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Perceptions of unwanted pregnancy, emergency contraception and abortion: a qualitative study of healthcare providers and community leaders in the Amazon Region of Colombia

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By

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B.A., Duke University, 2009

Thesis Committee Chair: Dr. Roger Rochat, M.D.

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

Perceptions of unwanted pregnancy, emergency contraception and abortion: a qualitative study of healthcare providers and community leaders in the Amazon Region of Colombia

Author: Shreya Rao

Thesis Advisor: Roger Rochat

Background: Colombia's 2006 decision to liberalize its abortion policy has made it one of the most progressive policies in the region to reduce the practice of unsafe abortion. In the capital city of the Amazon region, a local physician and founder of La Fundación Clínica Leticia identified adolescent pregnancies and unsafe abortions as a priority health concern in the community. No research has been done in this community to examine experiences of unwanted pregnancy and abortion.

Objective: Investigators sought to elucidate issues underlying unwanted pregnancies and propose solutions for Clínica Leticia. During the summer of 2010, we examined healthcare provider and community leader perceptions of unwanted pregnancies, emergency contraception (EC) and abortions through a qualitative research approach.

Methods: In-depth interviews were conducted with 33 healthcare providers and community leaders. Interviews were conducted in Spanish, transcribed verbatim and coded using MAXQDA10 software.

Results: Providers and leaders reported adolescence, poverty, poor education, inadequate access to contraception and local culture as determinants of what they called 'irresponsible sexual practices' that lead to unwanted pregnancy and abortion. Decision-making for managing an unwanted pregnancy was influenced by families and partners, financial considerations, young age and cultural or religious disapproval of abortion. Respondents commonly opposed abortion and its legalization on moral grounds, while they objected to EC based on fears of complications from long-term use. Their perceptions of irresponsible sexual behaviors led them to oppose EC and abortion.

Discussion: Participants identified adolescents as a high-risk group for unwanted pregnancies and unsafe abortions and suggested a need for sex education targeted to this group. Many reported that existing efforts lack consistency and should be adapted to address challenges adolescents face in accessing contraception. Respondents suggested barriers to preventing unwanted pregnancies might be reduced by increasing dialogue about sex and contraception and with efforts to promote education and employment opportunities for adolescents. Increasing awareness of current abortion laws and judicial decisions among providers and women may facilitate improved acceptance of legal abortions in the region while increased education about the safety and efficacy of EC products may address local barriers to the provision of EC.

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ACKNOWLEDGMENTS

I am indebted to a number of people for making this project possible. Dr. Javier Gutierrez and the staff of La Fundación Clínica Leticia in Leticia, Colombia, sponsored and inspired my work. Dr. Gutierrez gave me a home in Leticia and the opportunity and resources to experience public health in this truly incredible community. In addition I owe thanks to Jhon Jairo, Edelmira Rodriguez and the entire staff of Clínica Leticia who were my friends and supporters throughout my time in Leticia.

I am incredibly grateful for each of the 38 healthcare providers, pharmacists and community leaders who took the time out of their busy schedules to participate in this study. I owe them my gratitude for their trust, confidence and patience as they shared their stories and experiences with me.

Without the support and guidance of my mentors at the Rollins School of Public Health this project may have never left the ground. I am honored to have had the privilege of working with Dr. Roger Rochat, whose enthusiasm, empathy and wisdom was a constant encouragement. I owe my gratitude to Dr. Monique Hennink as well for her patience and support that made executing this thesis possible.

Finally, I must thank the Global Field Experience (GFE) grant and the Global Elimination of Maternal Mortality from Abortion (GEMMA) fund for financing this project.

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CHAPTER 1. INTRODUCTION

Globally each year, 19 million women risk their lives, health, and for many, their freedom, while undergoing unsafe abortions (Shah and Ahman 2004). Of these, the World Health Organization estimated that 47,000 women die annually, representing 13 percent of maternal deaths worldwide (Shah 2010). In Colombia—which legalized abortion in cases of rape, danger to the life of the mother and fetal malformations in 2006—an estimated 300,000 to 400,000 illegal abortions were being performed annually prior to the law change (Ceaser 2006). Challenges in enforcing the new legislation, as well as opposition from providers and religious groups have acted as barriers to effectively implementing the law and realizing significant changes in abortion practices (Roa 2008).

These statistics serve to demonstrate the immense public health burden in preventable morbidity and mortality resulting from unwanted pregnancies and unsafe abortions in Colombia. Although figures specific to the Amazon region of Colombia have not been documented in the literature, studies from other rural areas in the country and the experience of the sponsoring organization suggest that unwanted pregnancies and the practice of unsafe abortions continue to pose a risk for maternal morbidity and mortality. Meanwhile, researchers in the field have called for increased emphasis on qualitative studies as well as studies aimed at examining the experience of unwanted pregnancy among rural populations in the country.

In this study, investigators sought to describe the factors driving elevated rates of unwanted pregnancies and unsafe abortions in the Amazon region of

Colombia using qualitative methods. La Fundación Clínica Leticia sponsored research locally, and the study was intended to address issues within the organization's principal catchment area, including Leticia and the city's surrounding barrios and indigenous communities. The study site is composed of a largely rural population, much of which faces considerable barriers in accessing education and employment. We selected healthcare providers and community leaders for interviews because these individuals act as both key informants and gatekeepers for service provision and education in the community. The research team hoped to answer two questions through its research: what are the causes and outcomes of EC utilization, unwanted pregnancies and unsafe abortion as perceived by providers and community leaders, and how do these perceptions affect provider and leader attitudes toward and provision of EC and abortion services?

In the process of answering these questions, investigators set three primary objectives. First, the research team described perceived causes and social determinants underlying the incidence of unwanted pregnancies in the community. Second, investigators analyzed the perception of decision-making subsequent to an unwanted pregnancy and identified factors influential to women's decisions to abort or proceed with a pregnancy based on the observations of providers and leaders. Finally, the team described and analyzed provider and community leader attitudes toward abortion and EC utilization in the region.

CHAPTER 2. LITERATURE REVIEW

Abortion and Emergency Contraception

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
(Paxman 1980, citing the WHO definition of 'health')

Globally each year, 19 million women risk their lives, health, and for many, their freedom, while undergoing unsafe abortions (Shah and Ahman 2004). Of these, the World Health Organization estimated that 47,000 women die annually, representing 13 percent of maternal deaths worldwide (Shah 2010). South Americans obtain approximately 3 million unsafe abortions annually, with deaths from unsafe abortions accounting for 11% of maternal deaths on the continent (WHO 2003). The continent also has some of the world's most restrictive abortion laws, suggesting that most of the abortions being practiced in the region are illegal and unsafe (Paxman et al. 1993). In fact, the region has the highest incidence ratio of unsafe abortions to 100 live births: 32 for Latin America as compared to 18 for Asia (excluding Eastern Asia) and 14 for Africa (Shah and Ahman 2004). Moreover, Latin America ranks first in the world for having the highest proportion of maternal deaths attributable to these unsafe abortions, with case fatality rates that are five times those expected in most developed countries (Khan et al. 2006) (WHO 2003). And while trends in incidence appear to be on a slow decline, rates remain notably elevated relative to most other regions of the world (WHO 2003). It should be noted, however, that rates rarely tell the whole story as we lack accurate estimates of safe and unsafe abortion practices in most countries.

The toll of unsafe abortions may also be measured in the impact the practice has had on the health care system. Treatment of abortion complications often requires hospitalization—of which about 800,000 occur annually in the region—costly operating room visits, antibiotics, anesthesia and blood transfusions (Paxman et al. 1993) (Singh and Sedgh 1997). Among induced abortions classified as unsafe, hospitalization is expected in one out of every three to five abortions (Paxman et al. 1993). As a result, Paxman et al. estimated that in the early 1990's, approximately half of the Brazilian healthcare system's obstetrics budget was being directed toward the treatment of abortion-related sequelae, while such cases represented only about 12 percent of the admissions in this department (Paxman et al. 1993). Meanwhile, studies in Chile and Colombia, both of which maintained full bans on abortion through the 1990's, demonstrated that women suffering from septic abortions—caused by abortions practiced in unsanitary conditions and with unsanitary equipment—are likely to have hospital stays two to three times as long as women hospitalized for non-septic or spontaneous abortions (Paxman et al. 1993).

In many countries in the region, this trend has continued in spite of the widespread rollout of affordable contraceptives in Latin America (Singh and Sedgh 1997). Where, in the 1960's, contraceptive prevalence in the region was estimated at only 14 percent, it hit 55 percent in 1992, with 46 percent of those using some modern method (Paxman et al. 1993) and has increased steadily since then. In the 1960's, Requena described his observations of contraceptive and abortion use in the region as "the Latin American pattern"—referring to spikes in induced abortion

preceding contraceptive uptake in communities, followed by a peak and eventual decline in the number of abortions (Singh and Sedgh 1997). A two-scenario framework presented by Tietze and Bongaarts in the 1970s is a logical step from this description (Singh and Sedgh 1997). In the first scenario, communities begin with high abortion rates upon introduction of contraception and then follow a trend of decreasing abortions and increasing contraceptive use. In the second scenario, however, contraceptive uptake is outpaced by couples' desire to have fewer children, causing a steady or increasing reliance on abortion even as contraceptives are introduced (Singh and Sedgh 1997).

Abortion in Colombia:

If the experience of Colombia can be summarized in either of Tietze and Bongaarts' scenarios, we might say that the country fits the first description. Retrospective analysis in 1997 indicated that as contraceptive use in Colombia increased through the late 1980's and early 1990's, levels of abortion stabilized, and in some regions of the country even declined slightly (Singh and Sedgh 1997). The opposite was true in Brazil, where abortion rates appeared to rise as contraceptives became increasingly available (Singh and Sedgh 1997). We can attribute this discrepancy to infrastructural and cultural differences between the two countries; in Colombia, the strong presence of Profamilia, a national family planning program developed in the mid-1960's, and a stronger desire to control fertility in Brazil that outpaced contraceptive rollout create this difference (Singh and Sedgh 1997) (Echeverry, 1975).

This is not to give the illusion that abortion in Colombia has been adequately addressed with the introduction of effective family planning and contraceptive strategies. In some cities of the country in the 1990's, abortion was cited as the first pathological cause of hospital admissions, second only to normal full-term obstetrical admissions (Llovet and Ramos 1998). Even leading up to the monumental decision by the country's Constitutional Court to loosen regulations on abortion in 2006, an estimated 300,000 to 400,000 illegal abortions were being performed annually across the country (Ceaser 2006). A 1991 report estimated that one in seven pregnancies ended in abortion in Colombia, a statistic that earned the country the third place ranking in the region—after only Brazil and Mexico—for the prevalence of abortion (Paxman et al. 1993). The authors of the study also estimated that 40.3% of maternal deaths in the country could be accounted for by unsafe abortion practices, though rates estimated by the WHO are lower but still substantial (Paxman et al. 1993).

Statistics are only part of the picture, however. Colombia's experience with abortion is as much a story of a political, religious and cultural change as it is about healthcare. For much of the country's modern history, conservative social politics has reigned and earned Colombia the distinction of being one of only three Latin American countries to maintain a blanket ban on abortion prior to 2006 (Ceaser 2006). By law, performing or receiving an abortion in the pre-2006 era could earn an individual up to four and a half years in prison, though few cases were actually brought to court and most women convicted were sentenced to house arrest instead of prison placement (Ceaser 2006). Ceaser notes, moreover, that the greatest

decline in abortions in the country was in response to widespread increases in the availability of misoprostol, a medicine used for the treatment of gastric ulcers that is also known for its abortion-inducing ability (Ceaser 2006).

The beginnings of the national change in sentiment that prompted the 2006 liberalization of abortion policy can be traced back as far as 1991, when the country, emerging from decades of internal conflict, articulated a new broad charter of individual rights in its new Constitution (Posada 1997). This shift brought the issue of abortion into the realm of public debate as an issue of human rights for the first time in Colombia's history (Posada 1997). Two cases tried in court prior to 1997 demonstrate the court's conservative interpretation of the Constitution at that time. In both cases, the court held that punishment for a woman having an abortion was appropriate, even when the woman had become pregnant by means of rape. Posada notes that, "these decisions reflect the traditional Catholic position that life must be protected from conception" (Posada 1997). The judges argued in both cases that reproductive rights, including the right to decide the number of children a woman wishes to have, are not expressly granted in the Constitution and thus could not be used in defense of the act of abortion (Posada 1997). Challenging this position was a group of judges who argued that a fetus, having only a "physical", but not a "social" existence, is not entitled to the fundamental rights of individuals as expressed by the Constitution (Posada 1997). The argument was an encouraging step forward for reproductive health advocates in the country. Writing in 1997—still nine years before the 2006 liberalization—Posada hopefully reflects:

> "[I]t is no longer only women who are committed to sexual and reproductive rights who are speaking out in a language that favors the decriminalization of abortion." (Posada 1997)

Posada's optimism was rewarded on May 10, 2006, when the Constitutional Court ruled that the country's existing blanket prohibition "failed to respect a woman's rights, including dignity, liberty, health and life" (Roa 2008) (Boland and Katzive 2008). Today, abortion is permitted when a woman's life or health is endangered by the pregnancy, in the case of rape or incest, and instances of severe fetal impairment (Boland and Katzive 2008). Subsequent legislation enacted by the Colombian Ministry of Social Protection has sought to ensure adequate access to care for women seeking legal abortions by requiring that healthcare providers not cause unnecessary delays in providing care and ensuring access even for women without a means for paying for the procedure (Boland and Katzive 2008). The changes place Colombia on the map in a world slowly moving toward liberalization of abortion policy and make the country one of the most liberal in Latin America with regards to its political stance on abortion (Boland and Katzive 2008).

Nonetheless, significant barriers still face women seeking the legal abortions enumerated by the court. Monica Roa, a pro-choice campaigner, director of the Gender Justice Program at Women's Link Worldwide and the lawyer responsible for filing the petition against Colombia's abortion ban that ultimately led to its overturning, outlines in a 2008 article on the issue the obstacles to realizing the court's legal decision in women's everyday lives (Roa 2008). Among these is a lack of public knowledge and understanding of the legal changes, abuse of system loopholes by providers and judges and discrimination by a still predominantly

conservative society against those who provide and seek abortions (Roa 2008). While the law asserts that women seeking an abortion require only a certificate from a referring physician explaining a health impetus for abortion or a police report documenting sexual violence, providers have been known to demand additional information, including forensic examinations to confirm assault, authorization of family members or consent from a panel of physicians (Roa 2008).

Others have sought to avoid the situation entirely by taking advantage of the law's "conscientious objector" clause that allows individual doctors to refuse to provide abortions based on personal objections (Roa 2008). These providers are often in clear violation of the law, which stipulates that objectors refer patients to others willing to provide abortions (Roa 2008). Additionally, the law excludes doctors practicing in the public healthcare system from the right to be an objector as well as entire healthcare institutions, which are not permitted to form group-level policies against the practice (Roa 2008).

Regarding women who are victims of sexual violence, the Court formulated particularly liberal requisites, insisting that providers cannot require that a judge or a police officer find that a rape actually occurred or require women to obtain consent or notify others of her decision, regardless of the woman's age (Roa 2008). A failure to stringently enforce policies, coupled with a culture that has maintained a complicated moral relationship with abortion, have fostered the complicit participation of countless members of society in the continued denial of basic reproductive rights for many Colombian women, and the persistence of abortion as a national health issue.

Emergency Contraception:

Emergency contraception (EC), though believed by many researchers to be the magic bullet for Latin America's reproductive health woes, has been widely under-utilized in the region (Nations et al. 1997). Chile, known for its conservative stance toward women's reproductive rights was first to ban a dedicated EC product in 2001, due to a determination by the country's Supreme Court that the product was an abortifacient (Heimburger et al. 2003). Four months later, however, a second dedicated EC product, made with identical ingredients but carrying a different brand name was licensed and continues to be legally sold throughout the country, though it also continues to be practically inaccessible to many (Heimburger et al. 2003). The struggle in Chile represents a game of tug-of-war common to Latin American nations that pits the public health institution on one side and the Catholic Church and conservative right on the other, with the government caught between the two (Heimburger et al. 2003).

The stories of Colombia and Brazil, however, have been exceptions to the model exemplified by Chile. In Brazil, EC was endorsed by the Ministry of Health in 1997 to little fanfare, and continues to be available in the market (Heimburger et al. 2003). The work of Profamilia in Colombia has led to a similarly seamless integration of dedicated EC products into family planning strategies in the country. The 1993 passage of Law 100—responsible for revolutionizing health systems in Colombia and introducing universal healthcare—brought reproductive health services and strategies under the mandate of the national government (Heimburger et al. 2003). Bolstered by this and a steady shift toward a rights-based approach to

medicine, Profamilia now provides approximately 70% of family planning services in the country by means of 42 clinics and almost 6,000 distribution points (Heimburger et al. 2003) (International Planned Parenthood Federation 2011). EC products have been readily accepted as a piece of the nation's family planning strategy since Postinor-2, a levonorgestrel-only product, was granted exclusive licensing rights in 1999 (Heimburger et al. 2003). The product faced brief controversy a year later, but was held up as an "appropriate contraceptive alternative" by the courts and has since faced little challenge (Heimburger et al. 2003).

Where policies in Brazil and Colombia appear to fall short, however, is in effectively educating and promoting EC products to those who most need it (Heimburger et al. 2003). Previous studies indicate that adolescents living in low-income, rural areas of the country are most likely to face barriers in accessing contraception. Education for this population is often the purview of secondary schools that miss students who are no longer enrolled or are already sexually active (Pons 1999). Moreover, curricula often emphasize reproduction over "true sex education" that explicitly informs safe sexual behaviors (Pons 1999). Meanwhile, providers often cite fears that promoting EC will encourage irresponsible sexual decision-making and long-term medical side effects to support anti-EC recommendations. Neither fear has been corroborated in the literature and, in fact, studies on adolescents' behaviors after receiving education about EC in England indicate that students' sexual behaviors were not significantly altered by knowledge of EC.

Areas for Future Research:

> *"What is the real difference between two, three or ten million illegal abortions? Whatever the number is, it is too high. Whether fifty thousand, one hundred thousand, or two hundred thousand deaths occur secondary to illegal abortion—whatever the number may be, it is too many. Whether fifty, five hundred thousand or two million women experience complications due to unsafe abortion, regardless of whether they survive, that number is too high." (Rosenfield A, 1989)*

To date, abortion research in Colombia has emphasized a desire to quantify the problem, as well as to describe the demographics of the women most affected by abortion-related morbidity and mortality (Llovet and Ramos 1998). Due to heavy objections from countries, the Demographic Health Survey (DHS) does not ask about abortion directly, but does seek to gather information on abortion with a series of "filter" questions about unwanted pregnancy and contraception use (Llovet and Ramos 1998). In examining gaps in the field, however, researchers have called for a paradigmatic shift that would emphasize the "socio-political arena" over the "scientific-academic sphere" (Llovet and Ramos 1998). Included in the socio-political arena are studies that emphasize the decision-making process, with all of the ambiguity associated with personal and community-level morality. Given the key role played by lawmakers, law enforcement and healthcare providers, the authors also emphasize the need for exploratory research into the attitudes of these individuals (Llovet and Ramos 1998) (Yam 2006). Such studies demonstrate the extent to which public policy reflects public opinion and can even reflect the accessibility of legal services in the community and barriers affecting women seeking to exercise their new legal rights (Yam 2006).

Existing opinion research on the practice of abortion in restrictive and newly liberalized countries is undoubtedly on the rise (Yam 2006). Such research continues to suggest strong community-level stigma surrounding the practice, though it has also unearthed ways in which communities have integrated abortion into existing cultural and religious beliefs (Nations et al. 1997). This is true of a study of women in a poor community in Northeastern Brazil published in 1997 (Nations et al. 1997). In this study, the authors note that a language of ambiguity surrounding abortion and pregnancy help to provide an environment in which moral objections to abortion might be avoided (Nations et al. 1997). By treating the early stages of pregnancy as a medical grey area in which one may or may not be pregnant, women are given liberty to treat "delayed" or "suspended" periods via folk or modern medical means (Nations et al. 1997). And while the particular cultural definitions described in this study may be unique to Northeast Brazil, the process of cultural adaptation has been documented in countries around the world, including in Colombia (Nations et al. 1997).

A systematic literature review of abortion research in Latin America published in 2006 recognizes that opinion research continues to disproportionately represent Brazil and Mexico while entirely neglecting the Caribbean and paying little attention to other Latin American countries (Yam et al. 2006). The review does, however, present a useful baseline for understanding abortion opinions and some of the questions research in the arena might hope to answer. Of particular relevance to this study were previous studies on provider opinions and willingness to perform and recommend abortions, opinions on why women seek abortion and opinions

regarding the decision-making process for those seeking abortion. One study among Mexican physicians, for example, cites lack of responsibility, rape and lack of preparedness to have a child as explanations of why women seek abortions, while three studies in Brazil emphasize poverty, unstable relationships and unwanted pregnancies as determinants of abortion-seeking behaviors. This review also shows some disparities in reports on who professionals believe should be involved in the decision-making process, noting that in one study set at a Brazilian university, law students were more likely to support decision-making by the woman alone, while medical students favored partner participation in the process. The studies selected for the literature review do, additionally, favor quantitative surveys over qualitative data, suggesting a place for qualitative analysis in what is an undoubtedly complex issue.

Background on Colombia and Las Amazonas

General Demographic Information:

Significant changes to the healthcare sector since the early 1990's have done a great deal to bolster Colombia into the modern era of health. Today in Colombia, expected life expectancy at birth is 74 years, just four years below that of the United States, with a fertility rate comparable to that of the United States (CIA Factbook 2010). Still, the country can be seen lagging in other indicators, including its infant mortality rate of 16.87 per 1,000 live births, as compared to 6.14 deaths per 1,000 live births in the United States. While healthcare modernizes, it continues to struggle with the nearly half the country living below the poverty line and the 25 percent living in rural areas—many of which are burdened by issues of access to care (CIA World Factbook 2010).

Today, 99 percent of the country's urban population and 91 percent of the rural population has access to electricity (DHS 2010). Results from the 2010 DHS survey indicate, however, that only half of households in the Amazon region have access to public water services, as compared to 91 percent of the urban population (DHS 2010). Nationally, 40 percent of males and females have a high school education, while 14 percent of males and 17 percent of females have some form of post-high school higher education. Ethnically, the country is composed of a mix of "mestizos" or "whites" (86 percent), indigenous peoples (4 percent) and a slew of other cultural and racial groups including black, mulatto, Afro-Colombian and African-American groups that together make up 10 percent of the population.

Regarding women's reproductive health, the average age at first childbirth among women is 21.6 years (DHS, 2010). The median interval between births among urban dwellers is 52 months, as compared to 39 months in rural areas. The difference is more marked in comparisons by education level, which indicate that those with higher education have a median interval of 61 months between childbirths, while those of lesser education have a median interval of 34 months. Average age at sexual initiation among women was 18.4 years in urban areas and 17.7 years in rural areas.

Survey results indicate "universal" knowledge of contraceptive methods among reproductive age women, regardless of socioeconomic status and education. Female respondents named condoms, contraceptive pills, injections and female sterilization as the most commonly used contraceptive methods. Eighty-five percent of reproductive-age women in the DHS reported having used a contraceptive method at least once in their lives, while 61 percent reported using some method regularly—up from 56 percent in previous years. Popular methods appear to vary by region, with the injection prevailing as the most popular method for the Amazon region, where 19 percent of women reported use of this method. DHS results suggest, moreover, that use of any family planning method is approximately 79 percent in the Amazon region, equivalent to prevalence rates in urban regions of the country. Overall, fifty-six percent of individuals reported accessing family planning methods at hospitals, clinics, or other health institutions. Pharmacies were the primary provider of pills and condoms.

A DHS measure of unwanted pregnancies indicates a national desired fertility rate of 1.6 children, compared to the actual rate of 2.1 births per woman. In rural areas, women on average have one more child than desired, whereas women in urban areas have 0.5 additional children. This discrepancy was even more marked in comparisons by education levels; women with no education have approximately 2 more children than they desire, whereas women who have received some form of higher education report fertility at desirable rates. The report notes, moreover, that only 48 percent of births occurring in the five years prior to the survey were wanted at the time of pregnancy. This figure includes 29 percent that were wanted at a later time and 23 percent that were openly unwanted.

Nationally, 72 percent of pregnancies result in live birth, with 16 percent considered spontaneous abortions, 8 percent abortions or miscarriages and 4 percent ectopic pregnancies. Of terminations occurring after May 2006, 28 percent were abortions. Of these, 83 percent in turn sought medical care. Seventy-six to 79 percent of women surveyed correctly identified the legal grounds for abortions in Colombia, though only 67 women stated that they had requested a legal abortion since the ruling. Most of these women reported requesting an abortion on the grounds of danger to their life, fetal malformation and rape, in that order.

Politics:

Emerging from more than four decades of internal armed conflict, Colombia has made immense strides in its economic and social development in the past ten years (CIA Factbook 2010). Under the leadership of former President Alvaro Uribe,

who held the reins for eight years from 2002 to 2010, government forces stymied much of the violence that plagued the country through the 1990's (BBC 2010). Reductions in violence and narcotic trafficking have been crucial to strengthening the country's economy and have corresponded with huge growth of the country's GDP (CIA Factbook 2010). And though Uribe's crackdown on rebel forces, in particular the Revolutionary Armed Forces of Colombia (commonly known as the FARC), has pushed guerrilla-related violence out of the country's major urban areas, these groups have maintained a hold in some rural areas, where development has been slower and much of the population has been held in poverty (BBC 2010) (CIA Factbook 2010). Despite progress, Colombia continues to be affected by unemployment rates of more than 11 percent, with approximately 47 percent of its population living below the poverty line (CIA Factbook 2010).

Religion:

Roman Catholicism, as the religion of more than 90 percent of Colombians, plays a substantial role in influencing the national character of the country (CIA Factbook 2010). The country has long served as the "conservative anchor" of Latin America (Levine 1985). Throughout Latin America, the Church has been instrumental in impacting reproductive health legislation—most notably in the experience of Argentina and Chile, where Church opposition played a major role in combating EC programming (Heimburger, Gras and Guedes 2003).

The Amazon Region:

As the capital of Colombia's Amazonas department, Leticia has a population of more than 39,000, approximately 56% of the department (Gobernación de Amazonas 2008). With an economy that relies heavily on distribution of consumer products, agriculture and tourism, nearly 40% of the department's inhabitants live in poverty—defined as having more than two unmet basic needs (Gobernación de Amazonas 2008). Life expectancy in the department is estimated at 38 years for men and 32 for women (Gobernación de Amazonas 2008). Approximately 30 percent of children under-five suffer from chronic malnutrition and 17 percent are underweight (Gobernación de Amazonas 2008). Education is a challenge in the region as well, with school enrollment peaking at 53% in elementary schools while only 38% of eligible children enroll in basic secondary schools (Gobernación de Amazonas 2008). The department's government notes that the region is characterized by a deficiency of public and social services and weak physical and economic infrastructure (Gobernación de Amazonas 2008).

CHAPTER 3. MANUSCRIPT

Perceptions of unwanted pregnancy, emergency contraception and abortion: a qualitative study of healthcare providers and community leaders in the Amazon Region of Colombia

Primary Author:

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STUDENT CONTRIBUTION

The student was responsible for activities at each stage of the research process from development of the research question and interview guides, to execution of interviews and subsequent analysis and reporting of findings. Co-authors included Dr. Roger Rochat and Dr. Monique Hennink who guided the research and analytic process, as well as Dr. Javier Gutierrez, founder of La Fundación Clínica Leticia and local sponsor of the research. Dr. Gutierrez contributed to development of the research question and assisted with field methods in Leticia. Tables and figures, along with key findings, were produced by the student and reviewed by the student's advisors for content and presentation.

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Author: Shreya Rao

Thesis Advisor: Roger Rochat

Background: Colombia's 2006 decision to liberalize its abortion policy has made it one of the most progressive policies in the region to reduce the practice of unsafe abortion. In the capital city of the Amazon region, a local physician and founder of La Fundación Clínica Leticia identified adolescent pregnancies and unsafe abortions as a priority health concern in the community. No research has been done in this community to examine experiences of unwanted pregnancy and abortion.

Objective: Investigators sought to elucidate issues underlying unwanted pregnancies and propose solutions for Clínica Leticia. During the summer of 2010, we examined healthcare provider and community leader perceptions of unwanted pregnancies, emergency contraception (EC) and abortions through a qualitative research approach.

Methods: In-depth interviews were conducted with 33 healthcare providers and community leaders. Interviews were conducted in Spanish, transcribed verbatim and coded using MAXQDA10 software.

Results: Providers and leaders reported adolescence, poverty, poor education, inadequate access to contraception and local culture as determinants of what they called 'irresponsible sexual practices' that lead to unwanted pregnancy and abortion. Decision-making for managing an unwanted pregnancy was influenced by families and partners, financial considerations, young age and cultural or religious disapproval of abortion. Respondents commonly opposed abortion and its legalization on moral grounds, while they objected to EC based on fears of complications from long-term use. Their perceptions of irresponsible sexual behaviors led them to oppose EC and abortion.

Discussion: Participants identified adolescents as a high-risk group for unwanted pregnancies and unsafe abortions and suggested a need for sex education targeted to this group. Many reported that existing efforts lack consistency and should be adapted to address challenges adolescents face in accessing contraception. Respondents suggested barriers to preventing unwanted pregnancies might be reduced by increasing dialogue about sex and contraception and with efforts to promote education and employment opportunities for adolescents. Increasing awareness of current abortion laws and judicial decisions among providers and women may facilitate improved acceptance of legal abortions in the region while increased education about the safety and efficacy of EC products may address local barriers to the provision of EC.

3.1 INTRODUCTION

Globally each year, 19 million women risk their lives, health, and for many, their freedom, while undergoing unsafe abortions (Shah and Ahman 2004). Of these, the World Health Organization estimated that 47,000 women die annually, representing 13 percent of maternal deaths worldwide (Shah 2010). Meanwhile in Colombia, 300,000 to 400,000 illegal abortions were being performed annually before a blanket ban on the practice was lifted in 2006 (Ceaser 2006).

These statistics demonstrate the immense public health burden in preventable morbidity and mortality resulting from unwanted pregnancies and unsafe abortions in Colombia. Although figures specific to the Amazon region have not been documented in the literature, studies from rural areas in the country and the experience of the sponsoring organization suggest that unwanted pregnancies and the practice of unsafe abortions pose a risk of maternal morbidity and mortality.

Investigators sought to qualitatively describe the factors driving unwanted pregnancies and unsafe abortions in the Amazon region of Colombia. La Fundación Clínica Leticia sponsored research, and the study addressed issues within the organization's principal catchment area—a rural region characterized by poverty and poor health outcomes as well as its cultural diversity. Healthcare providers and community leaders were interviewed as both key informants and gatekeepers for service provision and education. The investigator hoped to answer two questions through the study: what are the perceived causes and outcomes of EC, unwanted pregnancies and unsafe abortion, and how do these perceptions affect provider and leader attitudes toward, and provision of, EC and abortion?

3.2 METHODS

Field Methods:

The investigator conducted this study in Leticia, Colombia, between June and August 2010. Participants included male and female health care providers, pharmacists and community leaders and educators above the age of 18 practicing in Leticia and the city's surrounding communities.

La Fundación Clínica Leticia, a locally based non-governmental organizational founded by Dr. Javier Gutierrez, sponsored research activities. The foundation's activities are centered on the operations of Clínica Leticia, a private clinic owned and run by the foundation, which provides medical care—including a full range of reproductive and sexual healthcare—in Leticia, Colombia. La Fundación endorsed researchers' field methods and provided logistical support, including local contacts and transportation to study sites. Expedited approval to conduct research was obtained from the Emory University Institutional Review Board.

Research Methods:

Investigators selected the research site in order to reflect the principal catchment area of La Fundación Clínica Leticia. The region is characterized by its rural population, a high prevalence of poverty and limited resources for research and programming. These factors suggest Leticia has been unexamined in previous abortion opinion research and may benefit from findings of this study.

The primary objectives of the study were to describe the issue of unwanted pregnancy from the perspective of healthcare providers and community leaders and

to characterize these individuals' attitudes toward EC use and abortion. This subgroup of participants was targeted in order to provide insight into their role in decision-making and service delivery in which providers and leaders often play a critical role. Participants included adults (above the age of 18) engaged in reproductive healthcare in the community in either a professional or voluntary capacity.

Interview participants were service providers working in Leticia and the surrounding communities and were purposively recruited in one of two ways. Participants in the healthcare provider group (16) included nurses, social workers, psychologists and public health professionals in the region. Nurses often worked directly in reproductive health or in family or emergency medicine, and reported working regularly with women of reproductive age. Pharmacists (6) were specialists in reproductive services and were often responsible for administering contraceptive injections and counseling women on contraceptive services. Leaders (11) performed a variety of roles in the community and included elected neighborhood and community presidents, religious leaders, educators and non-professional health workers including a shaman.

We targeted professionals—namely hospital and clinic workers, social workers and pharmacists—at the location of service provision. The primary investigator obtained manager or administrator permission prior to recruitment at each location and sought referrals to intra-organizational "experts" who were considered well-versed in issues relevant to the study material. Study staff described the research subject matter as well as the terms of participation to

administrators in the local language prior to approaching specific employees and obtaining informed consent for participation.

Staff of La Fundación Clínica Leticia assisted in identifying community leaders and providing local introductions. The investigator also used snowball sampling among community leaders in order to identify "experts" and individuals in the community specializing in work relevant to the study. Community leaders facilitated introductions and sometimes provided a physical location for interviews. The investigator sought endorsement of leaders in order to foster trust with participants because interviews included information about activities that might be considered sensitive or illegal.

No previous abortion literature on opinions of abortion is available for the region, prompting qualitative methods for this study in order to establish a more robust and detailed understanding of issues unique to the community. Focus groups were not conducted for fear of potential professional repercussions for care providers and leaders sharing unpopular or potentially illegal experiences and opinions.

The principal investigator executed verbal informed consent with each participant prior to initiation of each interview. Informed consent included a description of the study's purpose, rationale and participating institutions. The investigator provided participants with contact information for local and international study staff, as well as contact information with the study's IRB. The primary investigator conducted all informed consents and interviews in Spanish, the local language of the Amazon region.

In-depth interviews were approximately one-hour in length and were conducted at all times during the day, according to participant preference. Study staff often made multiple visits to interviewees' homes and offices in order to complete the informed consent and interview process. The primary investigator conducted all interviews in privacy, in locations agreed upon by both participants and the researcher. Locations included offices in providers' places of work, and homes of community leaders. The study team did not provide any form of compensation for participation.

The interview guide was developed by the principal investigator based on reviews of literature and was assessed in English by faculty of the Rollins School of Public Health and subsequently in Spanish by staff of La Fundación Clínica Leticia for clarity and appropriate content. An iterative process for making revisions to the interview guide was adopted in order to add probes and topics not covered in interviews. The structure and intent of interviews remained consistent through revisions. Final versions of the guide are presented in **Appendix B** in English and Spanish.

Data Analysis:

In all, 38 interviews were conducted, digitally recorded and transcribed verbatim in Spanish. Participants were assigned unique identifiers in order to preserve the anonymity of interviews and all names and personal identifiers were removed from the data prior to analysis. The number of participants was

determined based on the concept of theoretical saturation, which suggested that data collection should continue until no new concepts emerged in interviews.

Paid staff transcribed interviews subsequent to data collection and provided transcripts in Spanish to the primary investigator. Transcribers are native Spanish-speakers who are students of language and linguistics at La Universidad de las Americas Puebla with a background in transcription. Of the 38 interviews, five could not be transcribed and were not included in the analysis. Three of these interviews were lost due to a malfunction of the digital recording device, one could not be transcribed due to poor sound quality and one was excluded because the participant declined to answer all questions in the interview guide after providing informed consent.

Transcripts were uploaded and analyzed using the MAXQDA10 software package. All transcripts were reviewed for initial theme identification. One third of the sample was then re-read more carefully for development of a basic codebook. The codebook included 42 inductive, deductive and in vivo codes with functional definitions. Inductive codes were developed based on issues that emerged from the data unsolicited and included codes for 'poverty', 'fear of too many abortions' and 'child consequences', for example. Deductive codes, meanwhile, coded for segments in direct response to issues raised by the interviewer. Codes for 'family size', 'abortion cost' and 'EC risks' are thus all examples of deductive codes as each of these issues was prompted by questions in the IDI guide. Finally, in-vivo codes were intended to capture the exact language of participants in describing specific

phenomena. In this study, codes for 'sex for sport' and 'easy' were identified as in vivo codes because they represent the unique language of participants.

Analysis was conducted using a grounded theory approach (Glaser and Strauss, 1967) that included formulating thick descriptions of codes, comparisons of codes across participant subgroups and categorization and conceptualization that ultimately led to theory development. In the first step of the process, the investigator performed a close reading of all transcripts and coded interviews according to the developed codebook. The investigator then identified core codes relating directly to the research question as well as pervasive codes in the data and formulated thick descriptions of each. Codes relating to the experience of unwanted pregnancy, abortion and emergency contraception, as well as codes for poverty and unemployment, irresponsibility, sexual practices and decision-making were among those examined in this step. The investigator searched for coded segments relating to these codes and topics and re-read coded segments numerous times in order to gain a detailed understanding of each code and the context in which it was discussed. In addition, the investigator used code-matrix functions in MAXQDA10 to visualize correlations between codes. Thick descriptions allowed the investigator to recognize prominent issues in the data and patterns within discussions of unwanted pregnancy, abortion and EC.

After conducting thick descriptions, the investigator focused on making comparisons across the data set. Comparisons were considered primarily based on the deductive characterization of participants into one of three subgroups: healthcare providers, pharmacists and community leaders. The investigator

conducted searches within the data by subgroup and again re-read coded segments in order to capture differences between groups in both content and language. The investigator also conducted cross-case comparisons in exploring topics central to the research question. Later in the process of theory development, the investigator returned to this step to examine how broader themes and groups of codes were treated differently from subgroup to subgroup and interview to interview.

In the next step, the investigator collapsed codes into broad categories intended to capture core concepts in the data. Codes were organized into six categories: 'education and economics', 'sex to unwanted pregnancy' which included sexual practices believed to cause unwanted pregnancy, 'access to family planning/abortion', 'decision-making', 'feelings toward abortion' and 'feelings toward EC'. Of these categories, the latter four were deductive in that they stemmed from major topics in interviews, while the first two were largely inductive in nature. The category 'sex to unwanted pregnancy', for example, included inductive codes such as, 'multiple partners/unstable relationships', 'irresponsibility', 'adolescent sex' and 'rape/abuse', all of which were grounded in participants' discussions rather than questions specifically prompted in interviews.

In conceptualizing the data, the investigator identified a central process at work in participant accounts. This process linked the factors preceding an unwanted pregnancy to those affecting decision-making after an unwanted pregnancy and discussions of the acceptability of abortion among providers and leaders. The investigator took a 'big picture' approach to theory development, but returned to the data frequently in order to answer the 'how' of linkages between key concepts.

Doing so identified links between the categories of 'sex to unwanted pregnancy' and 'feelings toward abortion' for example. In this case, the cause of the unwanted pregnancy heavily influenced participants' feelings toward that pregnancy ending in abortion. Before solidifying a single theory the investigator examined a number of different pathways that may link these issues, constantly returning to the data in order to ensure that theories were grounded in participant accounts. The investigator then reviewed the developed conceptual framework against individual participant accounts in order to ensure that issues emphasized in the framework were consistent with those discussed by participants.

Because analysis was conducted away from the study site, the investigator could not also confirm the theory presented with participants and community members. In addition, limitations on time during the analysis phase and language barriers (as analysis was conducted in its original Spanish) meant that validation measures including tests for inter-coder agreement were not conducted. Coding was, however, conducted by a single researcher and efforts were made to ensure coding and subsequent interpretations were consistent from interview to interview. Due to budgetary limitations, moreover, the study team could not perform tests to validate interview transcripts for accuracy. The investigator did, however, examine transcripts against recorded segments of interviews in order to ensure that transcripts were executed verbatim.

3.3 RESULTS

During two months of fieldwork, the primary investigator conducted a total of 38 interviews, of which 33 were transcribed and analyzed. The five excluded interviews included three files that were lost due to a malfunction of the digital recording device, one interview that could not be transcribed due to poor sound quality and one interview that was excluded because the participant declined to answer questions after providing informed consent.

Of the 33 interviews analyzed, 16 were conducted with medical professionals, six with pharmacists and 11 with community and religious leaders. We interviewed 22 women and 11 men. Twenty-one respondents worked in the city center, five in the barrios and six in indigenous communities. The majority of participants hailed from cities outside of the Amazon region and nearly all participants self-identified as Catholic. Marital and relationship status varied widely amongst participants. The mean age of the group was 37 years with no notable difference in the mean age by gender. **Table 1** summarizes demographic information of the group. A full line listing of participant demographics is available in **Appendix C**.

Investigators had three primary objectives in analysis. The first was to describe perceived causes and social determinants underlying the incidence of unwanted pregnancies in the community. The second was to analyze the perception of decision-making subsequent to an unwanted pregnancy and identify factors influential to women's decisions to abort or proceed with a pregnancy. The last was to describe and analyze participants' feelings toward abortion and EC utilization,

emphasizing factors that distinguished socially acceptable versus unacceptable practices.

Table 1. Summary of participant demographic characteristics in the Amazon region of Colombia, 2010

Characteristic	N (%)
TOTAL	33 (100)
Gender	
Male	11 (33.3)
Female	22 (66.6)
Mean Age	37
Male	38
Female	36
Occupation	
Medical providers and social workers	16 (48.5)
Pharmacist	6 (18.2)
Community and religious leaders	11 (33.3)
Location	
City center (urban)	21 (63.6)
Barrio (urban)	5 (15.2)
Indigenous community (rural)	7 (21.2)
Place of origin	
Amazonas	9 (27.3)
Outside Amazonas	19 (57.6)
Missing*	5 (15.1)
Religion	
Catholic	20 (60.6)
Other, non-Catholic	1 (.03)
Missing*	12 (36.4)
Marital Status	
Single, not married	5 (15.2)
Married	8 (24.2)
"Union libre" (open relationship)	6 (18.2)
Separated/divorced	5 (15.2)
Missing*	9 (27.3)

**Additional demographic questions were added during revisions of the interview guide after approximately one-third of the interviews had been completed and were thus not asked in earlier interviews.*

Figure 1 depicts provider and leader perceptions of the causes and determinants of unwanted pregnancy (left—designated as "UP"), decision-making after an unwanted pregnancy (center) and determinations of acceptability regarding abortion (right). Respondents emphasized poverty, young age, poor education and inadequate access to contraception as determinants of irresponsible sexual behavior, which they believed was the primary cause of unwanted pregnancy. They noted birth and abortions as the two primary outcomes of an unwanted pregnancy and described factors, including family and partner influence and financial considerations that contributed to a woman's decision in each direction. Finally, they described the criteria for distinguishing acceptable and unacceptable abortion practices by discussing their personal opinions about the practice. Participants noted that unwanted pregnancies that were within a woman's control were caused by irresponsibility and were thus unacceptable, while those resulting from rape or health issues outside the control of a woman constituted acceptable reasons for abortion practices.

Themes were consistent among providers, pharmacists and leaders, though differences between the groups were often more marked in comparisons of the language used to characterize opinions. The following results are organized according to the three categories presented in the conceptual framework.

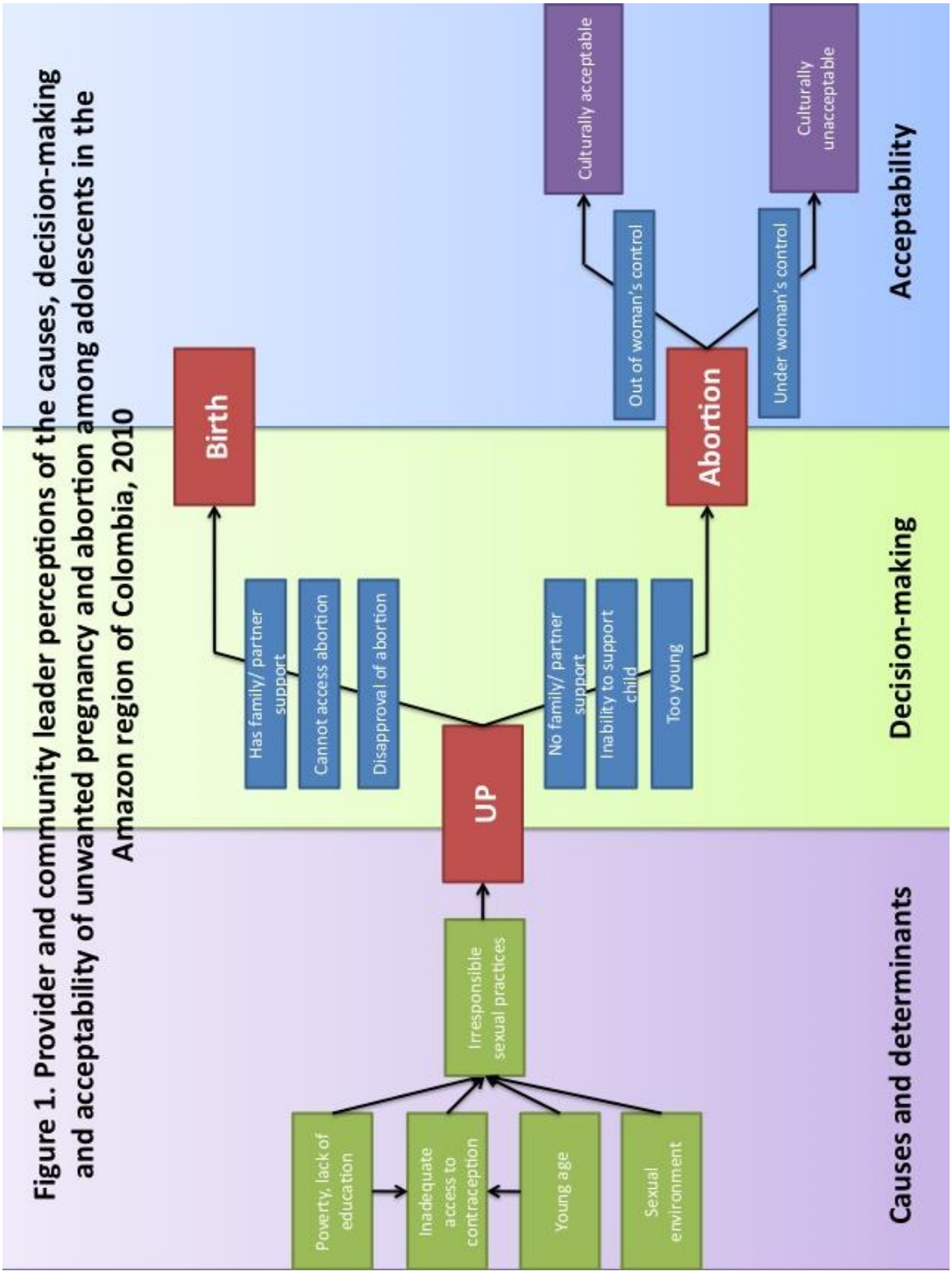


Figure 1. Provider and community leader perceptions of the causes, decision-making and acceptability of unwanted pregnancy and abortion among adolescents in the Amazon region of Colombia, 2010
Causes and determinants
Decision-making
Acceptability
Poverty, lack of education
Inadequate access to contraception
Young age
Sexual environment
Irresponsible sexual practices
UP
Has family/ partner support
Cannot access abortion
Disapproval of abortion
No family/ partner support
Inability to support child
Too young
Birth
Abortion
Out of woman's control
Under woman's control
Culturally acceptable
Culturally unacceptable

Causes and Social Determinants of Unwanted Pregnancy:

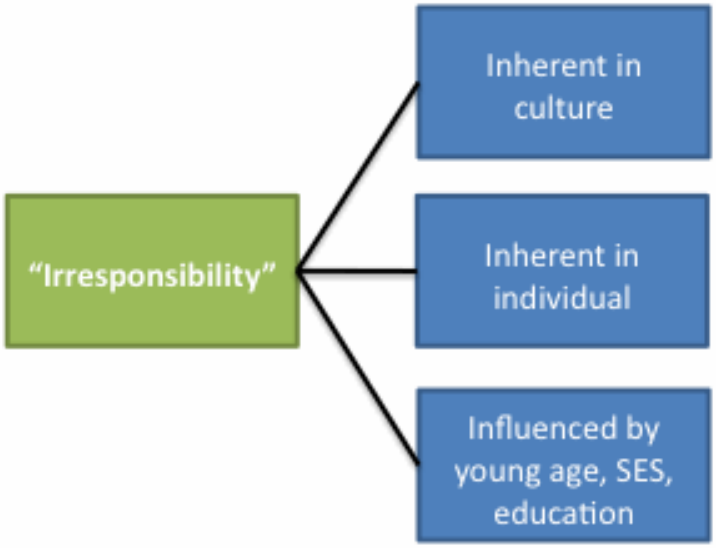
The respondents interviewed for this analysis identified two causes of unwanted pregnancies: the first of these we term broadly as "irresponsible" sexual practices, and the second is rape. In the following sections we will describe what factors constitute and contribute to irresponsible sexual behavior.

Participants cited rape as a second cause of unwanted pregnancy, but differed in their accounts of its frequency in the community. Participants who described rape, abuse and prostitution often attributed all three to a culture of multiple and fluid relationships among parents, and poverty that might increase mothers' dependence on sexual partners or encourage adolescent women to trade sex for money. These topics were not a focus of this study, however, making conclusions about the determinants and consequences of rape in the community difficult to gauge.

"Irresponsible" Sexual Practices

By using the term "*irresponsibilidad*" or "irresponsibility" in referring to sexual practices that cause unwanted pregnancies, the investigator intends to reflect the perceptions of interviewees, who frequently used the term in discussions of sexual behaviors. "Irresponsibility" undoubtedly carries with it a set of contextual and connotative implications, and is wrapped up in sentiments of both judgment and culpability. As participants used it, irresponsibility includes three components demonstrated in Figure 2.

Figure 2. Provider and leader perceptions of "irresponsibility" as it applies to sexual behaviors in the Amazon region of Colombia, 2010



The first of these components, which we term "cultural irresponsibility", refers to notions of irresponsibility that respondents applied to the local population of the Amazon. Providers and leaders described cultural irresponsibility as a characteristic of local cultures that they believed was inconsistent with mainstream Colombian culture. We might offer an explanation for this distinction by examining the demographic distribution of participants, most of who migrated to Leticia from other parts of the country and thus considered themselves ethnically distinct from the local population.

In their discussions, respondents often differentiated indigenous from urban culture and the mechanisms of irresponsibility for each. For the former, participants related cultural irresponsibility to traditional subsistence lifestyles of indigenous people. They often described indigenous people as less educated and less civilized

than the urban population in the region and suggested that these factors contributed to irresponsible sexual practices. Participants believed that high fertility and discomfort with modern contraception and abortion were cultural values for indigenous communities that resulted in low rates of abortions despite a high incidence of unwanted pregnancies.

In contrast, respondents used cultural irresponsibility within the urban population to imply a loss of traditional conservative values. They often reported sexual promiscuity in this population and attributed promiscuous behaviors to the influence of Brazilian culture in the city, which sits on the border between the two countries. Participants believed the urban variety of sexual irresponsibility lent itself to multiple, casual sexual relationships among adolescents, in particular, and resulted in a high incidence of unwanted pregnancies and abortions. In the urban center, participants said access to abortion was easier and more acceptable, though they noted that even abortions in the city center were likely to remain hidden.

Participants attributed the second aspect of sexual irresponsibility to characteristics of the individual. They suggested, for example, that a person might get caught up in a romantic moment and engage in irresponsible sexual behaviors occasionally. Other individuals with knowledge of and access to contraception may choose not to use it because they are simply irresponsible people. In addition, people who are innately irresponsible might be more likely to have multiple, casual partners and in turn be more likely to seek abortions. Irresponsible people might also be likely to exhibit other vices, including drug addiction and alcohol abuse that

some participants believed could predispose them to exhibiting irresponsible sexual behaviors and unwanted pregnancies.

The final aspect of irresponsibility takes into account the impact of a variety of social determinants of health including poverty, unemployment and a lack of education, as well as temporal qualities of the individual including young age—alone the most cited risk factor for unwanted pregnancy. Participants reported that young age, poverty and low education affected individuals' sexual environment and their ability to access contraception, which in turn predisposed them to irresponsible sexual behaviors and unwanted pregnancies. Individual determinants and their relationship with this final concept of irresponsibility are described in the following section.

Determinants of Irresponsible Sexual Practices and Unwanted Pregnancies

Young age

Respondents noted that sexual initiation was a characteristic of the adolescent years, with some estimating the average age at sexual debut as early as eight to 10 years of age, and others estimating age at initiation as high as 18 years of age. The reasons for early sexual debut were varied and often linked to discussions of familial support and influence, insufficient sexual education, a lack of future educational and employment prospects and issues of abuse. And while early sexual initiation had its roots in tradition in indigenous communities, respondents

suggested it was a more recent phenomenon in the urban population. As one nurse reflected: "in this era, the girls are no longer girls." (Nurse, city center)

Poverty and Education

The role of poverty and education in the experience of unwanted pregnancies can be seen at each step of the process. The two emerged in the data linked, with an individual's level of poverty dictating in large part the quality and amount of education the individual would be expected to receive. Participants attributed this both to the schools poorer populations had access to and the type of education children from poor families were likely to receive at home. Respondents frequently noted that poorer individuals and marginalized groups including indigenous communities, were less likely to receive information about family planning than individuals of higher socioeconomic levels and were in turn more likely to experience unwanted pregnancies. One pharmacist summarized this relationship:

> "It is because they lack information because I would say that the girls of better resources are more informed regarding the illnesses and sexual relationships. The poorer people, I would say that, they have more hours of work and they don't have the time to inform their children about sexuality, their bodies, the changes of puberty. One sees a large lack of information on the part of the parents and the children…. The girls of fewer resources find this information in school, with their friends, in the street, and it is wrong information." (Pharmacist, city center)

Participants added that adolescents were more likely to perceive unplanned pregnancies as unwanted in part because they lack the financial resources and education to support a child. Respondents noted that casual sexual relationships among adolescents meant the financial burden of childcare was often the purview of single adolescent mothers, which further exacerbated issues of poverty.

Decision-making for Women Experiencing an Unwanted Pregnancy:

Participants described two primary outcomes of an unwanted pregnancy: abortion and live birth. A third option, adoption, was mentioned only briefly and by few participants. Families and sexual partners, participants agreed, are most influential to decision-making between these options. Their attitudes toward the pregnancy might be expressed or simply perceived, but were influential in both cases. Additionally, according to respondent accounts, an individual's socioeconomic status can influence not only the final decision, but also the methods used to abort, in cases of abortion, the role families play in the process, and the experience of girls choosing not to abort. Almost unanimously, respondents expressed the opinion that any final decisions regarding abortion belonged exclusively to the girl experiencing the pregnancy.

Respondents varied in their estimates of the frequency with which abortions occurred in the community, with some suggesting that they were incredibly rare and others suggesting that as many as 50 percent of unwanted pregnancies ended in abortions in the region. Respondents with specific knowledge about legal abortions in the area suggested that such cases were extremely rare, with some stating that they believed few women with the legal right to abortion were likely to seek a healthcare-assisted abortion. Respondents agreed that non-healthcare professionals, including traditional healers and pharmacies performed most abortions in the region illegally, by providing abortifacient medications and traditional remedies. They noted, however, that woman may also self-induce by ingesting harmful materials or causing themselves physical harm.

Respondents reported the medical risks of these abortions as well as the potential social fallout experienced by women among whom abortions were suspected in the community. A number of participants also expressed concern regarding the psychological consequences of abortions for these women who were believed to harbor feelings of depression and guilt subsequent to abortions. They noted, however, that women considering abortion are unlikely to be discouraged by health concerns, and are more likely to base their decision on cultural, religious and financial considerations.

Abortion

Participants consistently identified three groups involved in decision making for abortion: the girl carrying the unwanted pregnancy, her immediate family and her partner. Some individuals made a distinction between the roles of stable partners and casual partners, but participants often simply referred to this individual with one word, "*pareja*" or partner. The birth of a child, participants said, affects families and partners as well as women and thus should be a shared decision. Not all participants included all three groups; a number of respondents suggested that the decision belongs to the couple alone or even the girl alone. Groups outside the three described—including health care providers, community leaders and religious leaders—were rarely mentioned and were not considered a crucial part of the decision-making process.

Participants consistently stated that final decisions are the purview of the woman experiencing an unwanted pregnancy, though they differed in their reasons for this sentiment. Most participants appeared to hold one of three common views

on the issue. Members of the first group referenced the rights of women to decisions about their bodies and health, but these arguments were rare when the interviewer specified the situation of abortion, and not other family planning methods. Participants in the second group, meanwhile, made the argument that women were those who most frequently carried the burden of children after birth, and were thus entitled to decision-making rights. This argument was also commonly used to discourage involvement of women's sexual partners. Members of the third group took on a more accusatory position, suggesting that women who had abortions did so of their own volition, and chose not to include others for fear of social repercussions and judgment. This position was rare amongst respondents but was often associated with strong views about the acceptability of abortion. This subject will be explored in more detail in a later section.

Nonetheless, a number of respondents recognized the complexity of the decision-making process, noting that women's decisions rarely occur in isolation from family members' and, in particular, partners' opinions and actions. While family members seemed more likely to express explicit opinions about the pregnancy or abortion, partner roles were subtler. Participants described situations in which a partner might leave a woman who reveals her pregnancy and thus influence her feelings toward the pregnancy and her ability to support a child. Often the fear of their partners' reactions alone might encourage women not to share their pregnancy and seek a method of abortion on their own. One pharmacist described this role of male partners:

> "Sometimes, he decides and she listens… There are boyfriends that also say that they are going to take responsibility for the pregnancy. Many times with unwanted pregnancies, a new family is formed. If the woman doesn't feel the support of the boy, then this can present as an abortion." (Nurse, city center)

Others, including one high school professor, noted that decisions that appeared to belong to a woman alone were often motivated by partners. Their influence was seen as an implicit force, sometimes explicitly demanding outcomes, but often influencing women's own feelings toward a pregnancy. Participants noted, on the other hand, that abortions are unlikely in cases where a male partner supports a pregnancy. Responding to the question of what women do when their partners express support of a pregnancy, one community leader responded as follows, suggesting that having support resolved any issues with the pregnancy.

> "Well, they let the baby grow. And this is a joy. When they have the baby, it will be a union of them forever. I knew a couple that both didn't want it [the baby] but when they realized that it would be expensive [to abort], she didn't want to have the baby, but he did. So he threatened her and said, "if you abort my child… something will happen to you" then the woman did in fact have the baby." (Community leader, barrio)

The community leader's anecdote reveals more than the issue of partner influence, however. The partner's threat in the anecdote, though not frequently described, was in fact corroborated in a few other respondents' accounts of partner roles. Another respondent, for example, noted that partners who do not support a pregnancy might physically abuse the pregnant woman, forcing an abortion. Thus, the role of partners, though varying in method, seems an undeniably important aspect of the decision-making process.

At the same time, the community leader's anecdote resurrects another issue. Once again in this anecdote, we see the role of poverty, in this case manifested in the couple's inability to access affordable abortion services, in influencing individuals' actions. The cost of abortions varied widely in participant accounts, often in accordance with the method of abortion being discussed and the location of the interview (city, indigenous community or barrio). And though price estimates ranged from as little as 20 or 25 mil pesos (approximately $10 to $12 USD) to as much as 400 mill pesos (approximately $200 USD), the majority of respondents believed that the cost of abortions was a barrier to accessing abortion services. Those who did not believe cost was a barrier sometimes noted that the burden of paying for abortion services might be covered by partners, with one participant explaining that, "if a woman wants to abort… the money is the most simple for her." (Community leader, indigenous community)

Participants rarely mentioned God, religion and morals explicitly, but all three seemed implicit in the discussion about the cultural acceptability of abortions. This seemed particularly true in discussions of family roles in influencing sentiments toward abortions. A social worker specializing in work with children who are victims of sexual abuse noted that of the four cases of unwanted pregnancies resulting from acts of abuse that she had handled in the previous year, none had aborted, despite their legal right to do so. She attributed the decisions to the girls' religious faith as well as their families' inability to accept the idea of abortion despite its legality, suggesting some deeper moral or cultural issue with the practice.

Most participants described the medical consequences of abortion in great detail: hemorrhaging, infections, cancer, sterility and death were amongst those most frequently named. Not all participants distinguished between abortions practiced legally or by licensed healthcare providers and those practiced in the community, raising doubt as to whether medical consequences were believed to be the result of the procedure itself or the conditions in which it was most often practiced.

Social consequences were discussed less and were generally considered to be minor in comparison to the medical risks. Participants noted that in cases where community members were made aware of an abortion, community members were likely to gossip but rarely was this believed to lead to any long-term consequences for the woman. Another group of participants expressed a greater concern for psychological issues that abortions might create for women experiencing them, including anxiety, guilt and depression. These emotions might be compounded by fears of long-term medical sequelae, like sterility, and by judgment and social isolation from community members. One provider noted that most women practicing abortions were unlikely to experience these consequences, however, because their actions would remain largely secret.

> "Many times, unfortunately, the majority of abortions that happen, the people rarely know about it. So there aren't any accusations because they don't know. The cases that they know about are cases that present with complications. The cases that they know about are when the women come to the hospital with hemorrhages and that's how we know that she aborted. But the abortions that are successful, well they don't know, or only few people who guard the secret." (Nurse, city center)

The topic of punishment for having an abortion was also discussed by a number of participants. Respondents most frequently referred to legal punishments, including police investigations and potential jail time for women, though no participants recalled ever witnessing such punishments in the community or in healthcare facilities. A smaller group of participants referenced moral punishments, describing abortion as a sin for which perpetrators were likely to experience punishment over the course of their lives. An anecdote by one participant was particularly jarring, though the idea of punishment by healthcare providers was not echoed in other participants' interviews.

> "I was like an assistant for abortions in the hospital… And I said to the doctor, 'Doctor, why are you letting this girl scream so much?' [and he said] 'because she had an abortion on her own. She took pills.' This is when I would say that the doctor doesn't have pity. We do not value this class of girls or women because they poison their babies… and when it is an accidental abortion… they [the doctors] help them with painkillers and everything." (Community leader, barrio)

Proceeding with the pregnancy

Participants typically considered the decision to follow through with an unwanted pregnancy to be both respectable and appropriate. Nonetheless, many identified consequences of this decision for both the woman and the unborn child. As described previously, respondents believed that the presence of a strong familial or partner support system were likely to influence a woman's decision to continue her pregnancy in conjunction with the girl's and her family's ability to support the child financially. Several respondents noted that girls of higher socioeconomic status were less likely to experience unwanted pregnancy, but they were also more

likely to be able to access abortions because they could afford to pay for the procedure and their parents would support their decision to abort. Girls of lower socioeconomic background, meanwhile, were more likely to experience an unwanted pregnancy and less likely to be able to financially support a child, but may still be dissuaded from having an abortion because of the cost of the procedure. Due to many adolescents' inability to support children, respondents noted that families once again played an important role in supporting and even caring for children in the case that a pregnancy was carried to term. This was particularly true within indigenous communities, where many women live in large extended families, facilitating mother and grandmother involvement in childrearing.

Many respondents described the consequences of unwanted pregnancies for adolescent girls in terms of physical and mental health, as well as its impacts on future projections and opportunities for education and employment. One nurse captured the rapid changes adolescent women faced in becoming pregnant:

> "Well, obviously it is a problem for the community because they are girls that are still studying. They are girls that still haven't made up their minds…. They are girls that become pregnant and their lives totally change. From playing with dolls to raising babies. Now they can't go to school. Their lives have changed totally while their friends go on partying. It is also physically difficult because they are girls that need vitamins and many things in their body and being pregnant, obviously they aren't going to have them. Because of this, they are girls that are going to have anemia or that are going to be malnourished." (Nurse, city center)

The effect of unwanted pregnancies on childrens' lives featured largely in many respondents' discussions on the topic, and appeared more frequently in community leader and medical provider discussions than among pharmacists. One community leader summarized his concerns:

> "Yes, for me it [unwanted pregnancy] is a problem. For me it is a problem because the children that you see here, walking around undernourished, without clothes, barefoot, malnourished, they don't have the care of their parents… they are children that are going to grow up without guidance… so for me it is a grave problem and one must work on this." (Community leader, barrio)

Among the few respondents who believed unwanted pregnancies were not common were two of three interviewed religious leaders . One of these, a father at a Catholic church in the city center, emphasized that while fertility was high in the community, particularly among indigenous populations, it posed few problems for the people because it was an element of the local culture. To have a child is a joy, he explained, noting that almost all of the children he has baptised were wanted. The second individual, a Catholic church leader and school teacher in an indigenous community described the problem differently, emphasizing that partner stability in the community meant that few pregnancies were unwanted.

> "It is not common here in the community. Because, it doesn't happen, practically it is like I told you, they have their partner and they want to have their children and that's it. It is a minority here that don't want it and end up pregnant. Very few." (Community leader, indigenous community)

Of note, a local nurse observed a dramatically different situation in the same commuity, stating that of 80 pregnancies in the community at the time of the interview, all but one could be described as unwanted.

Cultural Acceptability of Abortion:

As gatekeepers for reproductive health education and services, providers and community leaders were theorized to have a unique role in the narrative of unwanted pregnancies and abortions apart from their role as observers of a trend. They were probed on their knowledge of, as well as their feelings toward emergency contraception and abortion in order to describe professional sentiments toward the issue and characterize potential barriers to providing safe EC and abortion services. Results are presented separately for emergency contraception and abortion in the following sections.

Emergency Contraception

Knowledge of emergency contraception can be described in four ways: self-reported knowledge, ability to describe the method, ability to describe risks and benefits, and awareness of the method's utilization in the community. Asked the question, "Have you heard of emergency contraception?", participants in the study almost unanimously responded that they had at least heard of the method. With the exception of one nurse, who was also one of the oldest participants in the study, all respondents admitting to have not heard or not have a clear understanding of the method fell into the community leader group.

Only a handful of participants followed up on answers by providing a description of the method. Those who presented inaccuracies in their descriptions most often made mistakes in identifying the correct window of efficacy for the method. Respondents who spoke to levels of community awareness surrounding

emergency contraception most often stated that community knowledge and utlization levels were low, though few disagreed with this assessment and asserted that the method was frequently and normally accessed in the community.

Respondents' assessments of the risks of emergency contraception were complex as they tied into beliefs about both the practicality of EC as a contraceptive method in the community and ethical beliefs about its use. Participants most frequently expressed concerns that emergency contraception would be overused. Overuse itself meant different things to different participants, but the perceived consequences of overuse were fairly consistent, including damage to a woman's fertility or ability to bear future children, cancer and loss of efficacy of the medication with use. A cross-section of individuals from all three groups defended the method as both safe and practical, however. And though fears of the medical consequences of EC were severe, they did not consitute a purely anti-EC position; many participants said that despite potential health consequences, EC was a preferable alternative to abortion. One pharmacist summarized this position in her response:

> "I think that medically, anything that you abuse with time will have its consequences. And there in the pamphlet it says very clearly, the pill should not be used as a contraceptive method. I believe that this pill should be taken in cases of emergency. The cases can be like when a person is using family planning and then they realize that that method of planning is expired. Or when they realize that the methods they are using to plan doesn't work. Or when the person takes contraceptive pills and they forget to take it that day. I believe that it should only be used in cases of emergency. And of course, to take the pill is better than to abort." (Pharmacist, city center)

The fear that EC would be overused or incorrectly used appeared to have serious implications for respondents' perceptions of the method's practicality. A

number of respondents noted that those most likely to have unwanted pregnancies were unlikely to be using any method of family planning. As a result, they believed women were unlikely to access EC and that those at risk for unwanted pregancies were not ideal candidates for the method. Like the nurse in the previous quote, a number of respondents emphasized the term "emergency" in the name of the method, stating that use outside of strict emergencies was not only wrong, but potentially harmful to a woman's health. Responding to the question of why she felt EC was not practical for women in her community, one nurse responded as follows.

> "Well, for the simple reason that there the women, their relationships are very active, too, too active. Say for one girl, analyze one, no? I go to the parties and there are all of the young girls there. One sees one of these young girls, one girl that is dancing and she goes with a boy over there. A little while later, an hour or two later, they return and she goes again, but with another boy. And so in one night, she can be with three or four men. They do this same sequence, in one night, three or four times…. How many emergency medicines would she have to take? Four? What would this imply? This has to have some consequences." (Nurse, indigenous community)

Based in the argument of practicality, this notion tied into a number of participants' ethical evaluations of EC as well. As one nurse put it, EC should be used in cases of emergency, not in cases of irresponsibility. The latter situation, she equated with a culture that treated sex "as a game", and offerred cases of rape as an example of when EC might be used responsibly. This measured position was taken by a number of respondents when asked if they recommend the use of EC to those they advise.

> "Interviewer: Do you advise women… about the use of EC?
>
> Interviewee: No, I personally prefer to… send them for an external consult in order for them to be treated with a base contraception. One considers the

> emergency pill, it is not an abortifacient but it is not ideal, it is better to protect oneself with something more sure." (Nurse, city center)

A pharmacist, taking a similar position, expressed her discomfort with EC differently:

> "Well on one hand it is good and on the other it is bad, no? I think it is good becaue if you don't want to end up pregnant, well, it saves you and the other is bad because you become irresponsible with yourself. If I carry on an active sexual life, I have to be responsible if I don't want to end up pregnant, well I have to look for ways to protect myself, right? So it has two faces, I think it is good and at the same time, well it isn't bad, but it is a little irresponsible." (Pharmacist, city center)

Other healthcare providers and pharmacists noted that they lacked opportunities to educate and advise women about the use of EC because few women asked questions about the product, and most did not approach healthcare providers, including pharmacists, until after the window for use of EC had passed, if at all.

A minority of respondents also voiced concerns that EC was unethical on grounds that it was the equivalent of an abortifacient. This view was not common among respondents but is notable because of who took this position. Of three respondents explicitly stating this opinion, two were employed by the government and worked directly with family planning education in the community and health care centers. One of these two was in fact a nurse, responsible for not only educating women, but providing contraceptive services in the hub of promotion and prevention efforts in the city.

> "… And it isn't like here, where they are accustomed to saying, 'ay, it isn't a pregnancy. It is a ball of blood, a clot' but this is a baby where already the sperm and ovary have come together. From the moment in which they unite it is a baby, already it is living." (Community leader, barrio)

Abortion

> *"Always there will be illegal things and always there will be people prepared for these illegal things, so I would say it [having an abortion] isn't as easy as to go to the store and find a Coca-Cola but neither is it so difficult as to find the head of a needle in a haystack." (Healthcare provider, city center)*

Participants in this study responded overwhelmingly against the practice and legalization of abortion, with only one person explicitly supporting legalization. The language surrounding participants' negative views toward abortion was moral in nature, but was often associated with legal repercussions. Many participants equated abortion to murder, stating that those who practice abortions are in turn murderers. A minority of respondents referenced religion and God in defense of anti-abortion positions, suggesting that abortions were an offense against the Church and God.

Community leaders were most likely to use moral language is discussing the acceptability of abortion and to support legal means of punishment, including jailing, for women participating in abortions. This group was also least likely to clearly and accurately describe the legal provisions for the practice of abortion with five individuals specifically noting that regardless of the law, the practice was wrong and punishable. Asked what would happen if abortions were legalized, community leaders expressed fears that abortion rates would dramatically rise and would stop population growth and cause social disorder. Interestingly, a smaller group of community leaders were unique in taking the opposite position, arguing that whether abortion was legal or not, they would be impeded by cultural and religious norms.

Healthcare providers and pharmacists were more likely to clearly describe the provisions for legal abortions, though ambiguity regarding the circumstances and requisites for legal abortions was not uncommon. Individuals in this group most often deferred to legal language when discussing the practice of abortions, though many also used moral and religious arguments. They noted that despite legal sanctions, punishments for abortions were rare due to the clandestine nature of most abortions. Members of this group also introduced a concept not frequently used among leaders: severity of circumstances. Rather than describing specific situations when abortions are acceptable, members of this group often used phrases like "life or death" or "larger than life" to describe circumstances under which doctors might acceptably perform an abortion. Providers with intimate knowledge and power in the provision of abortion services in healthcare facilities in the region often described elaborate requisites for qualification including forensic exams of women reporting rape, agreement by a group of doctors regarding the risk of fetal malformation and required guardian consent for minors to receive the procedure. One provider noted, in addition, that legal abortions were rare in part because women were unaware of their legal right. No provider admitted to having recommended an abortion at any point, and most had never actually witnessed women openly seeking an abortion—legal or illegal.

Unlike with emergency contraception, objections amongst all groups were rarely founded in medical or health-related concerns. Although participants as a whole recognized abortion as a dangerous procedure, few, when asked about their feelings toward it, cited health risks as a reason for their opposition. In fact, those

citing risks of abortion often elaborated more on what might be considered social or mental consequences of the procedure than on purely physical sequelae. Asked what she thought about a woman who had an abortion, one community leader responded as follows:

> "I feel bad because she doesn't smile the same again. Always, she has this as if you are moving backwards. This is the feeling I have for the people who do this. They no longer hold their heads up high. They have a guilty conscience about the things they do. They want to hide what they did." (Community leader, barrio)

A nurse, taking a slightly different angle, described the community-level fallout a woman having an abortion might experience. The nurse's anecdote is exemplary of both perceived consequences of an abortion and the nurse's own feelings about the experience as she repeats the view that to have an abortion is equivalent to murder.

> "I know a neighbor who aborted a number of times and now she doesn't have any children. So one sees her as a person who doesn't value life. A person that… I don't know… one knows that a person is like that… as though they don't fit in in the community. She is doing bad things. She has killed a baby. I see these people as people who don't fit in." (Nurse, city center)

As was the case with emergency contraception, there were exceptions to general statements about the morality of abortions. A number of respondents did take a zero-tolerance position toward abortion, suggesting adoption as an alternative for women incapable of raising their children, but the vast majority fell in a grey area that was consistent with Colombia's current legal debate. This stance once again focused on the theme of "irresponsibility". Participants were more forgiving to women who became pregnant by rape or abuse, as this was seen to be

outside the woman's control, but were typically more critical of women who became pregnant as a result of "*descuido*" or "neglect". Rape, fetal malformation and risk to the mother's life were the only scenarios explicitly described as being outside the control of a woman and other issues relating to access to family planning were not described by any participants in reference to this topic. Asked what she thought of a woman who has an abortion, one community leader summarized this position:

> "The woman that does that… she isn't a woman. If you like to have relationships with men… then protect yourself. For this we have many things to protect ourselves… or go to the hospital [to access family planning]." (Community leader, barrio)

Another leader described women seeking abortions as "animals", adding that women often practiced abortion on a "whim". This position was typical even among individuals who described poverty, social stigma or inadequate access to family planning and sexual education as barriers to contraceptive use in the community and was shared by members of all three groups of respondents, though most respodents did not use such dramatic language.

Those expressing pro-abortion sentiments could not be generalized by profession, but emphasized practicality over either morality or legality. As one healthcare provider put it: "here it is bad because the legislation of this country prohibits it, but that doesn't imply that it is necessarily something bad." (Healthcare provider, city center) Others noted that while they would never have an abortion, socioeconomic status, education and age of the woman might contribute to evaluations of morality. There was an emphasis among these individuals on

describing pregnancy and abortion as experiences that were unique to each individual and about which general codes of conduct could not apply.

> "Just as one has the right to think it [abortion] isn't good, the person that makes the decision has the right to think that it is the best option for their life." (Healthcare provider, city center)

As stated previously, only one provider openly supported the legalization of abortion for all women. Other respondents, asked to describe the consequences legalization might yield suggested that legalization would result in more abortions and would contribute to perpetuating a cycle of irresponsibility. Legalization, respondents argued, would promote a culture of increased sexual irresponsibility as there would be no incentive to use contraception. This fear was voiced almost unanimously and from respondents from all groups.

3.4 DISCUSSION

Results from this study corroborate findings in the literature and offer insights into potential causes and outcomes of unwanted pregnancies. We assume that providers and leaders selected for this study have knowledge of typical experiences of pregnancy in the community and also that they wield power—through the provision of services or their ability to educate, inform and advise. We organize our results into three subtopics: causes and social determinants of unwanted pregnancy, management of an unwanted pregnancy and the determination of acceptable versus unacceptable practices within this process.

Providers, pharmacists and leaders hailed from a wide array of fields and backgrounds, producing a large amount of variability in responses within groups. Overall, healthcare providers were most consistent with each other, while community leaders, who included the largest mix of professions, varied most widely. Community leaders and pharmacists were most able to share personal anecdotes and examples relating to unwanted pregnancies and abortions, whereas providers most often observed women seeking medical care after inducing unsafe abortions. Providers frequently noted that they rarely or never had opportunities to inform women's decisions before women took actions. Leaders and pharmacists noted having more opportunities to influence decision-making about relationships, contraception and abortion. Religious leaders are the single exception to this rule, and were least consistent with all other groups in their reports of unwanted pregnancies and abortions.

Interviewees highlighted social determinants of unwanted pregnancies including poverty, poor education, young age, inadequate access to contraceptive services and a risky sexual culture that promote the direct causes of an unwanted pregnancy: irresponsible sexual practices and rape. Respondents believed the first of these causes, irresponsible sexual practices, was the primary cause of unwanted pregnancies in the community. The term "irresponsibility" took on a number of meanings as participants used it in interviews but most frequently described actions that were seen to be within a woman's control. Thus, while social determinants were thought to promote irresponsibility, they were perceived to act in conjunction with cultural, societal and individual irresponsibility.

Participants characterized rape by similar social determinants in interviews, and acknowledged it as a situation outside the control of a woman. That it was out of the control of the woman proved important in distinguishing rape as the only sexual practice for which it was widely agreed that an abortion would be a culturally acceptable course of action.

Participants described the roles of families, sexual partners and financial considerations for women's decisions about how to manage an unwanted pregnancy. Unanimously, respondents cited adolescents as a high-risk group for having an unwanted pregnancy. Adolescents were perceived to be more irresponsible than adults and less capable of supporting a child. As a result, participants believed girls' families played a crucial role in influencing her ability to support a child and her feelings toward pregnancy and abortions.

Partner roles were similarly multifaceted and again interacted with a woman's ability to support her child and her feelings toward the pregnancy. Interestingly, the role of partners was often most notable in their absence; most unwanted pregnancies in adolescents were believed to be the result of casual or unstable relationships so that resulting pregnancies were the purview of women and their families alone. Present partners were also extremely important to the decision-making process as their support for the pregnancy influenced a girl's feelings toward the pregnancy and cultural expectations of the girl.

Beliefs about abortion constituted the last piece of the decision-making framework and were most often thought to discourage a woman considering an abortion. These beliefs were not described in great detail in interviews but were most often associated with religious anti-abortion beliefs held by a woman's family or community.

The acceptability of abortions was most influenced by the extent to which a woman controlled the circumstances of pregnancy. Circumstances perceived to be outside of a woman's control, including rape, fetal malformations and danger to the health of the mother were notable exceptions to what were otherwise consistent anti-abortion sentiments. Abortions where participants perceived sexual irresponsibility to be at the root of the pregnancy were considered unethical and might result in community-level consequences. Permitting or condoning the practice of abortions, participants said, would promote increased sexual irresponsibility, and disincentivize the use of contraceptives and other methods to prevent pregnancy by providing a post-pregnancy alternative. This view was carried

over to discussions of emergency contraception as well, which, though not widely used, was feared for its potential to promote irresponsible sexual practices.

Providers and leaders in this study seemed to reinforce rather than set cultural expectations surrounding unwanted pregnancies and abortions in the community, but were also critical in many cases to the provision of care and services. Asked to suggest recommendations for addressing the issues of unwanted pregnancy and abortion, participants suggested increased sexual education almost unanimously in their interviews. This type of education was thought to be the purview of families and government above other entities; participants often reported that government programs were too inconsistent to make a meaningful impact and families were bound by cultural taboos and discomfort about the topic of sex. Importantly, the actions suggested by providers and leaders dealt only with the prevention of unwanted pregnancies. Only one participant favored legislation that would legalize abortion, while most feared legalization would only exacerbate problems in the community.

Based on participant responses, an increased emphasis on sexual education must be an integral part of any future intervention seeking to address the issues of unwanted pregnancy and abortion in the community. Adolescents should be the focus of such programming that should provide practical information on the provision of contraceptive services in the community. Potential fears of being discovered seeking contraceptives and family planning information must also be addressed in working to improve access to care. Transportation issues faced by women living in indigenous communities surrounding Leticia and adolescents living

in barrios located away from the city center also pose considerable barriers to access as they involve improvements in infrastructure as well as education.

Addressing the fundamental determinants of unwanted pregnancy identified in this study, meanwhile, will pose an even greater challenge. Unwanted pregnancies seemed to arise from a lack of money and educational and employment opportunities that might significantly disincentivize unsafe sexual practices were they available. Participants were consistent in reporting few opportunities for adolescents of low socioeconomic backgrounds to acquire higher education or the jobs such education might qualify them for. Increases in employment and educational opportunities might thus address both immediate issues of poverty and unemployment and cultural norms surrounding pregnancy.

This study has a number of limitations. Our qualitative approach means generalizations about providers, community leaders or the general population of Leticia cannot be made based on the results of this study. Although the investigators set out to explore the issue of emergency contraception in conjunction with abortion, our data did not support robust analysis of this theme. Participants reported that EC was not widely used in the community and thus could not speak to the decision-making process or issues of access for this method. This is a finding in its own right, however, and evidences the hypothesis that despite its legality, EC continues to be poorly understood and underutilized in the Amazon region.

In addition, we recognize that most abortions conducted in this region continue to be punishable by federal law in Colombia. Although no providers or leaders acknowledged having fears of repercussions regarding their participation in

the study, such concerns may have biased results. No provider or leader in our study acknowledged performing or assisting in an abortion, though some acknowledged having friends and family members who had received the procedure. One nurse noted that she had an abortion, but did not support legalization or increased availability of the procedure in the Amazon region.

In conclusion, it is evident that high rates of unwanted pregnancies, particularly among adolescents, contribute to unsafe abortion practices in the Amazon region. Poverty and inadequate access to education, employment and reproductive health services for many in the region contribute to what providers and leaders believe is a culture of sexual irresponsibility. Socially, dialogue about safe sexual practices with providers, leaders, educators and families is uncommon and may present an opportunity for impacting awareness of contraceptive practices in the community. Sentiments toward abortion and its legalization as well as more widespread use of EC among providers and leaders are negative and coupled with fears of how both might affect unsafe sexual practices in the region. Policies and programs to address unwanted pregnancies and abortions in the region should impact immediate barriers to safe sexual practices like contraceptive education, as well as longer term strategies that consider the effect of poverty, unemployment and weak general education.

CHAPTER 4. CONCLUSIONS AND POLICY RECOMMENDATIONS

1. As this study evidences, unwanted pregnancies among adolescents in the Amazon region are common and pose a serious challenge for efforts to reduce the practice of unsafe abortions. Policies and programs intending to address morbidity and mortality associated with unwanted pregnancies and abortions must address the unique barriers adolescents face in accessing contraceptive services and safe resolutions of unwanted pregnancies.
2. Based on the accounts of providers and community leaders in this study, education plays a pivotal role in women's experiences with unwanted pregnancy and abortion. Having a strong general education was believed to keep adolescent girls in schools and incentivize delaying pregnancy, while exposure to sexual education was thought to increase women's abilities to access contraception. In addition, education might better help women with unwanted pregnancies identify their options and know their legal rights with regard to safe abortion services.

   An honest effort to improve the opportunities in education for adolescents and engage the topic of sexual education will require increased financial support of schools and students wishing to seek higher education as well as dedicated curriculums and training for teaching sexual education.

   Additionally, education that engages community leaders outside of schools may offer a means for reaching adolescents who may be missed in the school system.

3. Poverty as a barrier to accessing contraceptive services must be addressed. Despite being offered for free in the government's promotion and prevention center, participants identified transportation, long waits and shortages of preferred methods as issues facing the effective distribution of contraception. This was particularly true for women in indigenous communities, who often had to travel hours by boat to reach the government distribution point, sacrificing their day's earnings as well as the cost of the transportation and housing in the city. Others noted that the availability of these government services was not widely known, and in fact a number of healthcare providers and leaders were themselves unaware of the service. Pharmacies carried contraceptives but noted that cost may present an issue for some individuals, and adolescents in particular.
4. Existing policies for addressing unwanted pregnancies and unsafe abortions must be effectively implemented in the region. Emergency contraception is a legal and effective method for preventing pregnancy but is underutilized in the region due to low knowledge on the part of providers and the community. Legal abortions are also rare in the region, in part as a result of low levels of understanding between both community members and providers of the legal provisions for seeking an abortion. Addressing misconceptions in both groups may increase the utilization of safe over unsafe practices by many women.
5. Findings from this study also indicate areas in which more information is needed. Studies emphasizing the perspective of adolescents in the

community might shed light on causes and consequences of unwanted pregnancies as well as opportunities for intervention with this high-risk group. Estimating the quantitative impact of unwanted pregnancies and unsafe abortions for this region was outside the scope of this project, but will be necessary in order to test interventions and emphasize the importance of prioritizing this issue from a policy perspective.

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Study No.: IRB00044074
Emory University IRB
IRB use only
Document Approved On: 6/8/2010
Project Approval Expires On: **6/7/2011**

APPENDIX A

Emory University
Rollins School of Public Health
Verbal Consent Script to Be A Research Subject

Title: Assessing Barriers and Facilitators to Emergency Contraception Uptake and Abortion Practices in the Amazon Region of Colombia

Principal Investigator: Shreya Rao

Co-Investigator: Roger Rochat, M.D.

INTRODUCTION AND PURPOSE
You are being invited to participate in a research study to examine access to reproductive health services for women experiencing unwanted pregnancy in the Amazon region of Colombia. I am asking you to participate because you were referred by staff members at Clinica Leticia or are a provider and/or facilitator of health services in your community. Up to 75 people will be interviewed for this study. This study is being conducted for my thesis under the direction of Dr. Roger Rochat.

PROCEDURE
If you agree to participate, I will interview you for up to two hours at a mutually agreed upon location. The questions will be about your knowledge and perceptions of emergency contraception and induced abortion, as well as the services or advice you offer to women facing unwanted pregnancy. I will tape record the interview with your consent. These voice recordings will be and immediately destroyed. Voice recordings will not be returned to the United States.

RISKS
Based on the illegal nature of some of the activities being discussed in this interview, there is some risk in choosing to participate in this study. The study staff has, however, taken measures to ensure your confidentiality in this process, should you choose to participate. Identifiers other than recordings of your voice will not be collected or recorded. In addition, voice recordings will be transcribed and subsequently destroyed by study staff by August of 2010 in order to ensure your privacy. We will not ask you to name other individuals or organizations in sharing your experiences. Nonetheless, should you feel uncomfortable answering any question your interviewer poses, you may decline to answer. Should you feel uncomfortable with your participation you may additionally withdraw participation at any point during the interview.

BENEFITS
Taking part in this research study may not benefit you personally. The information you provide, however, will add to our knowledge about the access to reproductive care of young women experiencing unwanted pregnancy in the Amazon region of Colombia.

CONFIDENTIALITY
I will not include your name in study results. If you feel uncomfortable, quotations or narratives can be left out of the analysis at your discretion. You will never be asked for any personal information beyond your perceptions of emergency contraception and induced abortion. All research records and recorded interviews will be kept in a locked secure location. People other than those doing the research may look at the study records. Agencies and Emory departments and committees that make rules and policy about how research is done have the right to review these records. We will keep all records that we produce private to the extent we are required to do so by law. Voice records of this interview will be maintained only until your responses have been transcribed and will be destroyed immediately thereafter.

CONTACT PERSONS
If you have any questions, I invite you to ask them now. If you have any questions about the study later, you may contact me at sgrao@emory.edu or 352-422-7133. If you have any questions later, please contact Javier Guiterrez M.D. gutierrezcamacho.javier0@gmail.com or (098) 59255-76 or (098) 59277-18.
You may also contact my advisor, Dr. Roger Rochat, at rrochat@emory,edu or 404-712-9506. If you have questions about your rights as a participant in this study, you may contact the Emory University Institutional Review Board at (404) 712-0720, which oversees the protection of human research participants.

VOLUNTARY PARTICIPATION AND WITHDRAWAL
Participation in this research is voluntary. You may refuse to participate, or refuse to answer any questions that you do not want to answer. If you decide to be in this study and change your mind you may withdraw at any time. Your participation or non-participation will have no negative repercussions. You will not be compensated for your participation in this study.

Study No.: IRB00044074 **Emory University IRB** IRB use only Document Approved On: 6/8/2010

Project Approval Expires On: **6/7/2011**

La Universidad de Emory
Escuela Rollins de Salud Pública
El consentimiento verbal de secuencias de comandos a ser un tema de investigación

Título: Evaluación de las barreras y facilitadores para la Anticoncepción de Emergencia de Captación y Prácticas Aborto en la región amazónica de Colombia
Investigador Principal: Rao Shreya
Co-Investigador: Rochat Roger, MD

INTRODUCCIÓN Y OBJETIVO
Ha sido invitado a participar en un estudio de investigación para examinar el acceso a los servicios de salud reproductiva para las mujeres que sufren embarazos no deseados en la región amazónica de Colombia. Pido a participar, ya que habían sido planteadas por los miembros del personal en la Clínica Leticia o es un proveedor y / o facilitador de los servicios de salud en su comunidad. Hasta 75 personas serán entrevistadas para este estudio. Este estudio se lleva a cabo para mi tesis bajo la dirección del Dr. Roger Rochat.

PROCEDIMIENTO
Si usted desea participar, le entrevista para un máximo de dos horas a un acuerdo para la ubicación. Las preguntas serán acerca de sus conocimientos y percepciones de la anticoncepción de emergencia y el aborto inducido, así como los servicios o asesoramiento que ofrecen a las mujeres que enfrentan embarazos no deseados. Voy a grabar la entrevista con su consentimiento. Estas grabaciones de voz se transcriben y destruidos de inmediato.Las grabaciones de voz no serán devueltos a los Estados Unidos.

RIESGOS
Sobre la base de la ilegalidad de algunas de las actividades objeto de debate en esta entrevista, hay algún riesgo en la elección de participar en este estudio. El personal del estudio, sin embargo, adoptado medidas para garantizar su confidencialidad en este proceso, en caso que quiera participar. Identificadores distintos de las grabaciones de su voz no se recabados o registrados. Además, las grabaciones de voz se transcribe y posteriormente destruidas por el personal del estudio de agosto de 2010 con el fin de garantizar su privacidad.No le pido que nombre de otras personas u organizaciones en compartir sus experiencias. Sin embargo, si siente incómodo contestando cualquier pregunta a su entrevistador plantea, usted puede rehusarse a contestar. Si se siente incómodo con su participación que, además, podrá retirar su participación en cualquier momento durante la entrevista.

BENEFICIOS
La participación en este estudio de investigación no puede beneficiarse personalmente. La información que nos proporcionan, sin embargo, se añaden a nuestro conocimiento sobre el acceso a la asistencia reproductiva de las mujeres jóvenes que experimentan un embarazo no deseado en la región amazónica de Colombia.

CONFIDENCIALIDAD
No voy a incluir su nombre en los resultados del estudio. Si se siente incómodo, las cotizaciones o los relatos se puede dejar fuera del análisis a su discreción. Nunca se le pedirá ninguna información personal más allá de su percepción de la anticoncepción de emergencia y el aborto inducido. Todos los expedientes de investigación y entrevistas grabadas se guardarán en un lugar seguro y bajo llave. Las personas que no sean los que hacen la investigación puede ver los registros de estudio. Las agencias y departamentos de Emory y los comités que hacen que las normas y políticas acerca de cómo se realiza la investigación tiene el derecho de revisar estos registros. Vamos a mantener todos los registros que producimos privado en la medida que estamos obligados a hacerlo por ley. registros de voz de esta entrevista se mantendrá sólo hasta que sus respuestas han sido transcritas y serán destruidos inmediatamente después.

Personas de contacto
Si usted tiene alguna pregunta, te invito a pedirles ahora. Si usted tiene alguna pregunta sobre el estudio posterior, puede llamarme al 352-422-7133 o sgrao@emory.edu. Si usted tiene alguna pregunta más tarde, póngase en contacto con Javier Gutiérrez MD gutierrezcamacho.javier0 @ gmail.com o (098) 59.255 a 76 o (098) 59277-18. Usted también puede contactar a mi asesor, el Dr. Roger Rochat, en rrochat @ Emory, la educación o 404-712-9506. Si usted tiene preguntas acerca de sus derechos como participante en este estudio, puede comunicarse con la Universidad de Emory en Junta de Revisión Institucional (404) 712-0720, que supervisa la protección de los participantes en la investigación humana.

PARTICIPACIÓN Y RETIRO VOLUNTARIO
La participación en esta investigación es voluntaria. Usted puede negarse a participar, o negarse a contestar cualquier pregunta que usted no quiere contestar. Si usted decide participar en este estudio y cambia de opinión puede retirar en cualquier momento. Su participación o no participación no tendrá repercusiones negativas. Usted no va a ser compensados por su participación en este estudio.

APPENDIX B

IDI Guide: English (Back-translation)

Good afternoon. My name is Shreya and I am a student doing a research project for Emory University on access to reproductive health services for women here in Leticia. As part of the project, we are talking to health professionals and community leaders like yourself. We feel that by talking with you we will better understand what health professionals and community leaders know and feel about various family planning services. I want to let you know that your participation in this interview is completely voluntary, so please don't hesitate to let me know if you don't feel comfortable answering a question or don't want to continue with our conversation. Also, the interview will be completely confidential and anything you say will not be shared with anyone in your community or other study participants. If you don't mind, I would like to tape-record our discussion so that I do not miss or forget anything that we talk about. So, is it okay for me to tape-record this interview? I want you to know that all research documents relating to our conversation will not include your name or any personal information.

I have a list of topics I would like to discuss, but I want this to feel more like a conversation so please feel free to bring up any topics you feel are related.

Before we start, do you have any questions?

Demographics and Career Choice: (Warm-up Activity)

1. To begin, can you tell me a little bit about yourself?
    a. How long have you been working in this community?
    b. How old are you now, if you don't mind me asking?
    c. Where are you from?
    d. Are you married or in a stable relationship?
    e. Do you have children? How many?
    f. What religion do you practice?
        i. Do you consider yourself to be a religious person?
2. Tell me a little bit about your work here: what type of services do you offer?
    a. If he/she is a doctor: what type of doctor? What specialty do you practice?
    b. If he/she is a nurse: what type of nurse?
    c. If other: what is your interaction with women in the community?
    d. In your career, do you work with women of reproductive age—between 14 and 49 years?
        i. In what capacity?
3. In your experience in the region, what are some of the most important issues facing the community?
    a. What are the most important health issues?

KNOWLEDGE:

4. Now we are going to talk about families in the community. Based on your experience, what is the typical structure of a family here?
    a. How many children does the typical family have?
    b. How is the structure?
5. I'd like to talk a little bit about the typical life of a woman in the community. What expectations or opportunities are there for a woman in this community?
    a. How are these expectations different than the expectations and opportunities for a man?
    b. Do you believe that this has an effect on the situation of unwanted pregnancies in the community?
6. At what age, on the average, do you believe that women become sexually active in the community?
    a. Generally, do women get married before their first sexual experience?
    b. With who do they have their first sexual encounter?
    c. What about the age of first pregnancy, are women generally married or single?
    d. What about with men? At what age do they become sexually active, and with whom do they have their first sexual encounter?
7. Can you talk about the availability and knowledge in the community about contraception?
    a. What are the common methods by which women in the community avoid unwanted or unplanned pregnancies?
    b. From where do women obtain information about contraception, how it works, where they can get it, or more?
        i. When? At what age?
8. Are unwanted pregnancies a common experience among women that you see in the community?
    a. What do you think about this—can you talk about the benefits or consequences?
    b. Why?
9. When a pregnancy is unwanted, what are some of the reasons for this?
    a. Are there groups in which unwanted pregnancies are more common? Which groups?
10. Based on your knowledge of the community, what options does a woman with an unwanted pregnancy have?
    a. What options do women use most often? Please explain.
    b. Do women come to you to look for advice in these situations?
        i. What options do you recommend to them most often? Please explain.
11. Based on your experience and work with women, how do women make decisions about what to do when faced with an unwanted pregnancy?
    a. Who is involved in this process?
    b. Who makes the final decision?

12. Have you heard of emergency contraception? How common is emergency contraception as an option?
    a. Is EC available in the community?
        i. Where?
        ii. In what form?
        iii. Is it legal?
    b. Can you tell me about the risks or secondary effects of EC, if there are any?
    c. How often do you receive questions about EC?
    d. What questions are most common?
    e. Who asks?
13. What about abortion? Can you talk about the availability and frequency of abortions in the community?
    a. What are the most common methods to abort in the community?
        i. What form is most common?
    b. Can you tell me about the risks or secondary effects of having an abortion—we can talk about the different methods of abortion also?
        i. Have you, in your career, seen patients with complications of abortions? What types of complications?
    c. Are you aware of what the law says regarding women who have an abortion?
        i. What are the consequences of the law—for the women and for those that help them?
        ii. How is the law enforces, and who enforces it in these situations?
    d. How often do you receive questions about abortion?
    e. What questions are most common?
    f. Who asks?
14. What members of the community know the most about these services?

OPINIONS:

15. We are going to return and talk a little bit more about EC and abortion. What are your personal thoughts and opinions about the use of EC?
    a. Who do you believe should be involved in the decision to use EC?
    b. We talked earlier about the health consequences of EC, but what are some of the social consequences of the use of EC?
    c. Are there situations in which you advise women who seek your services to use EC?
16. What interest do you believe members of the community have in the use of EC as a method of family planning?
    a. What concerns do they have about the use of EC?
17. What about with abortion? What are your thoughts or opinions about abortion as an option for women facing an unwanted pregnancy?

   a. Who do you believe should be involved in the decision to have an abortion?
   b. What are some of the social consequences of having an abortion?
   c. Are there situations in which you think it is acceptable to abort?
   d. Are there situations in which you advise women who seek your services to abort?
18. What interest do you believe members of the community have in the use of abortion as a method of family planning?
   a. Do you believe that the situation would be different if the method were legal here?
   b. What concerns or worries might members of the community have with respect to abortion?

ACCESS TO SERVICES:

19. What in your estimation is the total cost of obtaining EC?
   a. How much does the patient have to pay for the service?
   b. Do you think that the price is something that could impede a woman who wants to use it?
   c. Who usually accompanies women when they seek EC?
   d. How many visits does a patient need to make to obtain this method?
   e. IF HP: How prepared is this facility to provide EC?
20. What other requisites or barriers can impede a woman who wants to use EC?
   a. Cost? Age? Consent?
21. What would be your estimation of the total cost of obtaining an abortion?
   a. How much does a patient have to pay for the medicines or procedure?
      i. Legal
      ii. Illegal
   b. Do you think that the cost of this service is something that can impede a woman who wants to use it?
   c. Who usually accompanies a woman when she comes/goes to get the procedure?
   d. How many visits does a patient have to make to obtain this method?
   e. IF HP: How prepared is this facility to provide abortion services?
22. What other requisites or barriers can impede a woman who wants to have an abortion?
   a. Legal?
   b. Illegal?

CLOSER:

23. Do you have any recommendations to improve the situation around unwanted pregnancies here in Leticia?
   a. Who has the most important role to change this situation?
   b. What are some of the barriers to doing this?
24. We are going to review some of the main points of our discussion.

a. We have talked about the typical family of Leticia, contraception and abortion methods and what you know and think about these, including questions about access to these services. Is there anything more you'd like to talk about?

25. Do you have any questions for me?

Thank you for taking the time to speak with me! If you have any question or concern after leaving here today, please don't hesitate to contact me to speak more.

IDI Guide: Spanish

Buenas tardes. Mi nombre es Shreya y estoy haciendo un proyecto de investigación de la Universidad de Emory de los Estados Unidos en colaboración con la Fundación Clínica Leticia, para estudiar el acceso a servicios de salud reproductiva aquí en Leticia. Como parte del proyecto, estamos conversando con profesionales de la salud y líderes comunitarios como usted. Creemos que el conversar con usted nos ayudará a entender mejor lo que los profesionales de salud y líderes comunitarios saben y sienten acerca de la planificación familiar en la región. Quiero recordarle que su participación en esta entrevista es completamente voluntaria, así que por favor no duden en indicarme si usted no se siente cómodo respondiendo una pregunta o no quiere continuar con nuestra conversación. Además, la entrevista será completamente confidencial. Si no le importa, me gustaría grabar en una grabadora digital nuestra entrevista para que no se pierda o se olvide nada de lo que hablamos. Está bien si yo grabo esta entrevista? Quiero que sepa que todos los documentos de investigación relacionados con nuestra conversación no incluyen su nombre o información personal.

[Aquí muestra el consentamiento]

Tengo una lista de temas que me gustaría discutir, pero quisiera que sea más como una conversación, así que por favor siéntase libre de traer cualquier tema que usted crea que sea importante y que esté relacionado.

Antes de empezar, ¿tiene usted alguna pregunta?

Demografía y elección de su carrera:
(A la actividad de calentamiento)

1. Así que para empezar, ¿puede decirme un poco sobre ud.?
    a. ¿Cuánto tiempo ha estado prestando servicios en esta comunidad?
    b. ¿Qué edad tiene ahora, si no le importa que le pregunte?
    c. ¿Y de donde es, usted?
    d. ¿Y esta casado o en una relacion estable?
    e. ¿Tiene hijos? ¿Cuántos?
    f. ¿Y que religión practica?
        1. ¿Se considera usted religiosa?

2. Digame un poco sobre su trabajo aquí: ¿Qué tipo de servicios ofrece?
    a. Si es médico, ¿qué tipo de médico [qué especialidad tiene]?
    b. Si es enfermera qué tipo de enfermera?
    c. Si otros—cuál es su interacción con las mujeres en la comunidad?
    d. En su carrera, ¿trabaja a menudo con las mujeres de edad reproductiva—entre 14 y 49 años?
        1. ¿En qué capacidad?

3. ¿En su experiencia en la región, que son algunos de los problemas más importantes aquí?
    a. ¿Cual son los problemas de salud más importantes?

CONOCIMIENTO:

4. Entonces, vamos a hablar de familias de la comunidad. En base a su experiencia, ¿como es la familia típica aquí?
    a. ¿Cuantos hijos tiene la familia típica?
    b. ¿Como es la estructura?

5. Me gustaría hablar un poco sobre la vida típica de una mujer en la comunidad. ¿Qué expectativas y oportunidades hay por una mujer en esta comunidad?
    a. ¿Como son diferentes las expectaciones y oportunidades para un hombre?
    b. ¿Cree usted que esto tiene un efecto sobre la situación de embarazos no deseados en la comunidad?

6. Y ¿a qué edad cree usted en promedio las mujeres pasan a ser sexualmente activas en la comunidad?
    a. Generalmente, ¿las mujeres se casan antes de su primer encuentro sexual, o solteras?
    b. ¿Con quien tienen ellas su primer encuentro sexual?
    c. ¿Qué pasa con la edad del primer embarazo, son generalmente las mujeres casadas o solteras?
    d. ¿Qué pasa con los hombres? A que edad ellos pasan a ser sexualmente activas, y con quien tienen ellos su primer encuentro sexual?

7. ¿Puede usted hablar sobre la disponibilidad y el conocimiento de la comunidad sobre anticonceptivos?
    a. Cuáles son los métodos más comunes en las que mujeres de la comunidad evitan los embarazos no deseados o no planeados?
    b. ¿De dónde obtienen las mujeres información acerca de la anticoncepción, cómo funciona, dónde conseguirlo, o más?
        1. ¿Cuando? ¿A qué edad?

8. ¿Son o no los embarazos no deseados una experiencia común entre las mujeres que ve en su comunidad?
    a. ¿Que piensa ud. sobre esto—puede hablar sobre los beneficios o consecuencias ?
    b. ¿Por qué?

9. Cuando un embarazo no es deseado, cuáles son algunas de las razones para estos?

a. ¿Hay grupos en que los embarazos no deseados son mas común? ¿Cuales grupos?

10. En base a sus conocimientos de la comunidad, ¿qué opciones tiene una mujer que tiene un embarazo no deseado?
    a. ¿Qué opciones utilizan las mujeres más frecuentemente? Por favor, explique.
    b. ¿Vienen mujeres a ud. para buscar por consejo en esas situaciones?
        1. ¿Qué opciones le recomiendan con mayor frecuencia a las mujeres que buscan su consejo? Por favor, explique.

11. Basado en su experiencia y trabajo con mujeres, ¿cómo toman ellas decisiones sobre qué hacer frente a un embarazo no deseado?
    a. ¿Quiénes están involucrados en este proceso?
    b. ¿Quién toma la decisión final?

12. ¿Ha oído hablar de la anticoncepción de emergencia o la píldora anticonceptiva de emergencia? ¿Qué tan común es la anticoncepción de emergencia como una opción?
    a. ¿Es la anticoncepción de emergencia disponible en su comunidad?
        i. ¿Dónde?
        ii. ¿En que forma?
        iii. ¿Y es legal, el uso de anticoncepción de emergencia?
    b. ¿Puede decirme lo que sabe acerca de los riesgos o efectos secundarios del uso de la anticoncepción de emergencia?
    c. ¿Con qué frecuencia recibe ud. preguntas sobre la anticoncepción de emergencia?
    d. ¿Qué preguntas son las más comunes?
    e. ¿Quién le pide?

13. ¿Qué pasa con el aborto? ¿Puede hablar sobre la disponibilidad y frecuencia de abortos en la comunidad?
    a. ¿ Qué son los métodos más común para abortar en la comunidad?
        1. ¿Que forma es la más común?
    b. ¿Puede decirme lo que sabe acerca de los riesgos o efectos secundarios de tener un aborto—podemos hablar de los diferentes métodos de aborto también?
        1. ¿Ha visto en su carrera pacientes con complicaciones del aborto? ¿Que tipas de complicaciones?
    c. ¿Es usted consciente de lo que dice la ley acerca de las mujeres de tener un aborto?
        1. ¿Cuales son las consecuencias con la ley—para las mujeres y para los que les ayudan?
        2. ¿Cómo se cumple y quién hace cumplir la ley en estas situaciones?

d. ¿Con qué frecuencia recibe ud. preguntas sobre el aborto?
e. ¿Qué preguntas son las más comunes?
f. ¿Quién le pide?

14. ¿Qué miembros de la comunidad son los que más conocen sobre estos servicios?

PERCEPCIONES:

15. Vamos a volver atrás y hablar un poco más acerca de la anticoncepción de emergencia y el aborto. ¿Cuáles son sus pensamientos u opiniones personales del uso de la anticoncepción de emergencia?
    a. ¿Quienes cree usted que deben estar involucrados en la toma de la decisiones del uso de la anticoncepción de emergencia?
    b. Hablamos antes sobre las consecuencias de salud, pero ¿cuáles son algunas de las consecuencias sociales del uso de la anticoncepción de emergencia?
    c. ¿Hay situaciones en que les aconseja a las mujeres que buscan sus servicios usar la anticoncepción de emergencia?

16. ¿Qué interés cree usted que tienen miembros de la comunidad en el uso de la anticoncepción de emergencia como una opción de planificación familiar?
    a. ¿Que les preocupa a los miembros de la comunidad sobre el uso de anticoncepción emergencia?

17. ¿Qué pasa con el aborto? ¿cuáles son sus pensamientos u opiniones del aborto como un medio para hacer frente a un embarazo no deseado?
    a. ¿Quienes cree usted que deben estar involucrados en la toma de la decisiones de tener un aborto?
    b. ¿Cuáles son algunas de las consecuencias sociales de tener un aborto?
    c. ¿Hay situaciones en que piensa ud. que es aceptable a abortar?
    d. ¿Hay situaciones en que les aconseja a las mujeres que buscan sus servicios abortar?

18. ¿Qué interés cree usted que tienen los miembros de la comunidad en el uso del aborto como una opción de planificación familiar?
    a. ¿Cree usted que algo sería diferente si el método fuera legal aquí?
    b. ¿Qué preocupaciones o temores podrían tener los miembros de la comunidad con respecto al aborto?

ACCESO A LA ATENCIÓN:

19. ¿Cuál sería su estimación sobre el costo total de la obtención de la anticoncepción de emergencia?
    a. ¿Cuánto tiene que pagar un paciente por el servicio?
    b. ¿Piensa ud. que el precio de esto servicio es algo que puede impedir una mujer que quiere usarlo?
    c. ¿Quién suele acompañar a las mujeres cuando entran en la anticoncepción de emergencia?
    d. ¿Cuántas visitas tiene que hacer un paciente con el fin de obtener el método?
    e. ¿Qué tan bien equipada es esta facilidad para proporcionar anticoncepción de emergencia?

20. ¿Qué otros requisitos o barreras pueden impedir a una mujer que quiere usar la anticoncepción de emergencia?
    a. Por ejemplo, edad, el costo, consentimiento…

21. ¿Cuál sería su estimación sobre el costo total de la obtención de un aborto?
    a. ¿Cuánto tiene que pagar un paciente por las medicinas y/o el procedimiento?
        1. Legal
        2. Ilegal
    b. ¿Piensa ud. que el precio de esto servicio es algo que puede impedir una mujer que quiere usarlo?
    c. ¿Quién suele acompañar a las mujeres cuando llegan/van para el procedimiento?
    d. ¿Cuántas visitas tiene que hacer una paciente con el fin de obtener el método?
    e. ¿Qué tan bien equipada están los centros para prestar este servicio o abortos médicos?

22. ¿Qué otros requisitos o barreras impedir a una mujer que quiere tener un aborto?
    1. Legal?
    2. Ilegal?

PARA CONCLUIR:

24. ¿Tiene alguna recomendación para mejorar la situación de embarazo no deseado aquí en Leticia?
    a. ¿Quien tiene el papel más importante para cambiar la situación?
    b. ¿Que son las barreras para hacer esto?

25. Vamos a resumir algunos de los puntos clave de nuestra discusión. ¿Hay algo más?
    1. Hemos hablado de la familia típica de Leticia, los métodos de anticoncepción y el aborto y lo que sabe y piensa sobre éstos, incluyendo preguntas sobre el acceso a estos métodos.

26. ¿Tiene alguna pregunta para mí?

Gracias por tomarse el tiempo para hablar conmigo! Si tiene cualquier pregunta o preocupación después de salir de aquí hoy, por favor no dude en ponerse en contacto conmigo para hablar más.

APPENDIX C

Participants Line Listing: Demographic Information

Profession/ Community Role	Location	Gender	Age	Home	Religion	Marital Status	Children
Nurse	City center	F					
Nurse	City center	F		Bogota			
Nurse	City center	F	52				
Nurse	City center	F	34				
Pharmacist (homeopathic medicines)	City center	F	28			Married	1
Nurse	City center	F	33	Santa Marta			
Nurse	City center	F	27	Leticia			
Psychologist	City center	F	29	Risaralda		Single	None
Catholic priest	City center	M	63	Not Leticia	Catholic		
Public health outreach	City center	F	37	Magdalena		Married	1
Nurse (gynecology and obstetrics)	City center	F	25	Barranquilas			
Nurse (ER, gynecology, pediatrics, internal medicine)	City center	M		Bogota			
Daycare/child care	Barrio	F	38	Leticia	Catholic, but attends local Evangelical Church if invited	"Union libre" (open union)	3
Barrio president	Barrio	M	50	Nuqui Choco (Pacific coast)	Catholic	Separated	3
Nurse	Indigenous community	F	48	Cali	Catholic	Separated	1
Shaman (natural healer)	Indigenous community	M	56	Same indigenous community	Catholic	Married	9
Professor of health education, spiritual education	Indigenous community	F	47	Bogota, Putumayo	Catholic	Married	6
Health outreach worker ("Prometor de salud")	Indigenous community	F	34	Same indigenous community	Catholic	Married	5
Professor of natural sciences	Barrio	M	30	Leticia	Catholic	Single	None
Pharmacist	City center	F	32	Originally from different region	Non-Catholic Christian	Married	2
Pharmacist	City center	M	42	Cauca	Catholic	Separated, divorced	3
Pharmacist	City center	F	60	Medellin	Catholic	Married	3
Pharmacist	City center	M	32	Bogota, another location	Catholic	Married	3
Nurse	City center	M	25	Indigenous community near city	Catholic	Not married	1

Pharmacist (contraception specialist)	City center	M	29	Southern Colombia	Catholic	"Union libre" (open union)	1
Psychologist	City center	F	28	Torima	Catholic	Single	None
Community leader (barrio vice-president)	Barrio	F	42	Leticia	Catholic	Union libre (open union)	3
Community leader (former "Curaca")	Indigenous community	M	31	Same indigenous community	Catholic	In committed relationship	None
Social worker	City center	F	24	Bogota	Catholic	Single	None
Social worker	City center	F	26	Bogota	Catholic	Stable relationship, unmarried	None
Community leader ("Curaca")	Indigenous community	M	19	Another indigenous community	Catholic	Single	None
Community leader ("Curaca")	Indigenous community	F	32			Separated	4
Church group leader	Barrio	F	56	Peru	Catholic	Separated	4