woman's risk of experiencing an unwanted pregnancy (Goicolea 2010; Eggleston, 1999). A study conducted in the Amazon Basin of Ecuador found that being indigenous, young, and non-married were significant risk factors for unwanted pregnancy, as two thirds (73.7%) of indigenous women in the study reported having at least one intended pregnancy (Goicolea 2010). Compared with national statistics, which indicated that 43.3% of pregnancies in the Amazon region are unintended, Goicolea found that 62.7% of pregnancies occurring in the Amazon region are unintended (35.3% unwanted and 27.4% mistimed). Furthermore, the study found the likelihood of having an unwanted pregnancy was significantly higher among indigenous women, women who were young, single, low educated, and women who already had more than two children in the household.

The Ecuador National Demographic and Maternal Health Survey (ENDEMAIN, 2004) showed that the percentage of unwanted pregnancies was highest in the Amazon Basin, a region that is geographically and culturally identical to the Amazon region of Colombia. However, a limited number of published data has documented how unwanted pregnancy and abortion decisions are made among indigenous women in the Amazon of Colombia, and thus the specific process, context, and nuance of the said processes remain unexplained. The findings from the relevant research conducted in Ecuador are further supported by Singh (Singh 2006), who found that abortion rates are higher in the

Southwest region of Guatemala, which the authors characterize as a less developed, mainly indigenous population. The authors collected data using key informant surveys, and survey of hospitals that treat post-abortion patients to generate results.

Unwanted Pregnancy and Abortion Decision-Making

Limited research explores unwanted pregnancy and abortion decision-making, especially among indigenous populations in Colombia. Reasons why women choose abortion were listed in the AGI report titled, *Sharing Responsibility: Women, Society, and Abortion Worldwide* (AGI 1991), but lacked detail on the context in which such abortion decisions were made. Browner (1970), Cohen (1993), Llovet and Ramos (1998), and Sihvo (2003), highlighted the importance of examining the individual and social context in which such decisions are made. Llovet and Ramos (1998) conveyed the need to shift the focus of unwanted pregnancy and abortion decision-making analysis to include the "socially shaped frameworks of decision-making". Additional studies demonstrated how partner's attitudes and support greatly influence the decision to continue or to abort an unwanted pregnancy (Tornbom, 1994; Kroelinder, 2000; Zabin, 2000; Evans, 2001). Browner (1979) examined the unwanted pregnancy and abortion decision-making processes using in-depth interviews with 49 women in the urban city of Cali, Colombia, who reported having an unwanted pregnancy. Although Browner hypothesized that abortion decision would be made within female kinship networks, the study results showed that this was not the case. Browner found that the stability of the relationship in which the unwanted pregnancy originated was a primary determinant in influencing a women's decision to continue or to abort and unwanted pregnancy. If the unwanted pregnancy occurred within

a stable relationship, a woman was more likely to continue the pregnancy to term. In contrast, if the unwanted pregnancy occurred outside of a stable relationship, a woman was more likely to seek abortion services. A woman's decision to have an induced abortion is intrinsically affected by societal and cultural contexts. According to Browner (1980), policymakers lack data on the social context in which abortion practices and beliefs are generated. Lamentably, 20 years later, this need still remains. Furthermore, results from Browner's study were consistent with existing literature that demonstrated that a women's decision to continue or to abort and unwanted pregnancy was directly influenced by the level of stability in the relationship.

Gaps in the Literature

Literature examining unwanted pregnancy and abortion decision-making among women in indigenous populations is limited in scope and scarce in nature. Previous studies documented unwanted pregnancy and abortion among similar socio-demographic and ethnic groups (Goicolea 2010) to the target population, but none have yet to focus specifically on women residing in primarily indigenous populations in the Amazon region of Colombia. Existing quantitative research examined the issue of induced abortion in Colombia solely from an epidemiological and demographic perspective (Yam, Dries-Daffner et al. 2006). Such quantitative studies provided insight on the incidence of abortion in Colombia, and also on the characteristics of women who elect to have an induced abortion. However, these studies were limited in that they did not examine societal expectations of unwanted pregnancy and induced abortion, which play

an immense role in determining whether or not a woman will terminate a pregnancy (AGI 1999).

Published data on the specific social contexts that influence a woman's decision to have an induced abortion is limited especially among rural and indigenous populations (Llovet and Ramos 1998). Existing qualitative research on the topic is limited, as few studies have documented women's experience of induced abortion (Lafaurie et al. 2005). The literature lacks qualitative research that enlists the emic perspective, from those with personal experience of unwanted pregnancy and induced abortion in order to truly elucidate unwanted pregnancy and abortion decision-making processes (Llovet and Ramos 1998).

Given the alarming incidence of unwanted pregnancy and abortion in the restrictive context of Colombia very few studies have documented how the decision to abort or continue an unwanted pregnancy is made. Therefore, to address the aforementioned needs, the goal of the study is to elucidate the process by which women in the Amazon region of Colombia decide to abort or continue an unwanted pregnancy. For the reasons mentioned above, the study aims to shed light on the individual experiences and cultural and societal influences that potentially shape a woman's decision to abort or continue an unwanted pregnancy. Through qualitative methods, in-depth interviews, focus group discussions, and a ranking activity, the study will demonstrate how unwanted pregnancy and abortion decisions are made among women in the Amazon region of Colombia. The study is significant because the target population is at-risk and understudied, and given the recent legalization of abortion in Colombia, there

is a need to document the effects of the law change among marginalized, indigenous populations.

CHAPTER THREE: MANUSCRIPT

TITLE PAGE

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Contribution of Student

I am the primary investigator and author of the study. I conducted all data, with the assistance of in-country gatekeepers and reproductive health stakeholders. I analyzed all data using MAXqda10, with the guidance of my thesis advisor, Dr. Monique Hennink. Furthermore, Dr. Monique Hennink and Dr. Roger Rochat assisted in figure/table development.

Abstract

Background: Three years after the partial decriminalization of abortion in Colombia in 2006, less than 3,000 legal abortions have occurred, while 320,000 - 450,000 unsafe abortions continue to occur annually. National data shows that 27% of pregnancies are unwanted. Unsafe abortions caused 28% of all maternal deaths in Colombia, of which rural, poor and indigenous women were disproportionately affected. Yet, little data on unwanted pregnancy and induced abortion decision-making exists since this change in the law among women in the Amazon region.

Objectives: To understand the social and cultural perceptions, and individual experiences of unwanted pregnancy and induced abortion among residents in the Amazon Region of Colombia. To elucidate the process by which women decide to abort or continue an unwanted pregnancy.

Methods: 6 focus group discussions, which included ranking activities, were conducted separately among males and females. 13 in-depth interviews were conducted with women between 15-44 years of age, who had at least one unwanted pregnancy in their lifetime.

Results: Regardless of their decision, all women experienced the same stages in their decision-making process: knowledge, social and economic concerns, disclosure, contemplation of pregnancy outcomes, decision, and acceptance. A woman's decision was indirectly influenced by the advice provided by the maternal confidant and directly influenced by her relationship status at the disclosure stage. Women who decided to continue the pregnancy did so because they disclosed the pregnancy to a partner who desired the pregnancy. Women with less supportive partners, decided to continue the pregnancy in hopes that it would strengthen their current relationship. Women who did not have a partner at the time of disclosure decided to abort the pregnancy, in addition to other factors, which varied by age. Younger women's abortion decision was directly related to being single and a desire to continue school. Older women tended to abort due to marital problems.

Discussion: Decision making processes relative to unwanted pregnancy and abortion are intrinsically bound to socioeconomic and relationship factors. There is a need for future research in the Amazon region of Colombia that emphasizes the roles of the partner and maternal confidant at pregnancy disclosure.

Introduction

In Colombia, unwanted pregnancy and abortion are important human rights and public health concerns, especially among women in indigenous populations. From a human rights perspective, reducing unwanted pregnancy and having access to safe abortion are two indicators of women's reproductive health, and of the level of autonomy women have in reproductive decision-making (Eggleston 1999). From a public health perspective, an unwanted pregnancy that leads to abortion may increase a woman's risk of abortion related maternal morbidity and mortality (Glasier et al 2006); additionally, abortion is the leading cause of maternal morbidity and mortality in regions where abortion is legally restrictive, which is the case in most Latin American countries (Singh 2006), specifically Colombia. A recent study shows that unsafe abortions caused 28% of all maternal deaths in Colombia, of which rural, poor and indigenous women were disproportionately affected (Ceaser 2006). Other studies showed that women residing in indigenous populations are at greater risk for unwanted pregnancy; and therefore, unsafe abortion is more common among said populations. However, few studies examine the process by which and the context in which women in indigenous regions decide to abort or continue an unwanted pregnancy (Singh 2006; Goicolea 2010; Eggleston, 1999; Llovet and Ramos, 1998). The aim of this study is to elucidate the process by which women in the Amazon region of Colombia decide to abort or continue an unwanted pregnancy by shedding light on the individual, cultural, and societal influences that potentially shape a woman's decision. In doing so, this study will contribute to empirical research on unwanted pregnancy and abortion decision-making among marginalized women in the Amazon region of Colombia.

Methods

The Study

Figure 2: Map of Colombia

Source: http://www.umsl.edu/services/govdocs/wofact98/59.htm

In an effort to understand the process by which women in the Amazon region of Colombia decide to abort or continue an unwanted pregnancy, I conducted 13 in depth interviews and 6 focus group discussions with residents of Leticia, Colombia, the capital of the Amazonas department of Colombia. Located in the southernmost region of the country (See Figure 2), with a population of approximately 38,955 inhabitants (Regional Population Indicators 2008), Leticia shares its culture and its borders with Brazil and Peru in a union most commonly referred to as Tres Fronteras ("Three Borders"). Forty percent of Leticia's population is indigenous and dispersed relatively equally among urban and rural centers. Fieldwork lasted approximately 2 months (June 2010-August 2010). I conducted the interviews in Spanish. The settings in which in-depth interviews and focus group discussions were selected due to their affiliation with the sponsoring organization, Clínica Leticia. IRB submission was not required because the study was not human subject research.

Study Participants

Study participants for the in-depth interviews consisted of 13 women between the ages of 15-44 who reported having at least one unwanted pregnancy in their lifetime that they decided to abort or continue to term. Interviews were conducted with five urban women and three rural women who decided to continue an unwanted pregnancy to term. Additionally, five interviews were conducted with urban women who decided to abort an unwanted pregnancy. The aforementioned in-depth interview characteristics are shown in Table 2.

Table 2: In-Depth Interviews (IDIs), by unwanted pregnancy decision and residence, Leticia, July 2010

	Urban	Rural
	5 who decided to continue to term	3 who decided to continue to term
	5 who decided to abort	
Total	10	3

Participants were recruited based on the following criteria:

- Had at least one unwanted pregnancy in lifetime that they decided to abort or continue to term
- Must live in an urban or rural residential community in Leticia, Colombia

Participants were not asked whether or not they considered themselves to be indigenous, thus participant eligibility was not based on indigeneity, rather on urban or rural residency. The IDI participants averaged 20 years old and had an average of two children. At the time of the interview, three participants reported having obtained some primary school education; five participants reported some secondary education; and one

participant reported some level of college education. Three participants were currently pregnant at the time of the interview and one participant gave birth one day before the interview took place. Although employment status was not asked during the course of the interview, only four of the 13 participants made reference to any past or current employment during the interview. In regards to relationship status, three participants reported being single and 6 participants reported being in a domestic partnership. Some participants who reported being in a domestic partnership referred to their partner as their husband, but never specified being legally married. Thus the term, "domestic partnership" was used to describe all women in a relationship at the time of the study.

6 focus group discussions were conducted with 58 men and women (24 women and 34 men). Four focus group discussions were conducted with urban men and women. Two focus group discussions were held with rural men and women. The aforementioned focus group discussions characteristics are shown in Table 3.

Table 3: Focus Group Discussions (FGDs) by gender and residence, Leticia July 2010

	Gender	Urban	Rural
	Male (n=34)	2	1
	Female (n=24)	2	1
Total	58	4	2

Focus group discussions were conducted separately by gender. Participants were recruited based on the following criteria:

- Must live in an urban or rural residential community in Leticia, Colombia

FGD participants ranged from 13-81 years of age, most of who identified as indigenous. Because indigeneity was not a criterion for participation, participants were not asked whether or not they considered themselves to be indigenous. Participants' eligibility was based solely on urban or rural residency.

This study population is appropriate for this study for at least two important reasons. First, the study population is highly understudied, as literature documenting unwanted pregnancy and induced abortion in indigenous regions in Colombia is modest and limited in scope. Second, women who reside in indigenous regions are disproportionately affected by unwanted pregnancy, induced abortion, and maternal mortality/morbidity compared to their urban counterparts (Colombia Demographic Health Survey, 2005).

Participant Recruitment

8 in-depth interviews were conducted with women who reported deciding to continue an unwanted pregnancy. Five in-depth interviews were conducted with women who reported deciding to abort an unwanted pregnancy. Esteemed community leaders, and gatekeepers from Clínica Leticia were used to identify participants who experienced at least one unwanted pregnancy in their lifetime that ended in a life birth or termination (induced abortion and/or spontaneous abortion). Through active recruitment of participants using the methodology described above, as respondents entered the study, additional respondents were recruited by expanding into the social networks of previous respondents. This method is snowball sampling. It is a type of purposive sampling. Snowball recruitment relies on the notion that a woman who has experienced an unwanted pregnancy will be more likely to identify and/or know someone who has also

had an unwanted pregnancy. Snowball sampling was most appropriate for uncovering and gaining access to that population of women because they remain vulnerable and hidden, due to the fear, stigma and legal repercussions of induced abortion and unwanted pregnancy in their community.

A total of 6 focus group discussions were conducted with men and women residents of Leticia, Colombia. Separated by gender, three focus group discussions were conducted with male participants and three were conducted with female participants. Gatekeepers at Clínica Leticia introduced me to community leaders. The community leaders then recruited community members for the focus group discussions. Participants for the focus group discussions were recruited through snowball sampling, in that the existing social networks of the community leaders were used to identify individuals who shared similar characteristics (i.e. urban/rural residence) to participate in the focus groups. Given the anticipated nature of the study topic, gatekeeper and snowball sampling methods were most appropriate for participant recruitment for in-depth interviews and focus group discussions. As an outsider, I did not have existing social networks to build upon to recruit participants; thus, having to rely on the social networks of trusted and community leaders allowed the investigator to gain access into the communities and develop good rapport with respondents in order to conduct the study.

Participants for the in-depth interviews were asked a series of open ended questions from a list of topics on the interview guide, including: background information, family size, sex preferences, contraception preferences and knowledge, perceptions of unwanted pregnancy, unwanted pregnancy experience: identification, reaction and disclosure, opinions of abortion, knowledge of abortion law, and lastly, opinions of

reproductive health services in the region. Focus group participants were asked a series of open ended questions from a list of prescribed topics that proceeded as follows: pregnancy prevention knowledge, perceptions of unwanted pregnancy and community based solutions to mitigate incidence and effects of unwanted pregnancy. Furthermore, a short ranking activity was incorporated into the focus group discussion in which participants worked together to create a list of the most common reasons and causes of why women in their communities experience unwanted pregnancies. Questions asked during focus groups aimed to obtain contextual data about cultural norms and community perceptions of unwanted pregnancy and abortion. In contrast, those asked during in-depth interviews aimed to understand a woman's individual experience of unwanted pregnancy and in five of the 13 cases, induced abortion.

Research Instruments

Dr. Monique Hennink and I developed the research instruments, structured in-depth interview and focus group discussion guides, as provided in the Appendices section (Appendix A-D), from existing literature on the unwanted pregnancy and abortion decision making process. I translated interview guides from English to Spanish, prior to being tested in the field. An in-country collaborator checked and revised the translation of the interview guides. I pilot tested the research instruments once in the field.

Data Analysis

Data was recorded using a digital recorder. A hired transcriptionist transcribed verbatim all interviews and group discussions into Spanish to preserve the cultural significance and

nuances in participants' narratives. I used MAXqda10 to analyze data. Data analysis consisted of code development, data analysis (using description, comparison, categorization, and conceptualization tools), theory development, and theory validation. Codes were developed from common themes that emerged from the data. Using MAXqda10, a codebook was created that contained all relevant textual themes. Key codes that best pertained to the research questions were selected and then described and compared among textual data. Patterns were developed from the process of code comparison and description. Comparisons among in-depth interview participants were made based on the woman's pregnancy decision rather than the actual outcome of the pregnancy due to the myriad of pregnancy outcomes that existed for women who decided to abort, such as spontaneous abortion, termination of pregnancy, and/or live birth. A conceptual framework was then developed to illustrate the common patterns that emerged from the data. As the intricacies and nuances of the data contained within the conceptual framework became more eminent, grounded theory was developed. The grounded theory was validated using existing literature on the topic of unwanted pregnancy and induced abortion decision-making.

Results

Community vs. Individual Perceptions of Unwanted Pregnancy and Induced Abortion

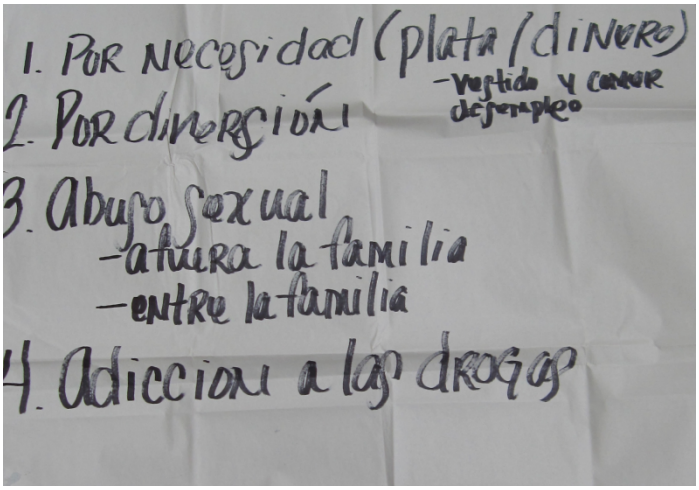
In order to understand the socio-cultural context in which women made the decision to abort or continue an unwanted pregnancy, focus group participants were asked to explicate the most common causes of unwanted pregnancy among women in their communities. When compared to the individual experiences of unwanted pregnancy as expressed by in-depth interview participants, the findings demonstrated a clear disconnect between societal perceptions and an individual's perceptions of unwanted pregnancy. Community perceptions of unwanted pregnancy obtained from focus group discussions and the individual experiences of unwanted pregnancy obtained from in-depth interviews differed in two fundamental aspects:

- Causes of unwanted pregnancy
- Who is to blame for an unwanted pregnancy

Community perceptions of unwanted pregnancy showed that sexual abuse (i.e. rape and/or incest) and sexual promiscuity (i.e. sex for pleasure or for diversion) were the most common causes of unwanted pregnancy among women, as shown in Figure 3 and 4. When compared, the study found that men and women shared similar perceptions of unwanted pregnancy. Furthermore, a similar trend was consistent among urban and rural participants. Furthermore, similar perceptions were found among urban and rural participants. Figures 3 and 4 show the similarities in responses among men and women in both urban and rural communities. Translated, the rankings of the most common causes of unwanted pregnancy as told by urban men, listed in Figure 3 proceed as follows: 1. For necessity (Women have sex for money to provide clothes and food, and

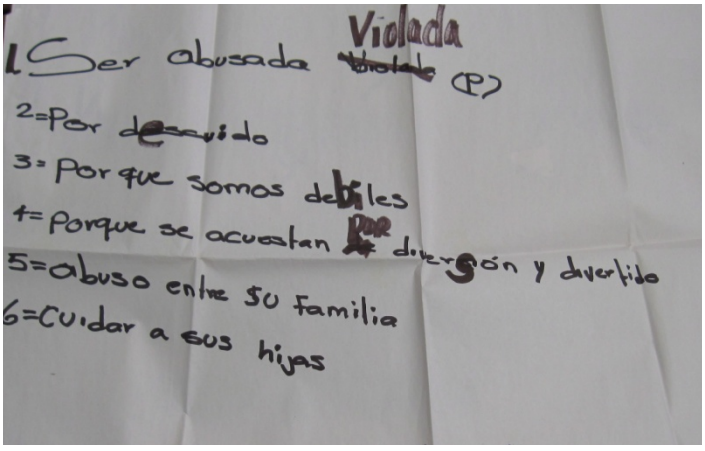
because of unemployment); 2. For diversion or fun; 3. Sexual abuse (intra and extra-familiar abuse, both within the family and outside the family); and, 4. Drug addiction.

Figure 3: Ranking of Most Common Causes of Unwanted Pregnancy by Urban Men in Leticia, Colombia



Translated, the rankings of the most common causes of unwanted pregnancy as told by rural women, listed in Figure 4 proceed as follows: 1. [We] Women are victims of sexual abuse; 2. For lack of care (contraception use); 3. Because we [women] are naïve; 4. Because we do things [have sex] for diversion and fun; 5. Sexual abuse in your [the] family; 6. Take care of your [the] daughters.

Figure 4: Ranking of Most Common Causes of Unwanted Pregnancy by Rural Women in Leticia, Colombia



Societal perceptions obtained from the focus group discussions depicted women who experienced an unwanted pregnancy as both the victims and culprits of sexual activity, a contradictory representation. As a result, when asked who was to blame for an unwanted pregnancy, male and female focus group participants in both urban and rural locations commonly mentioned that both the woman and the partner shared equal responsibility. Contrastingly, individual perceptions of women who experienced an unwanted pregnancy obtained from the in-depth interviews, showed that contraception non-use and/or contraception failure prior to conception were the primary causes of unwanted pregnancy In-depth interview participants, tended to depict themselves as victims of an unrequited love, rather than being sexually abused or promiscuous, as they commonly stated that they were involved in a monogamous relationship with a partner who cheats. In the same regard, these women also described themselves as "naïve" when it came to selecting a partner and beginning a relationship, as shown in Figure 4. Furthermore, individual perceptions showed that an unwanted pregnancy was the fault of the woman for not using a contraceptive method prior to or during contraception. Thus, such women tended to assume full responsibility for becoming pregnant unintentionally and therefore, expressed feeling sentiments of blame, either self-inflicted, inflicted by a partner or a close family member. The following two quotes provided examples of the immense sentiments of guilt expressed by in-depth interview participants in response to an unwanted pregnancy.

Interviewer*:* Tell me about your perceptions of unwanted pregnancy?
Women: Well my idea is that the woman is to blame for an unwanted pregnancy
Interviewer: And why do you think this?
Women: Because a woman knows that there are many methods for one to use to take care [prevent pregnancy]…she should not become pregnant

- In-depth interview participant, Rural, age 18

"And I was being stubborn then I took it off [the shot] so ... I got pregnant and he didn't want me to lose it because he felt that I was to blame [for getting pregnant]…Yes he told me that he didn't want me to abort. And he said, 'If you come to abort the child, you must leave here and leave the older girl.' That's what he said and I said I did not want that because I love him and my daughter…I thought about my family."

-In-depth interview participant, Urban, age 18

While community and individual perceptions about unwanted pregnancy differed significant, they aligned on the issue of induced abortion. Community and individual perceptions viewed abortion as a sin because it was believed to inflict suffering on an innocent life. Unborn children were often perceived as defenseless and therefore, did not deserve to be aborted. Additionally, abortion was considered as a sin because it went against God's will; it was viewed as a punishable crime in the eyes of God. All participants stated that women who have abortions would receive their punishment in the form of future infertility, birthing a child with severe health problems or malformations, and/or social isolation. Community perceptions characterized women who aborted as having a troubled or low moral character. In some cases, women who had an abortion were equated to murderers. Individual perceptions resonated these sentiments about abortion. Over half of women interviewed, considered having an abortion at first knowledge of the pregnancy. But because it was viewed as a sin, these women felt guilty for considering abortion. Commonly such women expressed sentiments of repentance, a desire for forgiveness, and a longing for moral strength, characteristics of moral distress. The similarities in feelings about abortion and the type of women who have abortion shared among by focus group and in-depth interview participants were represented in the following two quotes.

"Because there are many bad women. Take into account that to these women the child doesn't matter, but a good woman, she is concerned with the sacrifices and everything they [she] have to do for the baby."

-Focus Group Discussion, Urban Male

"It wore on me, I cried a lot. I thought about abortion. But after that I asked for God to give me strength… I felt alone, abandoned by my husband…it bothered him that I wanted an abortion, but I was embarrassed because I already had a lot of children. I was ashamed of society…"

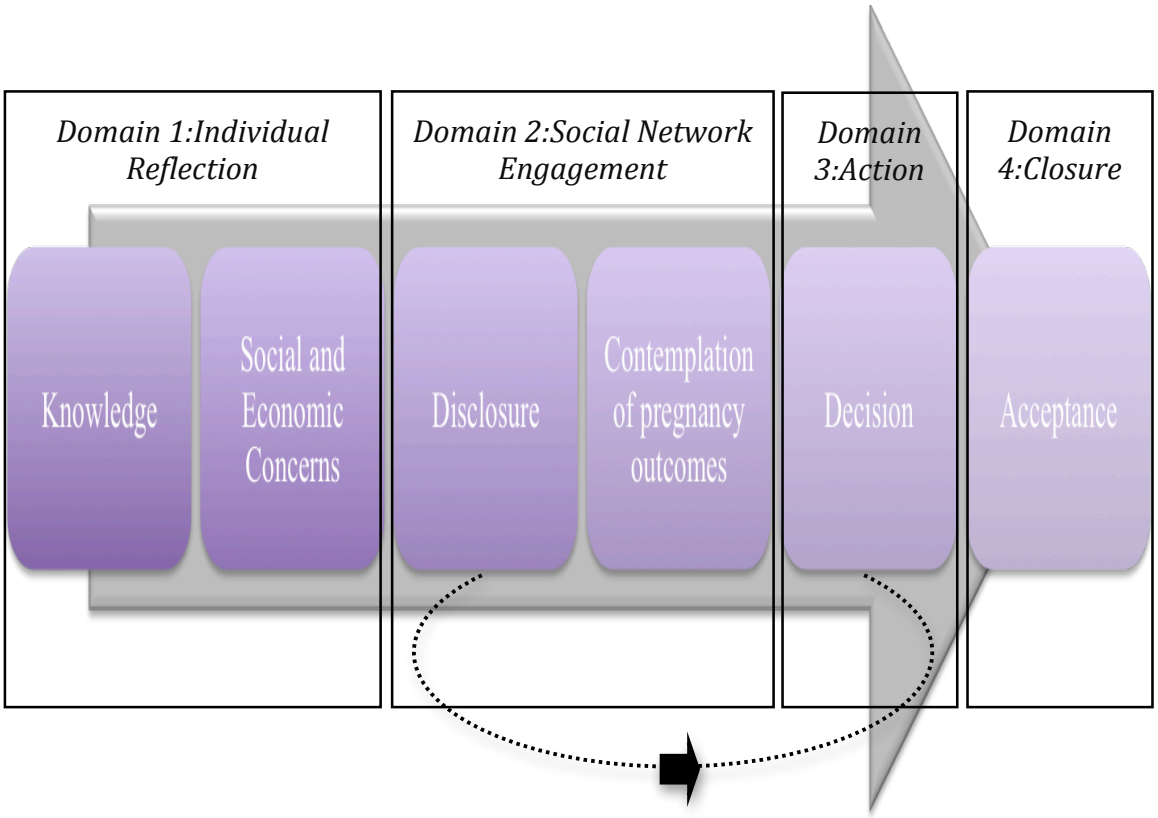
-In-depth interview participant, Rural, age 37

Abortion was not widely accepted among focus group participants. When informed of the recent 2006 decriminalization of abortion under the following three circumstances: 1. When pregnancy is a result of rape or incest; 2. When grave fetal malformations make life outside the uterus unviable; and, 3. When the life or health (physical and mental) of the woman is in danger, participants expressed strong opposition to the new law. They often perceived that there were no situations that warrant an abortion, even in the cases rape or incest. Additionally, among in-depth interview participants, the study found a strong disconnect between a woman's individual actions and their beliefs. This is represented by the fact that while all in-depth interview participants opposed abortion, half of in-depth interview participants reported considering abortion at first knowledge of the pregnancy. And a fourth of participants who decided to continue the pregnancy, reported having one or more abortions in the past. These findings suggest that a woman's moral views of abortion had little influence on her decision to abort or continue an unwanted pregnancy.

The Decision-Making Process

From data analysis, a grounded theory was developed to show the chronological order of the decision-making process. This study found that all women, regardless of their decision, followed the same decision-making trajectory. As depicted in Figure 5, the decision-making process was comprised of individual stages and action domains.

Figure 5: Unwanted Pregnancy Decision-Making Process for Women in the Amazon Region of Colombia



The first domain was individual reflection. In the individual reflection domain, the woman reflected on the pregnancy and its perceived social and economic implications. Her initial thoughts, reactions and concerns about the pregnancy are created in isolation, without any influence from outside sources, such as family members, friends, and/or partners. The individual reflection domain was comprised of two stages: knowledge and

social and economic concerns. And the first stage within the individual reflection domain was knowledge. This stage characterized women's initial response to the pregnancy. The knowledge stage was followed by the social and economic concerns stage, the second stage of the decision-making process. During the social and economic concerns stage, women began contemplating how the pregnancy would affect her economic and social standing in the community. It was also during this stage that women deemed the pregnancy as unwanted due to its perceived hindrance on her financial security and social status.

The social network engagement domain followed the individual reflection domain. In the social network engagement domain, the woman's disclosed the pregnancy to members of her existing social and familial networks. No longer reflecting in seclusion, the woman's thoughts, decision, and acceptance of the pregnancy were influenced by the opinions of others. The social network engagement domain was comprised of two stages: disclosure and contemplation of pregnancy outcomes. The first stage within the social network engagement domain was disclosure. During the disclosure stage, the woman disclosed the pregnancy to members of her existing social and familial networks. The study found a direct connection between the disclosure stage and the decision stage. The dotted line and the arrow linking the disclosure and decision stages, as seen in Figure 5, depicted the aforementioned finding. The relationship between this linkage, disclosure and the woman's decision, will be explained in greater detail in later sections.

The fourth stage was contemplation of pregnancy outcomes. At this stage the woman weighed the pros and cons of aborting or continuing the pregnancy. Religious beliefs,

perceived social and health risks of abortion, and previous life experiences with unwanted pregnancy and/or abortion emerged as indirect influences on the woman's decision during this stage. Such influences did not directly influence the woman's decision. Instead these indirect influences validated the decision she intended to make. In both stages, the woman shared the pregnancy with her existing social and familial networks, and was influenced by their opinions. The social network engagement domain and its two stages, disclosure and contemplation of pregnancy outcomes, were followed by the action domain.

The third domain was action. In this domain, the woman made the decision to abort or continue an unwanted pregnancy. The action domain was comprised of the decision stage. During the decision stage, the woman made her decision based on the specific socioeconomic and relationship influences that occurred in the previous domains. The decision stage was the only stage that comprised the action domain.

The closure domain followed the action domain. In the closure domain, the woman used all previous influences and experiences that transpired throughout the decision-making process to come to peace with her decision, to reach closure. In this domain women described their feelings about their decision and how it has shaped their life. The closure domain was comprised of the acceptance stage. The acceptance stage occurred at varying points in the woman's life post decision and it represented how the woman was able to accept her decision.

The Decision Process for Women who Decided to Abort

Women who decide to abort the pregnancy experienced all the following decision-making stages depicted in Figure 5. During the knowledge stage, when asked to recall how they felt when they first discovered they were pregnant unintentionally, participants reported feeling sad and emotionally distraught. Most participants considered abortion. Crying was commonly described as the participant's initial response to learning of the pregnancy. Women reported feeling sad because they felt responsible for the pregnancy due to their lack of contraceptive use prior to or during conception. Guilt was also described as a common emotion experienced during the knowledge stage.

The next stage was social and economic concern. This stage occurred after the knowledge stage, the stage in which the woman first discovered she was pregnant unintentionally. During social and economic concerns stage, participants began to consider how the pregnancy would affect their social and economic standing within their community. Women perceived the pregnancy to be an immense threat to their economic security and social standing. The economic burden of providing for the child was consistently characterized as the woman's problem, because the woman perceived the pregnancy to be her fault. Furthermore, the study found that types of social and economic concerns given by women who decided to abort varied by age. Younger women tended to live in the household with their parents and extended family members; and, therefore felt the pregnancy would hinder their familial relationships. They also feared that being a mother at such a young age would cause them to be rejected by their family members. Given that younger women tended to experience an unwanted pregnancy while in school, they felt that the pregnancy would hinder their educational attainment, and therefore,

prevent them from becoming successful in the future. These women often stated feeling that their age rendered them incapable of being able to provide for a child. Given these women's concerns about age, school, and their capacity of proving for a child, the following quote was an example of a young woman's abortion decision.

"The truth is at the age of fifteen I had my first relationship and I became pregnant with my first child. Which was never a planned pregnancy. But as time passed, it turned into an unwanted pregnancy because never did my parents agree with what I had done. I didn't agree either. I never had a clear picture of motherhood. And things happened that at first gave me much fear, I thought about abortion. I said I am a little girl, I cannot take raise a child. My studies came first."

-In-depth interview participant, urban, age 23

While younger women expressed social and economic concerns related to educational attainment and familial rejection, older women's tended to consider how the pregnancy would lead to marital problems. Older women often stated that the pregnancy would exacerbate economic conditions within the marriage. Economic instability in a marriage was perceived to lead to separation or divorce, two immense social fears among participants. The quote below provided an older participant's account of how her relationship became economically and emotionally strained as a result of an unwanted pregnancy.

"For example, for example, in this case… I mean at first I did not agree, I woke and I was with my husband..and for the situtation he didn't have work and I was in the house. Then he does it [leaves]…and I don't understand, I don't know where to find him. I spent my earnings because the children that I have are grown. I help them, I look for work, and this pregnancy comes…but, and he disappeared, found refuge in drugs and then came the problems and for it was unbearbale because I was pregnant. I had headaches, nausea and all that. Then it is not his problem and there are things that neither one of us can agree on…there is discussion and well there are things that one cannot stand, you just want to be quiet."

-In-depth interview participant, Urban, age 28

During the disclosure stage, women who decided to abort the pregnancy disclosed the pregnancy to a "maternal confidant" (e.g. a mother, aunt, older female friend or neighbor). The confidant figure was always female. Serving a dual role as a disciplinarian and also an unwavering support system, maternal confidants provided advice to participant during the disclosure stage. While the specific advice given by the maternal confidant varied greatly, the support given by the maternal confidant was unfaltering. Participants used words like, "trust", "dialogue", and phrases like, " we don't keep secrets", when describing their relationship with a maternal confidant. While most participants did not directly attribute their decision to the advice given to them by a maternal confidant, it was commonly reported that such opinions were of great assistance during the decision-making process.

After the woman disclosed the pregnancy to a maternal confidant, she contemplated the pregnancy outcomes. During the contemplation of pregnancy outcomes stage, indirect influences related to religion, perceived health, social, and spiritual risks did not affect the woman's decision to abort. Participants determined that their desire to abort outweighed the perceived risks.

As previously mentioned, myriad of other factors in addition to being single at the time of disclosure, influenced a woman to decide to abort the pregnancy. The study found that age, a desire to continue school, and marital problems were the primary influences on a woman's decision to abort. Younger women's abortion decisions were related to being young, a student, and being single, as described in the quote below and in Case Study 1.

"Obviously, because obviously, like I told you…bicarbonate, coffee….I don't want to remember exactly what happened in those moments…I did all of this because I wanted to finish school… I didn't have the possibility to give things to the baby. "

-In-depth interview participant, Urban, age 19

*Case Study 1: *Ana's decision-making process to abortion*

In 2002, at the age of fifteen Ana experienced her first relationship and her first pregnancy. She cried when she first discovered she was pregnant. She felt she was a child, and therefore felt incapable of handling the responsibility of taking care of a child. She thought about having an abortion as she was very afraid: afraid of motherhood; afraid of people in her community knowing that she was pregnant; afraid of disappointing her parents; afraid of not being able to continue attending school. The first person she disclosed and discussed her pregnancy with was her older best friend, Pilar. Pilar told her, " No, Ana you are too young and you have a full life ahead of you. No, this baby cannot come." Ana also disclosed and discussed her pregnancy to the child's father. He said that the child was not his and that he would not help her raise the child. Ana then told her mother about her pregnancy. Her mother was initially disappointed, but decided that it would be best for Ana to have an abortion. When her mother told her father, her father thought it was best for Ana to keep the child. He said, "Abortions take the life of the mother and the life of the innocent, the child." After an intense discussion, Ana's mother convinced her father that having an abortion was the best option for Ana because they both wanted her to continue school. Ana tried to figure out what was best for her. She didn't want to abort because she was afraid of the procedure; she thought she would hemorrhage or become infertile. She was also afraid that if she decided to have a child in the future that it would be deformed or ill because she had an abortion in the past. But when she thought about her strong desire to continue school so that she could be successful, and the fact that her boyfriend did not intend on helping to raise the child, she decided to abort. Ana's mother took Ana to Brazil to have the procedure, because the procedure was illegal in Colombia. Eight years later, when asked how she feels about her decision reflecting she stated, "what's done it done", and showed no remorse for her decision. She feels content about her decision because she was able to graduate high school. She is currently in a relationship and has a child that she loves dearly.

**Not the participant's actual name*

Case study 1 provides a typical example of a younger woman's decision-making process to abort. At first knowledge of the pregnancy the woman considered abortion. Feeling that the pregnancy would cause immense social and economic hardships because of her age, desire to continue school, and the fact that her partner did not accept the pregnancy, the women entered the stage of social and economic concern. At disclosure, she received social, physical and emotional support from her mother. And because she

was not in a relationship at the time of disclosure, in addition to the aforementioned social and economic factors, she decided to abort the pregnancy. During the contemplation of pregnancy outcomes stage, her initial social and economic concerns prevailed over her moral beliefs about abortion. At the decision stage, the women used each of the aforementioned factors related to age, desire to continue school, and relationship status at the time of pregnancy disclosure to influence her decision. After deciding to abort, the reached closure once she was able to resume with her studies.

In contrast, older women's abortion decisions were based on the stability of the relationship. These women tended to give marital problems as their reasons for deciding to abort. The following quote provides an account of an older woman's abortion decision.

"I was having a lot of problem with my spouse. Yes, we were having a lot of problems at the time. He turned to drugs and alcohol and I felt alone. I wanted to do something…anything…so I fell [in an attempt to abort the pregnancy]. And now I am here [hospital]. It is a very sad situation."

–In-depth interview participant, Urban, age 28

Once they decided to abort the pregnancy, women reported using one or a combination of the interventions listed in Figure 7 to intervene the pregnancy's course.

Figure 7: Reported induced abortion methods among women of reproductive age in Leticia, Colombia, by route of administration

Treatments taken by mouth	
	Bicarbonate
	Toxic solution
	Cytotec (Misoprostol)
	Café Amargo (bitter, dark coffee) with four aspirins
Trauma	
	Abdominal massage
	Falling onto stomach

Some women were successful in terminating the pregnancy and others were not. Women reported feeling extremely nervous at the time they attempted to induce abortion. The decision stage was followed by the acceptance stage. For women who decided to abort, the phrase "lo que hecho esta hecho" (what is done is done), was commonly to describe how they felt about their decision, in addition to feeling content with the decision. Younger participants said that they reached a stage of closure once they were able to continue school, while older participants reached closure once the economic situation of their relationship improved.

The Decision Process for Women who Decided to Continue to Term

Women who decided to continue the pregnancy experienced all the following decision-making stages depicted in Figure 5. These women experienced the same feelings of sadness and turmoil as women who decided to abort. These women also considered abortion during the knowledge stage. However, the study found that most participants who decided to continue the pregnancy had past abortion experiences. Thus, at first knowledge of the pregnancy, while the initially considering having a repeat abortion, their past experiences with unsafe abortion deterred them from aborting the current pregnancy.

" I mean in my situations, the abortion that I've had, I didn't have them because I wanted to, but because of the circumstances, the obstacles. I already know what happens while you are at work, where you are standing, the pain begins, and you are bleeding and you lose the baby. I did not have my conscious then."

-In-depth interview participant, Urban, age 39

After discovering they were pregnant unintentionally, women who decided to continue the pregnancy did not experience the same economic concerns as expressed by women

who decided to abort. Women who decided to continue the pregnancy tended to have more children in the household than women who decided to abort. Thus, these women felt that having another child would further strain their financial situation because they already had children, particularly young children in the household that they were providing for, in some cases without the support of their partners. The following quote described social and economic concerns expressed by a participant who experienced an unwanted pregnancy shortly after having her first child.

" I cried, because the truth, what was I going to do with two girls? My daughter is young and how was I going to be able to care for the other? Having to provide for them would be very difficult for me becasue I am alone. And I said ' the only thing I can do it abort the baby', this is what I thought."

-In-depth interview participants, Urban, age 18

In contrast, these women did share same social concerns as younger women who decided to abort. They felt that the pregnancy isolate them from their family and they feared of what community members would think about them.

After they reflected on the pregnancy alone, participants disclosed the pregnancy to their existing social and familial networks. At this time, participants reported disclosing the pregnancy to a maternal confidant (e.g. a mother, aunt, older female friend or neighbor), similar to women who decided to abort. However, the advice given to women who decided to continue the pregnancy by the maternal confidant was consistently in support of continuing the pregnancy. This was not the case for women who decided to abort, who often received advice that was in support of and/or against Fan abortion. Participants reported that their maternal confidant told them that it was best to keep the pregnancy because the child is innocent and that the parents should take responsibility for their actions by birthing the child. The following quote was an example

of the views against abortion, which were most commonly expressed by maternal confidants of women who decided to continue an unwanted pregnancy.

> "I didnt want to have babies, but because I didn't use contraceptive, well now I have my daughter. I have, at times I've had the desire to abort her, because I didn't want her. I didn't say anything to my mother or my father at first. I was scared of that they would reject me or hit me. Then I told my mother and she told me that the children are not to blame for coming into this world, but one parent for not being repsonsible in certain things."
>
> -In-depth interview participant, Urban, age 19

Similar to women who decided to abort, these participants did not directly attribute their decision to the advice given to them by a maternal confidant, but rather reported that such opinions were of great assistance during the decision-making process.

Women who decided to continue the pregnancy reported doing so because they were in a relationship at the time of disclosure. At this time the participants who had a partner who was in support of the pregnancy, reported feeling immensely supported and looked forward to having the child. Women who did not have a supportive partner felt that the pregnancy could strengthen their relationship. The intricacies that emerged from the data in regards to the role and support received from partner and its effect on the woman's decision to continue the pregnancy will be explained in greater detail in later sections.

After the woman disclosed the pregnancy to a maternal confidant and her partner, she contemplated the pregnancy outcomes. During the contemplation of pregnancy outcomes stage, indirect influences related to religion, perceived health, social, and spiritual risks indirectly influenced the woman's decision to abort. Participants determined that an abortion was not worth the perceived risks. And because they had the

support of their partner, or hoped to receive their partner's support, they ultimately decided to continue the pregnancy.

And as previously mentioned the study found a direct connection between relationship status and a woman's decision, as depicted in Figure 5 by the dotted line and arrow that links the disclosure and decision stages. For women who decided to continue the pregnancy, regardless of the quality, or rather the stability of the relationship, all participants reported keeping the pregnancy for one of following reasons: if they were having problems in their relationship, they imagined that the birth of the child would strengthen the quality of their relationship or their partner didn't want them to abort. The following quote was an example of how one woman contemplating keeping the pregnancy to improve the relationship.

"Although we were having problems, I never though about aborting my child because I thought about a life with the child's father, well that we would all be together."

-In depth interview participant, Urban, age 19

Case Study 2 represented an example of a woman who continued the pregnancy because her partner was against abortion. It provided a typical example of the decision-making trajectory of women who decided to continue an unwanted pregnancy.

*Case Study 2: *Rosa's decision-making process to continue to term*

Rosa is 18 years old and has just given birth to her second child. Becasue Rosa and her husband were not using contraception, Rosa became pregnant shortly after gving birth to her first child. This pregnancy was unwanted. When Rosa discovered she was pregnant, she began to cry as she thought about raising another child in addition to the small child already in the household. Thinking about how difficult it would be to provide for another child, Rosa thought about abortion. Shortly after, Rosa began to feel bad about her intial thoughts of aborting the child. She asked for forgiveness from God and her husband. One day, a female neighbor noticed that Rosa was pregnant. Rosa trusted the neighbor enough to discuss the pregnancy with her. She was honest and told her that she did not want to have the baby. The neighbor told her to think about her future family, to see the situation for what is really is and that it was best for her to keep the baby. Additionally, Rosa's husband did not want her to have an abortion. He told her, "Everything is fine. What you are going to do is have the girl and we will love and care for them both." Rosa then thought about the consequences of having an abortion. She was afraid that she would die and that an abortion would weigh heavy on her conscious. Not wanting to suffer from having an abortion, and knowing that her husband would be there to support her and the child, Rosa decided to have the baby. In reflecting on her decision, Rosa stated, " I feel good, happy, and pleased because this is my baby. Because if I had aborted it would have remained on my consciousness, inside me, that I killed my baby. Losing it is a pain." Rosa lives with her partner and their two children. Her daughters help her around the house and she is excited everyday to see them grow.

**Not the participant's actual name*

At first knowledge of the pregnancy the woman considered abortion. Feeling that the pregnancy would cause immense social and economic hardships because she already had a small child that she was providing for alone, the woman entered the stage of social and economic concern. She received social, physical and emotional support from an older female neighbor and her partner during the disclosure stage, which ultimately influenced her to decide to continue the pregnancy. Because she initially considered abortion, during the contemplation of pregnancy outcomes stage, she asked God to forgive her for initially considering abortion. She then used her renewed sense of spiritual resolve to decide that continuing the pregnancy was best. During the decision stage, the woman decided to continue the pregnancy. In this case, the woman reached closure shortly after giving birth

to the child, a commonly sentiment expressed by women who decided to continue to term. These participants reported that seeing their child made them happy about their decision. They also reported that having the child around to assist with daily household activities and chores, such as cooking, cleaning, and laundry, was of great assistance. It was commonly mentioned that being able to witness their child grow provided great joy, happiness, and closure.

Discussion

A myriad of factors influenced the woman's decision to abort or continue an unwanted pregnancy to term, such as the woman's age and relationship status. The study found the advice given to the women by the maternal confidant to be a secondary core influence on the woman's decision. Among women who decided to continue to term the maternal confidant provided sage advice that indirectly influenced the woman's decision to continue the pregnancy to term; however, this was not true in all cases for women who decided to abort. Although all women who decided to abort received advice from a maternal confidant, the type of advice varied, as it was not always in support of abortion. The core influence on a woman's decision to abort or continue an unwanted pregnancy was her relationship status at pregnancy disclosure. The disclosure stage was the first stage in which a woman transitioned from a state of individual reflection to social network engagement. Thus, this time was marked by a woman's need for support, particularly from her partner. The quality of the relationship at disclosure was inconsequential, as the present findings show that the actual state of being in a relationship has the most impact on a woman's decision to abort or continue an unwanted pregnancy. Women in a relationship at the time of pregnancy disclosure chose to continue an unwanted pregnancy to term. In contrast, women who were not in a relationship at the time of disclosure chose to abort the pregnancy. Previous studies have shown how a partner's attitudes and support greatly influence a woman's decision to abort or continue and unwanted pregnancy (Browner 1979; Torres and Forrest 1988; Tornbom, Ingelhammar et al. 1999; Kroelinger and Oths 2000; Zabin, Huggins et al. 2000; Sihvo, Bajos et al. 2003). But such empirical studies have failed to explore the key

nuances encompassed with disclosure stage that determine why women decide to abort or continue an unwanted pregnancy.

Another important finding was the variation in abortion decision by age. Younger women perceived that continuing the pregnancy would limit their personal and educational opportunities. These findings were consistent with existing literature that demonstrate that younger women, tend to give educational and work-related expectations, and financial difficulties with respect to their age as reasons for abortion (Mora and Villarreal 1998). However, the present findings differed from those provided by existing empirical studies, in that they targeted unwanted pregnancy and induced abortion decision-making among a primarily understudied and marginalized population of women in the Colombian Amazon. There is a dearth of existing literature that examines poor, rural, and indigenous women's experiences of unwanted pregnancy and induced abortion in Colombia. Therefore, this study showed that age has a similar influence on abortion decisions among Amazonian young women in comparison to women in more affluent regions in Colombia.

In 2005, out of the thirty-three departments of Colombia, the Amazonas department ranked fifth in secondary education completion percentage for women (Colombia Demographic Health Survey 2005). Thus the high expectation for young women in the region to graduate secondary school or obtain employment influenced young women who experienced an unwanted pregnancy while in school to abort. In contrast, older women chose to abort due to marital problems. While this finding is supported by the research of Shivo and Bajos (2003), it opposes that of Mora and Villarreal (1998), who found that among older women in Bogota, Colombia, the partner's

involvement did not influence the woman's decision to abort the pregnancy. Thus more extensive research is needed on unwanted pregnancy and induced abortion particularly among older women in the region.

In the study context, abortion is not widely accepted. Participants demonstrated limited knowledge about the legality of abortion in Colombia. When informed of the law, participants agreed with the legal restrictions of abortion imposed on women in the country. In further discussing the legality of abortion, participants showed great opposition to abortion even in the cases in which it is legal, and reported that it is only common among women of low moral character. While elicited community and individual perceptions viewed abortion as a sin, it is important to note that over half of woman in the study considered abortion at first knowledge of the pregnancy. At this time, women who continued the pregnancy immediately ruled out having abortion due to their previous abortion experiences. However, women who decided to abort followed through on their initial thoughts. This suggests that while abortion is not widely accepted, it occurs among all women, regardless of their individual religious or moral beliefs and those of society. The present finding is supported by the work of Llovet and Ramos (1998).

Two limitations in this study deserve mention. First, there is potential for bias in that participants may have felt pressured and/or obligated to participate as a result of being purposively selected by esteemed community leaders and gatekeepers. In order to minimize any pressure experience by the participant, I verbally informed each participant that participation in the study was voluntary, and that they had the right to stop the interview at any time they sought fit. Furthermore, to ensure the confidentiality of participants, recruitment strategies and eligibility criteria were completely confidential.

Second, given the legal environment surrounding abortion in Colombia, data may have been affected by participant's apprehension to accurately report their experience with induced abortion for fear of social isolation and/or incarceration. In order to minimize any pressure felt by the participant to participate, all interviews were conducted in private locations, such as private consultation rooms in the health center, the participant's home, or empty school classrooms. To ensure that participants who decided to abort, did not feel targeted during the interview and/or the focus group, an array of general reproductive health questions were asked to all participants throughout the course of the interview.

Conclusions

Explorative studies on the process by which women in the Amazon region of Colombia decide to abort or continue an unwanted pregnancy are scarce. This qualitative study shows that a woman's relationship status at time of pregnancy disclosure direcly influences her decision to abort or continue an unwanted pregnancy. While relationship status at time of disclosure is key, the study also found the advice given by the maternal confidant to be a secondary influence on the woman's decision to abort or continue an unwanted pregnacy. Futhermore, the study found that the influences on a woman's abortion decsion vary by age. The study shows that abortions occur in the region, most of which are unsafe, despite existing social and moral norms that oppose abortion under all circumstances. Lamentably, women who decide to abort resort to unsafe methods, and suffer disproportionately from emtional and physical complications like hemorrage, infertility; and, in the most severe cases, death (Ceaser 2006). This study also shows that contraception use in the Amazon is relatively low, when compared to urban regions of Colombia. Cultural preferences regarding tradtional methods has created a gap in contraception knowledge and decreased usage of modern methods among women in the region. A recent study states that the only way to avoid unwanted prengancies and induced abortion without restricting women's health, is to actively promote awareness and use of effective contraceptive methods (Mora and Villarreal 1998). Thus, in looking beyond the legal climate of abortion in Colombia, a significant amount of work is needed to mitigate the incidence of unwanted pregnancy by expanding access and knowledge of modern contraceptive methods.

CHAPTER FOUR: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

As previously mentioned, unwanted pregnancy and induced abortion are two salient public health and human rights issues, particularly among women in the Colombian Amazon. Although recent national statistics estimate contraception use in Colombia is 68%, which is comparable to that of developed countries, particularly the US, 27% of all pregnancies in Colombia were reported as unwanted. Recent statistics from the 2005 Colombia Demographic Health Survey show that women in the Amazon region of Colombia are disproportionately affected by higher fertility rates (3.4 per 1,000 live births versus. 2.4 per 1000 live births) and higher use of traditional methods of contraception (11.1 versus. 9.7) among married women, compared to their urban counterparts. Yet there is a lack of formidable research documenting women's contraceptive histories and experiences with contraceptive failure among women in the Amazon region of Colombia when it is evident that this population of women are at greater risk of unwanted pregnancy and consequently, unsafe abortion.

While abortion was recently legalized in 2006 by the Colombian Constitutional Court, statistics show that less than 3,000 legal abortions have occurred and estimates of unsafe abortions have remain unchanged. Numerous institutional barriers, such abuse of conscientious objection by providers and extended waiting periods for institutionally required documents, like police reports in the case of rape or incest, still remain. Such barriers impede women from accessing safe abortion services. While minor improvements have been made and furthermore, documented in major cities, like Bogota and Cali, unfortunately, the same cannot be said for indigenous regions like Leticia, Colombia. A recent study shows that in indigenous regions, the access to abortion and

knowledge of the abortion law may be less improved compared to metropolitan regions as a result of the weak infrastructure, less access to information and weaker advocacy initiatives (Amado, Calderon Garcia et al. 2010) prevalent in indigenous communities.

Drs. Javier and Gloria Gutierrez, the founders of Clínica Leticia initiated the present study in response to the urgent public health need to document unwanted pregnancy among women in the region given the changing climate around abortion in the country. Given the lack of empirical research on unwanted pregnancy and unsafe abortion among residents of the Colombian Amazon, Drs. Javier and Gloria Gutierrez felt that a qualitative study aimed to elucidate the process by which women decide to abort or continue an unwanted pregnancy would provide the best evidence to address the aforementioned issues among women in the region.

The present study determined that impact of relationship factors particularly at the pregnancy disclosure stage directly influence a woman's decision to abort or continue an unwanted pregnancy. This finding has immense public health implications.

In response to the role of the partner in a woman's pregnancy decision making in Colombia, Llovet and Ramos (1998) stated, "the link between men's responses and the cultural milieu in which gender relations and male involvement in sexuality and reproduction takes place have yet been sufficiently explored, though they have become a focus of social research in the region in the recent year" (pg 59). This study expands on existing literature by showing that a woman's decision is directly influenced by her relationship status at the disclosure stage. Existing literature does not specify the exact stage during the unwanted pregnancy decision-making process in which a partner's support influences the woman's decision. Knowing the exact stage in which the partner's

support is required, this study provides groundbreaking information that future public health initiatives in the region can expound upon. Public health initiatives in the region should target male populations as a means of better understanding how the support of the partner during the disclosure stage influences a woman's decision. The perspectives of male will shed greater light on the kind of support women need during the decision-making process. And in doing so, public health entities can develop programs that provide similar support to that of the support provided by a partner for women who lack partner support at the disclosure stage. By addressing the woman's need for support during the disclosure stage, future programs will have the potential to promote contraceptive to prevent future unwanted pregnancies, and to encourage safer abortion methods among women in the region.

The present study also found the advice given to the woman by a maternal confidant at pregnancy disclosure had an indirect, but noteworthy impact on the woman's decision to abort or continue an unwanted pregnancy. In addition to other factors, in most cases, women who aborted did so because they had a maternal confidant that instructed them to do so. Similarly, women who decided to continue the pregnancy had a maternal confidant that instructed them to do so. This is not a coincidence. Given their astute life experience and knowledge, these maternal confidants are beacons of support for the women who experienced an unwanted pregnancy. The role of the maternal confidant in the abortion decision-making process has immense public health implications, especially among indigenous women, whose culture emphasizes the passage of tradition and knowledge from elders to younger generations. The study found that older women, not the participants' mother, such as aunts and/or female neighbors, were viewed as

confidants. Thus women sought and took heed to the opinions given by said maternal confidants. While the present findings oppose the work of Brower (1980), who found that the role of kin did not play a significant role in post-conception decision making, this study diversifies the meaning of kin by showing that older female figures, such as trusted community leaders or neighbors, have a significant impact on a woman's decision to abort or continue an unwanted pregnancy. Furthermore, while most research focuses solely on the role of the mother during the woman's decision-making process, this study highlights the need for more formidable research on the role of maternal confidants, like aunts, female neighbors and coworkers, and older female friends in the woman's decision-making process. There is a direct need for more public health initiatives that target this group. Given their respected role in the community, public health programs aimed at addressing issues related to unwanted pregnancy and induced abortion should incorporate said maternal confidants. Such women could be used to promote contraceptive awareness and use among younger women and also assist women considering induced abortion with unsafe methods. Public health initiatives that focus on maternal confidants rather than solely on the mothers of women who experience an unwanted pregnancy, are more culturally appropriate and therefore, will provide a culturally relevant avenue to mitigate the incidence of unwanted pregnancy and induced abortion in the regions.

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APPENDICES

Appendix A: In-depth Interview Introduction and Guide

In-Depth Interview Introduction

Good morning. My name is Ryan Woodson. I am working with Clínica Leticia on a research project about reproductive health in the region. As a part of the project I am talking to women who have possibly had an unwanted pregnancy. Today I am particularly, interested in talking to you about your knowledge and attitudes about unwanted pregnancy and possible outcome of having an unwanted pregnancy, like abortion. I want to let you know that your participation in this interview is completely voluntary, and if you want to stop at any time please don't hesitate to let me know if you don't feel comfortable answering a questions or don't want to continue with our conversation. Also, the interview will be completely confidential and anything you say will not be shared with anyone in your community. If you don't mind, I would like to record our discussion so that I don't miss or forget anything that we talk about. So it is ok for me to record this interview? I want you to know that all research documents relating to our conversation will not include your name or any of your personal information.

I am very excited to speak with you. I have certain topics that I would like to discuss, but because I want this to feel like a conversation, please feel free to bring up any topics of you feel are important and related. I am very interested in your own ideas, thoughts and feelings on unwanted pregnancy and what factors influence one keep or electing to terminate the pregnancy, so please feel comfortable to be honest.

Do you have any questions?

In-Depth Interview Guide

Topic 1: Background Information

1. Please tell me a bit about your family.
2. Who lives in your household? (Probe: Immediate and extended relatives)
3. What is your relationship like with your relatives? (Probe: Involvement in decision making, seek for advice or counseling)
4. What is your relationship with your spouse/partner? (Probe: Involvement in decision making, seek for advice or counseling)
5. Who in your family makes the important decisions and why?
    a. [Probe: How do you feel about it]

Topic 2: Attitudes toward Childbearing

1. What are your feelings about having children? (Probe: Desire, When, Why, Number and Gender)

    a. What is the ideal number of years to have between children
    b. Is there an ideal order in which female and male children should be born? If so, what is the preferable birth order for boys and girls?
    c. What factors determine the composition of the family? (Probe: Generation, social and/or economic class, profession/work)
2. In this community, who makes the decision about number of children in the family? (Probe: Husbands, Mother-in-laws, parents)
    a. Who makes decisions about the spacing of births?
    b. How are these decisions made?
    c. How do women in the community feel about this? (Probe: Like, Dislike, Agree or Disagree)
3. Do you feel there is significance in having a family with a certain number of children in your community?
    a. Is one sex preferred over the other, and if so why?
4. According to you, what are the reasons for
    a. Having a lot of children? (Probe: Social/Family pressure to bear more children, gender preference)
    b. Having few children?
    c. Waiting a certain amount of time between pregnancies?

Topic 3: Pregnancy Prevention

1. What methods do women use when they want to wait before having another child or when they do not want to have another child?
    a. In your community what types of methods are available for women who want to prevent getting pregnant?
    b. Where do women go to get such methods? (Probe: Clinics, traditional healers, pharmacists, family members or neighbors)
2. How do you feel about such methods?
    a. Describe how theses methods are selected for the purpose of preventing pregnancies?
    b. What are some reasons women might choose a traditional method over a modern method and vice versa?
    c. What are some reasons women might not want to use any of these methods?
    d. Why would a woman who had already decided to use one of these methods change her mind?

Topic 4: Sources of Contraceptive Knowledge

1. Tell me what you know about these methods (Probe: Efficacy, Characteristics, Perceptions or attitudes of partners/spouses)

a. What are some of the good things you have heard about such methods
b. What are some of the bad things you have heard about such methods

2. Where did you get information about such methods? (Probe: Media, School, Family/Community members, social networks, health professionals-traditional and non traditional)
    a. Is this a common way that women in your community get information about such methods? Are there other more common ways in which women in your community get information about methods to prevent pregnancy.

Topic 5: Experiences and Perceptions of Unwanted Pregnancy

1. How do you feel about unwanted pregnancy?
2. Have you ever had a pregnancy that you didn't want?
    a. How did you deal with it? (Probe: Clinical abortion (medical or surgical), Keeping the pregnancy, Traditional remedies, Emergency contraception)
    b. What influenced you to deal with the unwanted pregnancy in the matter that you did?

Topic 6: Opinions about the legality of Abortion

1. What are your beliefs about abortions?
2. Are you aware of what the law says about women having an abortion? (Probe: If so, where did you hear the information from?)
3. Do you think that a woman has a right to have an abortion?
    a. Who do you think should be involved in a women's decision to have an abortion?
4. What are some of the consequences women in your community face when they seek abortion services? (Probe: health risks, social stigma, legal risks)

Topic 7: Sexual and reproductive health services

1. Can you tell me any place that young women can visit to find out about sexual and reproductive health services (Probe: Are these places comfortable for women to visit?)
2. Is there anything what would stop a woman from attending these services for sexual and reproductive health matters? (Probe: Privacy, staff, cost, etc)
3. What do you think needs to be done to improve access to such services?

Conclusion-Thank you so much for your time and participation. Please let me know if you have any questions or concerns.

Version; June 2010

Appendix B: In-depth Interview Introduction and Guide (Spanish)

Introduccion

Buenas Tardes. Me nombre es Ryan Woodson. Yo soy una estudiante de los EEUU y ahora yo estoy trabajando con Clinica Leticia en una investigacion que tiene como objectivo improvar salud reproductive en las Amazonas. Por eso razon, estoy hablando con mujeres en Letica, Tabatinga, y Santa Rosa sobre fertilidad, conceptivos y embarazo. Hoy me gustaria hablar con usted acerca sus experiencias, actitudes y conocimientos sobre estas temas.

Este es un formulario de consentimiento. Explica sus derechos como una participante en mi estudio. Su participacion es voluntaria. Puede detener la entrevista en cualquier momento. No voy a incluir su nombre en los resultados del estudio o en esta entrevista. Todo es confidencial. Si tiene alguna pregunta después de nuestra entrevista, aquí es donde usted puede llamar.

Tendré que grabar esta entrevista. ¿Tengo su permiso para grabar esta entrevista?

Tema 1: Información Básica

Vamos a emperzar con infomacion basica…..

1. Por favor, dígame un poco acerca de su familia. ¿Quién vive en su hogar? (Pregunte: inmediata y extendida familiares)

3. ¿Cuál es tu relación con tus parientes? (Pregunte: Participación en la toma de decisiones, Le pide consejo a ellos?)

4. ¿Cuál es su relación con su cónyuge/pareja/novio? (Pregunte: Participación en la toma de decisiones, Le pide consejo a ellos?)

5. ¿Quién en su familia toma las decisiones importantes y por qué? (Pregunte: Exemplo de decisiones importantes)

Tema 2: Composicion de la familia y preferencias de sexo

1. ¿Cuáles son sus sentimientos sobre tener hijos? (Pregunte: Deseo, Cuándo, Por qué, número y género)

    a. ¿En su opinion, qué cosas influyen la composicion de la familia? (Pregunte: generación, social y económica o clase, profesión / trabajo)

    b. En su opinion que es una familia ideal? Por que?

    c. Que genero le gusta mas? Por que? (Pregunta: beneficios y faltas)

    d. ¿Hay una orden ideal en el que los niños y las ninas deben

nacer? Si es así, ¿cuál es el orden de nacimiento preferible?

3. En su opinión ¿cuáles son las razones de

a. Tener un gran/pequeno volumen de los niños? (Pregunte: Social / Familia de soportar la presión más niños, el género de preferencia)

b¿Esperar entre hijos?

Tema 3: Conocimiento sobre prevención del embarazo

1. ¿En su comunidad, qué métodos utilizan para prevenir embarazos?

a. ¿Dónde va para comprar estos metodos? (Pregunte: Clínicas, los curanderos tradicionales, los farmacéuticos, los familiares o vecinos)

2. ¿Cómo se siente acerca de estos métodos?

a. ¿Que metodo prefiere y por que? Y por que no use otros metodos?

b. ¿Los metodo estan seguros? (Pregunte: Eficacia, Características, percepciones o actitudes de los socios o cónyuges)

c. ¿Cuáles son algunas de las cosas buenas/las cosas malas que han oído sobre estos metodos

d. ¿Al elegir un metodo para usar, a quien le pide?

e. ¿Hay algo que usted haria cambiar su opinion?

3. ¿Que son las diferencias entre de metodos tradicional y metodos moderno?

a. ¿Que metodo prefiere y por que?

b. ¿Donde va para comprar estos metodos?

c. ¿Que metodo es utiliza mas en su communidad?

d. ¿Cuáles son razones que tienen las mujeres pueden elegir un método tradicional más que de un método moderno y viceversa?

4. ¿De dónde sacaste la información sobre conceptivos? (Pregunte: Medios de comunicación, escuela, familia / miembros de la comunidad, las redes sociales, profesionales de la salud-tradicionales y no tradicionales)

Tema 4: Percepciones del embarazo no deseado

1. ¿Cómo son su percepciones del embarazo no deseado?

2. ¿Normalmente en su comunidad, cómo se lidiar embarazos no deseado? (Pregunte:

aborto clínico (médico o quirúrgica), mantener el embarazo, los remedios tradicionales, de emergencia anticoncepción)

Tema 5: Indentificacion de embarazo no deseado, reaccion y divulgacion

1. Cuando supo que estaba embarazada con un embarazo no deasdo, ¿Qué hiciste y por que? ¿Come se siente? ¿Que usted dije?
2. ¿Qué influyó su decision y por que? ¿Que participó?
    a. ¿Por qué no eligió tener (un aborto / matener al bebe)

Tema 6: Las opiniones sobre aborto

1. ¿Dime sobre sus opiniones del aborto? Es comun en su communidad? Por que?
2. ¿Que sabe sobre la ley del aborto? (Pregunte: Si es así, cuando se enteró de la información?)
3. ¿En que situaction/circumstancia piense una mujer debe el derecho a tener un aborto?
    a. ¿Quién piense que deben participar en la decisión de la mujer a tener un aborto?
4. ¿En su opinion, cuáles son las consecuencias en su comunidad en tener un aborto? (Pregunte: riesgos para la salud, el estigma social,los riesgos jurídicos)
5. De donde puedo ir para un aborto? Cuanto cuesta?
6. Que influye las mujeres a tienen/ a no tienen un aborto?

Tema 7: Servicios de salud reproductiva

1. ¿Donde puede ir para servicios de salud reproductiva en su communidad? (Pregunte: ¿Cual lugars son mas cómun para las mujeres a visitar? ¿Con que frequencia estan usaron?)
2. ¿Hay algo que impida a una mujer asistir a estos servicios? (Pregunte: privacidad, personal, costos, etc)
3. ¿En su opinion que hacer para mejorar el acceso de servicios reproductiva?
4. Que quiere ver? Que quiere cambiar? Que no quiere cambiar?

Version: June 2010

Appendix C: Focus Group Discussion Introduction and Guide

Focus Group Discussion Introduction

Good morning. My name is Ryan Woodson. I am working with Clínica Leticia on a research project about reproductive health in the region. As a part of the project I am talking to women who have possibly had an unwanted pregnancy. Today I am particularly, interested in talking to you about your knowledge and attitudes about unwanted pregnancy and possible outcome of having an unwanted pregnancy, like abortion. I want to let you know that your participation in this interview is completely voluntary, and if you want to stop at any time please don't hesitate to let me know if you don't feel comfortable answering a questions or don't want to continue with our conversation. Also, the interview will be completely confidential and anything you say will not be shared with anyone in your community. If you don't mind, I would like to record our discussion so that I don't miss or forget anything that we talk about. So it is ok for me to record this interview? I want you to know that all research documents relating to our conversation will not include your name or any of your personal information.

I am very excited to speak with you. I have certain topics that I would like to discuss, but because I want this to feel like a conversation, please feel free to bring up any topics of you feel are important and related.
Do you have any questions?

Focus Group Discussion Guide

Let's begin. Please, come forward and tell us a little about yourself. Tell me about opportunities and expectations of men and women here?

Introductory questions
1. What methods are used to prevent pregnancy?
    - Home Remedies, EC and modern methods

2. Tell me about your views on unwanted pregnancy?

Ranking activity (20 minutes)

3. I would like to discuss the most common reasons why women experience an unwanted pregnancy in your community. We have blank cards. On each card, please list the most common causes of unwanted pregnancy. Feel free to form small groups to discuss your ideas.
Now I would like to ask you about the causes that you listed as the most likely to occur. I have a large poster board that we will use to rank the causes you provided in an order from most likely to least likely to occur. (Allow time for organization of the cards) (Make people explain the most likely and the least likely and why)

Discussion

4. Why did you list the causes in the order that you did?
    - Ask- Why were certain causes not as likely to occur as other causes

5. Right now I'd like to talk about what women do when they first learn about the unintended pregnancy? (Choose the most common reasons that occur and discuss with the group)

6. Ask each of the following questions for the most commonly listed causes
    1. Probe - Where can women go for information / advice / help / support?
    2. Probe - Who do they ask for information / advice / help / support?
    3. Probe - What are options and services for women who have an unwanted pregnancy?(Abortion, keep the baby, EC, home remedies)
    4. Probe - Who makes the decision?
    5. Probe - Who participates in the decision?
    6. Probe – Are there factors that prevent a woman from attending services to end an unwanted pregnancy? (Silver, parental views and opinions of their friends etc.)
    7. Probe – Do you support her decision? How do you feel about this decision?
    8. Probe – Do you agree with her decision? Why or why not? What would you change or not change?

7. Solutions
    - Write thoughts on paper and discuss with the group
    1. Probe - What things need to do to improve the situation of unwanted pregnancy here?
    2. Probe - Who should be involved in order to mitigate the situation of unwanted pregnancy among women in the region?

Conclusion-Thank you so much for your time and participation. Please let me know if you have any questions or concerns.

Appendix D: Focus Group Discussion Introduction and Guide (Spanish)

Grupo Temático debate Introducción

Buenos días. Mi nombre es Ryan Woodson. Estoy
trabajando con Clínica Leticia enun proyecto de investigación sobre salud reproductiva en la región. Como parte delproyecto que estoy hablando con las mujeres que han tenido posiblemente un embarazo no deseado.

Hoy me siento especialmente, interesado en hablar con usted acerca de sus conocimeientos y actitudes sobre el embarazo no deseado y posible resultado de tener un embarazo no deseado, como el aborto. Quiero hacerle saberque su participación en esta entrevista es completamente voluntaria, y si quieres queparar en cualquier momento, por favor no dude en hacerme saber si usted no se siente cómodo respondiendo a una pregunta o no quieres continuar con nuestraconversación. Además, la entrevista será completamente confidencial y cualquier cosa que diga no será compartido con nadie en su comunidad. Si no te importa, megustaría dejar constancia de nuestro debate para que no se pierda o se olvide nada de lo que hablamos. Por lo tanto, es aceptable para mí para grabar esta entrevista?Quiero que sepan que todos los documentos de investigación relacionados connuestra conversación no incluir su nombre o cualquiera de su información personal.

Estoy muy emocionado de hablar con usted. Tengo algunos temas que me gustaría hablar, sino porque quiero que esto siente como una conversación, por favorsiéntase libre de traer cualquier tema de ustedes se sienten son importantes yrelacionados. ¿Tiene alguna pregunta?

Grupo Temático debate Guia

Vamos empezar. Favor de, preséntase y cuéntanos un poco sobre usted. Cuénteme sobre las oportunidades y expectaciones de hombres y mujeres aquí?

Preguntas principal (1 ahora)

1. Que métodos están usan para prevenir embarazo?
    - Remedios caseros, EC y métodos modernos

Actividad de clasificación (20 minutos)

2. Hemos identificado varias razones por qué las mujeres embarazos no deseado. Me gustaría discutir que razones/causas son las mas probable de ocurrir en su comunidad. Cada tarjeta tiene un razón por o una causa de embarazo no deseado. Si hay algunos razones no están aquí, favor de dime y pedimos hacer una otra tarjeta. (Explica que cada tarjeta dice)

Discusión

3. Me gustaría preguntar usted sobre que razón o causa es mas probable. Favor de, organiza las tarjetas en una orden desde las razones/causas son mas probable a las razones/causas menos probable. (Dar tiempo para organización de las tarjetas) (Hacer personas explicar las mas probable y las menos probable y por que)

- Cuéntame sobre sus opiniones sobre embarazo no deseado?
- Ahorita me gustaría hablar sobre que mujeres hacen cuando supieron tuvieron un embarazo no deseado. (Elegir las razones mas común para ocurrir que eligieron en la actividad y discutir con el grupo)
    1. Pregunte - Donde van para información/consejo/ayudo/apoyo?
    2. Pregunte - A quien le piden para información/consejo/ayudo/apoyo?
    3. Pregunte - Que hicieron?
        -Pregunte- Cual son opciones y servicios para una mujer que tener un embarazo no deseado? (Aborto, mantener el bebe, EC, remedios caseros)
    4. Pregunte - A quien lo dice?
    5. Pregunte - A quien participa en la decisión?
    6. Pregunte - Hay cosas que impidan una mujer que asistir servicios que terminar un embarazo no deseado? (Plata, opiniones de sus padres, opiniones de sus amigas etc.)
    7. Pregunte – Usted como se sienten sobre ella y esta decisión?
    8. Pregunte - Se acuerdan con estos decisiones? Si o no y porque? Que les gustaría cambiar? Que les gustaría no cambiar?

4. Soluciones

- Escribir pensamientos en el papel grande y discutir con el grupo
    1. Pregunte- Que cosas necesitan hacer para mejorar la situación de embarazos no deseado aquí?
    2. En un mundo ideal, que típico de clínica les gustarían crear para mejorar esta situación? (A quien deben trabajar en este clínica?)

Muchas gracias por su tiempo y participación. Por favor, hágamelo saber si ustedtiene cualquier pregunta o preocupación.