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Violence, unintended pregnancy, and the total ban on abortion: a qualitative examination  
of threats to women's autonomy in Ocotal, Nicaragua

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## **Abstract**

Violence, unintended pregnancy, and the total ban on abortion: a qualitative examination of threats to women's autonomy in Ocotal, Nicaragua

By Samantha M. Luffy

Ocotal, a relatively isolated city in the North Central region of Nicaragua, is characterized by severe poverty and limited sources of sexual and reproductive (SRH) care. National data suggest unintended pregnancies are more frequent in Ocotal compared to other major cities. Existing research does not adequately explain why unintended pregnancies are more common in this region.

Focus group discussions (FGDs) and in-depth interviews (IDIs) were utilized to explore women's experiences with unintended pregnancy as well as the context surrounding such experiences. From May to August 2014, three FGDs and ten IDIs were conducted in Spanish with young women ages 16-27 years old from various neighborhoods in the city. FGDs were completed with groups of women to elucidate community norms regarding the topics of interest: access to SRH services, knowledge of sexual and reproductive rights, and opinions of the total ban on abortion. The FGDs informed subsequent IDIs, in which individual women shared their personal experience with an unintended pregnancy.

Women identified numerous barriers to accessing SRH services, such as: criticism by others, violence against women (VAW), machismo, and lack of open communication with parents and partners. Though participants had limited formal knowledge of sexual and reproductive rights, they were able to provide examples of such rights. Women believed their sexual and reproductive rights originate from national laws, such as Law 779, which is meant to eradicate VAW. Due to religious ideologies, most participants agreed with the country's total ban on abortion, except in the case of rape. Women also had extremely varied experiences with unintended pregnancy due to: familial support, employment status, relationship with the biological father, and other factors.

The findings of this study provide context for the high prevalence of unintended pregnancy in Ocotal and describe the complex interactions between multiple factors that the study population believes are related to unintended pregnancy, including Law 779 and the total ban on abortion. The findings of this study serve as the foundation for future interdisciplinary research and offers suggestions for potential interventions at the neighborhood, city, and national levels to advance women's autonomy and improve SRH outcomes in Ocotal, Nicaragua.

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***Amigas, vamos a seguir adelante juntas siempre.***

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## Acronym List

<b>CEDAW</b>	Convention on the Elimination of All Forms of Discrimination against Women
<b>CRC</b>	Convention on the Rights of the Child
<b>CRPD</b>	Convention on the Rights of Persons with Disabilities
<b>DHS</b>	Demographic and Health Survey
<b>EmOC</b>	Emergency obstetric care
<b>FGDs</b>	Focus Group Discussions
<b>GEMMA</b>	Global Elimination of Maternal Mortality from Abortion
<b>GFE</b>	Global Field Experience
<b>HPV</b>	Human papillomavirus
<b>ICESCR</b>	International Covenant on Economic, Social, and Cultural Rights
<b>ICPD</b>	International Conference on Population and Development
<b>IDIs</b>	In-depth Interviews
<b>INIDE</b>	National Institute for Development Information
<b>IPV</b>	Intimate partner violence
<b>IRB</b>	Institutional Review Board
<b>IUD</b>	Intrauterine device
<b>LARCs</b>	Long-Acting reversible contraceptives
<b>MAM</b>	Autonomous Women's Movement
<b>MEC</b>	Maria Elena Cuadra
<b>MoH</b>	Ministry of Health
<b>MSM</b>	Men who have Sex With Men
<b>OAS</b>	Organization of American States
<b>PAC</b>	Postabortion care
<b>PI</b>	Principal Investigator
<b>RA</b>	Research Assistant
<b>RMCV</b>	Network of Women Against Violence
<b>SES</b>	Socioeconomic status
<b>SRH</b>	Sexual and reproductive health
<b>STIs</b>	Sexually transmitted infections
<b>TFR</b>	Total fertility rate
<b>UN</b>	United Nations
<b>UNFPA</b>	United Nations Population Fund
<b>VAW</b>	Violence against women
<b>WHO</b>	World Health Organization

## **Chapter 1: Introduction**

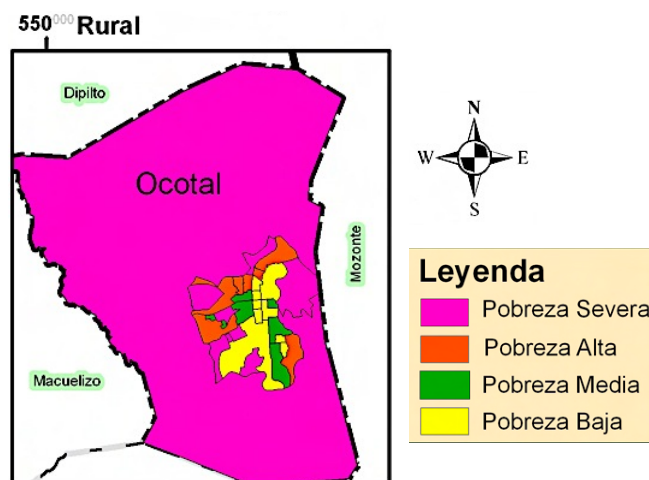
Nicaragua is one of the least economically developed countries in Central America. A recent rise of poverty in rural and periurban areas and high levels of unemployment nationwide have had widespread negative repercussions on health and access to health care services (WHO, 2006). Socioeconomic status (SES), gender, ethnicity, and geography also contribute to inequitable access to health services. Regarding access to sexual and reproductive health (SRH) services, specifically, 90.4% of women reported unmet reproductive health care needs in the most recent national Demographic and Health Survey (DHS) (INIDE, 2008). This statistic suggests that Nicaragua's current reproductive health care system does not successfully meet the needs of the population.

Ocotal is the small and relatively isolated capital city of the department of Nueva Segovia, which is located in the North Central region of Nicaragua and shares its northern border with Honduras. Of the approximately 208,000 inhabitants of Nueva Segovia, 47,000 reside in Ocotal (INIDE, 2007). Most of the area outside of Ocotal is mountainous and consists of undeveloped rural communities. The city itself is divided into 34 neighborhoods that have their own distinct identities and neighborhood leaders who are approved by assembly. These leaders are highly respected individuals within their communities and often interact with leaders of other neighborhoods at citywide events during national holidays. The neighborhoods are the functional units of the municipality and many public programs operate at this community level.

Though some neighborhoods in the center of Ocotal have a low poverty rate, as shown in yellow in Figure 1, individuals that live in the peripheral neighborhoods and

surrounding semiurban and rural areas suffer from extreme poverty (INIDE, 2007). Due to a lack of adequate medical facilities outside Ocotal, most women from these impoverished rural areas (68%) travel into the heart of the city to utilize the services offered at the public hospital and clinics (INIDE, 2008).

Figure 1. Map of Ocotal color-coded by poverty (*pobreza*) level, 2007.



The yellow areas within the city have the lowest level of poverty (*baja*), with increasing levels of poverty shown by the green (medium, *media*), red (high, *alta*), and pink (severe, *severa*) sections, respectively (INIDE, 2007).

The only hospital in the department of Nueva Segovia, Hospital Dr. Alfonso Moncada Guillén, was built in Ocotal in 1946 and is the oldest functioning public hospital in the country (INIDE, 2007). The hospital has a 15-bed women's clinic that provides basic SRH services like pregnancy tests and prenatal care, as well as labor and delivery services. This hospital is also the only location in Nueva Segovia where women can receive emergency obstetric care (EmOC) for complications that arise from pregnancy or unsafe abortions (INIDE, 2007).

Other public facilities in Ocotal include one health center and eight health posts that are located throughout the city. The health center offers various primary care services, as well as prenatal consultations for newly pregnant women. Health posts offer basic primary care, including family planning services, testing for sexually transmitted infections (STIs), and cervical cancer screening. These health facilities can be found throughout the city and are shared between neighborhoods. Published research suggests that most reproductive health clinics in Nicaragua lack competent health care providers as well as confidential counseling rooms, so women are not likely to receive adequate sexual health care or comprehensive family planning counseling at these facilities (Ehrle and Sarker, 2011).

PROFAMILIA, the International Planned Parenthood Federation affiliate in Ocotal, is a private clinic that provides both basic and specialty SRH services at a cost that is prohibitive to women of low SES. There are also numerous independently owned and operated pharmacies throughout the city. Most pharmacies sell contraceptives like condoms and emergency contraceptive pills, but do not offer quality education on contraceptive use or family planning (Ehrle and Sarker, 2011). As a result, public health facilities are the only option for most women to access SRH services.

Ocotal, a relatively isolated city in the North Central region of Nicaragua, is characterized by severe poverty and limited sources of SRH care. While such services may be available through private clinics or pharmacies, many women are reliant on public health facilities to receive care due to cost and other barriers. Public health facilities, however, do not often provide comprehensive SRH care due to a lack of both confidential counseling rooms and competent healthcare providers. As a result, women

living in Ocotal have limited access to sufficient SRH care, which may contribute to the nation's high unmet need for SRH services.

### **Problem Statement**

There is a dearth of research addressing the SRH needs of women living outside Managua and León, the two most frequently studied departments in Nicaragua. It is unknown why the total fertility rate (TFR) in Nueva Segovia (3.0 children per woman) is higher than the country's overall TFR (2.7) (INIDE, 2008). Additionally, unintended pregnancies account for 20% of the TFR in Nueva Segovia, which is a slightly higher percentage than those in other cities, such as Managua and Leon (18% and 9.5%, respectively) (INIDE, 2008). Existing research does not address why unintended pregnancies are more frequent in the department where Ocotal is located compared to other major cities. Furthermore, the literature does not adequately describe women's experiences with unintended pregnancy in the context of other social and cultural factors, such as the country's total ban on abortion, violence against women (VAW), machismo, and religion.

### **Purpose Statement**

Exploring women's perceptions of barriers to SRH care and their personal experiences with unintended pregnancy using qualitative methods provides crucial context for the available statistics. Detailed information regarding women's unique experiences with unintended pregnancy and access to SRH services may guide future

interventions designed to target these specific SRH issues in Ocotal and identify areas for future research.

### **Research Objective**

In order to adequately describe women's perceptions of and personal experiences with unintended pregnancy in Ocotal, Nicaragua, it is pertinent to also understand the legal and sociocultural factors that may play a role in women's decision-making process when faced with an unintended pregnancy, in addition to the circumstances surrounding the pregnancy itself.

The aims of this study are as follows:

**Aim 1:** Identify women's perceived barriers to accessing SRH care services in Ocotal.

**Aim 2:** Describe women's understanding of their sexual and reproductive rights within the context of legal policies and human rights in Nicaragua more broadly.

**Aim 3:** Document women's opinions and experiences with therapeutic abortion in light of the country's total ban on abortion and high rate of unintended pregnancy in Ocotal.

**Aim 4:** Examine women's personal experiences with unintended pregnancy and the factors that are involved in the decision-making process regarding an unintended pregnancy.

**Significance Statement**

The findings of this study could be utilized to design future public health programs and guide interdisciplinary research projects that focus on various health-related issues in Ocotal, such as: SRH access, unintended pregnancy, unsafe abortion, gender relations, machismo, and VAW. Conclusions drawn from this project can guide future research or interventions that are specific to the needs of the people of Ocotal. As this study was exploratory in nature, however, the methodology could also be adapted for research studies conducted in other regions of Nicaragua or Latin America regarding a vast array of health issues and contemporary social and cultural factors.

These data will also be used to gauge women's perceptions of legal policies that are related to women's SRH and human rights, such as the country's total ban on abortion and laws addressing VAW. It is pertinent to examine how women themselves perceive these laws and the ways in which these policies affect their lives at both the community and individual levels. Documenting their opinions and beliefs also provides a means to evaluate women's knowledge of their sexual and reproductive rights, as well as the effectiveness of these laws in real-world circumstances.

## Definitions of Terms

- **Adolescent:** an individual between 15-19 years old
- ***Andar escondida:*** a Spanish phrase that directly translates to “to walk in secret,” but is a colloquial phrase that refers to engaging in a secret activity; In this context, the phrase was used when participants referred to when a woman hides or conceals the fact that she is dating or using a method of family planning
- **Community:** this term refers to the strong familial and social ties within neighborhoods in Ocotlán; used synonymously with “neighborhood”
- ***Criticas:*** the Spanish word for criticism or judgment by others
- ***El niño no tiene culpa:*** the Spanish phrase that translates to: ‘the child is not at fault’ or ‘the child does not have blame;’ it is used to refer to a fetus in utero
- **Machismo:** while this is a Spanish word, it has become integrated into the English vernacular and is used to describe the hyper masculine and aggressive patriarchal tendencies of Latino culture
  - o ***Machista:*** a male individual whose actions or beliefs align with machismo
- **Nonconsensual sex:** rape or unwanted sexual intercourse



## **Chapter 2: Literature Review**

In order to adequately describe women's perceptions of and personal experiences with unintended pregnancy in Ocotal, Nicaragua, the legal and sociocultural factors that may play a role in women's decision-making process when faced with an unintended pregnancy must also be understood.

### **I. Sexual and Reproductive Health Outcomes**

Analyses of sexual and reproductive health (SRH) outcomes at a national level provide context for women's individual experiences with unintended pregnancy in Ocotal. Family planning practices in Nicaragua will be presented first, followed by a detailed review of the health implications of unintended pregnancy and unsafe abortion, both globally and in Nicaragua, specifically. National data from the Demographic and Health Survey (DHS) provide crucial statistics surrounding family planning and unintended pregnancy in Nicaragua, but the country lacks reliable data on the prevalence of unsafe abortion due, in part, to the stigmatized and illegal nature of abortion. The information presented in this section will provide key background information about SRH outcomes in Nicaragua.

#### **a. Family Planning**

The use of a contraceptive method is one of the most widely used proxies to measure fertility and it is also considered the most effective means to reduce unintended pregnancy (INIDE, 2008). Approximately 99% of Nicaraguan women reported knowing of at least one type of contraceptive method and 72% of surveyed women between 15-49

years old who are in a union (legally married or in a consensual union) had used a method of contraception in the last month (INIDE, 2008).

National data suggest that contraceptive use varies by region, as well as by age, socioeconomic status (SES), and educational level. Contraceptive use is higher in urban than rural areas and hormonal injection is the most common family planning method used in the North Central region where Ocotal is located (INIDE, 2008). The lowest levels of contraceptive use are among adolescent women ages 15-19 who are in a union (61%) compared to 76% among older women (INIDE, 2008). Adolescent women who are not in a formal union are also less likely to use long-acting reversible contraceptives (LARCs) like intrauterine devices (IUDs) or contraceptive implants; they most frequently rely on male condoms or emergency contraceptive pills (Ehrle and Sarker, 2011).

Women in Nueva Segovia also have lower educational attainment than women in other departments with larger urban centers, such as Managua. Only 7.6% of women have had some level of university education in Nueva Segovia, compared to 20.8% of women in Managua (INIDE, 2008). Additionally, no standardized, formal sexual education curriculum is offered in Nicaraguan public schools, which contributes to widespread ignorance regarding basic SRH information, including contraceptive use (Lion et al., 2009). Nationally, contraceptive use increases as age, SES, and educational level of women increases.

Public health facilities, such as hospitals and health centers, are the most common source of contraception for women who receive tubal ligations (70%), hormonal injections (78%), and oral contraceptives (54%) in Nicaragua (INIDE, 2008). An additional third of women, often those who are of high SES, obtain contraceptives from a

private pharmacy or clinic, such as PROFAMILIA (INIDE, 2008). Pharmacies provide the majority of male condoms (68%) and also are the second-leading supplier of oral contraceptives and the hormonal injection (INIDE, 2008). As previously mentioned, most pharmacies do not provide comprehensive information about family planning or contraceptive use as part of their services (Ehrle and Sarker, 2011). They are, however, open for longer hours than public health facilities. Pharmacies are often open in the evenings and on weekends, which increases women's access to certain contraceptives like the emergency contraceptive pill (Ehrle and Sarker, 2011).

Women have a variety of options as to where to obtain contraceptives, but the lack of comprehensive sexual education and other barriers, such as cost and limited access to confidential services, contributes to high rates of unintended pregnancy especially among the poor, those living in rural areas, and women of lower SES or educational level (Lion et al., 2009). Access to highly effective contraceptives and comprehensive information regarding their use is key to reducing unintended pregnancy.

#### **b. Unintended Pregnancy**

Worldwide, unintended pregnancy imposes significant burdens on populations, with greater social, physical, and financial costs in resource-poor settings (Gipson et al., 2008). Recent DHS data reveal that the Latin American/Caribbean region has some of the world's highest levels of unintended pregnancy (Gipson et al., 2008).

Unintended pregnancy is a widespread public health problem in Nicaragua that severely limits women's autonomy to pursue an education, hold a job, or engage in other activities. Oftentimes, unintended pregnancy results from a complex combination of factors including: low SES, low education level, lack of access to adequate reproductive

health care, and restrictive reproductive rights laws (Berglund et al., 1997; Walsh et al., 2008). Nicaraguan women of low SES with limited access to family planning services are at higher risk of depression, violence, and unemployment due to an unintended pregnancy (Berglund et al., 1997; Walsh et al., 2008). In Nicaragua, unintended pregnancy perpetuates the cycle of poverty and social marginalization of women that have this experience (Blandón, 2012).

National data suggest that 65% of pregnancies among women ages 15-29 are unintended (INIDE, 2008). This percentage includes adolescent pregnancy, which is defined as when a woman between 15-19 years of age gives birth. As previously mentioned, adolescent women may be more likely to use contraceptives such as male condoms purchased at a pharmacy. Due to stigma surrounding young women's sexual behavior, in conjunction with lack of comprehensive sexual education, adolescents are more likely to use these contraceptives inconsistently or incorrectly (Lion et al., 2009). Also, young women who are not in a formal union may engage in unplanned sex and are unlikely to be using LARCs, which may result in an unintended pregnancy (Lion et al., 2009). These social and cultural factors may contribute to a higher incidence of unintended pregnancies among women in this age group.

There are also disparities in the prevalence of unintended pregnancies in Nicaragua based on geography and educational status. The unintended total fertility rate (TFR) for women living in rural areas like Nueva Segovia (0.5 births per woman) is 1.3 times greater than that for women living in urban areas (0.4 births per woman) (INIDE, 2008). The rural environment of Nueva Segovia may limit women's access to SRH services and therefore contribute to the higher incidence of unintended pregnancy

compared to the incidence of unintended pregnancy within Ocotal city limits. Also, the unintended TFR for women without a formal education is 2.6 times greater than that of women who have reached university (INIDE, 2008). As previously described in the context of family planning, geography and educational level are important factors related to the impact of unintended pregnancy on women's lives.

### **c. Unsafe Abortion**

When Nicaraguan women are faced with an unintended pregnancy, they lack access to legal abortion services because national law prohibits the termination of a pregnancy in all circumstances (Reuterswård et al., 2011). This law also imposes serious penalties on women who obtain illegal abortions as well as on the medical professionals who perform them (Walsh et al., 2008; Kulczycki, 2011); the implications of this policy on the patient-provider relationship will be discussed at length in a subsequent section.

According to the World Health Organization (WHO), legal restrictions like Nicaragua's law increase the occurrence of unsafe abortion procedures (2011), which can have serious health effects on women and families. Unsafe abortions are often either carried out in unsterile conditions by unskilled providers or are self-induced by the woman herself (WHO, 2011). Maternal morbidity is the most common negative health outcome of unsafe abortions (WHO, 2011). An estimated 20-30% of unsafe abortions cause reproductive tract infections, which can contribute to long-term complications such as: infertility, chronic infections, and risks to later pregnancies (Gipson et al., 2008). Unsafe abortion procedures can also lead to a punctured uterus, incomplete abortion, postabortion sepsis, genital trauma, or hemorrhage, which can cause maternal death (WHO, 2011).

Even in the face of such harsh legal and health-related consequences, unsafe abortions remain prevalent in Nicaragua. One researcher estimates that more than 30,000 unsafe abortions are carried out every year, which contributes to maternal mortality among women in rural areas, such as Nueva Segovia (Kulczycki, 2011). Furthermore, about one third of the country's maternal deaths are caused by complications from unsafe abortion (Wessels, 1991). It is extremely difficult, however, to measure the true prevalence of unsafe abortions in Nicaragua. Such procedures tend to be underreported in surveys because women are reluctant to admit to having an abortion, especially when the procedure is illegal (WHO, 2011).

In conclusion, women in Nicaragua are familiar with many family planning methods and are likely to obtain such methods from public health facilities, such as hospitals or health centers, as well as commercial pharmacies. Demographic factors such as SES, age, and education level tend to contribute to variable contraceptive use across the country. The apparent lack of LARCs, such as IUDs and contraceptive implants, further limits women's choices of highly effective methods. The high prevalence of unintended pregnancy in Nicaragua could be due to contraceptive failure or misuse, as well as lack of access to comprehensive SRH services and education. Women of low SES that have limited access to educational or work opportunities are likely to suffer a multitude of negative consequences from an unintended pregnancy, such as poverty, abuse, and depression. In Nicaragua, therapeutic abortion is not an option to terminate a pregnancy due to harsh legal penalties instituted by national law. The illegality of abortion contributes to the prevalence of unsafe abortions, which are associated with negative health outcomes such as maternal morbidity and mortality.

## **II. Nicaragua's Total Ban on Abortion**

In 2006, the National Assembly unanimously passed a law to criminalize therapeutic abortions, which had been legal in Nicaragua since the late 1800s (Walsh et al., 2008, Reuterswärd et al., 2011). The Catholic Church actively supported this legal decision, which researchers often refer to as the “total ban” on abortion (Walsh et al., 2008; Kulczycki, 2011; Wessels, 1991). The total ban prohibits the termination of a pregnancy in all cases, even incest, rape, fetal anomaly, or danger to the life of the woman. Nicaragua joins the few countries to ban therapeutic abortion, such as the other Latin American countries of El Salvador and Chile. Similar to the legal codes in these countries, Nicaraguan law includes serious penalties for women who obtain illegal abortions, as well as the medical professionals who perform them, which can have profound negative effects on women's health (Walsh et al., 2008; Wessels, 1991).

### **a. Religion and Politics**

In a region where the majority of the population identifies as Catholic, therapeutic abortion is a highly contentious topic that spans religion and politics in Latin America. In Nicaragua, the Catholic Church exerts powerful influence on national politics due to its close ties to the National Assembly and other state institutions (Morgan and Roberts, 2012; Reuterswärd et al., 2011). The connection between the Church and the government became apparent when therapeutic abortion became highly politicized during the presidential race of 2006. The Church took advantage of the high-stakes election to push forward a bill to criminalize abortion in all circumstances based on the argument that therapeutic abortions, which had been legal in Nicaragua since the 1800s, were being consistently misused to terminate pregnancies (Kulczycki, 2011; Reuterswärd et al.,

2011). The Church publicly endorsed political parties that supported the bill and forged an alliance with the Evangelical Protestant Church to ensure that the total ban would become law (Reuterswård et al., 2011). All members of the National Assembly unanimously approved the total ban a mere ten days before the election and the incumbent president signed it into law due to pressure from Catholic and Evangelical Protestant leaders (Kulczycki, 2011). This series of events exemplifies the Catholic Church's strong political influence in Nicaragua.

#### **b. Fear of Prosecution**

The total ban has serious adverse effects on women's health outcomes, such as maternal morbidity and mortality from complications from unsafe abortions (Kulczycki, 2011). Due to women's fear of being prosecuted for inducing an abortion, women and their families will often wait until her condition is dire before seeking emergency obstetric care (EmOC) for complications that arise from pregnancy or unsafe abortion (Kulczycki, 2011). In Thaddeus and Maine's pivotal paper, the authors assert that "delaying the decision to seek care" is the first obstacle that prolongs the time interval between the onset of an obstetric emergency and its outcome (i.e.: receiving care, morbidity, or death) (1994, p. 1092). Delaying treatment can lead to poorer health outcomes and, in some cases, maternal deaths, which increased in Nicaragua after the total ban was implemented (Kulczycki, 2011).

Additionally, there is a common perception in Nicaragua that EmOC providers will not provide high quality care to their patients with abortion complications due to the legal repercussions for providers that violate the total ban. The trend of providers delaying or refraining from treating women with obstetric emergencies is referred to as



the total ban on abortion's "chilling effect" on health care providers (Walsh et al., 2008, p.34). Providers are less likely to treat women with complications from unsafe abortions, as well as those that are hemorrhaging or present with other obstetric emergencies. The total ban has also triggered a decrease in providers' willingness to provide postabortion care (PAC), due to fear of being criminally charged with providing an abortion. As a result, 70% of maternal deaths in Nicaragua are caused by preventable and treatable obstetric emergencies, such as hemorrhaging and complications from unsafe abortions (Ehrle and Sarker, 2011).

Requiring health care providers to report women who present with complications from unsafe abortions to the police violates the confidentiality inherent in the patient-provider relationship. Prior research in Chile, a South American country that also has a strict ban on abortion, found that a small group of health care providers reported the majority of women who were imprisoned for having had an abortion. Moreover, while most Chilean providers respected patient confidentiality, most denunciations came from providers at public hospitals that served low-income populations (Shepard, 2000).

These cases reflect the reality that the risks of imprisonment, morbidity, and mortality from an unsafe abortion disproportionately affect women of low SES, as they are more likely to go to a public hospital for such complications (Shepard, 2000). Women of higher SES most often have access to safer services through private clinics, so are therefore less likely to be imprisoned or experience negative health impacts from an abortion, even when the procedure itself is illegal. As such, low-income women are more likely to experience negative health and legal effects of abortion bans than women of higher income (Shepard, 2000).

### **c. Human Rights Related to Abortion**

After the total ban was passed, the Nicaraguan Supreme Court dismissed cases brought forth by feminist groups and human rights organizations that claimed that the law was “unconstitutional, violated international law, and denied women access to their basic right to life and health” (Kulczycki, 2011, p. 212). Many of these groups feared that the total ban would have negative effects on women’s health and autonomy to make their own reproductive health decisions, which has become evident in the years since the law was passed. Human Rights Watch is one of the leading human rights organizations that has continued to bring international attention to the harmful effects of the total abortion ban on women’s health (Walsh et al., 2008).

An analysis by Walsh et al. emphasizes the numerous human rights that are violated by restrictive abortion bans, such as the law in Nicaragua (2008). Though most human rights documents do not directly claim access to abortion as a right, numerous articulated human rights are relevant to this issue, such as women’s rights to: life, health, physical integrity, privacy, non-discrimination, and the right to autonomous decision-making regarding the number and spacing of children, among others (Walsh et al., 2008). Such rights are articulated in numerous conventions and treaties, like: the United Nations (UN) International Covenant on Economic, Social, and Cultural Rights (ICESCR) (UN, 1966), the UN Convention on the Rights of the Child (CRC) (UN, 1989), the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (UN, 1979), and others (UN, 2015). Based on human rights law, women should have the autonomy to make their own decisions regarding SRH, including whether or not to have an abortion (Walsh et al., 2008).

In response to the negative impacts of the total ban on maternal mortality as well as women's physical, mental, and emotional health, the Committee on the Elimination of Discrimination against Women has recommended that the Nicaraguan government review the total ban on abortion and remove the punitive measures imposed on women who have abortions (UN, 2007). Within the same report, the Committee also expressed concern regarding the lack of comprehensive sexual education programs, as well as inadequate family planning services, and high rates of unintended pregnancy throughout Nicaragua (UN, 2007). Strategic objectives outlined in the Beijing Declaration and Platform for Action emphasize that improved family planning services should be the main method by which unintended pregnancies and unsafe abortions are prevented (UN, 1995). The total ban on abortion directly contradicts these strategic objectives and violates women's right to comprehensive reproductive health care, which includes family planning and PAC.

Nicaragua's total ban on abortion is a highly controversial piece of legislation that has been contested by feminist groups, the Ministry of Health (MoH), and international human rights organizations, including those within the UN system as well as independent nongovernmental organizations, such as Human Rights Watch. The influence of the Catholic Church on politics in Nicaragua has made it difficult for these groups to challenge the constitutionality of the total ban, though many believe it violates international human rights treaties. The total ban has far-reaching impacts on both women and health care providers, as the law includes harsh legal penalties for both parties. Women are less likely to seek EmOC for an obstetric emergency and providers are less likely to treat women in such emergencies. Therefore, the total ban violates the

patient-provider relationship because both parties fear prosecution, which contributes to the incidence of maternal morbidity and mortality in Nicaragua.

### **III. Sexual and Reproductive Rights**

Over the last 20 years, the study of sexual and reproductive rights has become a distinct field as advocates and researchers apply a human rights framework to SRH issues (Miller and Roseman, 2011). The most commonly discussed sexual and reproductive rights include the right to expression, information, privacy, respect for bodily integrity, sexual education and services, and freedom from violence, torture, and cruel, inhuman, or degrading treatment. These rights also include the maternal rights to life and autonomy, which encompass economic rights and freedom from discrimination (Miller and Roseman, 2011). Though they are often discussed together, sexual rights and reproductive rights can also be described separately, as they originated at different times and have distinct definitions.

#### **a. Origins**

The term “reproductive rights” was first defined in the 1994 International Conference on Population and Development (ICPD) Programme of Action, or Cairo Declaration, as “the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence” (UNFPA, 1994, paragraph 7.3). It has been argued that the right to decide one’s number and spacing of children

should include access to safe abortion services (Shepard, 2000). The Cairo Declaration, however, does not declare access to safe abortion as a right, but instead includes purposefully vague language on the subject that has been interpreted as follows: “where legal it must be accessible; where illegal, women should not die or face morbidity because of the effects of illegal and unsafe abortion” (Miller and Roseman, 2011, p. 104).

The concept of sexual rights, alternatively, was alluded to in the Beijing Declaration in 1995: “The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality” (UN, 1995, paragraph 96). Though the original definition was solely focused on the sexual rights of women, the definition has since expanded to include the rights of both men and women. Sexual rights have also become central to movements involving gay and lesbian groups, men who have sex with men (MSM), and, specifically women’s rights groups that are concerned with sexual violence (Miller and Roseman, 2011).

#### **b. Nicaraguan Context**

Throughout Latin America in the 1980s and 1990s, women’s rights groups demanded sexual and reproductive rights that were consistent with those outlined in the Cairo Declaration and the Beijing Declaration (Richardson and Birn, 2011). For the first time, feminist groups began to hold governments accountable for the disparities they recognized between domestic and international law as it related to sexual and reproductive rights, specifically abortion and violence against women (VAW) (Reuterswärd et al., 2011).

In Nicaragua, feminist groups, such as the Autonomous Women’s Movement (*Movimiento Autónomo de Mujeres*; MAM) and the Network of Women Against

Violence (*Red de Mujeres Contra la Violencia; RMCV*), were the key opposition to the country's total ban on abortion. As previously discussed, they brought forth claims to the Supreme Court regarding the unconstitutionality of the total ban, which were supported by the Minister of Health and the country's professional medical association (Reuterswärd et al., 2011). Feminist groups were unable to defeat the total ban due to a lack of capacity to mobilize, especially compared to the Catholic Church and other influential stakeholders (Heumann, 2007).

Sexual and reproductive rights have become central to discussions surrounding the connections between human rights and SRH. In Nicaragua, feminist groups have used human rights documents to hold the government accountable for protecting the sexual and reproductive rights of all citizens. Unfortunately, these groups have been unsuccessful in using such a stance to repeal the total ban on abortion. They have, however, made significant progress in addressing VAW by utilizing a human rights framework.

#### **IV. Violence Against Women (VAW)**

Discourse about VAW in Latin America is centered on a regional human rights document entitled: the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women, or commonly referred to as the Belém Do Pará Convention. The Organization of American States (OAS), the regional human rights body for the Americas, adopted this convention in 1994 in the hopes of encouraging States to establish mechanisms to defend and protect women's right to live lives free of violence. The convention asserts that VAW is a specific type of violence, a

“manifestation of the historically unequal power relations between women and men” (OAS, 1994, p. 1).

As discussed previously in the Nicaraguan context, cultural, political, and sociocultural institutions support unequal power relations between genders (Carcedo, 2008). Machismo is one such cultural construct that perpetuates gender inequality and has been identified as a barrier to SRH promotion in Nicaragua (Sternberg, 2000). The term ‘machismo’ is most commonly used to describe male behaviors that are sexist, hyper masculine, violent, or chauvinistic towards women (Arciniega et al., 2008). These behaviors often legitimize the patriarchy, reinforce traditional gender roles, and are used to limit or control the actions of women, who are often perceived as inferior (Salazar Torres et al., 2012).

In recent years, however, researchers have noted a subtle shift in masculinity norms that are most likely due to influences by global changes, like modernization, urbanization, and prominent feminist activism (Sternberg et al., 2007; Salazar Torres et al., 2012). It is unclear, however, if such trends towards gender equality are extending to small cities like Ocotal and other locations where the majority of people live in rural areas.

The most recent data from the DHS suggest that 50% of women surveyed have experienced one of the following three types of violence in their lifetime: verbal/psychological, physical, or sexual. Additionally, 29.3% of women reported having experienced both physical and sexual violence at least once, while 10.4% reported having experienced all three types of violence (INIDE, 2008). In total, 89.7% of

Nicaraguan women have experienced some form of VAW during their lifetime, which poses a significant public health problem (INIDE, 2008).

In order to combat VAW across Nicaragua, a national law was introduced in 2012: The Comprehensive Law Against Violence Against Women and Reforms to Law No. 641, “Penal Code.” In the local vernacular, the law is simply referred to as *Ley 779*, or Law 779. As is explicit in the formal title, the purpose of Law 779 is to eradicate VAW in all social spheres in Nicaragua, both public and private.

Feminist groups in Nicaragua, such as MAM, RMCV, and the Maria Elena Cuadra Women’s Movement (MEC), have described Law 779 as ‘30 years coming’ because women first began demanding such a law in the 1980s during the Sandinista Revolution (McCarthy, 2012; Solís, 2013). In 2010, 14 feminist groups like La Corriente, which is led by Maria Teresa Blandón, partnered with civil society organizations to develop a proposal for a law that they presented to the National Assembly along with 30,000 signatures of support (Blandón, 2012). After two years, the National Assembly approved Law 779, which is unique in Nicaragua for numerous reasons.

First, this law directly references multiple international human rights treaties, such as: UN CEDAW, UN CRC, the UN Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2006), and the previously mentioned Belém Do Pará Convention. Based on these treaties, Law 779 declares that it is the State’s duty to protect the human rights of women, which include: the right to live a life free of violence, the right to live without discrimination, the right to effective access to justice, the right to protection from the State, and the right to redress victims of violence (Law 779, 2012). It



is the first law of its kind to include a statute regarding the victim's right to redress, which feminist groups see as a significant advancement for women (Blandón, 2012).

Secondly, Law 779 defines VAW and the many forms in which this type of violence may take, such as: misogyny, physical violence, economic violence, and others (Law 779, 2012). The law provides explicit definitions for these types of VAW and the associated sanctions or prison sentence lengths for each. Femicide is defined at length in Article 9 as the "the killing of females by males because they are females" (Law 779, 2012, p. 9) and identifies unequal power relations between men and women as the root cause of such an act (Widyono, 2008, p. 7). As a means of enforcement, the law includes the sentence length of 15 to 30 years in prison for the crime of femicide.

Thirdly, this law makes it the responsibility of the State to establish enforcement mechanisms to eradicate VAW and femicide, specifically. Mediation has been included in the law as a method of addressing VAW within personal relationships. An additional measure of enforcement included in the law is interdisciplinary coordination with civil society organizations, the MoH, and legal actors, such as the National Police and court system (Law 779, 2012); it is unclear how this means of enforcement will be put into practice. Since the law's implementation, the UN has released a Model Protocol to provide guidance for the investigation and implementation of laws meant to eradicate VAW in Latin America (UN, 2014). If this protocol is used to integrate Law 779's enforcement policies into existing legal structures, it may make Law 779 more effective.

Prominent feminist leaders, such as Solís and Blandón, have voiced their opinions about the strengths and weaknesses of Law 779 and its potential impact on the prevalence of VAW and femicide in Nicaragua (Blandón, 2012; Solís, 2013). The perceptions of the

general population regarding Law 779, particularly those of women in communities outside Managua, have not been adequately explored, however. It is necessary to understand women's opinions of this law because they are the ones Law 779 is aimed at protecting. Documenting women's knowledge and understanding of the law could be helpful in gauging the progress Law 779 has made in eliminating VAW in Nicaragua since its implementation.

## **V. Conclusion**

Though prior research has focused on unintended pregnancy among adolescents in Nicaragua and its many associated factors, there is a dearth of research that simultaneously addresses all of these factors in the context of individual experiences with unintended pregnancy. There is also a lack of qualitative data that examine women's opinions, perceptions, and beliefs around such topics as: the total ban on abortion, VAW, machismo, access to SRH services, and unintended pregnancy in smaller urban and rural communities. Examining these issues from the women's point of view will help identify appropriate points for intervention, as well as aid in the design of public health programs to address the needs of the community. Furthermore, there is no published research regarding women's ability to access SRH services and their individual experiences with unintended pregnancy in Ocotal, specifically. The purpose of this thesis is to explore unintended pregnancy and its interrelated factors from the perspective of the women in Ocotal who have had this personal experience.

### **Chapter 3: Materials and Methods**

Two qualitative methods, focus group discussions (FGDs) and in-depth interviews (IDIs), were utilized to explore women's experiences with unintended pregnancy as well as the context surrounding such experiences. Though the project was exempt from full review by the Institutional Review Board, procedural steps were taken to protect the rights of participants and ensure confidentiality. Verbal, informed consent was acquired from participants before all FGDs and IDIs were conducted. Participant confidentiality was maintained throughout data collection, management, and analysis. The data were analyzed using modified grounded theory and though the findings cannot be generalized to populations outside of Ocotol, they could reflect the sentiments of women from similar communities in Nicaragua and Central America.

#### **Study Site**

This qualitative study was conducted in Ocotol, Nicaragua from May to August 2014. All FGDs and IDIs were conducted in Spanish with young women ages 16-27 years old from various neighborhoods in the city. First, FGDs were completed with groups of women to elucidate community norms regarding the themes of interest. The FGDs informed subsequent IDIs that were held with individual women regarding their personal experience with an unintended pregnancy.

Given that no literature has been published regarding the topics of interest in this city in particular, qualitative methods allowed for a robust and detailed exploration of the experiences, perceptions, and opinions regarding the topics of interest among young women in Ocotol. Due to the iterative nature of qualitative research, data collected

during initial stages of the project were used to inform and refine the later phases of data collection (Hennink et al., 2011).

Proyecto Paz y Amistad, a local nonprofit organization that connects volunteers and researchers with opportunities for engagement in Ocotlán, sponsored the study activities. Proyecto Paz y Amistad approved the research methods, as well as provided logistical support for the completion of the project, which included: networking with community leaders and providing both audio recording equipment and private facilities to conduct FGDs and IDIs. Dochyta Falcon, the Director of Proyecto Paz y Amistad, acted as the primary gatekeeper to the study population due to her extensive contacts and existing relationships within the population of Ocotlán. With her assistance, the principal investigator (PI) was able to gain access to the study population, interact with community leaders, and develop rapport with the community.

### **Study Ethics and Informed Consent**

The Institutional Review Board (IRB) of Emory University determined that the study was exempt from full review, as it did not meet the criteria of human subjects research. However, IRB procedures were maintained to protect the rights of the participants and ensure confidentiality.

Verbal, informed consent was obtained in Spanish from all participants before each FGD and IDI. Participants were given informed consent documents in Spanish that followed IRB guidelines and included such information as: purpose of the study, risks of participation, and participating institutions. Participants returned the informed consent documents to the PI after providing consent in order to prevent others, such as parents or

male partners, from learning of the topics discussed during the FGD or IDI due to their sensitive and taboo nature. Additionally, participants were informed that they could refuse to answer a question or withdraw from participation at any time with no negative repercussions.

There was minimal risk to the participants, as their participation was voluntary and the information collected from them was kept confidential. Confidentiality was maintained by de-identifying the data once transcription was completed, which included changing participants' names to pseudonyms. Identifying information, such as the names of family and friends and job titles, was removed from the transcripts.

## **Research Methods**

The primary objectives of this study were to explore young women's experiences with unintended pregnancy and knowledge of sexual and reproductive rights given the various barriers to sexual and reproductive health (SRH) care and the country's total ban on abortion. The participants for both the FGDs and IDIs were chosen based on their ability to provide meaningful insight on the study topics, which is also known as the emic perspective (Hennink et al., 2011).

**Focus Group Discussions.** Conducting FGDs with young women allowed the PI to better understand group opinions regarding barriers to SRH care, perceptions about their sexual and reproductive rights, and opinions about the country's total ban on abortion. It was necessary to obtain this information first in order to provide cultural context for women's experiences with unintended pregnancy, which were later explored via IDIs with individual women.

In order to provide insight into these topics, young women from various neighborhoods were targeted for participation. The PI worked with neighborhood leaders to identify eligible participants and recruit them for participation. With the assistance of the gatekeeper, Ms. Falcon, the PI explained the inclusion criteria for participation to the neighborhood leaders and scheduled a time to conduct the FGDs. All participants were Spanish-speaking young women (ages 17-27) who had been pregnant at least once or who were pregnant during the time of data collection. The participants were required to have had experience with a pregnancy because these women would be able to offer rich information regarding the topics of interest, such as ability to access SRH services.

The PI developed a semi-structured discussion guide based on a review of relevant literature, as well as the study objectives. The discussion guide was initially drafted in English and approved by the English-speaking investigators. With the assistance of two native Spanish-speakers from Mexico and Colombia, the discussion guide was translated into written Spanish (See Appendix I). The research team made minor revisions while in country based on local cultural norms and common vernacular that the participants would understand.

The PI facilitated two pilot FGDs in Spanish in order to further develop the language used in the discussion guide according to the participants' level of education and cultural background. The participants for the pilots were sampled from a local university and the neighborhood, *Teodoro López*, respectively. Participants were asked open-ended questions regarding the themes: obstacles to receiving reproductive health care in Ocotlán, the participants' knowledge of women's sexual and reproductive rights, and their opinions about the country's total ban on abortion.

At the end of each pilot FGD, participants provided feedback on the nature and structure of the questions in order to improve the cultural appropriateness of the discussion guide. The investigators took their input into account and made appropriate changes for subsequent FGDs, but the structure and overall themes of the discussion guide remained constant throughout data collection. Probing, follow-up, and interpretive questions were employed to further explore unanticipated topics that were brought up by participants during the FGDs and were relevant to the study objectives.

Three FGDs were conducted for data collection and consisted of groups of up to six women from two neighborhoods: *Laura Sofia Olivas* and *Nuevo Amanecer*. Neighborhood leaders facilitated introductions to participants and provided a private space to conduct the discussions in their homes. The total time burden for each participant was approximately three hours. The time burden included: correspondence to determine their eligibility to participate in the FGD, travel to and from the data collection site, and the discussion itself. Refreshments such as juice and light snacks were offered to participants to thank them for their involvement in the study.

All participants were Spanish-speaking young women between the ages of 17-27 who had been pregnant at least once or were pregnant at the time of data collection. The beginning of each FGD consisted of demographic questions regarding such characteristics as: age, educational status, marital status, religious affiliation, and employment status. Demographic information for the FGD participants can be found in Table 1.

Table 1. Demographic data of participants in focus group discussions about sexual and reproductive health (n = 17), Ocotal, Nicaragua, May–June 2014

<b>Age at time of Interview (Average)</b>		Range: 17 – 27 years (21.5)	
<b>Marital Status</b>		<b>Employment Status</b>	
Single	35%	Unemployed	71%
In a Relationship	65%	Employed	29%
<b>Religious Affiliation</b>		<b>Education Level</b>	
Catholic	29%	Primary	12%
Evangelical	53%	Secondary	41%
Neither	18%	University	47%

This table was adapted from a publication in the *Pan American Journal of Public Health* focusing on a subset of these data (Luffy et al., in press).

**In-depth Interviews.** Conducting IDIs with individual women allowed the PI to explore each young woman’s personal experience with an unintended pregnancy, including the decision-making process she went through regarding how to respond to the pregnancy. Data were also collected regarding the participant’s pregnancy history and experiences receiving medical attention during pregnancy and labor. Given the personal nature of this experience (including the illegal nature of abortion if the woman terminated the pregnancy), IDIs allowed the participants to share intimate details and information with the PI that would be inappropriate or dangerous to for the individual to share in a FGD.

IDI participants were selected from the same study population as the FGDs with the additional requirement of having experienced an unintended pregnancy. In order to identify participants for the two pilots and initial IDIs, the investigators directly sampled from those who had shared personal information about an unintended pregnancy during a FGD. These women were ideal for participation in the pilots specifically, because they already had an understanding of the project and had demonstrated a readiness to share their experiences with the PI. The technique of sampling from a known population is



often used in qualitative research in order to identify ‘information-rich’ participants that can provide key information regarding the study topics (Hennink et al., 2011).

In a process identical to that used to develop the discussion guide for the FGDs, the PI developed a semi-structured interview guide based on a review of available literature and the objectives of the project. The interview guide was translated from written English to written Spanish using the same process as the discussion guide (See Appendix II). The PI facilitated two pilot interviews with participants from the FGDs and they provided feedback on the nature and structure of the open-ended questions. Though the structure and content covered by the interview guide remained consistent throughout data collection, minor revisions were made to improve the guide for clarity and cultural appropriateness.

The PI facilitated ten IDIs in Spanish with young women from various neighborhoods in Ocotlán. Demographic data regarding the participants can be found in Table 2. Participants were identified via purposive sampling of ‘information-rich’ individuals (i.e.: those from a FGD who had experienced an unintended pregnancy) followed by snowball sampling. At the end of each IDI, participants were asked to recommend other young women they knew who had experienced an unintended pregnancy and who were within the age range of interest. Via a “snowball effect,” this form of sampling created a network of participants that represented numerous neighborhoods and varied experiences with unintended pregnancy.

Table 2. Demographic data of participants in in-depth interviews about unintended pregnancy (n = 10), Ocotal, Nicaragua, May–June 2014

<b>Age at time of Interview (Average)</b>		Range: 16 – 23 years (19.2)	
<b>Age at time of Pregnancy (Average)</b>		Range: 14 – 21 years (17.3)	
<b>Marital Status</b>		<b>Employment Status</b>	
Single	50%	Unemployed	80%
In a Relationship	50%	Employed	20%
<b>Religious Affiliation</b>		<b>Education Level</b>	
Catholic	40%	Primary	10%
Evangelical	60%	Secondary	40%
Neither	0%	University	50%

The IDIs were held in a private room at the home of Ms. Falcon in order for the PI to have control over the confidential environment in which the interviews took place. The time burden for each participant was between 1-2 hours, including correspondence with the PI to schedule the IDI, travel to and from Ms. Falcon’s home, and the length of the interview itself. Participants were compensated for taxi fare to and from the data collection site in order to thank them for their participation.

### **Data Management and Analysis**

All FGDs and IDIs were audio recorded using an Olympus WS-801 (Olympus America, Inc., PA, USA) digital audio recorder. The audio files were uploaded to the personal password-protected computers of the PI and research assistant (RA). The RA, who is a native Spanish-speaker, transcribed each recording verbatim into written Spanish. After the transcripts were transferred to the PI’s password-protected computer for permanent storage, all audio and transcript files were deleted from the RA’s computer. Backup copies of all recordings and transcripts were stored on the PI’s personal external hard drive, which is also password-protected.

The data were analyzed using MAXQDA11 software (VERBI GmbH, Berlin, Germany), which aided in the coding of the transcripts and the analysis of deductive and inductive themes. All FGDs and IDIs were read multiple times in order to develop two codebooks, which consisted of deductive, inductive, and in vivo codes. The FGD codebook had 40 codes, whereas the IDI codebook had 15 codes.

Deductive codes reflected specific topics that were purposefully mentioned by the PI through questions from the discussion guide, such as: “religion,” “sexual and reproductive rights,” and “the total ban on abortion.” Inductive codes were created for themes that arose from the data naturally and were not necessarily expected. Examples of inductive codes are: “communication with partner,” “unemployment,” and “private clinics.” These were topics that the participants mentioned without being directly prompted by a question from the discussion guide. In vivo codes represent particular phrases that participants themselves used to describe a certain idea or phenomenon. In this case, all in vivo codes are in Spanish and include such codes as: “*andar escondida*” (to walk in secret), “*Ley 779*” (Law 779), and “*sentirse mejor*” (to feel better). These phrases often have a colloquial meaning that cannot be adequately captured by a direct English equivalent.

The PI used a modified form of grounded theory to analyze the FGD and IDIs separately. Grounded theory involves constant comparisons between inductive themes and subsequent observations to develop a theory that characterizes the data (Glaser and Strauss, 1967). Given the scope of this study, it was not feasible to conduct additional FGDs or IDIs in order to generate theory or reach full saturation, so the themes were compared to themselves within the data. For example, the IDIs were separated into

categories based on the marital status of the participant in order to identify differences in the themes across categories as well as between individual interviews. Through multiple close readings of the transcripts, the PI was able to identify key themes that arose from the data and develop thick descriptions of these issues. Thick descriptions were developed by re-reading specific segments to fully understand the code and the context in which it was discussed.

Relevant quotes that encapsulated the themes were translated into English using three different online translation tools and the three versions were combined in order to maintain the participant's original meaning throughout translation. Additionally, body language and language fillers, such as "em" and "ah" were removed from the block quotes as long as their removal did not change the meaning of the quote.

The PI has analyzed subsets of these data in order to produce manuscripts that have been submitted for publication in peer-review journals. The first manuscript utilized a portion of the FGD data and will be published in the *Pan American Journal of Public Health* (Luffy et al., in press). A second manuscript focusing on the FGD data related to violence against women (VAW) is currently in peer review. Though the data for the manuscripts and this thesis are the same, the analyses and conclusions presented in each report are different.

### **Limitations**

The methods of this study are subject to several limitations. First, the study area was limited to the municipality of Ocotlán, so the findings cannot be generalized to other populations. These findings could, however, reflect the sentiments of women from

similar communities in Nicaragua and Central America. Second, participants were not randomly sampled from all neighborhoods, so the experiences of women living in the neighborhoods that were not studied could differ from those expressed by the study population. Third, neighborhood leaders were informed of the inclusion and exclusion criteria to recruit participants, but the PI did not monitor their application of these criteria. The research team relied upon neighborhood leaders to assist with recruitment and aid in building rapport with the study population.

### **Conclusion**

Through the use of two different qualitative methods, women were able to share both community and individual perceptions, opinions, and experiences regarding the topics of interest. FGDs allowed participants to discuss community perspectives on study topics, while individuals shared personal experiences with unintended pregnancy during IDIs. Many measures were taken in order to protect the privacy and confidentiality of the participants, such as informed consent, de-identification of data, and secure data storage. Data were analyzed using a modified form of grounded theory, which identified key themes that provide detailed and contextual information regarding study topics.

## RESULTS

Themes that arose from the three focus group discussions (FGDs) were analyzed to provide insight to women's perspectives, experiences, and opinions regarding the sexual and reproductive health (SRH) topics of interest. Overall, the participants perceive that accessing certain types of SRH services is "easy" in Ocotlán, but that considerable cultural barriers prevent women from receiving all of the services that they want or need. Women also spoke openly about machismo as a common cause of violence against women (VAW) and femicide, which limit women's autonomy to make their own SRH decisions. Though women had limited formal knowledge of sexual and reproductive rights, they were able to provide examples of what they believe to be the most important women's rights. Participants also shared their opinions about the total ban on abortion and the importance of increasing open communication between women and their parents and partners as a means of promoting gender equality.

Additionally, themes present in the ten in-depth interviews (IDIs) provide further context for the FGD results, as some participants provided more detail about topics that were discussed in the FGDs. Women provided more personal examples of such experiences during the IDIs due to the more intimate setting. Data from the IDIs also provide detailed descriptions of women's highly varied experiences with unintended pregnancy.

### **Obstacles to Receiving Reproductive Health Care**

*Criticas.* Of the many obstacles that women perceive as having significant influence on their access to comprehensive SRH care, the *criticas*, or criticism, by others

in the community was expressed across the groups and in numerous interviews. One FGD participant became pregnant when she was 15 and felt that others in the community judged her harshly by saying “Wow, look how young she is,” when they saw her in the street. Women fear being judged or criticized by others because neighborhoods are often very close-knit and women value the opinions of those in their community.

One participant, Maria<sup>1</sup>, shared during an interview that she has recently tested positive for human papillomavirus (HPV). She described her anxiety about receiving care at a neighborhood health center as follows:

You know that when all the people that live in a neighborhood go [to the same health center] and you also live in that neighborhood, they will know you and they will publicize [information about you]. So, for this reason, I don't want it to be out there [that I have HPV]... Later they will say that all people that live in the neighborhood have the virus. Sometimes it is not the disease that harms you; it is the criticism.

Participants reported frequently experiencing criticism when they go to a health center or health post to receive family planning services or testing for sexually transmitted infections (STIs). Many participants also mentioned that health care providers will “scold” young women who come to a health facility after they become pregnant. In her interview, Lidia explained her interaction with the doctor when she found out she was pregnant:

I had such low self esteem when she [the doctor] spoke to me because I felt that she scolded me worse than my mother and my mother did not say anything to me, but a doctor that I didn't even know scolded me very harshly in front of the nurses... I could feel that I was blushing red at the time because I did not like [how she treated me].

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<sup>1</sup> All names have been changed to protect the participants' privacy.

Groups often shared personal experiences where nurses had yelled, “Who is here to receive family planning?” in front of the entire waiting room. Participants said this type of interaction is stressful and upsetting for women because health facilities are shared between neighborhoods, so women oftentimes encounter people they know. As Rosa explained:

When a young girl who is 15 or 16 begins to have sexual relations and thinks to protect herself, sometimes there are many people that know her in the health center and then these people she knows begin to judge her harshly.

The majority of participants in all groups and interviews agreed that criticism by others, whether from someone in the community or a health care provider, prevents women from being comfortable and confident while accessing SRH services.

*Andar escondida.* The participants agreed that this fear of criticism generally impacts younger girls, who are more likely to use a method of family planning and have a boyfriend in secret, which the participants referred to using the colloquial phrase *andar escondida*, or “to walk in secret.” Parents often do not allow their daughters who are younger than 18 years old to have boyfriends or use a method of family planning for fear that their daughter will become pregnant. Ironically, participants explained that prohibiting such behavior forces women, particularly adolescent girls, to secretly date or family plan, which puts them at even higher risk for getting pregnant – the very outcome that parents were trying to prevent in the first place.



Ana, who got pregnant at the age of 16, explained why she dated her boyfriend in secret and was hesitant to use a method of family planning:

I did not [family] plan. I sometimes had the urge to [family] plan, but sometimes I saw many people I knew at the [health] center and, since I was dating my boyfriend in secret, I was afraid that if they saw me receive a method of [family] planning, then my mother would find out and get mad at me. In order to avoid these problems with my mother, I did not [family] plan.

Additionally, some participants perceive that girls in Ocotol are beginning to “fall in love” and have sexual relations at younger ages, such as 13 and 14 years old, which puts them at a higher risk for an unintended pregnancy. Tania recounted a personal example:

I have a young girlfriend that has had, you know that in this time it is common, she has had relations with her boyfriend and I told her as a supportive friend that I would accompany her to the [health] center. Then she said no because she is embarrassed, ashamed to be criticized. One always tries to raise the self-esteem of others because we also have the right to counsel others who are at risk of an unwanted pregnancy. When we arrive at the center, they criticize us, so then we do not get the injection and could get pregnant.

Many women reported that the 1- or 3-month hormonal injections are the most common form of birth control used in Ocotol. Participants admitted, however, that they often did not go to receive the next injection in order to avoid being judged or criticized by their neighbors at health facilities.

During her interview, Mirna reported that she receives the hormonal injection in secret because her partner does not want her to family plan. She expressed difficulty receiving the next injection if she begins menstruating on a weekend when the public health center isn't open. If the clinic is not open on the date she needs the next injection, she said that she is unable to use a method of family planning for that month and must

wait for her next menstrual cycle to receive the injection. During the months where she has not been able to receive the injection, she “gives thanks to God” that she has not gotten pregnant.

Few participants reported taking the birth control pill and many shared their knowledge of female sterilization, the intrauterine device (IUD), and the emergency contraceptive pill as alternative forms of contraception. They were also familiar with the male condom, but often shared that men refuse to use them due to allergy or discomfort during intercourse.

### **Violence Against Women (VAW)**

The participants in all groups viewed VAW as “too common” in Ocotlán; a formidable obstacle that prevents them from making autonomous decisions regarding education, work, or reproductive health issues. Women gave examples of domestic violence between one or both parents and their daughter, referred to as parental use of violence, as well as violence between a woman and a male partner, or intimate partner violence (IPV).

According to the participants, parental use of violence commonly occurs when the father thinks the daughter has started having sex or discovers that she has been secretly dating. Reina explained some fathers’ reaction as:

There is domestic abuse after a girl becomes pregnant. What do the parents do when they’re incredibly ignorant? They aren’t educated and begin to be abusive and say, “It would be better for you to leave if you want this man. Get out of the house.” So the family also discriminates against her.

Participants also perceive that men who witness VAW as children are more likely to use violence against their partners when they become adults. IPV was commonly

referred to as “domestic violence” within groups and Katia expressed the following opinion:

I imagine that it [domestic violence] begins with men because ...if there is violence between a couple, a man and woman, then the [male] child says, “I am going to be like my dad. I am going to beat my wife.”

The women believe that such childhood experiences normalize VAW and can cause a man to perpetuate such acts of violence as an adult.

**Machismo.** Numerous participants also identified machismo as a highly prevalent characteristic of many men in Ocotlán. Based on the participants’ descriptions, machismo can be interpreted as any action or belief that men use to limit women’s autonomy or perpetuate gender inequality. As an example of the influence of machismo on women’s ability to make reproductive health decisions, Carmen said:

The [partner] must respect one's decisions to [family] plan because there are men who are *machistas* that do not like if one [family] plans and prefers if she is always pregnant, having child after child.

*Machista* is the Spanish word that participants used to describe men who engage in acts or have beliefs that align with machismo. Participants said that such men want to impregnate their partners because it proves their masculinity. According to the participants, machismo is also a major cause of numerous types of VAW, including rape, IPV and femicide.

Two IDI participants shared that they became pregnant after being raped, though neither participant explicitly said the Spanish word for rape, *violación*. This type of interaction will be referred to as ‘nonconsensual sex’ in this report. The participants shared feelings of helplessness and victimization by the men that took advantage of them.

One participant described her rapist's actions as follows:

He demanded me [to enter the room] and closed the bedroom door. He did not tell me that we were going to have [sexual] relations, but he told me, "You will not become pregnant," because he is sterile. "Do not worry," he said. I was stuck there and that is when he closed the door to his bedroom.

Other participants that had not been raped shared examples of other women they knew, such as sisters or neighbors, who had experienced rape or another type of VAW. Femicide was specifically mentioned in all three FGDs as a common form of VAW in Ocotal and Nicaragua as a whole. Though no participants reported personally knowing any victims of femicide, each group mentioned examples of femicides that had occurred in areas near Ocotal, as well as Managua, the capital. One participant explicitly stated, "machismo has led to femicide," which has significant implications for the success of Law 779 in reducing the prevalence of femicide in Nicaragua.

**Law 779.** The participants perceive Law 779 as "both good and bad" at combating VAW and machismo in Ocotal. Though participants believe that it is meant to be "a law that protects women" by giving women more power to sue their abusive partner or parent, women also stated that the law has caused more femicide nationwide. As Anita explained:

The opinion of the men now is that they prefer to kill the woman instead of hitting her because although they will go to jail for hitting her, they will also go to jail for killing her, so they say "It is better if I kill her." That is the opinion of the men now, young and old. I say it is awful how lost the men are because those are their thoughts now, that is better to kill the woman... This began because of Law 779. The law started it.

When a participant made such a statement, it was common for other participants to nod or murmur in agreement. The group had a similar reaction when Marta shared her opinion about the impact of Law 779 on femicide:

[E]ven though this law exists, there have been more femicides. This law, instead of protecting the women, has caused more femicides. As a result, this year, there have been several femicides all over the country.

Additionally, many participants shared their concern with the inclusion of mediation in Law 779 as a means of addressing cases of VAW. Yesenia explained that “sometimes men do not accept mediation and for this reason, sometimes they decide to kill the woman.” Overall, the participants believe that the use of mediation causes men to “kill women faster” instead of reducing incidence of femicide.

When asked why they believe that Law 779 will not effectively eradicate VAW in Nicaragua, participants identified “corruption” of the police, as well as their lack of ability to enforce the law in Ocotal. One participant shared that, “[N]either do the police respect the law, nor does another person respect it.” Participants in all three groups agreed that the law does not adequately protect women due to the high prevalence of machismo among the men in Ocotal, as well as a lack of enforcement from police.

### **Sexual and Reproductive Rights**

Though participants were unable to define the term “sexual and reproductive rights,” many gave examples of these rights. Participants provided similar examples across the FGDs, such as the right to decide when to have sexual relations and the right to choose how many children you want to have. Women also mentioned the right to have access to free sexual and reproductive health services and education. Individuals specifically expressed the importance of having the ability to decide what method of family planning to use and the right to have access to specialty gynecologic services. As an afterthought, one participant added that women have a right to be “treated well” by health care providers.

One participant shared that it is a right for women to have access to a psychologist for free services after she has been “raped or suffered traumatic abuse.” The other participants agreed that women should be offered such services in order to help them “overcome the trauma” of being raped or experiencing another type of VAW. Participants also acknowledged that there is a lack of psychologists in Ocotal that provide such services, though they should be freely available to all women who have this experience.

All three groups believed that their sexual and reproductive rights originated from the government of Nicaragua and national laws, such as Law 779. One participant, Catalina, expressed her view that, “The government promotes them [our sexual and reproductive rights] pretty well, but I honestly do not know who invented them.” Another participant mentioned a law that requires men to pay monthly child support if the man and the mother of the child are no longer in a committed relationship with one another. She believes that this is an example of the government supporting women’s right to be financially supported by the father of her child, but she acknowledged that it is difficult to receive child support if the couple is not legally married.

As a whole, women in all groups were uncertain about the origin of women’s rights and no group members seemed familiar with any international treaties or documents that define women’s sexual and reproductive rights. For the most part, women believe that the government is most responsible for providing these rights and do so via national laws. Women were able to provide examples of sexual and reproductive rights, though they have had no formal education on the topic.

## **Prohibition of Abortion**

**The Total Ban on Abortion.** All participants were familiar with the country's law that bans therapeutic abortion in all circumstances. Their reaction to this law was similar to that of Law 779 and Vilma explained her opinion as follows:

It is good and bad... Sometimes... women... make the decision to abort for some problem they have... they may have a very small uterus or sometimes the child does not develop where it should be. But then there are some women... who abort because they are very young. But I say you should not abort because one must fight for her children because our parents fought for us... So I agree with the law and at the same time, I don't, you know?

The participants reported that women may also consider an abortion if they believe their partners will abandon them after they find out about the pregnancy, as some men refuse to assume the financial responsibility of supporting the mother and child. Single women may also seek out abortions because they do not know how they will provide for the child without financial support from the father.

It was common for women to disapprove of therapeutic abortion in most cases, including an unintended pregnancy or if the mother is very young. Across all three FGDs, however, the participants agreed that in the case of rape, an abortion could be seen as acceptable or warranted. Juana said:

But I say in the example of rape, imagine... an unwanted child from a rape. To this I say... I don't know to be honest, that maybe God changes the woman's mind, but it hurts to have a child that is unwanted because it is from a rape.

Though many participants wavered on the fairness of the total ban in the case of rape, some participants used religious or cultural sentiments to justify keeping the child, regardless of whether the pregnancy resulted from a rape.

*El niño no tiene culpa.* At least one participant in each group mentioned the phrase, “*El niño no tiene culpa*” (the child is not at fault) when explaining why they disagree with therapeutic abortion. Oftentimes, the rest of the group nodded or murmured in agreement when this phrase was mentioned. Based on the participants’ word choice, it is apparent that the participants believe that a fetus in utero is considered a child.

When discussing abortion in the context of rape, Karla stated:

But the child is not to blame for what the father, the man, did to the woman. In this situation one has to start thinking that the child is not at fault, and she must have it because, either way, the child comes from her belly, her womb, and she has to have it, accept it.

Religion influences women’s opinions about abortion, as some participants viewed abortion as a sin, so were therefore in favor of the law. Multiple participants said that “a child is the greatest gift from God,” so women should not seek abortions. It was widely agreed that either giving the child up for adoption or giving the child as a gift to someone else who has the resources to take care of it are “more favorable than abortion.”

The participants also reported that abortion is uncommon in Ocotlán. Some group members mentioned extreme cases of young girls who had attempted or successfully completed an abortion, but they said the “majority” of women have the baby regardless of the circumstances surrounding the pregnancy.

### **Unintended Pregnancy**

**Varied Experiences.** Though some FGD participants mentioned personal details about their pregnancies during the discussions, individual IDIs provided women with the private space to share intimate details of their experiences with unintended pregnancy.

Women shared various circumstances surrounding their pregnancy, such as: relationship



with the biological father; current marital status; experiences receiving SRH care during pregnancy and labor; support from family and partner during pregnancy and after labor; and personal reactions to the pregnancy. There was wide variability in the women's experiences and no two accounts were the same.

As mentioned previously, two participants reported that their unintended pregnancy resulted from nonconsensual sex, though they did not specifically use the Spanish word for 'rape' (*violación*) when describing their interaction with the biological father. Only one of these participants, Ana Maria, 19, underwent an unsafe abortion to terminate her pregnancy, and did so at the request of her married godfather who raped her. Ana Maria said that he "pressured" her into getting the abortion because he did not want to lose his family. As this was her first pregnancy and she was terrified, Ana Maria relented.

Her godfather gave her 3,000 Córdoba (approximately USD\$112.00) and arranged for her to receive the unsafe abortion from an older woman who lived in a nearby city. Ana Maria reported that the woman did not give her any medication before inserting a "device like the one used for a Papanicolau... and then another device like an iron rod" to perform the abortion. After describing these devices, she made a jerking motion with her arm to imitate the technique the woman used. Afterward, Ana Maria received an unknown injection and was told that she would pass a few clots. That night, however, she became feverish and quickly began passing dark clots of blood and had trouble understanding other people's words.

At first, Ana Maria was too afraid to tell her mother or brother what had happened for fear of their reactions as well as the potential consequences that could befall her for

violating the total ban on abortion. Soon after, Ana Maria's brother heard rumors of his sister's pregnancy from neighbors "in the street" and confronted her. Though she was hesitant at first, Ana Maria eventually told her brother everything that had happened. Afraid for his sister's life, her brother and her aunts reached out to a local nurse who is known for discreetly providing postabortion care (PAC).

Ana Maria spent almost two weeks receiving inpatient care. She had become septic as a result of what she described as a "perforated uterus," which is a common complication from unsafe abortions. After receiving an ultrasound and undergoing multiple procedures to remove infected blood clots and surgery to repair her uterus, Ana Maria was finally able to return home.

As a result of this experience, she reported feelings of depression, isolation, and recurring dreams about a little girl, which she described as follows:

After I was discharged, I always dreamt of a little girl and that she was mine, standing in my doorway and when I awoke, I couldn't see her. I looked for her in my bed but she wasn't there. And this has tormented me because, its true: I am the girl that committed this error, but the little girl was not at fault, [but] he pressured me so strongly to get the abortion, so I did.

Ana Maria reported that she stopped having this dream after approximately 15 nights, but that she continues to feel isolated and depressed. One of the sources of her depression, she said, is that she has no one to share this experience with because women who have had unsafe abortions do not discuss it due to the illegal and highly stigmatized nature of such procedures. When asked what would improve her situation, both personally and socially, she said that it would be most helpful to have other people to talk to about her experience. She also reported a desire to go back to school to become a

lawyer, so that she could work in local politics. At the time of data collection, she was looking for a job in order to save money to attend university.

Two other IDI participants shared that they wanted to get an abortion when they found out they were pregnant. One participant reported engaging in strenuous physical activity, such as dancing, running up and down stairs, and lifting heavy objects. She claimed that she “did not love” her daughter and felt unprepared to have a child. The other participant did not want to have a child at that time because she is one of the primary breadwinners of her family. She had left school when she was 13 years old in the sixth grade in order to do domestic work to provide for her family. Both women ultimately decided against having an abortion because of helpful advice from their younger sisters. One sister said, “We must make good of all situations. Life goes on and a child is unlike anything else.” With such strong familial support during the pregnancy, both participants decided to continue their pregnancies, though they were originally unwanted.

Of the ten IDI participants, 6 of them were single mothers at the time of data collection. They all rely on financial and emotional support from their families to provide for their children. These participants expressed feeling worried about having the financial resources to take care of their children – especially because only 2 of the 10 participants are employed outside the home. Women reported three main reasons for not having a job other than traditional housework: 1) absence of employment opportunities; 2) lack of reliable childcare; and 3) not enough education to get a specialized job. Being a single mother makes these women especially dependent on support from their families if they want to continue their education or pursue employment.

Participants explained that one reason that single mothers are common in Ocotal is machismo. One participant, Lupita, alluded to machismo when she said:

Well, I say it is ... common that fathers do not take responsibility [for their actions]. It is rare for a father to be accountable. There are many single mothers here [in Ocotal]... The fathers are not with their children or they have other women, so there are many single mothers. The most common are the mothers that have to take care [of their children], work, and find ways to provide for their children.

These characteristics of men (i.e.: fathering children with many women) are personifications of machismo that contribute to the commonality of single motherhood in Ocotal. All IDI participants agreed that it is difficult for all women, whether they are in a relationship or not, to provide for their children due to the lack of employment opportunities in Ocotal. They also agreed that single mothers experience more of this burden because they are often dependent upon others to provide for their children.

Conversely, four IDI participants were still in committed relationships with the biological father of their child at the time of data collection. Some of these participants said they cried when they found out they were pregnant, but that their partner was very happy about the pregnancy. Since the birth of their children, financial support from their partners has allowed the participants to focus on childrearing and traditional household duties. In these situations, the women reported feeling content as mothers now, though they would not like to have more children in the near future.

Overall, the IDI participants shared very different experiences with unintended pregnancy, but many reported similar feelings of stress and apprehension in response to the pregnancy. Participants reported feelings of stress or anxiety upon finding out they were pregnant, but many of their perspectives changed over time based on other factors,

such as familial support. While some participants are content to be mothers now, the majority reported financial and childcare support from their partner and/or family as important contributors to their current happiness. It is crucial to note that even though the majority of participants reported feelings of contentment at the time of the interview, none of them said they currently want more children. Some said they would want more children in the future, but all ten said that they were not trying to get pregnant at the time of the interview. Instead, some participants described their desires to continue their education or find work outside the home.

### **Communication**

**Lack of Communication.** Across all groups, women expressed that a lack of open communication between a woman and her parents, as well as her partner, limits women's ability to make autonomous decisions about their reproductive health and future. Specifically, women shared their hesitance to discuss their desire to family plan, pursue higher education, or work outside the home. According to Catalina, some women are "very shy" with their husbands and parents and do not feel comfortable discussing their goals or problems with them.

Participants reported that they are unable to communicate with their parents or partners due to fear of discrimination, violence, and embarrassment. Many participants identified their partners as *machistas*, which makes such conversations about their SRH needs or future plans especially difficult.

Reina expressed how machismo influences her partner's reaction to her future goals:

Sometimes he understands me and sometimes he does not. Because when I say that I want to work, he does not like those decisions. If I tell him that I want to study, because I want to study a profession this year, he says, "No, I do not like that decision." ...Sometimes I do not understand his mentality.

In some circumstances, both FGD and IDI participants shared that they are family planning in secret because they know their partner would not approve, but they want to prevent another pregnancy. These women feared that their partner would leave them if he found out she was using a method of family planning, but also shared their worry that they'd be unable to go to school or get a job if they got pregnant in the near future.

**Improved Communication.** Many participants said that improved communication between women and their parents and partners would have a positive impact on women's autonomy in Ocotlán. According to the participants, being able to talk with parents and partners without fear of negative consequences would greatly increase trust in the relationship, as well as decrease the prevalence of unintended pregnancy. If young girls could talk with their parents openly, they would not have to family plan or date in secret, which would decrease their risk of getting pregnant. Tania expressed that "it's nice to have a relationship and a conversation with your family."

One participant described her father as a positive role model because he discussed gender equality with his children by saying, "You have seen how I am with your mother. You cannot accept if a man is violent with you because a woman is worth just as much as the man." Other participants in the group said it would be helpful if more men shared

this perspective and talked to their daughters about VAW because “it is rare [to find] a man that helps a woman.”

Additionally, the participants believe that open communication with their partners about their SRH needs (e.g. family planning), educational goals, and desire to work would mitigate the influence of machismo in their relationship. The man would begin to view the woman as an equal and see her as capable of making her own decisions about pursuing education or a career.

Participants acknowledged that some health providers offer free lectures about SRH issues that are open to the community, but specifically target adolescents of both genders. Women believe that these lectures are too infrequent and informal to have a large impact on people’s health behaviors and decision-making. During her interview, Claudia explained her opinion about the free lectures in the following way:

I think [we should] deliver the lectures to parents. Maybe it is the lack of communication between parents and their children; they [the parents] don’t talk about the methods of [family] planning, but a girl who is twelve years old and older needs to know the methods of [family] planning... . I say that the parents need to know the methods of [family] planning first because they already have children. We must give the lectures to them.

The participants acknowledged the need to engage various members of the community in such lectures in order to encourage and facilitate open communication about topics that they believe are important, such as: SRH, VAW, and machismo.

## **Conclusion**

Participants in the FGDs and IDIs shared their perceptions, opinions, and beliefs regarding a wide variety of topics related to unintended pregnancy. Many women identified key barriers that prevent women in Ocotal from accessing SRH services, such as: criticism by others, engaging in secret behaviors, and VAW and machismo. The influence of machismo on the high prevalence of VAW and femicide in Nicaragua was also discussed in the context of Law 779, which is meant to eradicate VAW nationally. The participants had limited knowledge about the origin of women's sexual and reproductive rights, but were able to provide concrete examples of such rights. In discussing the country's total ban on abortion, women described when they believe an abortion may be warranted, such in the case of rape.

Through an analysis of the IDIs, the participants had highly varied experiences with unintended pregnancy based on a combination of factors. The circumstances surrounding the pregnancy, current marital and employment status, and support from family members and/or partners were important factors that shaped women's decision-making processes when faced with an unintended pregnancy. Finally, numerous participants mentioned that increased communication between women and their male relatives or partners would be beneficial in increasing women's autonomy and ability to make their own decisions regarding SRH needs and future goals, such as education and employment.



## **Chapter 4: Discussion**

A thorough analysis of three focus group discussions (FGDs) and ten in-depth interviews (IDIs) conducted with young women in Ocotol, Nicaragua identified many key themes regarding women's highly varied experiences with unintended pregnancy. These included: barriers women encounter while accessing sexual and reproductive health (SRH) services, perceptions about their sexual and reproductive rights, and opinions of the country's total ban on abortion. Women also described their personal experiences with the following barriers: criticism by others, violence against women (VAW), machismo, and lack of open communication with parents and partners. The participants had little knowledge of sexual and reproductive rights and were unable to identify the international documents that define them, but were able to provide examples of such rights. This qualitative evaluation also found that due to religious ideologies and cultural beliefs, most women agree with the country's total ban on abortion, with rape as a possible exception.

One of the primary obstacles that women discussed was the criticism or judgment they receive from others in the community when attempting to access SRH services at public health centers and health posts. Women expressed that they experience criticism at these types of health facilities for two main reasons. First, they often encounter people they know due to the central location of these facilities in neighborhoods. Second, participants shared that health care providers commonly call out or reprimand young women for seeking information about a method of family planning in front of others in the waiting room. This behavior exhibited by health workers causes women to feel uncomfortable or hesitant to receive such services for fear of being criticized by others.

Research conducted at similar health facilities in the capital city of Managua found that health care facilities frequently lack private counseling rooms, which prevents women from receiving confidential information or counseling regarding SRH issues (Ehrle and Sarker, 2011). Such conditions violate women's right to privacy as well as the right to the highest standard of sexual and reproductive health (Miller and Roseman, 2011; UNFPA, 1994).

Many participants described engaging in secret behaviors, such as using a method of family planning or secretly dating, in order to avoid such criticism by others. This behavior is especially common among adolescent women due to widespread stigma surrounding young women's sexual behavior. When women feel forced to conceal such behaviors, prior research in Nicaragua has found that young women often use contraceptives inconsistently or incorrectly, which contributes to the high rates of unintended pregnancy among women in this age group (Lion et al., 2009). Numerous participants also reported secretive and inconsistent use of hormonal injections because their partners do not want them to use a method of family planning. If women are forced to conceal this behavior, they are less likely to receive consistent and comprehensive SRH care, which can lead to an unintended pregnancy.

National data suggest that contraceptive use increases as age, socioeconomic status (SES), and educational level of women increases (INIDE, 2008). Adolescent women, however, are more likely to use male condoms or the emergency contraceptive pill instead of long-acting reversible contraceptives (LARCs) (Ehrle and Sarker, 2011). Two participants shared experiences of nonconsensual sex where they were unable to negotiate condom use and both sexual encounters led to an unintended pregnancy. In the

FGDs, participants attributed difficulty negotiating condom use to machismo and the traditional belief that men must prove their masculinity by fathering many children (Lion et al., 2009).

Women believe that having a partner who is a *machista* severely limits women's ability to make her own decisions regarding reproductive health, employment, and education and also puts them at risk of VAW and femicide. The findings that highlight the connection between VAW and machismo are similar to past studies conducted in Nicaragua, which found that machismo and gender inequality are associated with women's poor physical, mental, and reproductive health (Sternberg, 2000; Sternberg et al., 2007; Salazar Torres et al., 2012).

Recent research in the major Nicaraguan cities has identified a subtle shift in masculinity norms toward gender equality, which has been attributed to globalization, modernization, and urbanization (Salazar Torres et al., 2012). These findings have not been documented in more rural locations like Ocotal, however. According to the participants of this study, machismo is still a harmful reality that affects women's lives in Ocotal. While the results of this study may not reflect a change in masculinity norms according to the study population, it does appear as if the women in the study population desire more equitable gender relations. The participants also acknowledged that machismo continues to be a major cause of VAW regardless of other social and political factors, such as Law 779.

Women were well informed about Law 779, a national law implemented in 2012 with the objective to eliminate VAW in both public and private spheres in Nicaragua. Participants described a connection between machismo and the recent rise of femicide

throughout the country. This finding is unique due to the recent implementation of Law 779 and the lack of available research to evaluate the effectiveness of this law on VAW nationwide.

From the perspective of both human rights law and domestic law, however, Law 779 is well written and well intentioned. Nevertheless, feminist groups have expressed concern that the law sets lofty goals that may be difficult to attain. According to Azahálea Solís, a leader of Nicaragua's feminist movement, the word of law is only the first of three elements that must be taken into consideration in order to eradicate VAW in Nicaragua (2013). The other two elements are: the implementation of enforcement and application mechanisms and the integration of change into the socio-political landscape (Solís, 2013).

Though the law includes precise definitions and sanctions for various types of VAW and femicide, no protocols describe how these will be incorporated into future legal decisions. Similarly, it is unclear how the enforcement mechanisms outlined in the law will be implemented. The participants believe that the National Police are corrupt and therefore unable to enforce Law 779 to the fullest extent. At present, the law's effectiveness of eradicating VAW and femicide at a national level has not been evaluated due, in part, to the complicated relationships between the stakeholders. Additionally, politics and culture in Nicaragua are steeped in Catholic traditions and morally conservative ideologies, which have diminished the effects of past political action made by the feminist movement, as is evident by their futile attempts to overturn the country's total ban on abortion (Reuterswärd et al., 2011).

Nicaragua's total ban on abortion is a highly controversial and restrictive policy that mirrors a similar policy in Chile. Prior research in Chile found that there is a 'double discourse' around the topic of abortion because public opinion is much more progressive than national policies would suggest (Shepard, 2000). Highly restrictive legal policies with heavy influence from the Catholic Church are often at odds with women's experiences and opinions. When surveyed, Chilean women believed abortion should be legal in certain circumstances, such as when the woman's life is in danger (78%), fetal deformity (70%), or in the case of rape or incest (59%) (Shepard, 2000). Opinion research on abortion throughout Latin America has also found that the majority of women favor legalization of abortion in select circumstances (Richardson and Birn, 2011).

In this study, the complexity and variety of opinions shared by participants regarding abortion is consistent with prior research. Very few women self-identified as completely for or against abortion, but instead shared more complicated views that took into account religious ideology, legal standards, and cultural practices. For example, the religious idea of fetal rights dominates the national discourse surrounding abortion in Nicaragua (Morgan and Roberts, 2012). The participants confirm this result through their use of the phrase "the child is not at fault," which implies that they believe a fetus in utero is a child. Regardless of the participant's religious affiliation or lack thereof, the groups agreed that a fetus is a child that has the right to live, regardless of the circumstances surrounding its conception.

Simultaneously, however, participants shared that the rights of the "child" could be waived in certain circumstances, such as rape. Shepard's idea of 'double discourse' is

applicable here because women have conflicting and ever-evolving opinions about abortion based on cultural norms, legal standards, religious ideas, and, most importantly, the unique circumstances surrounding a specific pregnancy (2000, p. 111).

This study also demonstrates that women in Ocotal have little formal knowledge regarding their sexual and reproductive rights due to the nonexistence of standardized comprehensive sexual education curricula in schools (Walsh et al., 2008). Overall, women are unaware of the documents that describe and define sexual and reproductive rights, though this information could be incorporated into sexual education curricula. It is pertinent to note, however, that participants were able to proffer distinct examples of sexual and reproductive rights even though they have had no “formal” education about international human rights treaties. This finding can be attributed to the fact that sexual and reproductive rights exist within the larger human rights framework, which is based in the inherent dignity of all human beings – an idea that the participants of this study exemplified by their ability to provide examples of such rights. Incorporating more formal education on this topic in conjunction with comprehensive sexual education can allow them to be more effective advocates for women’s rights, as well as communicate more effectively with partners and parents about issues related to SRH.

Other Latin American countries also lack standardized sexual education curricula and creating the political will to spur the reformation of sexual education has been incredibly difficult. In general, supporters of sexual education reform in Latin America believe that acknowledging the reality and risks of adolescent sexual behavior would help reduce unintended pregnancy and other poor SRH outcomes, such as unintended pregnancy and sexually transmitted infections (STIs) (Shepard, 2000). The Committee

on the Elimination of Discrimination Against Women has recommended that Nicaragua, specifically, introduce age-appropriate sexual education programs as a means of reducing unintended pregnancy among adolescents nationwide (UN, 2007). Opponents of such reform accuse public health-based sexual education programs of being too ‘permissive’ and promoting promiscuous behaviors (Shepard, 2000).

The conflict surrounding sexual education reform represents the tension between traditional religious values and objective public health standards related to the right to information. As mentioned in the Cairo Declaration, individuals should have access to all the information necessary to make personal decisions related to SRH (UNFPA, 1994). The right to information is only partially recognized in Ocotal through the offering of community lectures about SRH issues. Though participants in this study described community lectures about contraceptive use and STIs, they believe the lectures are too infrequent to provide the community with enough information to influence behavior or impact health outcomes. One benefit of such sessions is that they are open to both genders, which allows men of varying ages to become more informed about SRH issues, but it is unclear how many men actually attend such lectures. These lectures currently represent a missed opportunity to address cultural issues such as machismo and gender equality among communities in Ocotal. Participants believe that more consistent and comprehensive sexual education for both genders is necessary in order to have widespread health benefits in Ocotal.

Participants also shared that open communication with their parents and partners about topics such as family planning, employment, and education is difficult, which limits their ability to make autonomous decisions about such issues. Many participants

reported using a method of contraception without telling their partners because they wanted to prevent an unintended pregnancy. Women believe that communication would be made easier if there were programs in place to address machismo and gender inequality in Ocotol.

These findings echo the conclusions made by past research. Gender awareness programs for males in the cities of Managua and Leon, Nicaragua have helped promote awareness of gender inequality and harmful impacts of machismo on men and women's health, particularly SRH (Salazar Torres et al., 2012). Past qualitative research with Nicaraguan men demonstrates that machismo often presents as a barrier to effective social and political change (Sternberg et al., 2007). Women in Ocotol believe that more healthy communication with both partners and parents would be possible if men became more aware of SRH issues, as well the harmful behaviors associated with machismo.

The IDI participants also described highly varied and unique personal experiences with unintended pregnancy. Participants reported the importance of certain factors in their decision-making process regarding an unintended pregnancy, such as: financial support from their parents and partners, the circumstances surrounding the pregnancy (e.g. rape or sex with a committed partner) and current marital status. Only one participant shared her experience with an unsafe abortion and two revealed that their unintended pregnancy resulted from nonconsensual sex. Six participants described the hardships that single mothers have to face, such as financial insecurity, inability to attend school, and dependence upon others for support. These data provide a glimpse into the extremely variable ways in which individual women react to unintended pregnancies and provide rich context to better understand unintended pregnancies as a complex public



health issue. A systematic review of literature on unintended pregnancy globally has noted the usefulness of qualitative research in understanding the context surrounding such a pregnancy beyond what could be ascertained by a survey (Gipson et al., 2008).

Though DHS data suggest that unintended pregnancies were more common in Ocotal than in other major Nicaraguan cities (INIDE, 2008), there was no published research that put this statistic into context before this study was conducted. The findings of this study provide background information and cultural context for the available statistics and serve to describe women's SRH needs. Participants reported significant barriers that restrict women's access to SRH services and limit their autonomy, such as criticism by others, engaging in secret behaviors such as family planning or dating, VAW, and poor communication with parents and partners.

These barriers directly violate women's autonomy regarding SRH decision-making and are therefore related to women's experiences with unintended pregnancy in Ocotal. Additionally, lack of access to information and education regarding SRH issues limits women's capacity to make informed decisions regarding their personal health. The total ban on abortion also prevents women from safely terminating an unintended pregnancy, which puts them at risk of complications from unsafe abortions. All of these factors come into play when a woman in Ocotal is faced with an unintended pregnancy.

## Conclusions

The findings of this study provide context for the available statistics regarding the high prevalence of unintended pregnancy in Ocotal, Nicaragua. The detailed qualitative data collected in this study can also be used to better understand women's experiences with various public health topics that are related to unintended pregnancy, such as experiences with accessing SRH services, VAW, and unsafe abortion. This section will explain how the findings presented in this study can be used to develop community-level public health programs that address these issues in Ocotal.

Women in Ocotal perceive machismo, VAW, criticism by others, and lack of open communication as major barriers that limit women's autonomy and contribute to unintended pregnancy. The results from this study are exploratory and should be followed by more in-depth interdisciplinary research to better understand these issues. Community needs assessments and other participatory research methods that involve both men and women, followed by larger quantitative surveys can further clarify the health needs of the population before interventions are designed and implemented.

After further research has been conducted, public health campaigns to address the health issues identified by the community should be tailored to the city of Ocotal. This study suggests that programs targeting such issues as communication with partners and parents, criticism by others, machismo, VAW, and SRH education should be implemented at the community level because individuals often have strong ties to others in their neighborhood.

In order to address the impacts of machismo and VAW on their communities, both genders must be included in community-level programs that promote gender

equality. The goal of such programs would be to challenge traditional machismo ideals, such as forbidding a partner from using a method of family planning, because doing so can result in an unintended pregnancy and limits women's autonomy. If men in Ocotac are encouraged to take responsibility for their actions and adopt more gender equitable masculinities, they may also be less likely to leave their partner once an unintended pregnancy occurs. This outcome would result in less single mothers who are unemployed, lack educational opportunities, and are reliant upon others for financial support, which were major obstacles described by participants who are single mothers.

Similarly, information about SRH issues such as unintended pregnancy, STIs, and family planning practices must be provided to both men and women through community-based sexual education lectures that encourage the participation of parents. The purpose of offering such information to parents, in particular, is to better inform them of SRH issues and to increase the acceptability of family planning. As parents become more comfortable with the topic, educators should encourage parents to allow their daughters to receive family planning. In doing so, young women would no longer have to family plan in secret and would be encouraged to use contraception consistently and correctly, which may contribute to a decrease in both unintended pregnancy and unsafe abortion.

Given that comprehensive sexual education is not taught in schools in Ocotac, the ultimate goal of all community sexual education programs should be to raise awareness and reduce the stigma that currently surrounds SRH topics. Community leaders or volunteers could be trained to deliver the community sexual education program by offering topic-based lectures in neighborhoods, as they are familiar with the cultural context of Ocotac. Educational materials given to those present at the lectures must

include basic SRH information as well as information about sexual and reproductive rights and Nicaragua's legal policies related to SRH and women's health, such as Law 779.

Community workshops should also focus on developing healthy communication strategies within families and between partners regarding SRH decisions, as well as women's education and employment. These workshops should aim to increase acceptability of such conversations and reduce the amount of criticism that women receive when seeking SRH services in public health facilities. First conducting gender awareness workshops with males in Ocotal could foster more equitable and open-minded views among men, as has been discussed previously. Communication workshops with both men and women would build upon the success of community-level gender awareness and sexual education programs and thus encourage open communication with women and their parents and partners.

Conducting community-based programs to address the needs identified by women in Ocotal could have far reaching health benefits not only for women in the city, but men, children, families, neighborhoods, and the city overall.

### **Recommendations for Future Action**

The findings of this study could serve as the foundation of future research that addresses each key result in the context of Ocotal, other cities in Nicaragua, or the country as a whole. Given the exploratory objectives of this research, the limited size of the study population, and lack of generalizable results, further investigation into the most important needs of the larger populations of Ocotal and other cities is necessary.

Interdisciplinary teams made up of individuals from a variety of disciplines, such as: law, theology, international development, clinical medicine, economics, sociology, anthropology, and others, would be capable of analyzing the issues raised by this study from multiple perspectives. Public health is inherently interdisciplinary by nature, so future studies should incorporate researchers with varied backgrounds in order to design the most effective interventions to address these issues.

Criticism by others in the community, particularly health workers, is a substantial barrier that prevents women in Ocotal from accessing the SRH services they want and need. Unlike the programs presented in the prior section, which are all targeted at the community level, the issue of criticism from health workers should be addressed at the city level. The staff at all public health facilities in the city must be made aware of the negative effects of their open criticism of patients on their comfort accessing SRH services. This type of behavior is also a violation of the patient's right to privacy, so clinical practices should be modified to respect this right as a matter of professional duty. Additionally, public health facilities often lack confidential counseling rooms, which contributes to the vulnerability that young women feel while accessing SRH services. In order to address these issues, all staff in the public health facilities should be educated about confidential practices with patients and be encouraged to cease all forms of public criticism. Furthermore, facilities themselves should be renovated to facilitate confidential counseling where resources are available.

As found in this study, the lack of enforcement of Law 779 and the recent rise in femicide are issues that must be analyzed at the national level. Women in Ocotal believe that Law 779 is a national policy that is 'both good and bad' at addressing the issue of

VAW in Nicaragua. By utilizing a human rights framework, this law serves as an example of the FGD participants' belief that the government provides and protects women's sexual and reproductive rights through national laws. Even so, the participants believe that Law 779 is not adequately enforced in Ocotal and that more femicides have occurred nationwide since its implementation in 2012. As long as women perceive that this law has led to an increase in femicide, they will continue to view the law as an ineffective means of addressing VAW and femicide in Nicaragua.

In order to improve the effectiveness of Law 779, policymakers must clarify the enforcement mechanisms mentioned in the law. Clear objectives and detailed roles of the stakeholders, primarily the Ministry of Health and National Police, can aid in the enforcement of Law 779. The government must also prioritize the collection and dissemination of accurate data regarding VAW and femicide. The United Nations (UN) recently released a Model Protocol that provides clear guidelines for the investigation and classification of instances of femicide, which could be utilized by the National Police to facilitate the collection of accurate national prevalence data and adequately investigate such crimes (UN, 2014). These data will provide evidence for the effectiveness and implications of the law on women's lives. If future data suggest that Law 779 has contributed to the reduction of VAW in Nicaragua and these results are adequately disseminated to the population, hopefully women's perceptions of Law 779 will change over time and more women will feel empowered and protected by the law.

Another national law, the total ban on abortion, must also be reconsidered in light of the findings of this study. The majority of women in the study population support the total ban on abortion except in select circumstances, such as rape. Conversely, the

institution of strict abortion bans puts women at increased risk of maternal morbidity and mortality as a result of unsafe abortions. This policy has also demonstrated a ‘chilling effect’ on health care providers in Nicaragua, which contributes to poor emergency obstetric care (EmOC) outcomes and higher maternal morbidity and mortality. Though participants agreed with aspects of the total ban due to cultural and religious ideals, the question remains whether maintaining this policy is worth the risk of the total ban’s influence on maternal morbidity and mortality.

The total ban on abortion should be challenged based on the negative health outcomes and numerous human rights violations that are associated with such strict bans. Though past efforts to repeal this law have failed, international human rights organizations and Nicaraguan feminist groups should continue to challenge the constitutionality the total ban through a national campaign that focuses on these negative health outcomes. The use of a human rights framework may also effectively educate the general population of the numerous human rights that are violated by the law. Women in Ocotol have a basic understanding of women’s sexual and reproductive rights, so arming them with comprehensive education on SRH topics and sexual and reproductive rights may make them more effective advocates for safe abortion as a human right.

The national campaign to change the discourse about the total ban should also include examples of personal stories of women like Ana Maria whose lives were put in danger because of an unsafe abortion. Increasing the visibility of these experiences could help to humanize the issue and decrease stigma related to abortion in Nicaragua.

Finally, the results from this study suggest that it is ineffective to consider unintended pregnancy a single public health problem that can be easily addressed by just

one intervention. Instead, the results highlight the complex interaction of multiple factors that the study population believes are related to unintended pregnancy. Participants shared that national laws, such as Law 779 and the total ban on abortion, as well as social and cultural dynamics influence women's experiences with SRH care and unintended pregnancy. Gender inequality and machismo, stigma surrounding SRH issues, criticism from others, unsafe abortion, unemployment, lack of comprehensive sexual education, and VAW are just a few of the public health issues that must be addressed in conjunction with programs meant to reduce unintended pregnancy among young women in Ocotal.

The findings of this study are meant to provide context for existing SRH statistics and describe women's experiences with unintended pregnancy in Ocotal in a holistic and culturally sensitive manner. The extensive results and conclusions presented in this report achieve both of these goals. If these findings are incorporated into future research and public health programs designed to address these issues, they could contribute to the meaningful advancement of women's autonomy and improvement of all outcomes related to women's sexual and reproductive health in Ocotal.



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## Appendix I: Semi-structured Focus Group Discussion Guide (in Spanish)

### Guía para Discusión de Grupos Focales

Preguntas introductorias para que todos los participantes respondan; inicio para construir buena relación:

- ¿Cuántos años tiene?
- ¿Esta legalmente casada o acompañada?
- ¿Usted con quien vive en su casa?
- ¿Usted tiene trabajo afuera de la casa?
- ¿Usted estudio bachillerato o secundaria en el colegio?
- ¿Es usted católica religiosa o evangélica?

Obstáculos para el cuidado de la salud reproductiva:

- ¿Qué es la salud reproductiva?
  - o Ejemplos: Planificación familiar, anticonceptivos
- ¿Qué se siente al recibir servicios de la salud reproductiva en Ocotál?
  - o Ejemplos: Fácil, difícil, frustrante, confuso, estresante
- ¿Cuales son algunas obstáculos que inhiben su acceso a la salud reproductiva?
  - o Ejemplos: Costo, distancia a un centro de salud, trato de los médicos

Los derechos sexuales:

- ¿En su opinión, que significa la frase <<derechos sexuales>>?
  - o Ejemplos: Capacidad de tomar sus propias decisiones sobre su salud reproductiva, acceso a servicios de salud adecuados/apropiados, decidir cuando una persona tiene relaciones sexuales
- ¿Cuales son sus derechos sexuales?
  - o O ¿Cuáles son los derechos sexuales de las mujeres en Ocotál?
  - o Ejemplos: Capacidad de las mujeres para rechazar avances sexuales
- ¿De dónde vienen estos derechos sexuales?
  - o Ejemplos: Leyes nacionales/ internacionales, su pareja, familia
- ¿Cuáles son las influencias en sus derechos sexuales?
  - o Ejemplos: Religión, marido/pareja, familia, las leyes del país, machismo

El aborto y la prohibición total del aborto:

- ¿Cuál es su opinión sobre si a una mujer debe o no debe permitírsele tener un aborto?
  - o Ejemplos: Nunca, a veces, siempre
- ¿En cuales situaciones una mujer podría querer o necesitar un aborto?
  - o Ejemplos: Violación, incesto, peligro a la vida de la mama, embarazo no deseado
- Si una mujer tiene un embarazo no deseado, ¿qué puede hacer ella?
- ¿Que piensa usted sobre la ley que prohíbe por completo el aborto en Nicaragua?
  - o Ejemplos: Importante, estricto, pertinente
- ¿Que tan común es el aborto en su comunidad?

Preguntas de cierre:

- ¿Cómo se sienten usted a hablar sobre estas temas en este grupo?
  - o Ejemplos: Incomoda, cómoda, nerviosa, aliviada
- Afuera de estos grupos en su comunidad, su familia, su pareja, ¿cómo se sienten a hablar sobre estas temas?
  - o Ejemplos: Incomoda, cómoda, nerviosa, aliviada



## Appendix II: Semi-structured In-depth Interview Guide (in Spanish)

### Guía de Entrevista en Profundidad

Preguntas introductorias para que todos los participantes respondan; inicio para construir buena relación:

- ¿Cuántos años tiene usted?
- ¿Esta legalmente casada?
- ¿Usted con quien vive?
- ¿Usted tiene trabajo?
- ¿Usted estudio bachillerato/ secundaria en el colegio?
- ¿Es usted católica religiosa?

Historial de embarazos:

- ¿Cuántos veces ha quedado en estado de embarazo?
- ¿Cuántos niños/partos ha tenido?
- ¿Cuándo fue su ultimo embarazo?
  - o ¿Cuántos años tenía cuando salió embarazada?
- Antes de salió embarazada, ¿estaba planificando?
  - o Si no, ¿por qué no estaba planificando?
- Antes de salió embarazada, ¿usted quería estar embarazada ya?
  - o Ejemplos: nunca, más tarde, ahora
- ¿Ahora usted quiere más hijos?
  - o ¿Por qué?
  - o ¿Esta planificando?

Embarazo no deseado o planeado:

- ¿Como se sintió cuando se entero que estaba embarazada?
  - o ¿Cuáles fueron sus primeros pensamientos cuando se entero que estaba embarazada?
  - o Ejemplos: Nerviosa, feliz, triste, deprimida, preocupada → ¿Y Porque?
- ¿Como reaccionó su pareja/novio?
  - o Antes que salió embarazada, ¿ustedes hablaron sobre planificación?
    - ¿Por qué sí o no?
- ¿Como reaccionó su familia/sus padres?
- Durante su embarazo, ¿usted siempre quiso continuar el embarazo?

- Si usted no quería continuar el embarazo, ¿cuales opciones veía usted para terminar el embarazo?
- ¿Cual fue el resultando del embarazo?
  - Un parto, aborto involuntario, aborto provocado
- ¿Como llego a esta decisión?
  - ¿Qué cosas influyeron en su decisión?
- ¿En que manera ha cambiado su vida después del parto?
- Durante su embarazo, ¿hubo una persona familiar o amiga que la apoyo emocionalmente?
  - Ejemplos: madre, hermana, amiga
  - ¿En que manera?

#### Servicios de la salud reproductiva:

- ¿Como se sintió cuando usted fue a las citas mensuales?
  - Ejemplos: asustada, nerviosa, cómoda, incomoda
- ¿Como la trataron los médicos?
- ¿Recibió el tipo de atención/cuidado que usted quería?
  - Si no, ¿Como cambiaria usted la manera en que la trataron?
- Después del parto, ¿los médicos tenían que hablar con usted sobre un método de planificación familiar?
  - Si sí, ¿qué dijeron ellos?

#### Preguntas de cierre:

- ¿Qué tan comunes son los embarazos no deseados/planeados en Ocotlal?
  - ¿Por qué?
- ¿Qué tenemos que hacer para cambiar eso?
- Si la participante es una madre soltera:
  - ¿Qué necesitan las madres solteras aquí en Ocotlal para ayudarlas a seguir adelante?
- ¿Cómo se siente usted a hablar conmigo sobre su experiencia?
  - Ejemplos: Incomoda, cómoda, nerviosa, aliviada