



**LUNDS**  
UNIVERSITET

Lund University Master of Science in  
International Development and Management  
May, 2019

**STIGMA OF ADOLESCENT PREGNANCY AND MOTHERHOOD IN BOLIVIA**  
EXAMINING HOW PREGNANT AND MOTHERING ADOLESCENTS EXPERIENCE  
STIGMA IN THE CITY OF COCHABAMBA, BOLIVIA

---

Author: **Josefin Edberg**  
Supervisor: **Maira Nelson**

*[Page intentionally left blank]*

## **Abstract**

Stigma of pregnant and mothering adolescents is linked to socially constructed gender roles and sexual identities, ideals of motherhood, and stigma of adolescent sexual activity. As such, it constitutes an adolescent sexual and reproductive health issue. It is a contributing factor to several negative consequences related to adolescent pregnancy, such as adverse health outcomes, lower educational attainment, and reduced social participation. Despite this, limited research exists on the topic. This study investigates stigma among pregnant and mothering adolescents in Bolivia by using Pryor and Reeder's (2011) model of four manifestations of stigma. Through a qualitative case study set in Cochabamba, in-depth interviews with 16 young women were used to understand experiences of public stigma and self-stigma due to adolescent pregnancy and motherhood. The main findings suggest that adolescents who are in a relationship experience less public and self-stigma, and that stigmatising treatments are experienced both within family and in public spaces, although public stigma from family seem to have more negative effects in adolescents. Additionally, processes of self-stigma were evident through adolescents' endorsement of public stigma, and experiences of guilt and embarrassment. These feelings were often intensified if adolescents experienced or anticipated stigmatising treatments of people closely associated with them.

**Key Words:** Adolescent pregnancy, adolescent motherhood, stigma, discrimination, Adolescent Sexual and Reproductive Health, Bolivia

**Word count:** 14 904

*[Page intentionally left blank]*

## **Acknowledgements**

First and foremost I would like to thank all my respondents for taking the time to participate in the study, and for bravely and openly sharing your experiences with me. Without your contributions this thesis would have never been possible. Thank you Brenda for helping me conduct interviews and providing respondents with support when needed. Thank you Save the Children in Bolivia, especially Neva, Fernando and Rolando, for your engagement and input, and for introducing me to health staff in your programme. Thank you Argemis, Felicidad and Thelma for welcoming me in your Young Mothers Groups.

I would also like to thank my supervisor, Moira, and my friends in the supervision group, for your advice and guidance during the research and writing process. Lastly, I want to extend my gratitude to my partner, family and friends for the tireless support and encouragement you have offered me during my time in Bolivia and while writing this thesis.

# Table of content

<b>1. Introduction</b>	<b>9</b>
1.1 Motivation for study	9
1.2 Purpose and research question	10
1.3 Thesis outline	11
<b>2. Background</b>	<b>12</b>
2.1 Adolescent sexual and reproductive health	12
2.2 Adolescent sexual and reproductive health and pregnancy in Bolivia	13
<b>3. Literature review</b>	<b>15</b>
3.1 Gender roles and sexuality in Latin America and Bolivia	15
3.2 The “problem” of adolescent pregnancy	16
3.3 Stigma of pregnant and mothering adolescents	18
<b>4. Theory</b>	<b>20</b>
4.1 Conceptual definitions of stigma	20
4.1.1. <i>Public Stigma</i>	21
4.1.2. <i>Self-stigma</i>	22
4.1.3. <i>Stigma-by-association</i>	22
4.1.4 <i>Institutional stigma</i>	23
4.2 Analytical framework	23
<b>5. Methods</b>	<b>24</b>
5.1 Research strategy and design	24
5.2 Epistemological and ontological assumptions	24
5.3 Data collection	25
5.3.1 <i>Site description</i>	25
5.3.2 <i>Sampling strategy</i>	25
5.3.3 <i>Interviews</i>	26
5.4 Data analysis and triangulation	27
5.5 Limitations	27
5.6 Ethical considerations and consent	28
5.7 Positionality and reflexivity	29
<b>6. Findings</b>	<b>30</b>
6.1 Demographics and living situations	30
6.2 Experiences of public stigma	30
6.2.1 <i>Cognitive reactions</i>	31
6.2.2 <i>Affective reactions</i>	33
6.2.3 <i>Behavioural reactions</i>	35
6.3 Experiences of self-stigma	38
6.3.1 <i>Perceived stigma</i>	38
6.3.2 <i>Processes of internalization</i>	39
6.4 Indications of stigma-by-association	41
6.5 Potential effects of institutional stigma	41

<b>7. Analysis.....</b>	<b>43</b>
7.1 Public stigma .....	43
7.2 Self-stigma .....	45
7.3 Stigma-by-association .....	47
7.4 Institutional stigma .....	47
7.5 Elaborating the theoretical model.....	48
<b>8. Conclusion.....</b>	<b>49</b>
8.1 Concluding remarks .....	49
8.2 Suggestions for future research .....	50
<b>9. References .....</b>	<b>51</b>
Annex A: Detailed list of key informants .....	57
Annex B: Interview guide .....	58
Annex C: Written consent form .....	61
Annex D: Ethics clearance.....	63
Annex E: Authorization form – Directors of health facilities .....	64

## List of acronyms

ABR	Adolescent Birth Rate
ASRH	Adolescent Sexual and Reproductive Health
ISAGS- UNASUR	Instituto Suramericano de Gobierno en Salud – Unión de Naciones Suramericanas (South American Institute of Governance in Health – Union of South American Nations)
NGO	Non-Governmental Organisation
PMA	Pregnant and Mothering Adolescents
PPEAJ	Plan Plurinacional de Prevención de Embarazos en Adolescentes y Jóvenes (Plurinational Plan for the Prevention of Pregnancies in Adolescents and Youth)
SCI	Save the Children
SRH	Sexual and Reproductive Health
YMG	Young Mothers Groups (arranged at health facilities)
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WHO	World Health Organisation



# 1. Introduction

## 1.1 Motivation for study

Every year around 16 million girls between the age of 15 and 19 become pregnant in the world, and additionally two million girls under the age of 15<sup>1</sup>. Adolescent pregnancy is often considered a risk to adolescent women's healthy development and a barrier to reaching their full potential. Although the global Adolescent Birth Rate<sup>2</sup> (ABR) has been declining since the 1950's, the progress is uneven between and within countries (UNFPA, 2015). Adolescent pregnancy and motherhood is problematic in many ways since there are several negative outcomes related to the phenomenon, such as increased health risks and negative economic and social consequences (WHO, 2018; UNFPA, 2015 and 2017). One important factor that may contribute to many of these negative outcomes, but which is often only mentioned briefly, is the stigma of adolescent pregnancy and motherhood. Studies have found that stigma may lead pregnant adolescents to seek healthcare at a later stage, contribute to the decision to drop out of school early, and cause pregnant and/or mothering adolescents to withdraw from social life (Wiemann et al, 2005; Wilson and Huntington, 2005).

One country that faces the challenge of having a large young population and already high indices of adolescent pregnancy is Bolivia, with the second highest ABR in South America, and the highest in the sub-region of the Andean countries (UNFPA, 2016a). Although sexual activity and reproductive status of Bolivian adolescents and youth have been described elsewhere, few studies have examined the stigma around these issues. In their study UNFPA (ibid) conclude that stigma of pregnant and mothering adolescents is found in various spheres of the Bolivian society, however there is a lack of in-depth research in the issue. In general in Latin America, it is argued there is a lack of adolescents' own perspective in research on their Sexual and Reproductive Health (SRH)(Jaruseviciene et al, 2013). To this background, this study was conducted to gain a deeper understanding of stigma around adolescent pregnancy and motherhood in Bolivia, and how it may be experienced by adolescent women. The study was set in Cochabamba, Bolivia's third largest metropolitan area, a city with a large adolescent population whose sexual and reproductive health situation can be considered representative<sup>3</sup> of urban adolescents in the Andean region (ibid).

---

<sup>1</sup> Adolescents are often divided into the age groups of 10-14 and 15-19 years of age (Castro Mantilla and Salinas Mulder, 2017). This research has solely focused on adolescents that have become pregnant between the ages of 15-19, further elaborated below.

<sup>2</sup> Number of live births per year, per 1000 women ages 15-19 (World Bank, 2019).

<sup>3</sup> It should be noted that the findings of this study are not intended to be generalised to other cases.

To better understand experiences of stigma the study uses Pryor and Reeder's (2011) model of four manifestations of stigma; public stigma, self-stigma, stigma-by-association and institutional stigma. The model considers all manifestations to be inter-related but the root of all stigmas is *public stigma* (ibid). Briefly, *public stigma* can be described as the negative social reactions towards people perceived to have a stigmatized condition or label (ibid), i.e. general negative thoughts and actions aimed at stigmatized individuals, in this case Pregnant and Mothering Adolescents (PMA). *Self-stigma* is the reaction to enacted or anticipated (perceived) public stigma in the individual subjected to it, in other words the social and psychological impacts of stigmatizing treatments (ibid). *Stigma-by-association* is stigma that falls on individuals closely associated with the individuals who are 'originally' stigmatized, thus the social and psychological effects in them (ibid). Lastly, *institutional stigma* is manifested through the legitimisation of stigmatising treatments by society's institutions, such as laws or policies (ibid).

## **1.2 Purpose and research question**

The purpose of this case study is to develop a deeper understanding of how stigma is experienced by pregnant and mothering adolescents in Cochabamba, Bolivia. This will be investigated using the analytical model of public stigma, self-stigma, stigma-by-association and institutional stigma, introduced by Pryor and Reeder (2011). The study focuses on experiences of *public stigma*, described as the negative reactions of people towards a stigmatised condition, and *self-stigma*, which explains in what ways public stigma impact the person with the stigmatised condition. The following research question was elaborated to guide the case study.

How are pregnant and mothering adolescents in Cochabamba, Bolivia, experiencing enacted and perceived public stigma as well as self-stigma?

Since adolescence is a culturally defined age, it should be clarified that this study understands adolescent pregnancy as between 15-19 years of age, in line with the general definition ABR, which is number of births per 1000 women ages 15-19 (World Bank, 2019a). By interviewing 16 young women between the ages of 15-21 whom had become or were becoming mothers during their adolescence, the study aims to provide a more nuanced understanding of stigma of PMA, through the perspectives of the women themselves. Hopefully this will help inform

and improve policies and interventions targeting adolescents in this situation. Before moving on it is worth noting that the thesis refers to pregnant and mothering adolescents as PMA, and the stigmatizing treatments of this group as stigma of PMA.<sup>4</sup> Although literature often discusses stigmatized attributes, labels or conditions, theory suggests that these normally become so important and distinguishing they define the person carrying it, thus it is the whole person that is stigmatized (Miles, 1981).

### **1.3 Thesis outline**

Second to this introduction, a background section will provide information about adolescent sexual and reproductive health, and the situation of adolescent pregnancy and motherhood in Bolivia. Third, a literature review gives an overview of gender roles and sexuality in Latin America, further a problematisation of the on-going discourse around adolescent pregnancy is presented, as well as previous research on stigma of PMA. Forth, stigma theory and Pryor and Reeder's (2011) model of four manifestations of stigma is explained in depth. Fifth, the research methods are explained, as well as ethical considerations and limitations of the study. Sixth, the findings from in-depth interviews with PMA are presented. Seventh, an analysis section will link findings to existing research and theory. Lastly, in chapter eight, the main conclusions are presented and suggestions for future research given.

---

<sup>4</sup> It is general praxis to use abbreviations for the stigmatized group. For example Pryor and Reeder (2011) refers to Persons Living With HIV/AIDS as PLWHA, and Guo, et al (2012) uses 'stigma of PWE' to describe stigma of Patients With Epilepsia.

## 2. Background

To get an overview of adolescent pregnancy and motherhood this chapter will start by looking at it from the perspective of Sexual and Reproductive Health.<sup>5</sup> After that, the Bolivian context will be described to provide a deeper understanding of adolescent SRH and pregnancy in the country.

### 2.1 Adolescent sexual and reproductive health

Adolescent Sexual and Reproductive Health (ASRH) has become an area of increased interest to states, the development community and academia (Santhya and Jejeebhoy, 2015; ICPD, 1994; UN, 2015). Adolescent pregnancy, especially unintended, is often considered an outcome of poor ASRH, and generally considered a sexual and reproductive health risk, along with for example sexual violence, early marriage, unsafe sex, and sexually transmitted infections (ibid). However, it should be emphasised that not all adolescent pregnancies are unintended. For some, pregnancy is the result of barriers to SRH education and services, such as lack of access to information and methods of contraception or restrictive laws on abortion, but for others pregnancy is a deliberate choice (Córdova Pozo et al, 2015). Becoming a mother may, for example, be a way to gain adult status or fulfil traditional expectations (ibid; Langer and Nigenda, 2000). Further, it should be mentioned that pregnancy can also be the result of sexual violence and abuse, and lack of comprehensive post-rape care, like emergency contraception and/or abortion services (PAHO, UNFPA and UNICEF, 2014).

Research has found that (public) stigma around adolescent sexuality<sup>6</sup> and sexual activity in many cases is a barrier to the enjoyment of good ASRH. In fact, scholars argue that as a first step to understand the stigma of PMA, one must understand stigma and taboos around sexuality and sexual activity that exist within a specific context (see Ellis-Sloan 2014). Since adolescent pregnancy and motherhood makes sexual initiation and activity visible, these two topics are inseparable (ibid). This relationship will be returned to later but before that it is considered important to have an understanding of the Bolivian context, and the status of ASRH and adolescent pregnancy and motherhood in the country.

---

<sup>5</sup>According to UNFPA, “good Sexual and Reproductive Health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.” (UNFPA, 2019).

<sup>6</sup> According to the WHO “sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.” (WHO, 2006: 5).

## **2.2 Adolescent sexual and reproductive health and pregnancy in Bolivia**

According to Novilla et al (2005), sexual activity among adolescents and youth is increasing worldwide, and Latin America stands out as the region where it starts the earliest. Although adolescent men engage in sexual activity more than adolescent women (ibid), it is suggested that myths about a passive female sexuality, and the practice of chastity for women are breaking (Chant and Craske, 2003). Despite this development, stigma and taboos around adolescent sexuality and sexual activity are still prevalent in Bolivia (Paulson and Bailey, 2003). Even in the government's Plurinational Plan for the Prevention of Adolescent Pregnancies (PPEAJ, 2015), stigma around adolescent sexuality is acknowledged as a barrier for adolescents to access services and information about their sexual and reproductive health.

Another way in which stigma and taboo's of adolescent sexuality and sexual activity is manifested is in the low levels of communication that exist between parents and children around the issues (ibid; UNFPA, 2016b; Córdova Pozo et al, 2015). A report by Save the Children in Bolivia (2017) suggest that sexuality is generally understood as sexual intercourse, and a common view among parents is that talking about the topic of sex with their children implies an authorization to initiate their sexual lives, thus parents prefer to avoid this topic (ibid; UNFPA, 2016b). This puts adolescents in peculiar situations since accurate information and general emotional support around the issues is hard to find (Save the Children in Bolivia, 2017).

The PPEAJ (2015) is considered a huge progress towards the recognition of ASRH in Bolivia, and especially for addressing adolescent pregnancy as a separate, complex issue. However, lack of economic funds and political priority has made the implementation of the plan less successful.<sup>7</sup> Another state initiative affecting pregnant and mothering adolescents in Bolivia is the rather new Law 548 for Children and Adolescents (Ley 548 Código Niño, Niña y Adolescentes) passed in 2014. This law (hereinafter referred to as Law 548) gives everyone the right to complete school, thus illegalising the earlier common practise of expelling adolescent girls from school if they got pregnant.<sup>8</sup>

Currently the Bolivian ABR is declining, and in 2017 it was at 68 births per 1000 ages 15-19 years (World Bank, 2019b). However, Neal et al (2018) argue that the percentage of women

---

<sup>7</sup> Suggested by key informants: Neva and Joaquín

<sup>8</sup> Described by key informants: Neva and Rolando

who become mothers before the age of 20 has increased since 1990.<sup>9</sup> In addition, the situation looks very different between groups and areas, indicated by table 1.

Country / Census year	Age group	Indigenous Population			Non-Indigenous Population		
		Urban	Rural	Total	Urban	Rural	Total
Bolivia (Plurinational State), 2008	15 - 17 years	6.6	8.4	7.5	6.8	15.3	8.6
	18 - 19 years	18.4	36.4	26.4	17.7	45.5	22.6
	15 - 19 years	11.6	18.7	15	10.8	25.5	13.7

*Table 1. Adolescents between 15-19 years of age who are mothers in Bolivia, by age group, ethnic status and area of residence (ISAGS-UNASUR (2017:24)).*

Although research on stigma of PMA in Bolivia is limited, a study from 14 different municipalities in the country suggests that pregnant and mothering adolescents are stigmatized in various spheres of society (UNFPA, 2016a). Furthermore it finds that becoming a mother during adolescence is generally seen as a sign of bad upbringing (ibid). In summary, although efforts have been made to improve ASRH and address high indices of adolescent pregnancy, several barriers prevail, such as stigma and taboo around adolescent sexuality and sexual activity. In order to understand such stigma, it is considered important to grasp how socially constructed gender roles shape attitudes towards, and experiences of SRH (De Meyer et al, 2014; Paulson and Bailey, 2003). The following chapter will thus start by reviewing literature on gender roles and sexuality in Latin America.

---

<sup>9</sup> Reductions in ABR are driven by a decrease in subsequent births, rather than fewer adolescents becoming mothers at all (Neal et al, 2018).

### 3. Literature review

This chapter will start by giving an overview of the inter-relation of gender roles, sexuality and stigma of PMA, in the context of Latin America and Bolivia. It will also present literature that questions and problematises the on-going discourse around adolescent pregnancy and motherhood, and lastly previous research on stigma of PMA will be outlined.

#### 3.1 Gender roles and sexuality in Latin America and Bolivia

As the previous chapter suggest, stigma and taboos exist around adolescent sexual activity in many parts of the world, including Latin America and Bolivia. In relation to this, Cordova Pozo et al (2015) argue there are two key determinants that influence ASRH in the Latin American context.<sup>10</sup> The first one is ease of communication, which the previous chapter suggests is lacking in Bolivia. The second is gender norms and/or attitudes (ibid), whereby these will be addressed in this section.

The construction and reproduction of gender roles starts at an early age in Latin America, and the family is a crucial institution when it comes to the socialisation of gender roles and definitions of sexuality (Chant and Craske 2003). Whilst boys are allowed spatial and social freedoms, girls are kept at home, often under stricter rules and often penalised more than boys for disobedience (ibid). The same pattern persist when it comes to addressing sexual development; young women are controlled and monitored, whereas young men are encouraged and allowed liberties (Krauskopf, 1999). The macho male adolescent is supposed to be heterosexual, have several sexual partners and engage in risky sexual behaviour (De Meyer et al, 2014), and a common trend among young men is to not use contraception because a macho should have children anywhere (Córdova Pozo et al, 2015). In line with this, Chant and Craske (2003) describes a ‘sexual double standard’, according to which women should have restricted or no access to sex before, or sometimes even during, marriage, whilst men are allowed to engage in multiple sexual liaisons. The system in which these stereotypical and binary constructions of gender roles and sexual identities are produced is referred to as the machismo-marianismo system (ibid; Cupples, 2014; De Meyer et al, 2014). Within this system, female roles are divided into two discursive ‘categories’ of femininity; the *good woman*, often depicted as the mother, and the *bad woman*, who is the eroticised and

---

<sup>10</sup> Latin America is a highly diverse region, however it is also similar in many ways, not the least in terms of sexual and reproductive health and rights for women (Chant and Craske, 2003). For this reason, research from the Latin American region can explain the Bolivian context rather well too.

sexual woman, summarized as ‘the whore’ (Chant and Craske, 2003; Nencel, 1996: 62; Rudzik, 2018). Furthermore, in accordance with the ideals of marianismo, women’s sexual activity is only endorsed in relation to reproduction and marriage, and otherwise concealed or considered a taboo (Chant and Craske, 2003).

In general, the ‘fertile mother’ is often valorised throughout Latin America and considered a natural role for women, which ties them closer to determined roles (Chant and Craske, 2003:144). This cultural perception that the basic responsibility for women is reproduction, and the consequential general low societal expectations on women, are factors that Bolivian adolescent women often consider when deciding to come mothers (Alfonso, 2008). However, the strong ideals of motherhood make it hard for adolescents to reach this valued position since motherhood, especially lone, during adolescence is considered deviant from social norms (Rudzik, 2018; McDermott and Graham, 2005). Thus, should an adolescent woman become pregnant, it is much more accepted if it is within marriage than as a single mother (Córdova Pozo et al, 2015). According to Rudzik (2018) this leads some adolescents to engage in ‘identity repair work’ when becoming pregnant, including for example, marrying or moving in with the father of the child.

With a better understanding of how culturally specific relationships and identities shape women’s and men’s ideas of gender roles, sexuality and sexual activity, the focus is turned to the discourse around adolescent pregnancy and motherhood.

### **3.2 The “problem” of adolescent pregnancy**

Several scholars argue that the dominant negative discourses around adolescent pregnancies, as well as the public and policy responses, contribute to the marginalisation and stigmatisation of PMA (Barcelos and Gubrium, 2014; McDermott and Graham, 2005; Rudzik, 2018). For this reason, “research about this group [...] must engage in, and respond to, these dominant discourses and representations of the ‘pregnant teenager’” (Luttrell, 2003:4). With this in mind, the following section will outline the general discourse around adolescent pregnancy and motherhood, and present literature that questions and problematises it.

In general, adolescent pregnancy is often described as a problem related to health, inequity, development and/or human rights (PAHO, UNFPA and UNICEF, 2016). From the perspective of states, it is also considered an economic problem since it is costly for various



reasons (WHO, 2018; Hanna, 2001; Yardley, 2008). A common way to discuss adolescent pregnancy and motherhood is in relation to poverty and poor economic outcomes, which is often linked to personal development. For example, general discourse suggest that adolescent pregnancy leads girls to leave school, which implicates less formal skills followed by less employment opportunities (WHO, 2018). With this logic adolescent pregnancy is also considered responsible for perpetuating cycles of poverty (WHO, 2018). However, several scholars argue that poor economic and educational outcomes may be effects of pre-existing poverty, and not necessarily outcomes of adolescent pregnancy or early motherhood per se (Kelly, 1995; Kearney and Levine 2012; Rudzik, 2018). Furthermore, Wilson and Huntington (2005) observe that by viewing adolescent pregnancy and motherhood as problematic, the discourse ignores the possibility that adolescent women consider their opportunity costs when becoming pregnant and deciding to continue to term. This goes in line with Alfonso's (2008) suggestion that adolescents in Bolivia may consider the lack of future opportunities as a reason for having children early. McDermott and Graham (2005) adds that the general discourse of adolescent pregnancy as something that only happens to women living in poverty, adds to the social understanding that they are inappropriate mothers.

Health-wise, adolescent pregnancy is related to elevated risks of maternal mortality and pregnancy-related health complications due to physical immaturity, as well as increased health-risks for babies (Santhya and Jejeebhoy, 2015; Langer and Nigenda, 2000; WHO, 2018). An important factor for these elevated health risks is that pregnant adolescents tend to seek care at a later stage (Schutt-Aine and Maddaleno, 2003). This reluctance to seek care is often based on feelings of shame or embarrassment related to SRH issues (ibid). Furthermore, studies have found that adolescents are often met by paternalistic, insensitive attitudes from health staff (Carvacho, et al, 2008). Thus, increased health risks due to physical immaturity are problematic, but social factors related to adolescent pregnancy and motherhood, like stigma, also play an important role in this health-problem. Lastly, UNFPA (2013), suggest that girls who get pregnant during their adolescence are more likely to become victims of violence within their marriage or partnership, than girls who postpone their child-bearing. Whilst this is an important health- and rights-related issue, there might be several underlying causes to this other than simply the adolescent pregnancy. In general, many critics to the discourse around adolescent pregnancy argue that causative relationships such as this one, should be questioned (Kelly, 1995), to avoid scapegoating adolescent women for all kinds of social ills, as argued by Luttrell (2003:4).

### 3.3 Stigma of pregnant and mothering adolescents

This section provides an overview of what previous research has found about stigma of PMA. When reviewing the literature on stigma of PMA it is evident that most studies are conducted in postmodern societies.<sup>11</sup> Although stigma often varies between cultural and economic contexts (Link and Phelan, 2001), this review draws on findings from all contexts to get a richer understanding of the phenomenon. According to Kelly (1996) the popular belief is that stigmatisation of PMA is declining, however she and others (Wiemann et al, 2005; Bermea, Toews and Wood, 2018; Yardley, 2008) argue that it still persists in various spheres of society, which was also demonstrated in the previous section.

Given the knowledge of PMAs' reluctance to seek care, as mentioned earlier, several studies have investigated stigma of PMA in health care facilities (Hanna, 2001; Yardley, 2008). In Australia, Hanna (2001) finds that PMA often consider health staff to be authoritarian and controlling, and felt that they were judgemental of their situation. Similarly, Yardley (2008) found that PMAs in the U.K. had experienced discriminatory attitudes and stigma from staff in health services and hospitals.

Moving to educational environments, several studies (Bermea, Toews and Wood, 2018; Vinson and Stevens, 2014; Wiemann et al, 2005) find that PMA experience stigmatizing treatments from teachers, peers and even study materials. Vinson and Stevens' (2014) observes that PMA were constantly reminded of their "mistake" through comments and actions from teachers and peers, as well as the way sex education classes were structured. Stigmatizing treatments generally take the form of "weird looks" and direct or indirect comments or questions, making PMA feel lesser than their peers (ibid; Bermea, Toews and Wood, 2018). General loss in self-esteem among PMA, was found by Wiemann et al (2005) whereas Rudzik (2018) concludes that although PMA were stigmatized, some found determination in their situation and worked hard to succeed at work or in school in order to provide a better future for their baby than they felt they had themselves (ibid).

It is worth noting that several studies on stigma of PMA find that some adolescents are coping better than others with being stigmatized (Yardley, 2008; Wiemann et al, 2005). According to Yardley (2008), numerous factors explain differential coping mechanisms and effects of

---

<sup>11</sup> This term is used by McDermott and Graham (2005) to describe societies like Britain, United States, Canada, and Scandinavia, where the general situation for PMA and young mothers is considered similar.

stigma in individuals, however some of the common effects found are; feelings of shame, fear, resentment, and anger (Yardley, 2008), as well as distress and lack of confidence (Ellis-Sloan, 2014; Wiemann et al, 2005).

The effects of family support have been investigated in relation to stigma of PMA and in stigma-research of other areas, and it is generally considered a determinant for how well the stigmatized person copes with the experiences of stigma (Guo et al, 2012). For pregnant and mothering adolescents Yardley (2008) suggest that, together with the social network of the adolescent, the emotional family support act to normalise the early motherhood and thus mitigate the experiences of stigma. McDermott and Graham (2005) found that family relations offered PMAs safe spaces, often free from stigmatization. However, this is not taken for granted by PMA, thus many fear telling their parents, who often react with disappointment. Whilst this sometimes lead to broken relationships they were mostly renegotiated and restored (ibid). Looking at research where family support does not exist, Pryor and Reeder (2011) finds that this lack is particularly stressful for the stigmatized individual. In fact, stigmatising treatments from family tends to cause stronger reactions of, for example, anxiety, depression, and general negative affect in the stigmatized person, than the same treatment from friends or leisure acquaintances (Stutterheim et al, 2009). In relation to this, Guo et al (2012) find that people with a stigmatized condition are often aware of the potential burden it may cause their families, which may lead stigmatized individuals to reduce their social lives and activities to minimize the risks of potentially embarrassing their family (ibid).

With a deeper understanding of gender roles and sexuality in Latin America, an overview of the discourse around adolescent pregnancy and motherhood, as well as an understanding of previous research of stigma of PMA, the thesis now turns to explain the theoretical model used for the study.

## 4. Theory

Connecting to the literature review on previous stigma-research around adolescent pregnancy and motherhood, this section will elaborate on the four manifestations of stigma, suggested by Pryor and Reeder (2011), which provide a theoretical framework through which this stigmatization can be understood.

### 4.1 Conceptual definitions of stigma

The most established definition of stigma was introduced by Goffman in 1963, stating that stigma is “an attribute that is deeply discrediting” that reduces someone “from a whole and usual person to a tainted, discounted one” (Goffman, 1963: 3). In line with this, Miles (1981) argue that a stigmatized attribute is considered so important and distinguishing, to the perceiver, that the person with the attribute is defined by it. Adding to this, Link and Phelan (2011) emphasise that a stigma is not san attribute *in a person*, rather it is a label or judgment that other people affix to the person. Hence, stigma is a social process that labels persons with certain characteristics, and allows for processes of separation, stereotyping, status loss and discrimination to occur (Link and Phelan, 2001). This form of labelling is described as being done to a whole group, “branding them all” (Dain, 1994; 1011), which is why stigma of groups is generally discussed, like ‘stigma of PMA’ in this case.

The stigma described here is what Pryor and Reeder (2011) would call public stigma, but as outlined in the introduction, the scholars identify at least three other manifestations of stigma; self-stigma, stigma-by-association, and institutional stigma. These manifestations originate from public stigma but they are all interlinked, as illustrated in figure 1. Pryor and Reeder (ibid) first used this model to describe HIV-related stigma but in a study on adolescent motherhood, Bermea, Toews and Wood (2018), used the same understandings to confirm that many adolescent mothers experience public stigma.

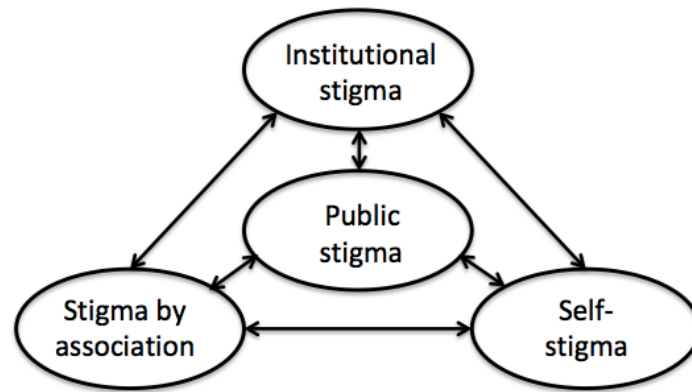


Figure 1. Four manifestations of stigma (Pryor and Reeder, 2011).

For this study, Pryor and Reeder's (2011) model was used as a basis to categorize and understand the experiences of perceived and enacted public stigma as well as self-stigma among PMAs. After elaborating on each manifestation of stigma the analytical framework for the study will be presented, which consists of Pryor and Reeder's model incorporated into societal, inter-personal and individual levels, suggested by Bos et al (2013).

#### **4.1.1. Public Stigma**

As mentioned throughout the thesis, Pryor and Reeder (2011) understands public stigma as the central manifestation of stigma. It is comprised of the social and psychological reactions in people towards a stigmatized condition, or person (ibid). According to the scholars, these reactions can be broken down to *cognitive, affective and behavioural elements*. The *cognitive elements* are commonly held beliefs and stereotypes about the stigmatized person (ibid). These cognitive reactions are often more negative if the stigmatized person is considered responsible for her condition (ibid; Bos et al, 2013), which becomes highly relevant to the stigma of PMA. A common cognitive element of public stigma is the belief about potential dangers of having casual contacts with the stigmatized person. Pryor and Reeder (2011) found this in stigma of HIV-patients, but it has also been noted in other kinds of stigma depending on general knowledge about the condition and the cultural context (Guo et al, 2012).

The *affective elements* of public stigma consist of emotional reactions to the stigmatized condition that derive from the cognitive elements described above (Pryor and Reeder, 2011). It could for example be anger or irritation coming from thinking someone is responsible for her condition, or fear stemming from beliefs that casual contact is dangerous (ibid). Lastly, the *behavioural elements* of public stigma can be described as negative behavioural reactions

that follow the cognitive and affective reactions, which are often based on exaggerated beliefs due to the negative stereotypes around the stigma (ibid). Behavioural reactions range from avoidance and social rejection, to discrimination and abuse, such as verbal threats or psychological and physical violence (ibid).

#### ***4.1.2. Self-stigma***

According to Pryor and Reeder (2011), being the target of public stigma, and experiencing stigmatising treatments, can be psychologically damaging to people and lead to *self-stigma*. Further elaborated, public stigma can be said to impact the self, i.e. the person with a stigmatised condition, in three different ways: (a) through *enacted stigma*: negative treatment of the stigma-holder, (b) through *perceived stigma*: the experiences of anticipation of being stigmatized, and (c) through the process of *internalizing the stigma*: reduction of self-worth and psychological distress in the stigmatized individual (Bos et al., 2013).

In terms of perceived stigma, studies have found that among PMA the expectation and anticipation of stigma can sometimes be even worse than enacted stigmatising treatments (Macvarish 2010; Fessler, 2008; Ellis-Sloan, 2014). Furthermore, both enacted and perceived stigma can lead to experiences of internalisation of stigma. The process of internalisation has been theorised as a multi-stage process; first an awareness of public stigma, followed by endorsement of the public stigma where the stigmatised person considers public reactions partly justified. In the last stage the person considers the public stigma to be relevant to the self, resulting in a diminished sense of self-efficacy and self-worth, including feelings of shame and guilt in the stigmatized person (Pryor and Reeder, 2011).

#### ***4.1.3. Stigma-by-association***

The third manifestation of stigma that Pryor and Reeder (2011) identify was originally identified by Goffman (1963) and called courtesy stigma, but more recently *stigma-by-association* has become the most common word for it. This kind of stigmatization falls on people who are closely associated with the person who is originally stigmatized, but do not have the stigmatized attribute themselves (Pryor and Reeder, 2011). These people might also feel shame due to the stigma, and be concerned with concealing their connection to the stigmatized person (ibid).

#### 4.1.4 Institutional stigma

The fourth manifestation of stigma is referred to as institutional stigma. According to Pryor and Reeder (2011), *institutional stigma* legitimises and perpetuates the stigmatised status of certain people directly or indirectly. For example, laws can exclude or discriminate people directly, or uphold discriminatory practices and thus indirectly stigmatising them (ibid).

#### 4.2 Analytical framework

To get a clearer understanding of where Pryor and Reeder's (2011) four manifestations of stigma are materialised, their original model was combined with Bos et al's (2013) suggestion that stigmatization happens on societal, inter-personal and individual levels. From this, an analytical framework for the study was elaborated (figure 2). It understands *cognitive reactions* of public stigma as occurring on both societal and interpersonal levels, since cognitive reactions are considered shaped by general, public understandings. Similarly, *enacted stigma* is placed between the inter-personal and individual levels, as it per nature happens between people, but may lead to self-stigma and internalisation of stigma on an individual level. It should also be noted that although stigma-by-association and self-stigma are experienced by different individuals.

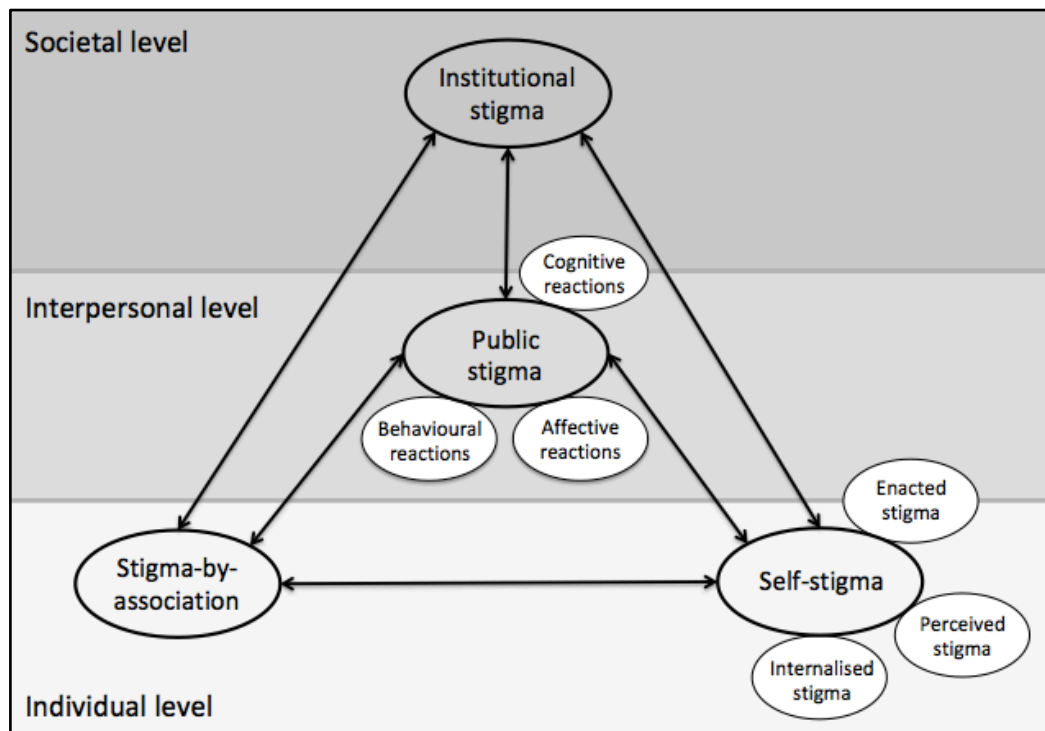


Figure 2: The four manifestations of stigma suggested by Pryor and Reeder (2011) understood at different societal levels, based on Bos et al (2013).

## 5. Methods

Following the discussion of theory and elaboration of an analytical framework to understand the findings, this chapter will present the research strategy and design, methods for data collection and analysis, as well as limitations and ethical considerations of the study.

### 5.1 Research strategy and design

In order to get an in-depth understanding of the experiences of enacted and perceived public stigma as well as self-stigma, among PMAs in Bolivia a qualitative research strategy was chosen. Qualitative research allows for a closer, less hierarchical, relationship between the researcher and participants of a study and has the potential to empower the participants to share their stories and make their voices heard (Creswell, 2007: 40). Furthermore, a single instrumental case study was employed since that design fits well for exploring questions of “how” and “why” (Hammett Twyman and Graham, 2014).

### 5.2 Epistemological and ontological assumptions

The research takes a constructivist approach to ontology, as it is believed that social phenomena, like stigma, are constructed. Constructivism understands social phenomena as formed by social interactions, and under constant negotiation, revision and renewal through these interactions (Bryman 2012: 33). This goes in line with the idea of stigma as a social process consisting of labelling and stereotyping, as well as processes of devaluation and discrimination (Goffman, 1963; Link and Phelan, 2001). As observed by Creswell (2007: 20), the constructivist worldview assumes that individuals develop their own subjective meanings of the world they live in. Researchers should thus look for a complexity of understandings and rely on the participants’ varying views of the situation (ibid). With this logic, the end results should be considered a version of a social reality, not necessarily a definite truth (Bryman, 2012: 34).

The epistemological assumptions in the research take an interpretivist approach, as it does not seek to *explain* human behaviour, rather *understand* it (Bryman 2012: 28). With this said, it should be recognised that several interpretations of social reality will be going on simultaneously in this research since I as a researcher will provide interpretations of others’ interpretations (Bryman, 2012: 31). As Creswell puts it, “the stories voiced represent an interpretation and presentation of the author as much as the subject of the study” (Creswell, 2007:18).



### **5.3 Data collection**

The data collection was conducted in the city of Cochabamba, Bolivia, from the end of January throughout February 2019. The selection of the site was mainly based on the accessibility to the population, as well as the high indices of adolescent pregnancy in the area. Prior to the study, I did an internship with Save the Children in Bolivia, who run a programme in the city, supporting health facilities that work with young mother's groups (hereinafter referred to as YMG). Through my internship I came in contact with staff at these health facilities, whom were later asked to participate in the study.<sup>12</sup> During the internship I also got to know Brenda, a psychologist with experience from working with YMGs at one of the health facilities in the programme<sup>13</sup>. Given her expertise she was recruited to the study as a precaution to provide professional emotional support to respondents during interviews.

#### ***5.3.1 Site description***

The city of Cochabamba is the third largest metropolitan area<sup>14</sup> in Bolivia, it has around 1 100 000 residents (Hoogendam and Boleens, 2019), and is the capital of the department with the same name. The three health facilities where the study was conducted, Alalay, K'ara K'ara and España, are located in different parts of the area Zona Sur (the Southern Zone), and they are all part of the public health system. Zona Sur is generally understood as the poorest part of the city and the area with the highest population-growth, hosting several large semi-legalised squatter settlements of rural migrants (Marston, 2013).

#### ***5.3.2 Sampling strategy***

The sample for the study was drawn from groups of pregnant and mothering adolescents who participate in YMGs in health facilities in Cochabamba. These respondents (as I will refer to them) were selected through a convenience sampling technique based on their availability – being present at a YMG<sup>15</sup> meeting – and their willingness to participate in the study (Kapiszewski, MacLean and Read, 2015:212). The sampling was also somewhat purposive,

---

<sup>12</sup> Healthcare staff was informed that the study was separate from my previous work with Save the Children in Bolivia, and that their collaboration was not going to yield additional financial support.

<sup>13</sup> Brenda did her practical training as a psychologist at the health centre Cerro Verde, where she worked with Young Mothers Groups. This health facility was not part of the study.

<sup>14</sup> After La Paz/El Alto in the highlands region and Santa Cruz in the tropical lowlands.

<sup>15</sup> Normally the young women are invited to participate in the support groups when they approach the health centre to determine if they are pregnant, or when they come for their first check-up. They are usually allowed to participate until the child is around two years old.

since I tried to get a sample with varying characteristics<sup>16</sup> (Kapiszewski, MacLean and Read, 2015:212). The potential respondents were approached towards the end of YMG meetings, where Brenda and I had participated. By then we had familiarised with the adolescents and achieved rapport (Bryman, 2012: 218). Additionally, six key informants were sampled for the study to gather context related information (full list in annex A). An overview of study participants is presented in table 2.

<b>Study participants</b>	<b>Number of interviews</b>
Respondents: Adolescent or young women (age 15-21)	16
Key informants: Staff at health facilities	3
Key informants: with experience from working with adolescents and youth in Bolivia	3
<b>Total</b>	<b>22</b>

Table 2: Descriptions of interview data sources.

### 5.3.3 Interviews

The main data collection technique of the study was semi-structured, in-depth interviews with respondents. These took the form of *interpretive interviews*, since I wanted to understand respondents' reality and hear their experiences, rather than questioning the truth in what they said (Hallin and Helin, 2018). Keeping in mind that a pregnancy and potential experiences of stigma can be both traumatic and personal, the interviews were individual. They were conducted in the health facilities right after, or the day after, the YMG meetings in a quite, private setting to make respondents feel safe enough to share their stories, suggested by Dickson-Swift et al (2007: 338). As advised by Bryman (2012), an interview guide was elaborated to ensure some core questions were included in each interview (annex B). Key informant interviews were more *dialogue oriented* (Hallin and Helin, 2018), as I sought deeper understandings of the local context, potential cultural boundaries, and societal power structures. All interviews lasted between 20-60 minutes.

---

<sup>16</sup> The varying characteristics referred to were for example a mix of pregnant and mothering adolescents, indigenous and non-indigenous (based on clothing), and a varied age-span in terms of what age they were when they got pregnant (from 15 to 19 years of age).

## 5.4 Data analysis and triangulation

With the participant's approval, all interviews were recorded to get full and trustworthy records of everything that was said (Kapiszewski, MacLean and Read, 2015: 227). The interviews with respondents were transcribed verbatim and later coded through a selective coding technique (Bryman, 2012: 569), using the four manifestations of stigma as core codes to which categories of experiences were integrated. Throughout this process I was also open to emerging themes, which could be grouped into new categories. The transcripts were coded manually using NVivo12.

To ensure trustworthiness and credibility, triangulation was used as a technique for comparing and confirming interview data from respondents and key informants interviews (Bryman, 2012: 390). However, in line with the epistemological and ontological assumptions of the study, everyone's perception and interpretation of reality are considered different, thus the experiences shared by respondents should be considered real, although complex. In order to understand them as well as possible, I have provided so-called *thick description* of the case (Tracy, 2010; Bryman, 2012).

## 5.5 Limitations

There are several factors that introduced limitations and potential biases to the research that need to be addressed. Time constraints and external factors beyond my control limited the scope of the study since I was only able to visit one YMG meeting at each health centre.<sup>17</sup> This limited me from getting to know participants better and make more structured ethnographical observations, which was originally planned. The fact that all interviews were conducted in Spanish, my third language, limited my ability to notice implicit meanings of local words or sayings. This was partly overcome by having Brenda present in the interviews since she could pick up on these. Another important limitation was the decision to only include adolescents between the ages of 15-19 years, since it leaves out experiences of younger adolescent girls who might be even more stigmatized for their situation.<sup>18</sup>

A potential bias to the study is the fact that it was carried out in health facilities. Research suggests that PMAs may experience stigmatizing treatments in these settings and therefore choose to avoid them, which limits the study in its ability to reach these adolescents. In the

---

<sup>17</sup> The YMG meetings were conducted either monthly or every two weeks and were only starting up again after the holiday season, which stretched from December to mid-February in Bolivia.

<sup>18</sup> Suggested by key informant: Neva

same line, given that the sample consists of participants in YMG, the study misses the views and experiences of girls that do not partake in such activities. However, most respondents had only been to one or two YMG meetings prior to the interview, giving them little time to feel the intended strengthening effects<sup>19</sup> of them.

## 5.6 Ethical considerations and consent

Given the sensitive nature of the topic and the vulnerable situations the adolescents live in, several ethical concerns were reflected on continuously throughout the research process. In terms of *procedural ethics* (Tracy, 2010), respondents were informed of the purpose and intended use of the study, as well as their right to confidentiality, and right to withdraw from the study at any time. To formalize this, a consent form was signed by every participant<sup>20</sup> (annex C). To safeguard respondents from exposure all names of PMAs have been changed. The research was approved verbally by Dr Narda Malaga at the Bolivian Department of Health and later authorized in writing (annex D). Furthermore, directors (or interim staff) at the health facilities gave permission to the study in person and by signing an authorization form (annex E).

Regarding *situational ethics*, which are often subtle, unpredictable concerns that come up during fieldwork (Tracy, 2010), a key factor of the study was the participation of Brenda in every interview. As mentioned, she was invited to offer professional, emotional support to the respondents during interviews, which was considered highly important to avoid doing harm. Both Brenda and I stayed attuned to any signs of discomfort or refusal that respondents might have displayed during interviews, as suggested by (Kapiszewski, MacLean and Read, 2015: 226). If this was expressed, we took a break, changed topic, or went back to other themes that the respondent had seemed to be empowered by.

When leaving Cochabamba and the fieldwork site and while writing the thesis, *exiting ethics* (Tracy, 2010). As advised by Olesen (2005), I considered my use of language and ways of presenting results to not distort the voices of the participants. Furthermore, I was careful not to portray respondents as victims, which is a stereotype about women often re-produced by research in developing countries (Mohanty, 1988: 333). Lastly, to make the study relevant,

---

<sup>19</sup> Suggested by key informants: Argemis and Thelma

<sup>20</sup> According to Lund University Research Ethics (2018), a research volunteer between 15-18 years of age should consent personally to participation in the study and no consent needs to be sought from guardians.

reciprocity is considered highly important (Sheyvens and McLennan, 2014). The findings will be shared with all participating health facilities and Save the Children in Bolivia.

### **5.7 Positionality and reflexivity**

Recognising that my background and subjective understanding of things as a researcher may have influenced the study in several ways, I do not pretend I can fully represent the respondents in the study England (1994). Aware of this, and to offer transparency, it is important to reflect on my positioning during the research process (Tracy, 2010; Sheyvens and McLennan, 2014; Creswell, 2007: 26).

I believe my position as a young woman helped me connect with the respondents and talk about things that particularly occur to women, like pregnancy and childbirth. However, being a foreign researcher I did seem to make some respondents shy, and possibly reluctant to share all of their stories, especially on more personal and sensitive issues. The presence of Brenda seemed to make respondents more relaxed, and some even took the opportunity to ask her questions in her capacity as psychologist. The fact that Brenda is a young woman from the local context was considered when recruiting her to assist in interviews. These characteristics place her as an insider to the study, however her university-education and seemingly different “class” from the respondents, makes her an outsider in some aspects too (Hammet, Twyman and Graham, 2015).

## **6. Findings**

Before presenting the findings of the study, it is worth recalling the research question, which asks how pregnant and mothering adolescents in Cochabamba, Bolivia, are experiencing enacted or perceived public stigma as well as self-stigma. The chapter is organised by Pryor and Reeder's (2011) understandings of public stigma, and its cognitive, affective and behavioural elements, and self-stigma, including experiences of perceived and internalized stigma. Since indications of stigma-by-association and institutional stigma came out in the interviews as well, these will be presented briefly. Before turning to respondents' personal stories, a summary of their general living situations is outlined to give an overview and emphasize the heterogeneity of the group.

### **6.1 Demographics and living situations**

The respondents in the study were between 15-21 years of age. At the time of their interviews, seven of them were between 6-8 months pregnant and nine were already mothers, with children from 1 week to 3 years old. One of the respondents had two children. All had very different living situations, either they resided with their parents – with or without the father of the child, with the family of the father of the child, or alone with the father of the child. Three of the respondents had migrated from the countryside to work in Cochabamba, without their families. A majority grew up in Cochabamba and have their families in the city, however levels of contact with, and support from, families varied. Most of the respondents stayed in school when they got pregnant, three of them were able to finish secondary school before their belly started showing and could thus go to classes without telling teachers or peers. The women who had migrated to Cochabamba had all left school when they moved, before they got pregnant, and had no plans of taking up their studies. Most of the girls considered their education important and they showed both desire and commitment to complete at least secondary school. Some of them wanted to get a university degree too, however these plans were often interrupted by their pregnancy and they expressed varying optimism towards fulfilling them. With this general understanding of the living situations of the respondents, we turn to their experiences of stigma.

### **6.2 Experiences of public stigma**

The following section will present experiences of public stigma. According to Pryor and Reeder (2011), the basic manifestations of public stigma are negative social or psychological reactions to the stigmatised person, broken down into cognitive, affective and behavioural

reactions. Although some experiences may overlap, the findings are presented using these reactions as categories. Keeping the analytical framework in mind, the cognitive reactions are considered to take place on both societal and interpersonal levels, whereas affective and behavioural reactions are considered to take place on the interpersonal level. Before presenting the results it is worth noting that since these are the PMAs own stories, it is only *experiences* of public stigma that are presented.

### **6.2.1 Cognitive reactions**

Cognitive elements of public stigma are commonly held beliefs and stereotypes about stigmatized persons (Pryor and Reeder, 2011). Among the respondents, most recognised that adolescent pregnancy is socially looked down upon, or “mal visto” as they say. Many were aware that people talk about girls who get pregnant at a young age, and some respondents indicated that them too had participated in this form of gossiping. María, for example, explained that she could be surprised if she saw someone at the age of 13-14 being pregnant, and then comment to her friends on how young she was, before stopping to think that she should not judge. Junieth gave some examples of what people often say about PMAs.

*They say “she is going to be a child with another child” [...] or “how are you going to take care of this child?” which says that you’re not mature yet. They always say that. Or they talk badly about me or my mother, who hasn’t been able to protect me from these things [according to them].*

- Junieth

The idea that an adolescent mother is a child raising another child speaks to the strong ideals of motherhood present in the Bolivian and Latin American contexts, as suggested by Rudzik (2018) and McDermott and Graham (2005). These kinds of sayings were echoed by one of the informants (Neva) who explained that people often refer to PMA as “wawa con wawa” (child with child in Aymara<sup>21</sup>). Furthermore, Junieth’s reflections go in line with previous findings from Bolivia, suggesting that adolescent pregnancy is considered a sign of bad upbringing (UNFPA, 2016a), which will be returned to in section 6.4. Lidia’s account, below, describes experiences of people talking behind her back and judging, additionally her story reveals that the situation with the father of the child is often included in this judgement.

---

<sup>21</sup> Aymara is one of the biggest of 39 different languages spoken in Bolivia (Ethnologue, 2019).

*I have heard other people talk like this, they talk behind your back, and say bad things, like “she is like that, and he doesn’t do anything”, and all that.*

***Have you heard them say this about other girls?***

*Yes.*

***And what do you feel when you hear them saying things like this?***

*Bad. We feel bad, because every person know what to do and that’s it, other people just talk without knowing, they just invent things...*

- Lidia

According to Lidia’s story, the cognitive reactions to adolescent pregnancy seem to be mitigated or strengthened depending on her situation with her partner, which resonates with Córdova Pozo et al’s (2015) observation that adolescent motherhood is more accepted if it is within marriage. In the same line Alejandra described how both she and her parents took the news of her pregnancy with more ease since she was in a serious relationship. She also explained that the looks she sometimes got from peers and professors at school did not affect her because all of them knew she was living together with her boyfriend, suggesting this may also reduce experiences of self-stigma.

***What was it like when you found out you were pregnant?***

*Aaah haha, when I found out... mmm, I don't know, I was calm, you know, because, I was already together with my partner, and... I don't know, I was just calm. [...]*

***How did your parents react?***

*Good, because we were already together. [...] Well, not good good. But I was already pregnant. They just said “okay, that’s okay, take care of yourself”, so not happy and cheerful, but you know... normal.*

- Alejandra

In contrast, several of the respondents whom were never together with the father of the child, or had ended things with him for various reasons, witnessed of this being a factor that added to the stigmatizing treatments, like Adriana, below.

*In the case of my family, for example, I have a cousin who is a single mother. Yeah, and there were times when I listened to them talk, friends and family members, who are very close to us, [they] talked about her badly. [...]*

*Then I thought, "that’s how they're going to talk about me" and so on. So I was more or less standing by that person [the father of the child] because I was scared of hearing these things. It has taken me some effort to understand, and to say "no", that a person does not have to be ashamed of being a mother, or for becoming a mother at an early age.*

- Adriana



Adriana's statement further strengthens the notion that strong ideals of motherhood are present in the context, and the consequential stigma of single motherhood as described by Rudzik (2018) and Córdova Pozo et al (2015). Similar to this is Rosana's account, below, which suggests an adolescent pregnancy that is planned is more socially accepted.

*[...] I tell them "no, its not a baby... it's a planned baby that I wanted and my boyfriend and I want". And they go "aaah" because they think that... some are abandoned by the father, you know, and for this, people give you looks too.*

- Rosana

In accordance with Pryor and Reeder's (2011) understanding of public stigma, the cognitive reactions outlined above, may lead to affective and behavioural reactions towards the stigmatized person, which are presented in the following section.

### ***6.2.2 Affective reactions***

The affective elements of public stigma constitute emotional reactions to the stigmatized condition or person (Pryor and Reeder, 2011). This section will thus outline some of the common emotional reactions that respondents had experienced towards them. In line with McDermott and Graham (2005) this study finds that one of the most common affective reactions respondent had experienced was disappointment from parents, which seem to have been mainly related to the belief that their daughters would not finish school. Patricia and Joselyn, below, were some of the respondents who felt they had disappointed their parents:

#### ***How was it when you told your parents?***

*My mom started crying, and my father got angry. My brother too.*

#### ***Why?***

*It's because they wanted me to continue studying, and get a university degree, but I didn't think of this. I didn't know how to tell them so I waited as long as possible.*

*But then they said they wanted to get to know the father of the baby.*

- Patricia

*In school I had started to get my grades up, and my mom was proud because when I went to get my report card the teacher had congratulated her and all that. And for this she was very proud, and all of a sudden, when she found out [about the pregnancy] ... everything fell apart.*

- Joselyn

Joselyn started crying when she described this experience and just like her, many girls in the study got very emotional when talking about how they felt they had disappointed their parents. Very few blamed their parents in any way for treating them badly when hearing the news, rather they were very understanding of their reactions. represents one of several girls that postponed telling her parents because she was scared of what they might say or do. This speaks to the awareness of negative cognitive reactions to PMA, and the high levels of anticipated stigma from parents among the respondents, also found by McDermott and Graham (2005).

As described in the theory section, a common affective reaction to a stigmatised condition is fear, often based in exaggerated beliefs and stereotypes that lead people to avoid the stigmatized person (Pryor and Reeder, 2011). Notions of such exaggerated fear seem to be present in public stigma of PMA: fear among parents that PMA are a bad influence on their own daughters. As described, the fear is considered an affective reaction, however it often leads to the behavioural reaction of social rejection. Joselyn explained the following when asked if she still sees or keeps in contact with her friends:

*I thought they would distance themselves once they knew I was pregnant. You know, for being a bad influence... there are parents that tell their children to get away [from the pregnant person].*

***Is this common?***

*Yes, well, the majority, or well at least I have seen cases of this. Even to me my mom said that we should distance ourselves, or rather “I am going to end up like those girls”, because they say that she is a bad influence, I mean the mother fear her daughter is going to end up like that too.*

- Joselyn

Luckily, Joselyn was still spending time with her friends and she said they were very supportive in her pregnancy, so this was rather perceived stigma than enacted, but as she points out, avoidance is a common reaction at least among older generations. Key informants (Neva and Rolando) reiterated this by explaining that it used to be common that parents at schools would put pressure on the headmaster to expel girls who got pregnant because they did not want their daughters to be around her. However, she suggested this has changed since the Law 548 gave every child the right to finish school, thus illegalizing the practice of expulsion due to pregnancy.

### 6.2.3 Behavioural reactions

Behavioural reactions to stigmatised people are derived from the cognitive and affective reactions in people towards a stigmatized condition (Pryor and Reeder, 2011). Among the respondents' experiences there were several accounts the described behavioural reactions, ranging from people giving them bad looks and indirect or direct offensive comments, to discriminating them or abusing them verbally or physically. Almost all respondents described experiences of people looking at them or giving comments that directly or indirectly signalled disapproval with their pregnancy or motherhood, in line with previous research (Vinson and Stevens, 2014; Bermea, Toews and Wood. 2018).

*When my friends found out they said “but Adriana, what about your plans?”. They started questioning me in all kinds of ways [...] “oh Adriana, but why? You don't have to do this”, I mean they want to discourage you, or they give you indirect comments to make you feel bad. There are people like that, I don't know if they can be considered real friends actually.*

- Adriana

Going on the bus or in trufi<sup>22</sup> had exposed several girls to indirect or direct comments. Some explained that when they entered the trufi with their pregnant belly people would start talking about how wrong it is with adolescent pregnancy. Junieth, below, described experiences of direct comments and discrimination when going on the bus.

*In the bus, sometimes they don't say anything more than that they don't want to give you their seat. One man said, “you are young, you can stand”. Sometimes this has been a problem in the buses, and it's hard. [...] More than anything it's because we are pregnant and we are young. “Aa, if you have gotten pregnant so easily, then there should be no problem standing”, they say. It used to affect me a lot, but not now, now I don't care anymore.*

- Junieth

In the hospital, or at health centres, several respondents described having gotten offensive and judgemental comments from health staff, similar to treatments described by Hanna (2001) and Yardley (2008), although some experiences are considered more brusque and offensive than what previous studies have found, like Carolina and Jhenny's accounts below:

---

<sup>22</sup> Going by trufi is a common transportation mode in Cochabamba, a trufi is a small minibus with around 10 seats. It works as a bus in the sense that it usually has the same route, but picks people up depending on available space in the car.

*I came in with severe pains. And there, a nurse told me “you are still a child, why the hell did you open your legs?” [referring to having sexual intercourse]. “Now know how to endure because we are occupied”, they told me.*

- Carolina

*“Why did you get pregnant so early?”, she said. And she explained to me, “you should be playing with dolls”, “you should be in school”. That’s what the doctor told me.*

- Jhenny

Moving to experiences of social rejection, the most common rejection described by respondents was from the partner or members of the family or extended family. It could either be as a threat, or a lived experience that occurred temporarily (often in the moment the person received the news about the pregnancy), or during a longer time. Below, Sofia describes how her mother took the news when she got pregnant with her first child three years ago.

*When I was four months pregnant I told my mother. [...] She hated me then, “it’s way to early, you don’t exist to me anymore daughter”, she told me. [...] Just recently my mother started accepting me again.*

- Sofia

*When I told the boy [father of the child] he said to me, “no, you have to have an abortion”,<sup>23</sup> and I said, “no, I’m not going to abort it, this is not the baby’s fault, it’s our fault”. And he said, “well, if you’re not going to have an abortion, I’m not going to help you”.*

- Michaela

A specific tendency in public stigma of PMA, that almost all respondents described, is that it seems to change throughout the process of the pregnancy and when giving birth. Several adolescent’s explained how people in their closest surroundings, especially parents, changed their affective and emotional reactions to their pregnancy with time, especially when the baby was born, which is also found by McDermott and Graham (2005). Below, Alejandra explains how her family’s treatments changed completely when she went from being a pregnant to a mother.

---

<sup>23</sup> It should be noted that abortions illegal in Bolivia, however certain circumstances, such as being under 15 years of age or foetal disabilities incompatible with life, can be ground for approval (Oxford Human Rights Hub, 2018). In the case of Michaela it can be assumed that the father of her child suggested an illegal abortion.

*Since my baby was born, practically everything [changed]. When someone is born, all problems disappear.*

***Is that so? Why?***

*Yes, because it has to do with seeing someone, you know. Someone new to the family, it's like "wow, you are the daughter of my daughter". That's why, when my daughter was born everyone just... my father too, he forgot all his sadness. [...]  
Now they don't complain to me, or tell me "why did you get pregnant?" Now they just give me advice.*

- Alejandra

One of the gravest forms of behavioural reactions to a stigmatized condition or person is violence. Two of the girls openly said that their parents had hit them once they gave them the news. Carolina explained, as if it was rather normal, that her parents had physically punished her, and even more naturally that they had hit her partner.

*They reacted completely bad, they almost hit me, well a little bit... But they understood too. But I told them "what can I do about it?", I said. And they did hit the boy [father of the child]. [...] They hit him and they wanted to bring him to jail too, but I defended him.*

- Carolina

***How was it when you told your mother?***

*She reacted ugly. I knew she was going to get upset. She hit me. I had told her and then I went to visit her. I went there and later she hit me. There was blood and everything.*

***She hit you until you bled?***

*Mhm, from the nose. She is bad my mother.*

- Sofía

Other accounts of violence came out when the relationship with the father of the child was discussed with respondents, for example Adriana explained how she experienced domestic violence from her partner, which ultimately made her leave him. Adriana had lived in the house of her partner's family when she was a victim of domestic violence but had been able to move back home with help from her sister. Alicia still lives with the father of her child and his family, and described events that suggest psychological violence. Below, she explains how he does not let her leave the house or keep in contact with her friends and family.

***Did you stay in the university until she was born?***

*Until I was five months pregnant. Then I couldn't. Her dad told me "don't go". Because I had to go up some stairs, and he told me "you can fall, I am scared something will happen, it's better if you just stay here". I wanted to work, but he didn't want me to work either.*

*[...] He doesn't want me to have any contacts. That is why I don't have a phone at the moment. [...] I can't have any contact with my friends, at times not even with my mother, when I am living in his house.*

- Alicia

Alicia explained that she felt incarcerated living under her partner's roof, and that he always had to accompany her if she was going anywhere. When organizing the interview we asked for her number in case we needed to get in contact, she then gave her mother's number, suspecting that her partner might ask questions if we were to contact her on his phone.

### **6.3 Experiences of self-stigma**

Going back to theory, it is worth reiterating that public stigma impacts the self in three ways; through enacted, perceived, and internalized stigma, which become *self-stigma* (Pryor and Reeder 2011; Bos et al., 2013). While the previous section on public stigma mainly described enacted stigma, this section will focus on how perceived stigma affects the person being stigmatised. Both enacted and perceived stigma may lead to an internalisation process in which PMAs endorse the stigma makes it relevant to herself (ibid). Considering the analytical framework of the study, enacted stigma is understood to occur both on interpersonal and individual levels since the enacted stigma may become self-stigma. However, the actual internalisation that follows upon the enacted stigma occurs on an individual level, as well as experiences of perceived stigma.

#### ***6.3.1 Perceived stigma***

Perceived stigma is described as the experiences of anticipation of being stigmatized (Pryor and Reeder, 2011). In line with previous research (Macvarish 2010; Fessler, 2008; Ellis-Sloan, 2014) the findings suggest that experiences of perceived stigma may be just as bad as enacted stigmatising treatments. Some examples of experiences of perceived stigma are given below, but note also that some have already been mentioned.<sup>24</sup>

---

<sup>24</sup> For example, Adriana who *anticipated* people would talk bad of her if she left her partner and became a single mother, or Joselyn who *thought* her friends in school would distance themselves due to their parents' fear of a bad influence to their daughters.

***How did your professors react to the news?***

*They took care of me a lot. [...] It felt good because I thought they would... I don't know, that when they learned I was pregnant, they would discriminate me, or something. But no, it wasn't like that, everyone supported me, they encouraged me.*

- Michaela

*I was a bit scared of my friends. [...] Because some of them were still studying, and, well, because of that I was scared to go to my village, you know, pregnant. Maybe they would have laughed or something.*

- Jhenny

Below, Pilar explains how she feared she would be thrown out of the house when her parents learned she was pregnant, so she decided to move out before she told them.

***Why did you decide to move away from your parents?***

*Because in the beginning, when I was living in their house, I thought that they would have thrown me out. So I thought "no" and I just felt safer with him [the partner], so I moved there when I found out I was pregnant.*

*[...] So then, one month or so after I left home [...] then we went to my parents and told them I was pregnant.*

- Pilar

**6.3.2 Processes of internalization**

A third way in which self-stigma is experienced is through internalising the stigma (Pryor and Reeder, 2011). By internalising the stigma the PMA, in this case, endorses it and applies it to herself (ibid). This section outlines how some of the girls agreed with, i.e. endorsed, the public stigma and how they felt embarrassed or guilty for their situation. As a first example, Junieth, below, reflects on the discriminating treatment she received at the hospital during her pregnancy. In the interview she did not mention exactly what health staff had said or done to her, but for a moment she debated whether or not this treatment could have been justified.

*You don't know what they will do to you, you ask and they treat you badly. Especially us [adolescents or youth], because they say things like... I don't know, maybe they are right but they don't have to say it so brusquely. [...]*

***Why do you say that maybe it's right?***

*Because maybe they have a good reason; we have gotten pregnant at a very young age. But either way, I don't think they should treat us that way.*

- Junieth

Sofia, who has given birth to two children (at 15 and 18 years old), compares some of her experiences between the two pregnancies, below. She felt guilty for getting pregnant the first time and in the way she thinks of herself then, it can be considered she endorses the public stigma of PMA. Note that she uses the same words as Junieth (section 6.2.1) when describing generally held opinions about adolescent pregnancy.<sup>25</sup>

*With this one [her second child] I was happy. I didn't want the first one. But after a while I accepted that I was to blame for getting pregnant, because I didn't protect myself, that's what I realized. [...]*

***But did you feel guilty the first time?***

*Yes, for getting pregnant... I was just a baby raising another baby.*

- Sofia

Theory suggest that feelings of shame or guilt are common in the internalization process, as is loss in self-esteem and self-worth, as described by Wiemann et al (2005). Apart from Sofia, several other respondents also explained how they experienced these feelings, due to the stigmatized situation they were in.

*When people look at me I feel bad, I feel embarrassed, because I have to be like this and, I don't know... walk around like this.*

- Carolina

***What is the future you want for your daughter?***

*That she is a professional. That she doesn't commit the same mistake I did.*

- Patricia

The statement from Patricia shows that she has endorsed the general belief that a pregnancy in your adolescence is a mistake. In a way Patricia also seem to believe that her own chance of becoming a professional, i.e. go to university and have a career, was taken away once she got pregnant, which suggest a lost faith in herself.

The findings presented above indicate that self-stigma is experienced in many different ways by pregnant and mothering adolescents, which goes in line with previous findings (Yardley, 2018). Before moving to analysis, findings on stigma-by-association and institutional stigma will be presented. Guided by the research question, the study did not specifically investigate

---

<sup>25</sup> In the beginning of the chapter, section 6.2.1, Junieth mentions that a common cognitive reaction to a PMA is that she is a "child raising another child".



stigma-by-association or institutional stigma of PMA, but since indications of the two manifestations came out during interviews, these findings are presented below.

#### **6.4 Indications of stigma-by-association**

Revisiting the analytical framework of this study, stigma-by-association can be considered to be experienced on an individual level, but by individuals closely associated with the stigmatized individual (Pryor and Reeder, 2011), thus not the PMA herself. For this reason the following section does not describe experiences of stigma-by-association, it rather draws on indications that this kind of stigma is present. One example of this is Pilar's statement:

*I don't know but I think that my parents were bothered when I came home to see them. It seemed like they didn't want me to come there when I was pregnant, because they didn't want people looking judgmentally at them, I think. [...]  
My sister gave me sweatshirts, wide ones, for me to put on when we had to go to the market [...]. My mom gave me sweatshirts too, "put this on" she told me.*

- Pilar

Pilar's experience suggests that her mother or sister might have experienced stigma-by-association, or rather perceived stigma-by-association. In the case of Pilar, her family members made her cover up to avoid stigmatizing treatments of her and themselves. What seems to be more common though, is that the adolescents themselves take the initiative to cover up or hide, to avoid the stigmatization of their family members, as in the case of Alicia:

*I was scared my uncles would see me [...] and that they would say to my mom "how can you have let her get pregnant?", that they make my mother feel bad. I was scared of that, and sometimes I didn't want to leave my house because of it.*

- Alicia

That the stigmatized individual changes her behaviour or social participation to avoid embarrassment of family members have been suggested by Guo et al (2012) in their study on stigma of patients with epilepsy. However, no such findings have been made in research on stigma of PMA.

#### **6.5 Potential effects of institutional stigma**

Institutional stigma is understood as socio-political forces that directly or indirectly legitimize and perpetuate the status of stigmatized people through, for example, laws (Pryor and Reeder, 2011). As mentioned in section 6.2.2 the findings of this study indicate that Law 548 in this

case seem to have reduced institutional stigma, by illegalizing the formerly common practice of expelling pregnant adolescents from schools. This will be elaborated further in the analysis section, which follows below.

## **7. Analysis**

Drawing on the findings of the study, this chapter sets out to respond the research question asking how pregnant and mothering adolescents in Cochabamba, Bolivia, are experiencing enacted or perceived public stigma as well as self-stigma. The discussion will suggest connections between stigma of PMAs in the Bolivian context to its' constructed gender roles and stigma of adolescent sexuality. For clarity, the discussion follows the same structure as the findings section, based in Pryor and Reeder's (2011) categorisation. The chapter ends with suggestions on how to elaborate the theoretical model.

### **7.1 Public stigma**

The findings suggest that respondents were well aware of the public negative idea about adolescent pregnancy, understood as cognitive reactions as an element of public stigma (Pryor and Reeder, 2011). However, respondents appear to have been affected and reacted differently to it, as previous research have suggested (Goffman, 1963; Yardley, 2008). Most girls, both the more and less affected, seemed to get used to the looks and some expressed that it used to bother them but it does not anymore. This indicates that, while the public stigma may persist, the negative effects that PMAs experiences from it are diminishing.

Several respondents' experiences of public stigma appear to have been influenced by their relationship or situation with the father of the child. Respondents, who were in a stable relationship with their partners, seem to experience less judgment and public stigma than adolescent who were single mothers. In the case of Alejandra (section 6.2.1), being in a relationship also seem to give her more confidence in coping with potential public stigma, thus reducing experiences of self-stigma. Another respondent, Adriana (section 6.2.1) explained how she stayed with her partner because of what people say about single mothers, suggesting a form of 'identity repair work' (Rudzik, 2018) to fit the ideals of good motherhood. These findings suggest that stigma of PMA is connected to both stigma of adolescent sexual activity and single motherhood, in line with what (De Meyer et al, 2014) and Paulson and Bailey (2003) suggest.

In terms of adolescent sexual activity, previous studies and theories explain that adolescent pregnancy renders sexual activity visible (De Meyer et al, 2014; Paulson and Bailey, 2003), and as the findings indicate; signs of being sexually active, i.e. having a pregnant belly, is labelled differently depending on if you are in a relationship or not. Furthermore, Rosana

(section 6.2.1) explained that she told people her baby was planned in order to avoid judgement. The suggested social acceptance of planned pregnancies, goes in line with the culture of *marianismo* and the norm that women should only have sex within marriage, or relationships in this case, and mainly for reproduction, otherwise it should be concealed (Chant and Craske, 2003). Thus, it seems to be more socially accepted to have been sexually active if you are in a stable relationship.

Furthermore, several respondents described how some stigmatizing treatments from their closest surrounding, especially family members, had decreased and almost disappeared once their baby was born. This pattern was found by McDermott and Graham (2005) too, who argue that potentially broken family relations are often restored after a while. Arguably, it may also be the simple factor of time that eventually makes people get used to new situations. However, going back to the valorisation of women as mothers, as explained by Chant and Craske (2003) and Rudzik (2018), it could be argued that this has an impact on the social processes of stigma of PMA. As proposed by previous research (Córdova Pozo et al, 2015; Alfonso, 2008) some adolescents want to get pregnant since becoming a mother means gaining the status of an adult. Thus, stigma-components of status loss and discrimination may to some extent be countered by the potential status-gain of becoming a mother.

The findings suggest that experiences of negative cognitive, affective and behavioural reactions from family members influenced respondents the most, in line with Stutterheim et al (2009) and Guo et al (2012). Stigmatising treatment from family members did not just expose the adolescents to emotional distress but sometimes also practical issues, such as looking for a place to live if the family rejected them. Some girls reported being beaten by their parents for becoming pregnant, which can be considered one of the gravest forms of behavioural reactions. Other studies on stigma of PMA (Yardley, 2008; McDermott and Graham, 2005),<sup>26</sup> also emphasise the importance of family support, however they do not report accounts of physical punishment as a common reaction. Furthermore, physical and psychological violence from partners were experienced by some of the girls. While previous literature (UNFPA, 2013) suggest there is a relationship between adolescent pregnancy and higher risks of violence, this study cannot confirm this given its design. However, stories shared by some of the girls indicate that they live in vulnerable situations in which a violent relationship might be hard to escape from. Furthermore, since the alternative of becoming a single mother

---

<sup>26</sup> Both studies were conducted in Great Britain.

potentially means further stigma (Rudzik, 2018; Córdova Pozo et al, 2015), enduring violence might seem like an easier option.

With regards to public services, respondents described experiencing support rather than stigmatizing treatments from professors, which goes against previous studies on stigma of PMAs in school environments (Wiemann et al, 2005; Bermea, Toews and Wood, 2018).<sup>27</sup> The findings suggest that in relation to school environments, most respondents described experiences of perceived rather than enacted stigma. However, this was strong enough to make respondents reluctant to disclose their pregnancy to teachers. In health facilities, experiences of public stigma appear to be more frequent, and respondents' experiences of behavioural stigma seem to be brusquer than what has been found in postmodern societies (Hanna, 2001; Yardley, 2008). Furthermore, the findings suggest that stigmatizing treatments were somewhat punitive, from both health staff and the general public. For example, some behavioural reactions to PMA included making them stand in the bus, which they were told should be easy for them since they had "gotten pregnant so easily". In a similar way some were told they should "know how to endure" in the hospital. By penalising PMA a lot of blame is put on them for their situation. Furthermore, the reactions ignore the possibility that adolescent pregnancies are sometimes planned, which supports Wilson and Huntington's (2005) and Alfonso's (2008) claim about the general discourse on adolescent pregnancy shaping it as a mistake rather than a conscious choice. It is worth noting that none of the girls mentioned being treated badly by the staff that lead or participate in YMGs, which supports the call for specialised health staff and the need for differentiated care, made by the PPEAJ (2015) among others.

## **7.2 Self-stigma**

Turning to the processes of self-stigma, Pryor and Reeder (2011) explain that public stigma impact the self through enacted perceived and internalized stigma. The findings of this study resonate with what previous research has concluded; perceived stigma might have just as strong consequences as enacted stigma of PMAs (Macvarish 2010; Fessler, 2008; Ellis-Sloan, 2014). Throughout the interviews, several respondents explained how they *thought* their parents would reject them, or hit them, that their friends would laugh at them or avoid them, or that their professors would punish them in some way. Although these anticipations had turned out to be unwarranted, they still had an impact on how the respondents were feeling or

---

<sup>27</sup> Both studies were conducted in the USA.

behaving. Furthermore, common experiences of perceived stigma indicate that the negative social understanding of adolescent pregnancy and motherhood is deeply engrained in the adolescents themselves before becoming pregnant or mothers, and they are aware that people, including themselves, look down on women in this situation.

With this awareness of public stigma the step to internalizing it, i.e. endorsing it and making it relevant to the self, is not far. During the interviews several respondents used the negative terminology often applied to PMAs about themselves, which suggest an endorsement of public stigma. Furthermore, some agreed with the social understanding that pregnancy or motherhood in your adolescence is a mistake, which is a discourse that PMAs in Vinson and Stevens (2014) research also seem to return to. Additionally, most respondents seem to agree the adolescence is not the adequate age for having a baby. However, some respondents questioned the way others treated them, like Junieth (section 6.3.2) who argued that her age does not justify health staff's bad treatment of her. Other respondents stated that it is not other peoples' business to judge. Thus, while the respondents did seem to experience an internalisation of the public stigma, they were also able to question it and stand up for themselves.

Despite showing signs of resistance, the findings suggest that the enacted or perceived stigma had an impact on respondents and made the experience losses in self-worth, as theorised by Pryor and Reeder (2011) and found in several other studies (Wiemann et al, 2005; Bermea, Toews and Wood, 2018). Several respondents described feeling embarrassed and guilty for their situation, however it was not made completely clear whether these feelings derived from enacted and/or anticipated stigma, or if it was related more to disappointing their parents or themselves in their life plans. Although, it should be noted that most respondents saw education as important and wanted to have a degree and career, thus what Alfonso (2008) suggest about some adolescents choosing to become pregnant given the lack of alternatives or future prospects, does not seem to apply to respondents in this study. However varying support from families made the adolescents more or less optimistic of this future.

Lastly, an important finding is that experiences of self-stigma seem to have been more negative among respondents who were aware of or anticipated that people closely associated to them were subjected to stigmatizing treatments, i.e. stigma-by-association. Some adolescents described that they felt sorry for doing this to their family, or for bringing shame

upon their mother, which shows an awareness or anticipation that public stigma has or will reach persons closely associated with them. The findings suggest that respondents who feared their family members would be affected by stigma-by-association, experienced additional guilt and distress. Some respondents also described how they stayed inside to avoid bringing shame upon their family, or particularly their mother, which goes in line with Guo et al's (2102) suggestion that stigmatized individuals shape their behaviour to avoid exposing family members to embarrassment for their condition. However, this study cannot explain experiences of stigma-by-association, thus more research is needed to confirm this suggested inter-relationship. Nonetheless, the following section will discuss indications of stigma-by-association, in the Bolivian context.

### **7.3 Stigma-by-association**

The strongest signal indicating that stigma-by-association occurs in relation to adolescent pregnancy, was that some adolescents described how their family members participated in trying to hide the adolescent's pregnancy. This indicates that they too experience enacted or perceived stigma. Furthermore, it goes in line with UNFPA's (2016) study of adolescent pregnancy in 14 Bolivian municipalities, which explained that adolescent pregnancy is often considered a sign of bad upbringing, in other words a judgement of parents. Tying in to the discussion about public stigma and its relation to gender roles and stigma of adolescent sexuality, it could be discussed whether this "failure in upbringing" is related to the gender roles that are constructed at young age, suggested by Chant and Craske (2003) and Krauskopf (1999). The culture of oppositional gender roles and sexualities involves a much stricter control of girls than boys (ibid), thus it could be assumed that when an adolescent daughter becomes pregnant parents are stigmatized much more than if their adolescent son was to impregnate someone or become a father. Furthermore, adolescent men are encouraged to have several sexual partners and it is considered macho to "have children everywhere" (Córdova Pozo et al, 2015), thus neither themselves nor their family members are stigmatized for this. However, the lack of stigma of fathering adolescents and their family members could also be explained by the fact that they do not display the stigmatized label of a pregnant belly.

### **7.4 Institutional stigma**

Although Pryor and Reeder (2011) suggest that institutional stigma is stigma upheld by laws and policies, findings in the study suggest that laws may have the potential to reduce public stigma too. It is suggested that Law 548 might have had a reverse effect on stigma, by giving

every child and adolescent the right to an education, thus indirectly illegalising the discriminatory practise of expelling pregnant girls from schools. In this sense, Law 548 can be discussed as an example of how laws might be able to reduce, discriminatory and stigmatizing practices. Further, by not responding to suggested demands from the public, it limits the space where public stigma can flourish. This suggests elaborations of Pryor and Reeder's (2011) model, which will be discussed in the following section.

### **7.5 Elaborating the theoretical model**

When using Pryor and Reeder's (2011) model to understand stigma of PMA some adjustments can be suggested. The scholars describe public stigma to be the root of stigma, and from this, self-stigma, stigma-by-association and institutional stigma are derived (ibid). The findings of this study suggest, however, that institutional stigma seems to feed into public stigma too, suggesting there is a mutually strengthening relationship between these two manifestations that is not found from stigma-by association and self-stigma to public stigma. This elaboration is based on the potential positive effects of Law 548, which was just discussed. Furthermore, a similarly strengthening tie is suggested from stigma-by-association to self-stigma since findings indicate that some respondents felt increased guilt or shame, i.e. self-stigma, by knowing or anticipating that people closely associated with them would be stigmatized too. In this sense enacted or perceived stigma-by-association feeds into self-stigma, causing potential additional negative effects in the stigmatized individual. Revising Pryor and Reeder's (2011) model and the analytical framework, these processes might already be implied since all manifestations of stigma are considered interlinked, as illustrated by arrows. However, the suggested specific processes are not mentioned or elaborated on by the scholars, and would thus be interesting to investigate further. More suggestions for future research will be given in the end of the conclusions section, which we turn to now.



## **8. Conclusion**

The purpose of this study was to develop a deeper understanding of how stigma is experienced by pregnant and mothering adolescents in Cochabamba, Bolivia. Going back to the research question, the study sets out to explore how pregnant and mothering adolescents in Cochabamba, Bolivia, are experiencing enacted or perceived public stigma as well as self-stigma. This section will revisit and discuss the research question based on the analysis, and suggest areas for future research.

### **8.1 Concluding remarks**

This study has found that experiences of enacted and perceived public stigma were lived by all participating PMA to some extent, and all were aware about the general negative beliefs and cognitive reactions towards adolescent pregnancy and motherhood in the Bolivian context. Experiences of judgement and looks from others, however, seemed to have a diminishing influence on the participants. A common experience was that the public stigma, including reactions from parents, was milder if the PMA was in a stable relationship with the father of the child, or if the child was planned. This made some consider staying with partners and thus engage in a form of identity repair work, to fulfil ideals of motherhood. In line with previous research, this study finds that family support is an important factor in experiences of stigmatizing treatments. Most PMA experienced both perceived and enacted public stigma from families, in the form of affective reactions of disappointment. Some also experienced behavioural reactions of physical punishment from parents. The study finds that other forms of punitive behavioural reactions were also experienced from health staff and the general public, which presumes that adolescent pregnancies are unintended and puts blame on the PMA for the situation. On a positive note, few respondents experienced enacted public stigma in their school environment, which might be an effect of the rather new Law 548 in Bolivia, giving every child and adolescent the right to an education. However, perceived stigma from teachers and peers made some PMA reluctant to disclose their pregnancy, and some avoided going to school.

Furthermore the study concludes that self-stigma was experienced by many PMA as a consequence of both enacted and perceived stigma, in line with previous research. The findings suggest that while the public stigma was often endorsed, judgment and/or stigmatizing treatments were also questioned and considered unfair. Nevertheless, some

respondents explained feelings of embarrassment and guilt for the situation they were in, and sometimes also a lost faith in themselves. The findings of the study further suggest that experiences of guilt and shame may get worse from enacted or perceived stigma-by-association of people closely associated to the PMA, which might impact her social participation. Thus, findings suggest that manifestations of stigma-by-association may have negative impact on self-stigma.

To this background the thesis can conclude that experiences of enacted and perceived public stigma as well as self-stigma may in several ways be a risk to PMA's healthy development and a barrier to reaching their full potential. While this risk is generally applied directly to the "problem" of adolescent pregnancy and motherhood, the thesis proposes that social and internalised processes of stigma may constitute important factors leading to this suggested outcome. The findings indicate that strong ideals of motherhood and norms about female sexual activity, present in the Bolivian context, add to the negative social understanding causing both enacted and perceived public stigma of PMA. However, interventions from the state, in the form of laws or specialised training of health staff, might work to counteract the on-going stigmatization of PMA. Nonetheless, future research is yet to determine this, which brings us to final section of the thesis.

## **8.2 Suggestions for future research**

Throughout this study several gaps in research and lack of perspectives were found, this section will comment on these and suggest further research. First of all, there are few in-depth studies about stigma of PMA conducted in other countries than postmodern societies. Although this study finds that experiences of stigma among respondents in Bolivia go in line with many of these studies, stigma is context-based and in order to get a broader understanding of the issue more contexts should be studied. This is an issue of representation and whose voices are heard, in the shaping of, for example, policies and interventions. On that note, more studies with adolescents own perspectives are suggested, especially investigating stigma of PMA who are under the age of 15. Some themes that emerged specifically from this study that need further research are; how PMAs, or in general the original stigma holder, is affected by the stigma-by-association that may occur in her surroundings. This implies that more research is needed on how stigma-by-association is experienced. Additionally, as suggested above, more research is needed on how public stigma may be reduced through policies or interventions.

## 9. References

- Alfonso, M. (2008). *Girls just want to have fun? Sexuality, pregnancy and motherhood among Bolivian Teenagers*. New York: Inter-American Development Bank
- Barcelos, C. A. and Gubrium, A. C. (2014) Reproducing Stories: Strategic narratives of teen pregnancy and motherhood. *Social Problems*, 61:3, p. 466-481
- Bermea, A. M., Toews, M. L., and Wood, L. G. (2018). “Students getting pregnant are not gonna go nowhere”: Manifestations of Stigma in Adolescent Mothers’ Educational Environment. *Youth and Society*, 50:3, p. 423-436
- Bos, A. E. R., Pryor, J. B., Reeder, G. D. and Stutterheim, S. E. (2013). Stigma: Advances in Theory and Research. *Basic and Applied Social Psychology*, 35, p. 1-9
- Bryman, A. (2012). *Social research methods*. (4th ed.). New York: Oxford university press.
- Castro Mantilla, M. D. and Salinas Mulder, S. (2017). Diagnóstico de Situación del Embarazo en la Adolescencia en la Subregion Andina 2016. [online] ORAS and UNFPA. [accessed 2018-12-12] Available from:  
<https://www.adolescenciasema.org/ficheros/GRUPOS%20DE%20TRABAJO/SITUACION%20DEL%20EMBARAZO%20EN%20LA%20ADOLESCENCIA%20ANDINA%20%202016.pdf>
- Carvacho, I. E., Mello, M. B., Morais, S. S., Silva, J. L. (2008). Factors associated with access to health services prior to pregnancy by pregnant adolescents. *Rev Saude Publica* 2008:42, p. 886-94
- Chant, S. and Craske, N. (2003). *Gender in Latin America*. New Brunswick: Rutgers University Press
- Córdova Pozo, K. C., Chandra-Mouli, V., Decat, P., Nelson, E., De Meyer, S., Jaruseviciene, L., Vega, B, Segura, Z., Auquilla, N., Hagens, A., Van Braeckel, D., and Michielsen, K. (2015). Improving Adolescent sexual and reproductive health in Latin America: reflections from an International Congress. *Reproductive Health*, 12:11
- Creswell, J. W. (2007). *Qualitative Inquiry & Research Design: Choosing Among Five Approaches* (2. ed.). Thousand Oaks, CA: SAGE
- Cupples, J. (2013). *Latin American Development*. London: Routledge
- Dain, N. (1994). Reflections on antipsychiatry and stigma in the history of American psychiatry. *Hospital and Community Psychiatry*, 45:10, p. 1010-1014

- De Meyer, S., Jaruseviciene, L., Zaborskis, A., Decat, P., Vega, B., Cordova, K., Temmerman, M., Degomme, O., and Michielsen, K. (2014). A cross-sectional study on attitudes toward gender equality, sexual behaviour, positive sexual experiences, and communication about sex among sexually active and non-sexually active adolescents in Bolivia and Ecuador. *Global Health Action*, 7:1, p. 1-10
- Dickson-Swift, V., James, E. L., Kippen, S., and Liamputtong, P. (2007). Doing sensitive research: what challenges do qualitative researchers face? *Qualitative Research*, 7:3, p. 327-353
- Duncan, S. (2007). 'What's the problem with teenage parents? And what's the problem with policy?' *Critical Social Policy*, 27:3, p. 307-334
- Ellis-Sloan, K. (2014). Teenage Mothers, Stigma and Their 'Presentations of Self'. *Sociological Research Online*, 19:1, p. 1-13
- England, K. V. L. (1994). Getting Personal: Reflexivity, Positionality, and Feminist Research\*. *Women in the Field*, 46 (1), p. 80-89.
- Ethnologue (2019) Bolivia [online] ethnologue.com [accessed 2019-05-04] Available from: <https://www.ethnologue.com/country/BO>
- Fessler, K. B. (2008). *Reclaiming a spoiled maternal identity: Young mothers' experiences and rejection of stigma*. (Unpublished doctoral dissertation). Ann Arbor, MI: University of Michigan.
- Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall
- Guo, W., Wu, J., Wang, W., Guan, B., Snape, D., Baker, G. A., and Jacoby, A. (2012). The stigma of people with epilepsy is demonstrated at the internalized, interpersonal and institutional levels in a specific sociocultural context: Findings from an ethnographic study in rural China. *Epilepsy and Behavior*, 25, p. 282-288.
- Hanna, B. (2001). Negotiating motherhood: the struggles of teenage mothers. *Journal of advanced nursing*, 34: 4, p.456-464
- Hallin, A. and Helin, J. (2018). *Intervjuer*. Lund: Studentlitteratur
- Hammett, D., Twyman, C., and Graham, M. (2015). *Research and fieldwork in development* [online]. London: Routledge, Taylor & Francis Group
- Hoogendam, P. and Boelens, R. (2019). Dams and Damages. Conflicting Epistemological Frameworks and Interests Concerning "Compensation" for the Misicuna Project's Socio-

Environmental Impacts in Cochabamba, Bolivia. *Water*, 11:408

ICPD (1994). *Programme of Action*. [online] unfpa.org [accessed 2019-03-11] Available from: [https://www.unfpa.org/sites/default/files/pub-pdf/programme\\_of\\_action\\_Web%20ENGLISH.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf).

ISAGS-UNASUR (2017). Unintended pregnancy among adolescents in South America. Rio de Janeiro: ISAGS-UNASUR

Jaruseviciene, L., Orozco, M., Ibarra, M., Cordova Ossio, F., Vega, B., Auquilla, N., Medina, J., Gorter, A. C., Decat, P., De Meyer, S., Temmerman, M., Edmonds, A. B., Valius, L., and Lazarus, J. V. (2013). Primary healthcare providers' view on improving sexual and reproductive healthcare for adolescents in Bolivia, Ecuador, and Nigaragua. *Global Health Action*, 6:1, p. 1-8

Kapiszewski, D., MacLean, L. M., and Read, B. L. (2015). *Field Research in Political Science: Practices and Principles*. Cambridge Books Online

Kelly, D. (1996). Stigma stories: Four discourses about teen mothers, welfare and poverty. *Youth and Society*, 27:4, 421-449

Kearney, M. S. and Levine, P. B. (2012). Why is the teen birth rate in in the United States so high and why does it matter? *Journal of Economic Perspectives*, 26:2, p. 141-63

Krauskopf, D. (1999). El desarrollo psicológico en la adolescencia: las transformaciones en una época de cambios. *Adolescencia y Salud*, 1:2

Langer, A. and Nigenda, G. (2000). *Sexual and Reproductive Health and Health Sector Reform in Latin America end the Caribbean: Challenges and Opportunities*. Mexico: Population Council/Inter American Development Bank

Law 548: *Estado Plurinacional de Bolivia, Ley 548 Código Niño, Niña, Adolescente*, 2014. [online] derechoteca.com [accessed 2019-04-17] Available from: <http://www.derechoteca.com/gacetabolivia/ley-no-548-del-17-de-julio-de-2014/>

Luttrell, W. (2003). *Pregnant Bodies, Fertile Minds: Gender, Race and the Schooling of Pregnant Teens*. New York: Routledge

Link, B. G. and Phelan J. C. (2001). Conceptualizing Stigma. *Annual Review Sociology*, 27, p. 363-385.

Lund University Research Ethics (2018). Research ethics information [online]. Lund University [accessed 2018-10-28]. Available from: <https://www.researchethics.lu.se/research-ethics-information/informed-consent/incapacity-to-give-informed-consent>

- Macvarish, J. (2010). Understanding the Significance of the Teenage Mother in Contemporary Parenting Culture. *Sociological Research Online*, 14:4
- Mander, H. (2010). ‘Words from the Heart’: Researching People’s Stories. *Journal of Human Rights Practice*, 2(2), p. 252-270
- Marston, A. J. (2013). Autonomy in a post-neoliberal era: Community water governancy in Cochabamba, Bolivia. *Geoforum*, 64, p. 246-256
- McDermott, E. and Graham, H. (2005). Resilient young mothering: Social inequalities, late modernity and the “problem” of teenage motherhood. *Journal of Youth Studies*, 8:1, p. 59-79
- Miles, A. (1981). *The Mentally Ill in Contemporary Society*. Oxford: Martin Robertson
- Mohanty, C. T (1988). Under Western Eyes: Feminist scholarship and colonial discourses. *Feminist review*, 30:1, p. 61-88
- Neal, S., Harvey, C., Chandra-Mouli, V., Caffè, S., and Camacho, A. V. (2018). Trends in adolescent first births in five countries in Latin America and the Caribbean: disaggregated data from demographic and health surveys. *Reproductive Health*, 15:146, p. 1-10
- Nencel, L. (1996). ‘Pacharachas, Putas and Chicas de su Casa: Labelling, Femininity and Men’s sexual self in Lima, Peru’ in Melhuus, M. and Stølen, K. A. (eds.) *Machos, Mistresses, Madonnas: Contesting the Power of Latin American Gender Imagery* (p. 56-82). London: Verso
- Novilla, M. L. B., Dearden, K. A., Crookston, B. T, De La Cruz, N., Hill, S., and Torres, S. B. (2005). Adolescents Engaging in Risky Sexual Behaviour: Sexual Activity and Associated Behavioral Risk Factors in Bolivian Adolescents, *International Electronic Journal of Health Education*, 2006:9, p. 42-55
- Olesen, V. (2005). Early millennial feminist qualitative research: Challenges and contours. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 235-278). Thousand Oaks, CA: SAGE.
- Oxford Human Rights Hub (2018). Abolition of Social Grounds for Abortion in Bolivia [online] [ohrh.law.ox.ac.uk](http://ohrh.law.ox.ac.uk) [accessed 2019-05-13] Available from: <https://ohrh.law.ox.ac.uk/abolition-of-social-grounds-for-abortion-in-bolivia/>
- PAHO, UNFPA and UNICEF (2016). Accelerating progress toward the reduction of adolescents pregnancy in Latin America and the Caribbean. Washington: Pan American Health Organization/United Nation Population Fund/United Nations Children’s Fund

- PPEAJ (2015). Plan Plurinacional de Prevención de Embarazos en Adolescentes y Jóvenes (2015-2020). La Paz: Estado Plurinacional de Bolivia - Ministerio de Justicia
- Pryor, J. B., and Reeder, G. D. (2011). 'HIV-related stigma' in Hall, J. C., Hall, B. J., and Cockerell, C. J. (eds.), *HIV/AIDS in the post-HAART era: Manifestations, treatment, and epidemiology* (p. 790-806). Shelton, CT: People's Medical Publishing House.
- Rudzik, A. (2018). Mothering, identity construction, and visions of the future among low-income adolescent mothers from São Paulo, Brazil. In Taylor, T and Bloch, K. (eds.) *Marginalized Mothers, Mothering from the Margins*. Online: Emerald Publishing Limited
- Santhya, K. G. and Jejeebhoy, S. J. (2015). Sexual and Reproductive health and rights of adolescent girls: Evidence from low- and middle-income countries. *Global Public Health*, 10:2, p. 189-221
- Save the Children (2017). Campaña Hasta la Última Niña – El Embarazo Adolescente desde una Mirada Joven: Sistematización de Conversatorios realizados en La Paz, Beni y Cochabamba. La Paz: Save the Children
- Schutt-Aine, J. and Maddaleno, M. (2003). Sexual Health and Development of Adolescents and Youth in the Americas: Program and Policy Implications. Washington, DC: PAHO
- Sheyvens, R. and McLennan, S. (2014). Introduction. In Sheyvens, R. (ed.) *Development Fieldwork: A Practical Guide*. (p. 1-16). London: SAGE
- Stutterheim, S. E., Pryor, J.B, Bos, A. E., Hoogendijk, R., Muris, P. and Schaalma, H.P. (2009). HIV-related stigma and psychological distress: the harmful effects of specific stigma manifestations in various social settings. *AIDS*, 23:17, p. 2353-2357
- Tracy, S. J. (2010). Qualitative Quality: Eight “Big-Tent” Criteria for Excellent Qualitative Research. *Qualitative Inquiry*, 16:10, p. 837-851
- UN (2015). Transforming our world: the 2030 Agenda for Sustainable Development [online] Sustainable Development Knowledge Platform [accessed 2019-02-11]. Available from: <https://sustainabledevelopment.un.org/post2015/transformingourworld>
- UNFPA (2013). Adolescent pregnancy: A Review of the Evidence. New York: UNFPA
- UNFPA (2015). Girlhood, not motherhood: Preventing Adolescent Pregnancy. [online] [unfpa.org](https://www.unfpa.org/publications/girlhood-not-motherhood) [accessed 2019-03-14] Available from: <https://www.unfpa.org/publications/girlhood-not-motherhood>

- UNFPA (2016a). Estudio sobre el embarazo en la adolescencia en 14 municipios en Bolivia. La Paz: UNFPA
- UNFPA (2016b) and Ministerio de Autonomías. Maternidad temprana, pobreza y violencia en Pando: un reto para las autonomías. Cobija: Ministerio de Autonomías
- UNFPA (2019). Sexual and reproductive health [online] unfpa.org [accessed 2019-05-02] Available from: <https://www.unfpa.org/sexual-reproductive-health>
- Vinson, J. and Stevens, S. Preventing pregnancy OR supporting students? Learning from the stories of young mothers. *Sexual Research and Social Policy*, 11, p. 322-336
- Wiemann, C. M., Rickert V. I., Berenson, A. B., and Volk, R. J. (2005). Are pregnant adolescents stigmatized by pregnancy? *Journal of Adolescent Health*, 36, p. 352-357
- Wilson, H. and Huntington, A. (2005). Deviant (M)others: The Construction of Teenage Motherhood in Contemporary Discourse. *Journal of Social Policy*, 35:1, p. 59-76
- WHO (2006). Defining sexual health. Geneva: World Health Organisation
- WHO (2018). Adolescent Pregnancy. [online] who.int [accessed 2019-03-22] Available from: <https://www.who.int/en/news-room/fact-sheets/detail/adolescent-pregnancy>
- World Bank (2019a) Adolescent fertility rate [online] data.worldbank.org [accessed 2019-04-23] Available from: <https://data.worldbank.org/indicator/sp.ado.tfrt>
- World Bank (2019b) Adolescent fertility rate: Bolivia [online] data.worldbank.org [accessed 2019-04-27] Available from: <https://data.worldbank.org/indicator/SP.ADO.TFRT?locations=BO>
- Yardley, E. (2008). Teenage mothers' experiences of stigma. *Journal of Youth Studies*, 11:6, p. 671-684



## Annex A: Detailed list of key informants

Note: All key informants gave their consent to being mentioned by name in the thesis.

Name	Capacity
Neva Terrazas	Employee at Save the Children in Bolivia (at the time of the interview). Has experience from working with children and adolescents in various NGO's in Bolivia, and the target group of pregnant and mothering adolescents.
Rolando Zapata	Employee at Save the Children in Bolivia. Works with the programme Mamas Jóvenes (Young Mothers) that support YMGs in health facilities in Cochabamba, has several years of experience working with youth empowerment.
Joaquín Mamani Fuentes	Responsible for the Programa de Atención Integral Diferenciada para adolescentes y jóvenes - AIDAJ (Programme of Integral Differentiated Attention [in healthcare] for Adolescents and Youth) in the city of El Alto.
Argemis Hernández Crúz	Auxiliary nurse at Centro de Salud España in Cochabamba. Has experience from running the YMGs at the centre since the programme start more than 3 years ago.
Felicidad de la Crúz	Licenced nurse at Centro de Salud Alalay in Cochabamba. Has experience from running the YMGs at the centre for 2 years.
Thelma Rodriguez Diaz	Doctor at Centro de Salud K'ara K'ara in Cochabamba. Has experience from running the YMGs at the centre for 2 years.

## **Annex B: Interview guide**

For English, see below.

---

### **Primero: Informed consent!**

Tienes alguna pregunta?

Quieres decir algo antes que empezamos?

### **Antecedentes de la participante:**

- Cuantos años tienes?
- De donde eres? (de Cochabamba, del campo, de un municipio etc)
  - o Quieres decirme un poco de como es allá?
- Como es tu situación de vida en el momento?
  - o Donde vives? con quien? Trabajas? Estudias? Etc.
  - o Como es tu relación/situación con el padre del bebe?
  - o Como sostienes económicamente?
    - Recibes el bono Juana Azurduy?
- Cuales son tus intereses? Que te gusta hacer?
- Tienes algunas metas en tu vida? Cuales son? Porque es una meta?

### **Bueno empezamos desde el inicio:**

Como sabia que estaba embarazada?

Que sentiste en este momento?

Quien era la primera persona que contaba? Porque dijiste a ella/el?

Como reaccionó frente las noticias?

### **Desde que embarazaste has sentido algunos cambios en tu persona?**

Como?

Porque crees que has sentido esto?

### **Desde que embarazaste ha cambiado algo en tu vida cotidiana?**

(Por ejemplo tus estudios, tu vida social, tus costumbres, etc).

### **Sigues en la escuela?**

Has sentido algunas diferencias de tratamiento desde que embarazaste/dio luz?

Cuales / como?

### **Como fue cuando hablaba con tus padres, como han reaccionado?**

- como te hacía sentir?

### **El padre del bebe/tu pareja:**

- Como ha reaccionado el frente las noticias?
- como te hacía sentir?

**De que has notado tu, cual es la opinión general sobre el embarazo adolescente en la comunidad?**

- Que opinas tu sobre esta opinión?
- Conoces a otras chicas que también están embarazadas?

**Quieres explicarme un poco como fue cuando empezó a crecer tu panza?**

- Que sentiste en esta momento?

**Si ya es mama: Como fue cuando diste luz? Donde fue? Como era tu experiencia?**

**Si sigue embarazada: como ha sido ir a tus controles?**

**Sientes que has sido tratado diferente o mal por ser embarazada o mama joven?**

- En que manera?
- Nos quieres compartir un poco de estas experiencias?

**Hay algo que quieres añadir?**

**Tienes alguna pregunta?**

In English

---

**First: Informed consent!**

Do you have any questions?

Do you want to say something before we start?

**Background of the participant:**

- How old are you?
- Where are you from? (from Cochabamba, the countryside, a municipality, etc.)
  - o Do you want to tell me a bit about how it is there?
- How is your life situation at the moment?
  - o Where do you live? with whom? Do you work? Do you study? Etc.
  - o How is the situation with the father of the baby?
  - o How do you sustain yourself economically?
    - Do you receive the Juana Azurduy bonus?
- What are your interests? What do you like to do?
- Do you have some goals in your life? Which are? Why is it a goal?

**We start at the, at the beginning:**

How did you know you were pregnant?

What did you feel at that moment?

Who was the first person you told? Why did you tell him/her?  
How did he/she react to the news?

**Since you got pregnant have you felt some changes in yourself as a person?**

How?

Why do you think you have felt like this?

**Since you got pregnant, has something changed in your daily life?**

(For example your studies, your social life, your customs, etc).

**Are you still in school?**

Have you felt any differences in treatment since you got pregnant / gave birth?  
What / how?

**How was it when you told your parents, how did they react?**

- How did it make you feel?

**The father of the baby / your partner:**

- How did he react to the news?
- How did that make you feel?

**From what you have noticed, what is the general opinion about adolescent pregnancy in the community?**

- What do you think about this opinion?
- Do you know other girls who are also pregnant?

**Do you want to explain to me a little bit about what it was like when your belly started to grow?**

- What did you feel at this moment?

**If she is already a mother: How was it when you gave light? Where was? How was your experience?**

**If she is still pregnant: how has it been to go to your controls?**

**Do you feel that you have been treated differently or badly because of being pregnant or young?**

- In what way?
- Do you want to share a little of these experiences?

**Is there something you want to add?**

**Do you have any question?**

## Annex C: Written consent form

For English, see below.

---

### **Consentimiento informado para participantes del estudio 'Estigma y discriminación en el embarazo adolescente y maternidad temprana'**

Al firmar este documento yo ..... acepto participar en la investigación cerca de experiencias de estigma y discriminación durante el embarazo adolescente y maternidad temprana en Cochabamba, Bolivia. La investigación es conducida por Josefin Edberg y la información obtenida por ella será incluida en su tesis de maestría de la Universidad de Lund, Suecia.

Me han indicado que mi participación implicará participar en una entrevista de aproximadamente una hora, en lo cual tengo que responder preguntas sobre mis experiencias personales del embarazo y/o maternidad. He sido informada que la entrevista será individual pero que participará la psicóloga Brenda Roxana Pinto Bautista juntamente con la investigadora, para ofrecer apoyo emocional durante o después de la entrevista, siempre y cuando sea necesario. Entiendo que todo lo que diga durante la entrevista estará bajo confidencialidad de la investigadora y la psicóloga. Acepto que la entrevista sea grabada por la investigadora y que la grabación sea únicamente utilizada por ella, y que sea eliminada después de ser usada a los fines específicos indicados en el actual documento.

Reconozco mi derecho a mantener anónima mi identidad, durante la investigación y en el producto final que será la tesis de maestría de Josefin Edberg. Me han explicado que puedo hacer preguntas durante todo el proceso de la investigación, que puedo negarme a responder ciertas preguntas durante la entrevista si no me siento cómoda, y que puedo retirarme de la misma en cualquier momento. Además, tengo el conocimiento de que puedo retirarme de la investigación sin tener que dar una razón de esta decisión. Si surgieran preguntas sobre el estudio o acerca de mi participación puedo contactar la investigadora con los datos provistos abajo.

Finalmente, he sido informada, que puedo pedir información sobre los resultados del estudio cuando éste haya concluido. Puedo contactar a la investigadora Josefin Edberg al teléfono: 7320-6079 (o +4673 997 07 45) o al correo electrónico: josefin.edberg@gmail.com.

Entiendo que yo y la investigadora tendrán una copia de esta ficha.

Lugar y fecha:

\_\_\_\_\_  
Participante

\_\_\_\_\_  
Investigadora

\_\_\_\_\_  
Firma de la participante

\_\_\_\_\_  
Firma de la investigadora

**Informed consent for participants of the study**  
**‘Stigma and discrimination in adolescent pregnancy and motherhood’**

In signing this document, I ..... agree to participate in research on experiences of stigma and discrimination during adolescent pregnancy and early motherhood in Cochabamba, Bolivia. The research is conducted by Josefin Edberg and the information obtained by her will be included in her master's thesis at the University of Lund, Sweden.

I have been told that my participation will involve participating in a one-hour interview, in which I have to answer questions about my personal experiences of pregnancy and/or motherhood. I have been informed that the interview will be individual but that psychologist Brenda Roxana Pinto Bautista will participate together with the researcher, to offer emotional support during or after the interview, if and when necessary. I understand that everything I say during the interview will be kept confidential by the researcher and psychologist. I agree that the interview be recorded by the researcher and that the recording be used only by her, and that it be removed after being used for the specific purposes indicated in the current document.

I recognize my right to keep my identity anonymous, during the research and in the final product that will be Josefin Edberg's master's thesis. I have been told that I can ask questions throughout the research process, that I can refuse to answer certain questions during the interview if I don't feel comfortable, and that I can withdraw from the interview at any time. In addition, I am aware that I can withdraw from the research without having to give a reason for this decision. If questions arise about the study or about my participation, I may contact the researcher with the information provided below.

Finally, I have been informed that I can ask for information about the results of the study when it is completed. I can contact the researcher Josefin Edberg by telephone: 7320-6079 (or +4673 997 07 45) or by e-mail: josefin.edberg@gmail.com.

I understand that I and the researcher will have a copy of this record.

Place and date:

\_\_\_\_\_

Participant

\_\_\_\_\_

Investigator


\_\_\_\_\_

Participant's signature

\_\_\_\_\_

Investigator's signature.

## Annex D: Ethics clearance

  
*Estado Plurinacional de Bolivia*  
*Ministerio de Salud*

La Paz, 14 de Mayo de 2019  
**MS/VMSyP/DGSS/URSSyC/ACON/CE/112/2019**

Señora  
Lic. Josefín Edbger  
ESTUDIANTE UNIVERSIDAD DE LUND SUECIA  
**Presente.-**


*Ref.: Estudio sobre las experiencias de estigma y discriminación  
al rededor del embarazo y la maternidad en la adolescencia*

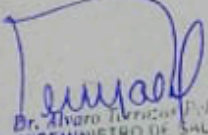
De nuestra mayor consideración:




A tiempo de saludarle, tenemos a bien comunicar que en el marco de la Constitución Política del Estado, la Ley N° 548 Código Niño Niña Adolescente, Ley N° 342 Ley de la Juventud y el Plan Plurinacional de Prevención de Embarazo Adolescente y Joven 2015-2020, el Área del Continuo de la Atención dependiente de la Unidad de Redes de Servicios de Salud y Calidad de la Dirección General de Servicios de Salud del Ministerio de Salud, esta interesado en conocer los resultados del "Estudio experiencias de estigma y discriminación alrededor del embarazo y la maternidad en la adolescencia", que su persona viene desarrollando en el territorio del Estado Plurinacional de Bolivia.

Con este motivo, seguros de contar con su intervención nos despedimos.

Atentamente,

  
**Dr. Oscar Velasquez Encinas**  
DIRECTOR GENERAL DE SERVICIOS DE SALUD  
MINISTERIO DE SALUD

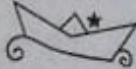
  
**Dr. Alvaro Velasco Peltier**  
VICEMINISTRO DE SALUD  
Y PROMOCION  
MINISTERIO DE SALUD

C/Arch  
AMR

---

Tel: Edif. Central 2407079 - 2495086 - 2490564 - 2495083  
Tel: Viceministerio de Salud 2492048 - 2491702      Site Web: [www.minsalud.gob.bo](http://www.minsalud.gob.bo)  
Tel: Viceministerio de Medicina Tradicional 2900288

 # MarParaBolivia  
# EIMarNosUne

## Annex E: Authorization form – Directors of health facilities

For English, see below.

---

### **AUTORIZACIÓN - ESTUDIO DE MAESTRÍA SOBRE EL ESTIGMA Y DISCRIMINACIÓN ALREDEDOR DEL EMBARAZO Y MATERNIDAD ADOLESCENTE**

Señor / Señora,

Me dirijo a Ud. respetuosamente a objeto de solicitar una aprobación para realizar un estudio con el grupo de mamás jóvenes en su centro de salud. La investigación servirá para mi tesis de maestría del programa interdisciplinario “*Desarrollo y Gestión Internacional*” de la Universidad de Lund, Suecia. El objetivo del estudio es saber más acerca del estigma social del embarazo y maternidad adolescente, su origen, como afecta a las adolescentes y sus pensamientos del futuro; para este propósito, deseo hacer entrevistas a adolescentes embarazadas y/o mamás, y saber más acerca de sus experiencias de embarazo, si es que hubieran vivido algún estigma y en este caso como lo ha manejado para seguir adelante.

El estudio deseo realizar con un grupo de aproximadamente 20 madres jóvenes y adolescentes embarazadas de varios centros de salud en Cochabamba donde se implementan grupos para mamás jóvenes. La participación de las adolescentes será completamente voluntaria y antes de cada entrevista se informará a la participante de su derecho a la anonimidad, y su opción de interrumpir la entrevista en cualquier momento en caso de no sentirse cómoda. En cada entrevista participará una psicóloga o trabajadora social para atenuar los recuerdos o emociones doloras que pudieran surgir durante las entrevistas. Finalmente, el estudio se desarrollará cumpliendo las normas éticas establecidas por la Universidad de Lund.

Agradeciendo su gentil aceptación con las consideraciones más distinguidas.

Atentamente,

Josefin Edberg

Lugar y fecha: Cochabamba,

---

Nombre

---

Firma



**AUTHORIZATION – MASTER’S DEGREE STUDY ON STIGMA AND DISCRIMINATION AROUND ADOLESCENT PREGNANCY AND MOTHERHOOD**

Sir / Madam,

I respectfully address you in order to request approval to conduct a study with the group of Young Mothers at your health facility. The research will be used for my master’s thesis in the interdisciplinary programme “International Development and Management”, at the University of Lund, Sweden. The aim of the study is to learn more about the social stigma of adolescent pregnancy and motherhood, its origin, how it affects adolescents and their thoughts of the future; for this purpose, I wish to interview pregnant and/or mothering adolescents, and to learn more about their experiences of pregnancy, whether they have lived any stigmatizing situation and, in that case, how they managed it to move forward.

I aim to carry out the study with a group of approximately 20 young mothers and pregnant adolescents, from several health centres in Cochabamba where groups for young mothers are implemented. Participation of the adolescents will be completely voluntary and before each interview the participant will be informed of her right to anonymity, and her option to interrupt the interview at any moment should she not feel comfortable. A psychologist or social worker will participate in each interview to alleviate painful memories or emotions that may arise during the interviews. Lastly, the study will be carried out in compliance with the ethical standards established by the University of Lund.

Thanking you for your kind acceptance with the most distinguished considerations.

Attentively,

Josefin Edberg

Place and date: Cochabamba,

---

Name

---

Signature