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"They Will be Mothers"

PERCEPTIONS AND PRACTICES OF MIDWIVES TOWARDS ADOLESCENTS WITH AN UNWANTED PREGNANCY IN PERU

Author: Tessa Stockburger
Supervisor: Prof. Agnes Andersson Djurfeldt

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ABSTRACT

Pregnancy decisions are notably connected to maternal well-being, particularly for groups disproportionately affected by unplanned and unwanted pregnancies such as adolescents. Midwives are health professionals most likely to care for a pregnant adolescent in a public healthcare setting and spend the most time with her during her pregnancy. However, there are no studies in Peru of the perceptions and practices towards unwanted pregnancies from the perspective of midwives who can have a direct influence on the outcome of adolescent pregnancy.

This thesis uses semi-structured interviews and an online survey to identify the perceptions and practices of midwives towards pregnant adolescents with a particular focus on unwanted pregnancy. By using Bourdieu's 'theory of practice', this thesis uncovers some of the social structures and beliefs in the midwifery field that shape the practices of midwives.

This qualitative study demonstrates how an adolescent's desirability of her pregnancy impacts the perceptions and practices of midwives. Midwives in this study perceived the adolescent's desirability of her pregnancy as ambivalent and fluid. Midwives would often support and encourage adolescents in accepting their pregnancy and motherhood. These perceptions and practices are influenced by a number of mechanisms explored in this study.

Key Words: Midwives, Adolescent Pregnancy, Unwanted Pregnancy, Unplanned Pregnancy, Healthcare Practices, Perceptions, Reproductive Rights, Peru, Lima, SRH, Reproductive Autonomy, Bourdieu, Doxa

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LIST OF ABBREVIATIONS

CSO	Civil Society Organization
ENDES	National Household Survey
EsSalud	The Peruvian Health and Social Security
KI	Key Informant
MDGs	Millenium Development Goals
MINSA	Ministry of Health
NGO	Non-Government Organization
NMPI	National Maternal Perinatal Institute
NSM	National School of Obstetricians/Midwifery
SDGs	Sustainable Development Goals
SIS	Comprehensive Health Insurance
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
THS	Technical Health Standard *(for the Comprehensive and Differentiated Care of the Adolescent Gestant during Pregnancy, Childbirth and Puerperium)*
UNFPA	Population Fund of the United Nations
WHO	World Health Organization

1. INTRODUCTION

Providing access to reproductive health care is critical in improving maternal health. Maternal health services are directly linked to maternal mortality, where it has been recognized that maternal deaths are preventable as they often stem from insufficient healthcare during pregnancy or delivery (WHO, 2019). The reduction and improvement of maternal mortality and morbidity are priorities of the global health and international development agendas being integrated in the Millennium Development Goals (MDGs) and have continued in the Sustainable Development Goals (SDGs) agenda for 2030 (United Nations, 2016). Furthermore, it is important to acknowledge that not all populations or groups exercise the same level of access to reproductive health care or reproductive autonomy[1], such as adolescents. The reduction of inequalities and focusing on vulnerable groups is fundamental in the most recent, 'leaving no one behind' strategic framework of the SDGs (United Nations, 2016).

Social norms regarding pregnancy decisions (parenting, adoption, and abortion) are notably connected to maternal well-being, particularly for groups disproportionately affected by unplanned and unwanted pregnancies such as adolescents (Rice et al., 2017). However, there are no studies of the perceptions and practices of health care professionals towards adolescent's pregnancy decisions in Peru. Midwives in many circumstances have a direct influence on the information and options provided to a pregnant adolescent. Furthermore, social structures are likely to influence the services and information midwives provide to a pregnant adolescent in particular health settings. In the context of Peru, midwives are the most likely health professional to provide prenatal care and sexual and reproductive health (SRH) services to a pregnant adolescent (INEI, 2019). Midwives present a fundamental resource in maternal health and this study aims to demonstrate how their practices are often embedded in and limited by social structures.

This study will analyze perceptions and social norms operating at the institutional level, specifically the field of midwifery through midwives, how it manifests and how it is managed

[1] Reproductive autonomy is having the power to decide and control contraceptive use, pregnancy, and childbearing (Bixby Centre, 2020).

(e.g. provision of information, social exclusion, counseling, social distancing, coercion, avoidance etc.). This study will build on Bourdieu's concepts of 'habitus' and 'fields', and identify patterns influencing the perceptions of midwives that are likely to guide practices. This study will demonstrate how reproductive health and autonomy in the midwifery field is deeply contextual in Peru.

1.1 Definitions

Many definitions exist when referring to adolescents. However, most define adolescents by an age range. The World Health Organization (WHO) defines adolescents as individuals from 10 to 19 years old (2020). However, this thesis uses secondary data from the last National Household Survey in Peru 2018, that included individuals from 15 to 19 years old as adolescents (INEI, 2019). For the purpose of this study, adolescents will be defined as individuals aged 15 to 19. This will ensure consistency with both primary and secondary data presented.

In addition, an unplanned pregnancy will be defined as one that occurred when an adolescent had not intended to become pregnant (Santelli et al., 2003). Unwanted pregnancies in this study are pregnancies that are not desired (Ibid). In comparison, a wanted pregnancy is a pregnancy that is desired. Often studies have lumped unwanted and unplanned pregnancies in the same category, however this study makes a distinction between the two and considers both separately whilst still acknowledging that they can often overlap (D'Angelo et al., 2004).

Stigma is defined by Goffman (1963, in Parker & Aggleton, 2003:14) as an attribute that is significantly discrediting. Generally, stigma includes beliefs that lead to social exclusion and discrimination of other people due to differences in sexual orientation, ethnicity, behavior, age, etc. (UNAIDS, 2017), with the individual possessing an undesirable difference compared to norms that are culturally accepted by a social space (Kinsler et al., 2007).

Lastly, the International Confederation of Midwives (ICM) definition of 'Midwife' has been used for the purpose of this study. Where a midwife is identified as a person who has succesfully completed a midwifery educational program that is recognized by the state, in the country where it is taught as well as received the required qualification to be registered and/or legally licenced

to practice obstetrics (ICM, 2017). In Peru, a midwife or 'obstetra' is required to complete an undergraduate degree of 5-6 years in the field of obstetrics and be registered with the National School of Obstetricians/Midwives (NSM) to practice in state institutions as a midwife (Universities of Peru, 2020).

1.2 Why Adolescent Pregnancy?

The WHO has classified adolescent pregnancy as a major health risk. Complications during pregnancy and at the time of delivery are the main causes of death among adolescent mothers between 15 and 19 in middle-income countries, such as Peru (World Bank, 2019). Higher risks of maternal complications include eclampsia, postpartum, hemorrhaging, pregnancy-induced hypertension, anemia, systemic infections, and pre-term delivery as compared to pregnant adult women (Shahabuddin et al., 2016; Brown & Eisenberg, 1995). Pregnant adolescents of 15-19 years old have between a 17% to 28% greater risk of dying than women older than 20 years old (Nove, et al. 2014). In addition, babies born to adolescent mothers are much more likely to suffer from low birth weight, early neonatal deaths and injuries (Shahabuddin, et al., 2016; Brown & Eisenberg, 1995). Although adolescent pregnancy is often discussed as a public health problem it often goes beyond health, having wider social and economic implications. Studies demonstrate that pregnancies during adolescence can have negative social and economic effects on adolescents, their families and communities due to school-dropout and subsequently reduced opportunities in the labor market (Brown & Eisenberg, 1995; Shahabuddin et al., 2016; WHO, 2019). Evidently pregnancy in adolescence has the potential to harm development, life projection and sexual and reproductive health (Defensoria del Pueblo, 2019).

In addition, adolescent pregnancies are much more likely to be unplanned and unwanted than adult pregnancies (UNFPA, 2019; INEI, 2019). Unwanted pregnancies present a number of additional health risks and are considered high-risk for both the pregnant adolescent and the potential baby (Yazdkhasti et al., 2015). Adolescents with unwanted pregnancies experience higher rates of suicide, depression, poor nutrition during pregnancy, unstable family relationships, experiencing physical and psychological violence, delayed onset of prenatal care, risk of miscarriage and having infants with low birth weight (Ibid).

Collecting data on unplanned and unwanted pregnancies can be difficult and often figures can vary. However, it is accepted that adolescents in Peru disproportionately experience unplanned and unwanted pregnancies. In an interview in 2018, the Population Fund of the United Nations Peru (UNFPA) reported that approximately 50% of adolescent pregnancies were unwanted and another study reported 25.1% (Echaiz et al., 2018). Then for unplanned pregnancies among adolescents, figures are even greater from 56.1% to 68.2% (Echaiz et al., 2018; INEI, 2019 respectively). Ultimately, unplanned and unwanted pregnancies magnify the physical and mental health risks as well as societal challenges, further marginalizing a population that was already very vulnerable.

This study does not wish to take away the fundamental importance in preventing adolescent pregnancy but acknowledges that adolescent pregnancy and unwanted pregnancies are unlikely to entirely disappear. Thus, the healthcare provided to this population should not be neglected. Perceptions and practices of health professionals can influence the wellbeing and reproductive autonomy of pregnant adolescents (Recto et al., 2018). This is an area where research falls short in Peru but is significant considering the vulnerable circumstances adolescent pregnancy often manifests.

1.3 Why Midwives?

In Peru, midwives are essential for the delivery of integral SRH services and are the health professionals most likely to be in contact with a pregnant adolescent (INEI, 2019). According to the last National Household Survey (ENDES) in 2018, for adolescents giving birth under 20 years old, 81.8% received prenatal care by a midwife for their last birth (INEI, 2019). This is compared to 24.1% of adolescents who received prenatal care from a doctor and 10.9% of adolescents who received prenatal care from a nurse (Ibid). With more than 37,500 midwives in Peru, midwives fulfill important functions for the health of pregnant women, mothers and newborns, performing prenatal controls, delivery, postpartum, newborn care and other SRH services (NSM, 2019). Midwives are also critical in providing family planning services, which are essential for pregnant adolescents in preventing or spacing a second pregnancy (Ibid). Being the most likely to provide SRH services and information to pregnant adolescents, midwives are a fundamental resource in maternal health of adolescents. Furthermore, the NSM Peru has

committed to strengthening the capacity for women and adolescents to care for themselves through comprehensive SRH services (Ibid).

It is well documented that attitudes of health professionals may positively or negatively impact the utilization of health services undoubtedly shaping health outcomes (Rice et al., 2017). In addition, considering the social tendency to make pregnancy decisions that maintain approval from close others (Ibid), stigma regarding unplanned and unwanted pregnancy may manifest in forms of reproductive coercion such as pressure to terminate a pregnancy, pressure to choose adoption, or pressure to continue with an unwanted pregnancy (Ibid). No studies have been carried out on the social norms and perceptions of midwives towards adolescent pregnancy in Peru.

1.4 Aim and Research Questions

In Peru, midwives are often the first health professional to consult a pregnant adolescent and usually the health professional that spends the most time with the adolescent during her pregnancy (INEI, 2018). This study aims to document and analyze the experiences and perceptions midwives have towards adolescent pregnancy, particularly unwanted pregnancies and how this may affect how midwives respond.

The study will address the following 3 research questions (RQs):

1. How do midwives perceive their role in relation to pregnant adolescents?
2. Why do midwives consider the adolescent's desirability of their pregnancy important in shaping health outcomes?
3. How and why does the adolescent's desirability of their pregnancy affect midwives' perceptions and practices towards the adolescent?

1.5 Structure of Thesis

The following chapter presents a review of relevant literature and the background to the study, including an overview of adolescent pregnancy and healthcare in Peru as well as the current health standards and laws that intersect both. Chapter 3 lays out the theoretical framework and the concepts that this study will use to analyze the findings. Chapter 4 details the research design and methodology used for this study including the two methods used, the sampling, the data collection process and the reliability of data. Chapter 4 also includes the positionality, ethical considerations and the limitations of the study. Chapter 5 encompasses the findings and analysis that will be structured around the three RQs with thick accounts from the midwives. This thesis will end with Chapter 6 which summarizes and draws from the theoretical underpinnings of this study.

2. PREVIOUS RESEARCH & BACKGROUND

Smith et al. (2016) and Cook & Dickens (2014) demonstrate that women's decisions at the time of an unplanned pregnancy are constrained by multiple factors, such as intimate partner relationships and socioeconomic resources. Social norms and stigma regarding unplanned and unwanted pregnancies and pregnancy options also play an important role in how women experience and respond to an unplanned pregnancy (Ibid). Pregnant adolescents are much more likely to be criticized for their pregnancy status than pregnant adults and studies have identified fear of judgment as a common factor preventing health-seeking behavior[2] among pregnant adolescents (Recto et al., 2018).

2.1 Hindered Health-Seeking Behavior

Health establishments are often resources where pregnant adolescents may seek SRH information and services. However, evidence has demonstrated that people who experience or fear stigmatization in the healthcare setting may avoid seeking healthcare services (Cook & Dickens, 2014; UNAIDS, 2017). Furthermore, the quality of interactions with health providers may hinder or facilitate pregnant adolescents from health-seeking behaviors. In addition, the information and services provided to pregnant adolescents can undoubtedly have an impact on their sexual health and reproductive autonomy.

There have been a number of studies that have demonstrated how stigma can seep into healthcare services resulting in individuals being feared avoided, regarded as deviant and even blamed for engaging in immoral behaviors (Cook & Dickens, 2014). This type of social climate can be devastating to members of vulnerable populations who have a stigmatized trait or condition that needs medical healthcare (Ibid).

[2] Health-seeking behavior is the patterns of decision making in seeking and later utilizing health services (Clewley et al., 2018). This process is often influenced by various relationships, community norms and expectations of services (Ibid).

2.2 Legal Structures

The law is also important to consider as it can produce or perpetuate stigma. The law is often used for the purpose of deterring behavior considered socially undesirable by producing the stigma of criminality (Cook & Dickens, 2014). For example, abortion internationally has traditionally been stigmatized to some extent on moral grounds and there are conservative agencies, particularly inspired by religious convictions that are committed to uphold these beliefs using political dialogue and the law (Ibid). It is well understood that the personal guilt, humiliation and shame that stigmatized individuals or groups may experience can compromise their physical, mental and/or social well-being. (UNAIDS, 2017).

2.3 Healthcare in Peru

Peru has a mixed healthcare system of both public and private healthcare delivery (Zschock, 2018). The public sector has two types of national insurance including SIS (Comprehensive Health Insurance) provided by the Ministry of Health and EsSalud (The Peruvian Health Social Security), which is obtained through employment (MINSA, 2014a, 2018). EsSalud provides health insurance to the employed population and their dependents. EsSalud is funded by employer contributions that equal 9% of active employees' salaries. Approximately 26.7% of the population benefits from EsSalud (Ibid). SIS is the largest health insurance provider in Peru and by December 2015, more than half of the population of 31 million was insured by SIS (Ibid). SIS is targeted towards people without health insurance and with a particular focus of citizens living in high levels of poverty in both rural and urban regions. Under the Ministry of Health (MINSA), pregnant women that are uninsured are covered by the free SIS program during their pregnancy and 42 days after giving birth (Ibid). Consequently, a large portion of SIS recipients are pregnant women. SIS is primarily financed by general budget resources. Peru has set a target to have 100% universal insurance coverage by 2021 (Ibid).

In analyzing the distribution of health care facilities in Peru, it is notable that healthcare facilities are heavily concentrated in the major urban coastal areas of Peru particularly Lima and Callao. The capital, Lima has 55% of all hospital beds available despite having 31% of the Peruvian population (Zschock, 2018). Health centers are better distributed than hospitals, however the

need for them still exceeds their supply in both rural and urban areas of the country (Ibid). Furthermore, in comparison to other Latin American countries, Peru has been noted as one of the least efficient and least equitable in the use of its health sector resources (Ibid). Peru uses 75% of its health sector resources to support expensive urban hospitals, and only 25% for low cost health centers that provide primary health care to its urban and rural poor. As a result, 6 million Peruvians have no access to public state health services (Ibid).

2.4 Adolescent Pregnancy in Peru

The rate of adolescent pregnancy in Peru has remained high and stable with no significant changes despite decreases in overall fertility rates (INEI, 2019). This is according to the latest National Household Survey (2018), where 12.6% of girls in the age group 15-19 are mothers or pregnant at the time of the survey. The fertility rate for adolescent pregnancy in the last 5 years has indicated stable prevalence seeing only an incremental decrease of 1.3% from 13.9% to 12.6% not considered significant (Ibid). In respect to the causes of death for pregnant adolescents, hypertension followed by abortion are the main direct causes of maternal mortality and the primary cause of indirect mortality is suicide which in Peru increased from 39% in 2010 to 44% in 2012 (Del Carpio, 2013).

Adolescents in Peru are likely to experience limited reproductive autonomy. This is in the context where sexual education is maintained as a taboo (Motta, 2017), where access to therapeutic abortion[3] is highly restrictive and where adolescents have the lowest rates of contraceptive use and experience the highest rates of sexual violence (INEI, 2019). Utilization of contraception tends to be much lower among adolescents in comparison to adults. This may be explained due to a lack of knowledge of contraceptive methods, taboos around contraceptives, structural barriers as well as reduced decision making and autonomy among adolescent girls (Shahabuddin, et al., 2016). Efforts in prevention of adolescent pregnancy are critical, however providing healthcare to already pregnant adolescents is also essential considering the on-going prevalence and elevated health risks of this population.

[3] Therapeutic abortion as defined in Peru is the legal procedure to interrupt a pregnancy when the woman's life or health is at risk with her informed consent (PromSex, 2019).

2.5 Determinants of Adolescent Pregnancy

Adolescent pregnancy in Peru must be viewed through an intersectional lens where economic, social and political resources are unevenly distributed. Resources are exercised among girls in making health decisions about their bodies, sexuality and reproductive choices (WHO, 2017). Rural and indigenous populations experience lower economic incomes and reduced access to government services including health facilities (INEI, 2019; Armenta-Paulino, et al. 2018). Thus, women in rural areas and indigenous women are less likely to use modern contraceptives than urban, non-indigenous women (Armenta-Paulino, et al. 2018). Rural populations have a much higher percentage of adolescent pregnancy than urban populations with 22.7% compared to 9.8% in urban areas (INEI, 2019). The median age of first sexual relationship is also earlier in rural areas aged 17 compared to 18.6 years in urban areas (Ibid). Particular geographical locations are also a key determinant where areas such as Loreto and Ucayali have a much higher percentage of adolescent pregnancy of 30.6% and 26.7% respectively (Ibid). Another key determinant of adolescent pregnancy is the wealth quintile adolescents are positioned in. According to the last ENDES (2018), 23.9% of adolescents in the lowest wealth quintile have been or are pregnant in comparison to 3.6% of adolescents in the highest wealth quintile (Ibid). These determinants provide a better understanding of the circumstances under which early pregnancy is most likely to occur.

2.6 Abortion Law in Peru

Despite generally having restrictive abortion laws, Latin America and the Caribbean are estimated to have the highest abortion rate in the world (Elgar, 2014). In 2014, a therapeutic abortion act was developed in Peru, providing guidelines and a legal framework of abortion for doctors to abide by (MINSA, 2014b). Article 119 in the protocol allows for therapeutic abortion up to 22 weeks of gestation if it is the only means to save a woman's life or to avoid serious or permanent damage to her health (Ibid).

It is well understood that accessing therapeutic abortion can be difficult in Peru both as a result of the rigid qualifying requirements, the limited tertiary level health facilities that can legally provide the service as well as the lengthy decision making process which must be a joint medical

decision (Grossman et al., 2018). Consequently, lack of access produces the risk of unsafe abortions[4] outside the formal healthcare system. Every year it's estimated that 350,000 induced abortions are performed in Peru, nearly all performed outside a formal health setting (Huff, 2007; Sánchez-Siancas, 2018; UNICEF, 2016a). Of these abortions, approximately 30% result in complications (Huff, 2007; UNICEF 2016b). This has a significant impact in contributing to maternal morbidity and mortality particularly for adolescents. In comparison to adults, adolescents that interrupt an unwanted pregnancy are more likely to experience complications and present late to formal healthcare services when these complications arise (Olukoya et al., 2001). Pregnant adolescents often have reduced economic and social resources and thus are most likely to be exposed to unsafe circumstances when seeking to interrupt an unwanted pregnancy outside the formal healthcare system. (UNICEF, 2016b). Maintaining the right to SRH services and information for adolescents is a fundamental state priority. However, stigma of abortion can prevent adolescents with unwanted pregnancies accessing appropriate information, referral pathways and care (Rousseau, 2007).

2.7 Health Standards for Pregnant Adolescents in Peru

Healthcare professionals are in a pivotal position to provide information and counseling to pregnant adolescents and mitigate the risks associated with adolescent pregnancies. Recently in 2017, to standardize the integral care provided to pregnant adolescents, MINSA established the *Technical Health Standard for the Comprehensive and Differentiated Care of the Adolescent Gestant during Pregnancy, Childbirth and Puerperium (*Resolución Ministerial, 2017*)*. This Technical Health Standard (THS) outlines the functions and responsibilities of the health professional responding to a pregnant adolescent. This includes the right to SRH, emphasizing the responsibility of health providers to offer information to pregnant adolescents on how to exercise their sexual and reproductive rights (Ibid). The THS recognizes the mental health risks associated with adolescent pregnancy and recommends integral care with a psychologist (Ibid). These standards that the state has developed and implemented are important to take into consideration when understanding the practices and perceptions of the midwives towards adolescent pregnancies.

[4] Unsafe abortions include abortions performed by persons lacking the requisite medical skills or in an environment not in conformity with minimal standards, or both (PAHO, UNFPA & UNICEF, 2016)

3. THEORETICAL FRAMEWORK AND KEY CONCEPTS

This section will introduce the theoretical framework and concepts of sociologist Pierre Bourdieu that will be used throughout the analysis of this study. This chapter begins with Bourdieu's 'theory of practice' followed by the concepts that intertwine to formulate this theory (See Figure 1). These concepts include; *habitus, fields & doxa, practice* and four different forms of *capital* which are economic, social, cultural and symbolic capital (Bourdieu, 1977). This section will end with the operationalization of the theoretical framework explaining how it will be applied to this study and be used to answer the research questions.

3.1 Bourdieu's Theory of Practice

Bourdieu's theory of practice hypothesizes that social behaviour is related less to the explicit rules that dictate behavior and more to the implicit likelihood and tendency to behave in ways that the group expects (Bourdieu, 1990). One's actions are highly dependent on the implied expectations of how one ought to act as defined by collective beliefs and individual positions in a social space. The theory of practice is ideal in analyzing the connections that are established between specific groups (in this case, midwives and pregnant adolescents) and the practices that take place when they come in contact, as it focuses on how norms and perceptions are internalised and translated into practice (Grenfell, 2014).

3.2 Habitus

Habitus is a concept that orients the way we see and interpret the social world. It is a 'practical sense' that guides individuals and groups in evaluating what to prefer, how to act, what to say and how to say it (Bourdieu, 1990). According to Bourdieu, habitus is the social *structures* and history within individuals developed through interactions such as family upbringing and educational experiences (Maton, 2014; Power, 1999). And, habitus is also social *structuring*, as one's habitus shapes present and future practices by bringing one's history into their present circumstances (Ibid). Habitus is fitting for this study as it is recognized for its potential to contribute to our understanding of the different practices or perceptions of social groups (Wiltshire et al. 2019). Bourdieu's concept 'habitus' has been applied in other studies to illustrate

that individual behaviors in the form of healthcare interventions can in fact be socially structured (Bourgois & Schonberg, 2007; Cockerham, 2000). However, Bourdieu is not suggesting that we are pre-programmed machines acting out the implications of our upbringings (Maton, 2014). The practices of actors cannot be understood by habitus alone, as individuals can still act in ways that are not consistent with their habitus (Chang et al., 2016; Maton, 2014). The habitus represents just one part of the equation as illustrated below in Figure 1 on page 23.

3.3 Fields and Doxa

Habitus cannot be understood without reference to the social space or context from which it is formed – what Bourdieu calls 'fields' (Bourdieu, 1977, Bourdieu & Wacquant, 1992). These fields or arenas of practice are described as structured spaces organized around different types of capital and the competitive positions held by actors or agents such as midwives, other health professionals and patients in the field of a healthcare center. Fields have been described as specific sites of cultural production with particular norms, boundaries and forces of power at work. (Wiltshire et al., 2019). The term field is a flexible one given that new contexts are constantly arising and being re-shaped (Ibid). For example, a health establishment can be considered a field but so can the profession of midwifery inside that health establishment. Habitus and fields are constantly interacting and at interplay. In the case of this study midwives may perceive or respond differently to adolescent pregnancy depending on the fields those perceptions and practices are constructed in; the field of midwifery, the institutional field and the cultural field of Peru.

These fields are filled with specific rules coined by Bourdieu as 'doxa'. Doxa are the social structures that creates the sense of our position in a given field and regulates what is doable and what is not in that position (Walther, 2014). The doxa is internalised by actors in a specific social space in order to demonstrate appropriate practices (Ibid). These 'rules' of a specific field might seem arbitrary to an outsider but agents or actors in this space sense their weight with huge emotional force (Crossley, 2001). To summarize, doxa is associated with the conformity of an actor's position in a social space, which thus is closely related to habitus. However, it is also important to note that the field or doxa and habitus does not always match and this can thus create a feeling of alienation or discomfort (Hardy, 2014). This phenomenon is referred to as a

'hysteresis effect' where the habitus does not correlate with the field or the doxa. As a result, the habitus of the individual does not adjust to the present social context. An individual may be subject to this effect when their habitus is out of line with the collective expectations in a field which are considered the norm (Ibid).

3.4 Capital

Every field values particular types of resources that Bourdieu calls 'capital' (Bourdieu & Wacquant, 1992). There are four main types of capital; economic, social, symbolic and cultural, with cultural capital having three forms (Ibid). Economic capital is the most straightforward and the type that is associated with money, wealth and an income and can be transformed the most easily into other capitals such as buying a painting - attaining cultural capital (Walther, 2014). Social capital is the product of positive human interactions associated with networks of relationships and can lead to positive outcomes such as future opportunities, access to resources or useful information. Cultural capital exists in three forms including the objectified state, which are cultural goods such as books, instruments, and pictures (Ibid). The embodied state that consists of perceptions, skills and knowledge, such as through undertaking training that midwives would have had to complete. And finally, the institutionalized state refers to the recognition received from an institution, primarily through educational qualifications such as a midwifery certificate or diploma (Ibid). Lastly symbolic capital is what economic, social and cultural capital is transformed into in a social field often associated with recognition, honor or reputation depending on what capital is valued or not in any given field (Crossley, 2014). The accumulation of capital within a field can position actors or institutions in a 'higher' position with particular forms of capital being advantageous (Ibid).

3.5 Practice

Bourdieu's concept of *practice* is the outcome of the relationship between habitus, capital and fields which grows out of their interaction (Power, 1999). Specifically, practice is the result of the field and the rules that apply there (doxa) together with habitus and capital. For example, midwives may have similar habitus as a result of their socialization in tertiary education and it is

when that habitus, capital and entering a healthcare facility 'field' interacts that 'practice' is then produced.

[(habitus) (capital) + field] = Practice

Figure. 1 Formula of interaction (Bourdieu, 1984:101)

3.6 Operationalization

In summary, the theory of practice describes the interaction of mechanisms that can increase the likelihood of particular outcomes. This theory will be applied to midwives to better understand how their perceptions and practices manifest as a result of their habitus, resources, or capital, available to them within the midwifery field. By understanding the different mechanisms this study will explore the practices and perceptions of midwives in responding to an adolescent with an unwanted pregnancy. Bourdieu's theory of practice is suited to this study as it focuses on social norms often produced or appropriated in specific arenas, in this case the *midwifery arena*. The concept doxa will be used to understand the social 'rules' and limits that shape and develop social norms within the midwifery field (Deer, 2014).

4. RESEARCH DESIGN AND METHODOLOGY

This chapter will explain the ontological and epistemological position of this study, followed by outlining the research design, the research methods chosen, sampling, the demographic details of participants and the process of data collection. This chapter also dedicates a section to the reliability, analysis and limitations of the data, as well as the positionality and ethical considerations of this study.

4.1 Ontological and Epistemological Position

The role of theory in this study takes a primarily inductive approach where the theory of practice and its concepts are emphasized. This study will draw out patterns from the data collected using theory and conceptual terms. This strategy has generally been associated with qualitative research designs (Bryman, 2012).

The epistemological position in this study is hermeneutic phenomenology (Bryman, 2012). To understand human behavior, theory and methods through interview transcripts providing textual narratives have been used as a way to interpret human action. With a phenomenological position, this study is concerned with the perspectives of midwives and how they make sense of their 'field' and the rest of the world around them and in addition how they may embody their view of social reality (Ibid). By adopting a phenomenological position, the researcher has the role of gaining access to the midwives' perspective to be able to interpret their actions and their social world. Thus, in this thesis, human behavior is interpreted as a product of how people interpret the world (Ibid). From this position it is acknowledged that several realities exist without a universal explanation.

The term ontology refers to the nature of reality (Bryman, 2012). The ontological position that this study has taken is constructionism. This implies that a social phenomenon, such as adolescent pregnancy, is not only produced by social interaction but that it is in a constant state of revision by social actors. This acknowledges that social actors, or myself as the researcher, will always present a specific version of social reality rather than one that can be regarded as

definitive. For example, how adolescent pregnancy may be framed as a social fact or biological state, can also be ascribed to particular meaning (Ibid).

4.2 Research Design

This thesis will present a case study design, generating an intensive, detailed examination of midwifery in Peru. The focus is predominately on midwives in Lima however has also included midwives outside Lima to reflect some of the disparities between Lima and other regions. Emphasis has been placed on the contextual understanding of social behavior (Bryman, 2012). This coincides with Bourdieu's concept of 'fields' where behaviors of a social group cannot be understood outside of their specific environment and the social structures in which they operate (Wiltshire et al. 2019). Thick descriptions provide detail of social situations and individual midwives that highlights the multi-layered complexity in a particular context (Bryman, 2012).

4.3 Research Methods

This thesis uses mixed qualitative methods (Bryman, 2012). These methods include semi-structured interviews and an online survey with a combination of closed, open-ended questions and questions with a 'strongly agree to strongly disagree' scale range (Appendix 1). In this study priority has been given to the data collected through the interviews as it allows greater detailed responses as opposed to the online survey, where responses are often less specific. In addition, secondary data including journal articles and reports, such as the National Household Survey (ENDES) have been used in the contextual background of this study.

Semi-structured interviews provide enough structure to ensure some level of comparability, with the relevant aspects being raised in all interviews (Bryman, 2012). Whilst the open-ended format allows the flexibility for midwives to provide their knowledge, motivations and personal reflections openly. Semi-structured interviews provide the opportunity to observe emotional responses throughout the interview and seek to minimize any uncomfortable or negative feeling that may arise from participating in the research. They also allow for opportunities to delve deeper into sensitive themes when cues arise for probing questions. Thus, the semi-structured interviews provide this study an in-depth perspective of the midwives' experiences, attitudes and

opinions. Subsequently, thick descriptions will be presented to contextualize social behavior and perceptions (Ibid). Qualitative online surveys were also used as part of this study primarily to triangulate the findings in this study (Ibid). Although online surveys do not provide the same level of depth as the semi-structured interviews, it does provide breadth, reaching a larger sample size. In addition, a larger proportion of midwives outside Lima were reached using the online survey. The online survey provides a greater level of anonymity providing greater privacy for participants which may increase validity. Also, as the researcher is not asking the questions nor receiving the answers directly, the researcher is less likely to influence responses in relation to positionality. A triangulating strategy means both sets of data can be juxtaposed to support or challenge the findings (Bryman, 2012).

4.4 Sampling and Data Collection

Data collection was facilitated with the support of UNFPA Peru and the NSM Peru. A snowballing strategy was adopted in the sampling of participants for both the interviews and the online survey. Although this meant that sampling was not random, this strategy provided access to a niche, hard-to-reach population (Bryman, 2012). To participate in the study as an interviewee or survey participant, respondents were required to self-report as a registered midwife in Peru. In addition, participants had to have had experience working with pregnant adolescents within the last 12 months. These two attributes were required to ensure all participants had some level of knowledge and experience in working with pregnant adolesents and more likely to have encountered adolescents with an unwanted pregnancy, a key aspect of this study.

4.4.1 Semi-Structured Interviews

In total there were 15 interviews conducted (see Appendix 5) including two Key Informants (KI's). Although a snowball strategy was used to recruit midwives for interviews, there was still a great deal of variation in the midwives captured, demonstrated in Table 1 and 2.

The 15 interviews conducted ranged from 36 minutes to 2 hours and 17 minutes. The wide range was largely a result of extended interviews with the KI's. An interview guide (Appendix 2) was

used to facilitate the 15 semi-structured interviews. All interviews were carried out in Spanish without a translator. All interviews were audio recorded to ensure no data was lost, as although I have a high level of Spanish, I am not a native speaker. These audio recordings were later manually transcribed and translated to English. All participants were able to choose the location of the interview depending on their preferences. Most interviews were conducted in the participants workplace, however some chose to be interviewed in a cafe, their home or at the UNFPA office space that I was able to offer. Each interview started with questions on their background, their workplace and what motivated them to become a midwife before focusing on adolescents with wanted and unwanted pregnancies. The interviews provided the opportunity for midwives to elaborate in detail of their experiences.

The broad range in experience, age, as well as capturing both male and female midwives demonstrates variation in demographics. In addition, different work-places demonstrates diversity in the midwifery contexts.

Table 1: Demographics of Interviewed Practicing Midwives

Interview	Gender	Workplace	Years Work Experience	Age	Location of Work
1	F	National Maternal Perinatal Institute	34	58	Lima
2	F	National Maternal Perinatal Institute	30	54	Lima
3	F	National Maternal Perinatal Institute	15	46	Lima
4	F	National Maternal Perinatal Institute	25	49	Lima
5	F	National Maternal Perinatal Institute	40	69	Lima
6	F	Health Establishment 1	4	28	Piura
7	F	Sexual Health Education	18	46	Lima
8	M	Hospital 1	27	50	Cusco
9	F	Hospital 2	4	35	Lima
10	F	Hospital 3	9	37	Lima
11	F	Hospital 2	20	53	Lima
12	F	Hospital 2	15	50	Lima
13	M	Health Establishment 2	4	35	Bagua Grande, Amazonas

F: Female M: Male

Source: Own primary data from interviews wed had an enormous range of experience from 4 to 40 years with the majority of midwives having more than 15 years working experience. In addition, 5 interviewed midwives were from the National Maternal Perinatal Institute (NMPI) in Lima. These midwives were working in the adolescent maternity unit, thus would be caring for a

number of pregnant adolescents before and after birth on a daily basis. NMPI is unique having the only maternity ward specifically dedicated to pregnant adolescents in Peru. Although the interviews were predominantly with midwives from Lima, three had experience working in more rural areas and two were male midwives. Lastly all interviewed midwives were from the public sector as opposed to the private sector (Table 1). A focus was placed on the public sector since this sector is more likely to serve the demographic that would experience the highest rates of adolescent pregnancy.

Table 2: Demographics of Key Informant Interviews

Interview	Gender	Workplace	Years Work Experience	Age	Location of Work
KI1: Maria	F	Colegio de Obstetra del Perú / National School of Midwifery	17	40	Lima
KI 2: Rosa	F	Católicas por el Derecho a Decidir /Catholics for the Right to Decide	6	55	Lima

KI: Key Informant

Data Source: Own Primary Data from Interviews

Presented in Table 2 are the two KI's interviewed, Maria and Rosa[5]. The first KI, Maria is a midwife and representative of the NSM, the governing body for midwives in Peru. The second KI, Rosa is a midwife and representative of the advocacy, non-government organization (NGO), Catholics for the Right to Decide. This is a human rights-based organization focusing on sexual and reproductive health and rights (SRHR) with a focus on training and working with health professionals including midwives. Rosa is also involved in advocacy for SRHR for adolescents. Both KI's have had extensive experience working with adolescents and many midwives in Peru.

[5] Pseudonym names have been assigned to both Key Informants to preserve their confidentiality and anonymity.

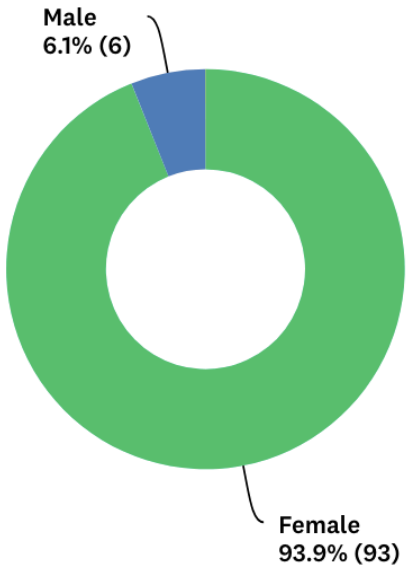
4.4.2 Online Survey

The NSM was a central contact for the distribution of the online survey across all regions of Peru. This led to a total of 101 participants entering the online survey with 2 being excluded since they didn't fulfill the requirements to participate. Of the remaining 99 participants, not all participants answered all questions, since respondents had the option to skip questions.

The survey contained a mix of closed, open-ended questions and questions with a 5 range agree/disagree scale. This survey was developed using the platform, SurveyMonkey that was then distributed by email by the NSM Peru. By using an online survey this study was able to not only recruit a larger sample, but also participants working in areas outside Lima, where adolescent pregnancy often occurs at a much higher rate. That being said the survey sample is not statistically representative, where Lima is over-represented at 42.7% (See Appendix 7). The 99 participants came from 17 different regions out of a total of 25 regions in Peru. Although the majority of midwives came from Lima the survey was far reaching and captured many midwives from rural settings (Appendix 7). These demographics as well as demographics presented in the following figures (Figures 2, 3 & 4) is data captured from the closed questions in the online survey.

Figure 2: Gender of Respondents

Answered: 99 Completion: 100%

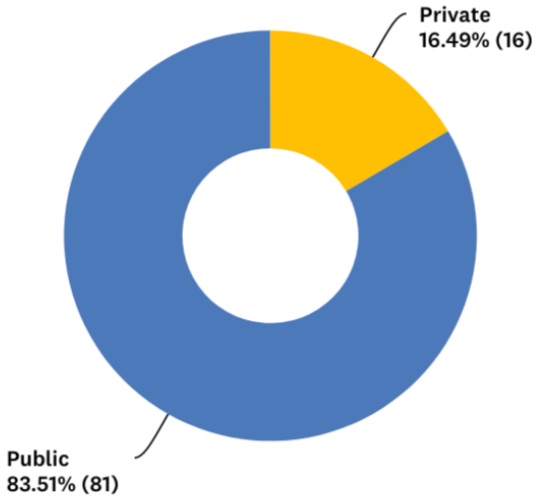


Source: Own primary data from online survey

Midwifery is a largely female dominated field of work in Peru, however this survey was able to capture a small percentage of male midwives (Figure 2). In addition a small percentage of midwives from the private sector was also included in the survey whilst still maintaining a focus on the public sector (Figure 3).

Figure 3: **Health Sector of Respondents**

Answered: 97 Skipped: 2 Completion: 98%

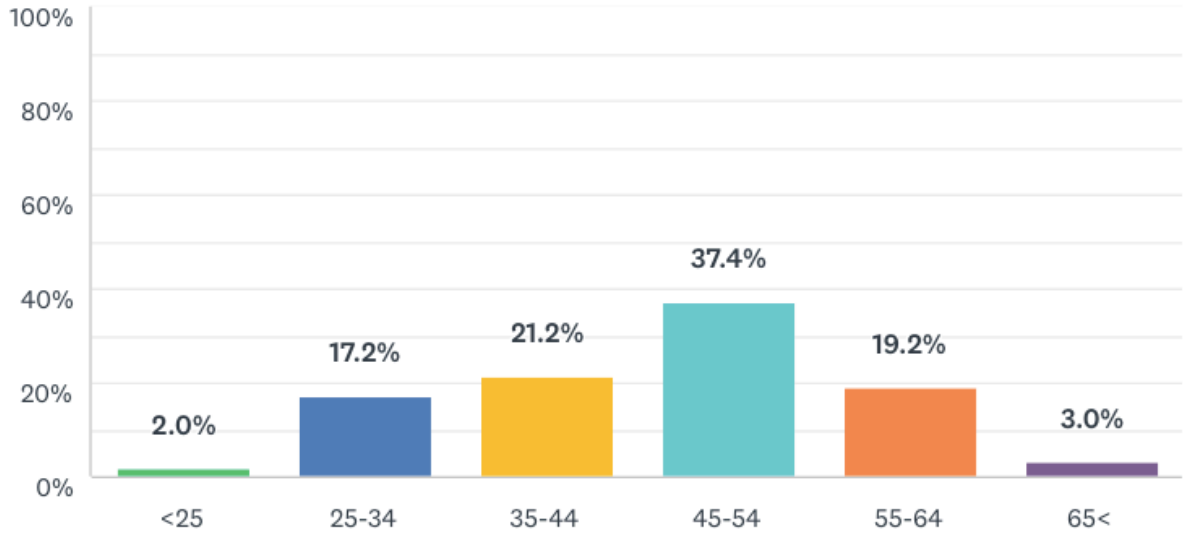


Source: Own primary data from online survey

The online survey also captured a wide range of ages (Figure 4), from under 25 to over 65, with the bulk of participants sitting in the 45-54 age group.

Figure 4: Age Group of Respondents

Answered: 99 Completion: 100%



Source: Own primary data from online survey

4.5 Reliability of Data

Reliability, transferability and validity are presented as criteria for assessing the quality of social research (Bryman, 2012). Ecological validity is concerned with the question of whether social scientific findings are applicable to people's everyday, natural social settings (Ibid). The interviews were carried out in natural settings preferred by the participant. Semi-structured interviews allowed the midwives' stories to be heard and to avoid these midwives being objectified or controlled by research technical procedures. However, the unnaturalness of having to answer an online survey denotes that findings may have limited ecological validity (ibid). In an attempt to address this limitation open-ended questions were also used in the online survey. There was only one researcher so internal reliability was not a problem for this study. This study has used more than one method or source of data, a strategy known as triangulation (Ibid). By

using two qualitative methods of data collection a stronger confidence in findings is developed. Triangulation in this study strengthens credibility and ensures good practice (Ibid). As this is an intensive study of a small group using a qualitative research strategy, this study is oriented to the contextual uniqueness of midwives in Lima as well as highlighting some midwifery perspectives outside Lima. Thus, a thick description detailing cultural context is provided, if transferability would be considered. An auditing approach was taken during the planning and data collection of this study to support credibility of the research. This included keeping records of when the phases of the research process such as when interviews and surveys took place (Appendix 5 & 6), field work notes and transcripts. Lastly this study is not a representative sample of a population, the findings of this research will generalize to theory as opposed to the population of midwives of Peru.

4.6 Data Analysis

All interviews were audio recorded, manually transcribed and translated into English by the researcher. Following transcription, Nvivo was used to code and analyze the interviews and data analytics of SurveyMonkey were used to analyze the online surveys. A thematic analysis was used in reviewing interview transcripts where data was grouped in recurring themes and subthemes.

4.7 Positionality and Ethical Considerations

As the researcher of this thesis, it is important to take my positionality into account in relation to the participants and research. I approach this thesis as a feminist with a SRH background. As a foreigner, it is not unreasonable to acknowledge that my 'white' appearance, unfamiliar accent or that I identify as local to Australia and Sweden may have influenced the responses of the midwives. In addition, I was also undertaking an internship at UNFPA at the time of this research. It is likely that these factors may have influenced the output of the empirical material such as through social desirability[6]. For example, many participants were aware that I came from settings where abortion was more readily available by making reference to western settings and

[6] Social desirability is the tendency of respondents answering what they believe is socially acceptable rather than disclose their true attitude or behavior (Eivarsen & Våland, 2014).

'othering' me in interviews. Thus, participants may have responded in what is percieved as the most socially desirable for the researcher. In addition, for interviews that were conducted in a workplace, responses may be influenced by the social desirability of what is expected in that workplace. In addition, as a cis-gender woman, this may have been an advantage in discussing such sensitive areas regarding reproduction with mostly female midwives.

There were a number of ethical considerations that were adopted in this study, taking into account the sensitive areas of SRH and personal attitudes this study delves into. Firstly, all interviewed and surveyed participants were provided an executive summary (Appendix 3) of the study informing all participants of the objective of the study and their rights in this study. Once being informed of this study, all participants provided their written, verbal or online consent (Appendix 4) to take part in this study prior to their participation. Interviewed participants also provided consent to have the interviews audio recorded. These steps ensured all participants understood that their participation was voluntary, anonymous and that they had the right to skip questions or withdraw at any time during the interview or survey without consequences. All participants were also informed that there was no economic reimbursement for participating in the study as part of the consent form. In addition, participants understood that the data collected will not be used for any other purpose than this study.

Furthermore, no identifying information of patients was sought from midwives and all participants interviewed have been made anonymous. Given the sensitivity of this study, consultation with UNFPA Peru was made throughout the development of this study and all interview and survey questions were reviewed by UNFPA Peru to ensure cultural sensitivity. The research proposal was shared with the Department of Public Health at the Medical Faculty at Lund University and is in compliance with the Helsinki Declaration (1997).

4.8 Limitations

In this study there are a number of limitations that must be considered. Firstly, a snowball sampling strategy means that recruitment was not completely randomized and instead this sample may have been swayed to represent a group of midwives with similar attitudes. This was addressed by distributing an online survey through the NSM to seek a broader sample.

Furthermore, some of the highest rates of adolescent pregnancy occur outside of Lima, it was important to capture the perspectives of midwives in more rural settings. However, as demonstrated in the sampling (5.4.1 & 5.4.2), a limitation of this study is that the vast majority of midwives interviewed were from Lima. And although the online survey aimed to include a wider sample, Lima was still hugely over-represented and some regions of Peru were not represented in this study at all. Thus, this study is not representative but provides insights of 15 midwives in their unique contexts, cross-referenced with an additional 99 midwives in the online survey.

Furthermore, in both the interviews and surveys participants were provided the option to skip questions, which was in line with the ethical considerations of this study. However, this also denotes that not all questions were answered in the survey by all 99 participants with some participants choosing to skip questions. Overall this led to a 78% completion rate[7] for the online survey. To be transparent in the findings any figures presented from the online survey includes the number of participants that responded. Another limitation in this study is the normative barrier of illegal abortion with the exception of therapeutic abortion. The restrictive abortion laws in Peru means health professionals may not share their attitudes or opinions if they contradict current national laws.

[7] The completion rate is the percentage of fully completed surveys.

5. FINDINGS AND ANALYSIS

This section encompasses the findings and is the main analytical section of the thesis that responds to the RQ's. This section will respond to the 3 RQ's (*1. How do midwives perceive their role in relation to pregnant adolescents? 2. Why do midwives consider the adolescent's desirability of their pregnancy important in shaping health outcomes? 3. How and why does the adolescent's desirability of their pregnancy affect midwives' perceptions and practices towards the adolescent?).* A comprehensive overview of the interviewed midwives' insights will be laid out with direct quotes and Bourdieu's theory of practice will be used to interpret the findings. In addition, for RQs 2 and 3, interview findings will be supplemented with the findings from the online survey presented in figures.

5.1 The Field of Midwifery and Perceptions of Adolescent Pregnancy

To answer the first RQ, a background of how midwives perceive midwifery and how midwives position themselves in relation to pregnant adolescents within the midwifery field will be presented. Although participants had unique experiences and *habitus* to some degree, all were practicing within the *field* of the midwifery. Many midwives shared similar motivations for becoming a midwife to care and help as one participant describes:

> Because it's a very humble career where I serve someone else, another human being in the care of the mum but also the baby and I like to help the people so my quality of care is to serve and bring a baby, a human being alive. And that's why I picked this career (Interview 12, 2019).

She highlights two key actors, the to-be mother and the to-be baby. How midwives would position themselves to these actors would vary slightly however naturally it would often be quite maternalistic, a relationship of providing care. Rosa, KI 2 described the relationship between midwives and adolescents as the following, "Many of the ones [midwives] that are attending adolescents are facing barriers and often orient them as if it was their own child." (Rosa, KI 2 2020). This statement is supported by other participants interviewed:

> The counseling needs to be very personal of course if there's a case of violence or she's alone crying of course you need to spend more time with her… and often, that adolescent she attaches herself to you and you become like her mum. They have faith in you (Interview 3, 2019).

This relationship highlights how the midwife is in a position of power in her role of counselling, providing and advising as opposed to the adolescent who is percieved as vulnerable, in need and infantile.

Furthermore, building a relationship with the pregnant adolescent is a theme that all midwives raised in the interviews which allows them to 'participate or facilitate' in the pregnancy of the adolescent. As one midwife describes her role:

> I see our role in SRH for adolescents very important... we are there throughout the whole process and with everything we know in educating, supporting, showing, caring- then imagine we can detect something and explain it to them but giving them time, explaining to them in their own time… the Doctor will do this but it's us that will explain it to them with more time because the Doctor is more rushed they have more things whereas for us yes we can do it, and support the diagnosis, prevent, detect – because part of the problem in care is that there is a lack in explaining, which is ugly, I am very delicate in that (Interview 4, 2019).

Many of the midwives shared their perceptions of their role, one participant describing, "Our career here as the midwife has a very special role because it's the start of life, the nuclear of the family is the woman who is with the children." (Interview 11, 2019). This extraction outlines where the interviewed midwife places value, in motherhood and the baby. This participant later expanded on what she liked about midwifery; "And more than anything I like it [midwifery] because mothers are the possessors of the start of life and the guides of human life." (Interview 11, 2019). There is a great weight that is placed on pregnant women that is motherhood. Other midwives interviewed expressed similar perceptions. This reflects a 'rule' or doxa to the midwifery field that all pregnant women will give birth and enter motherhood. How midwives perceive their role is often a social construct based on their habitus and field.

Although midwives have their clinical role many of the midwives provided many emotive descriptions outlining characteristics such as the provision of emotional support, compassion, a counseling role and relationship of trust and care. One interaction raised by a midwife was the practice of building a connection between the adolescent and her fetus or baby. One participant states:

> And that's why it is so special here because we work in a team... We can show the adolescent the heartbeat and show them photos of their baby. We invite them to be part of their babies' growth (Interview 3, 2019).

The midwife describes her role as a bridge between the adolescent and their baby. This perception came to light particularly when discussing unwanted pregnancies. Midwives shared the perception that the vast majority of adolescent pregnancies were unplanned in their experience and most believed many of those pregnancies were also unwanted. However, there were mixed thoughts of the proportion of unwanted pregnancies among adolescents, as the adolescent's desirability for the baby would often shift during the pregnancy. There was also an acknowledgement that many adolescents wouldn't attend a health establishment with an unwanted pregnancy. Instead adolescents were more likely to present with ambivalence towards their pregnancy as opposed to complete rejection in a midwifery setting. However, even with this in mind all interviewed midwives had experiences consulting and attending to adolescents with an unwanted pregnancy. In all these scenarios midwives would perceive their role as developing and building a connection between the fetus and the adolescent and working towards the adolescent accepting their pregnancy. One interviewed midwife describes her role:

> Those girls who come with an unwanted pregnancy we show them that they can love their babies and that they can accept it because those babies don't have the blame of anyone, they will be mothers and they will feel that baby how it kicks, how they feel, how it moves all of that we show them, that if they abort the pregnancy how the baby will suffer (Interview 12, 2019).

Midwives would often attribute an unwanted pregnancy to the circumstances of the adolescent describing attributes related to relationships such as an abandonment of the partner, rejection of the pregnancy by family members or a fragmented family. In addition, nearly all the midwives had experiences consulting an adolescent with an unwanted pregnancy as a result of sexual violence. Even in these circumstances midwives would often perceive the best outcome resulting in the adolescent accepting the pregnancy, accepting motherhood and continuing with the pregnancy. Many of the midwives would discuss their role in fostering a connection between the fetus or baby and the adolescent using different strategies. Midwives place value in motherhood, birth and good health outcomes for both baby and pregnant adolescents and perceive their role in facilitating these aspects as central to their professional roles. As such, these aspects can be considered to constitute the *doxa* of the field of midwifery in the context of the interview material.

5.2 The Importance of the Desirability of a Pregnancy

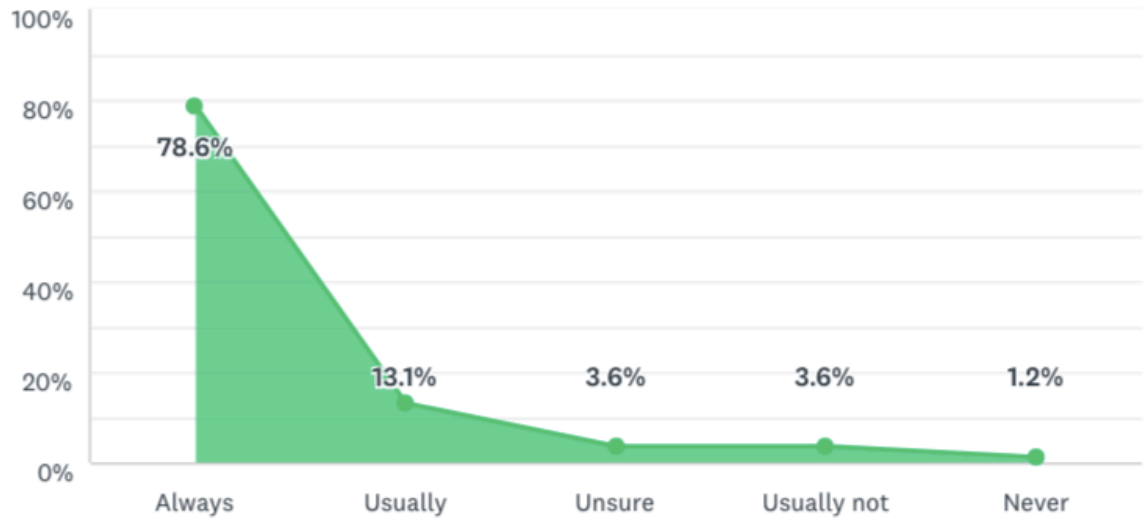
In Peru, if a midwife attends to a pregnant adolescent in nearly all cases the adolescent is expected to continue with her pregnancy regardless if the pregnancy is wanted or unwanted. However, despite the rigid options that exist for unwanted pregnancies in Peru, midwives perceive the desirability of the pregnancy as important when attending to a pregnant adolescent. In this section to answer RQ 2 the reasons why midwives perceive the desirability of the pregnancy as important will be analyzed. This section will start by describing the process of how midwives identify the desirability of a pregnancy.

All midwives interviewed identified if the pregnancy was wanted or not when consulting pregnant adolescents. And the majority of the midwives interviewed also emphasized the importance of identifying if the pregnancy was wanted or not. When one midwife was asked if she thought desirability was important, she responded: “Yes because in most cases the complications are because of that, because of the fear, the not acceptance, the frustration.” (Interview 4, 2019). This was also supported by the online survey where the vast majority of midwives (91.6%) responded that they would ‘always’ or ‘usually’ identify if the pregnancy was wanted or unwanted (see Figure 5).

Figure 5: Identifying Desirability of Pregnancy

Do you identify if the pregnancy is wanted or unwanted when attending to a pregnant adolescent?

Answered: 84 Skipped: 15 Completion: 85%



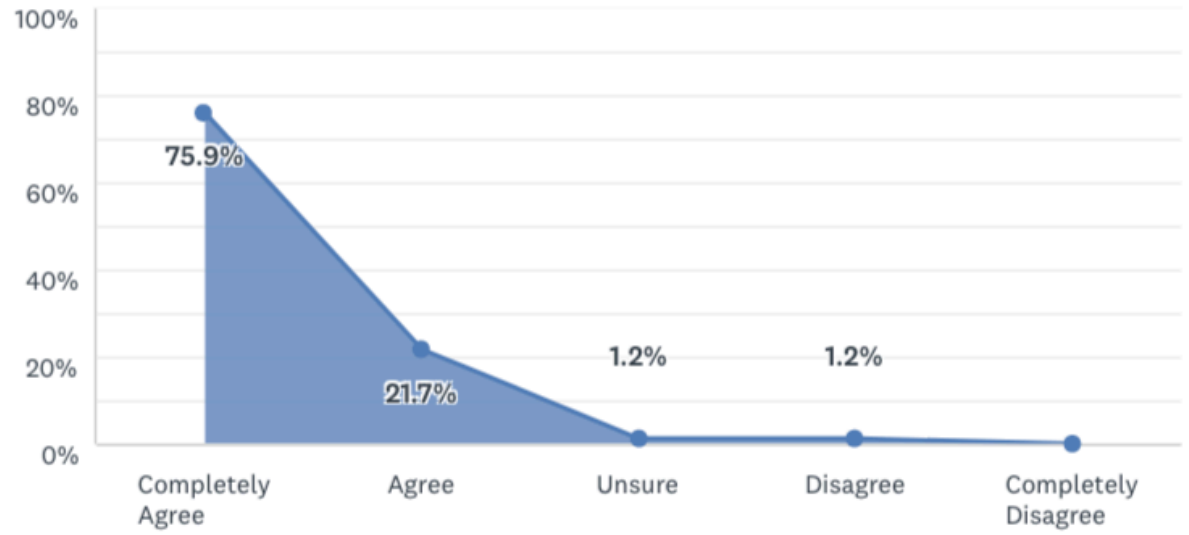
Source: Own primary data from online survey

Even if there are 8.4% of midwives that were unsure or didn't identify if the pregnancy was wanted or not when consulting an adolescent, as indicated in Figure 5, some of these midwives still thought the desirability was important. This is demonstrated in Figure 6, where 97.6% of midwives from the online survey agreed that it was important to identify if the pregnancy was wanted or not when attending to a pregnant adolescent. Thus, leaving only 2.4% of midwives that were unsure or thought the desirability of the pregnancy was not important (see Figure 6).

Figure 6: Importance of Desirability of Pregnancy

Do you think it is important to know if the pregnancy is wanted or not, when attending to a pregnant adolescent?

Answered: 82 Skipped: 17 Completion: 83%



Source: Own primary data from online survey

Interviewed midwives described many similar or overlapping attributes attached to adolescents with an unwanted pregnancy. Some of these attributes or characteristics included delayed health-seeking behavior, a poor connection with the fetus, the adolescent may be isolated, scared, depressed, suicidal or feel rejected by society. One participant explained, "they might leave their studies, they might no longer go out and play with their friends or pass time with their family. An unwanted pregnancy can generate negative thoughts" (Interview 6, 2019). In addition, many midwives made the connection between these attributes and the health consequences that are more likely to result from an unwanted pregnancy. Most interviewees shared the view that identifying if the pregnancy is wanted or not was a good indicator for complications during pregnancy as well as the collaboration of the adolescent in prenatal care. For example:

> ...a patient with a wanted pregnancy will be committed to all the appointments and will come on time and collaborate with me… she is responsible and you notice that they come with lots of love about her pregnancy and if she sees indicators she will complete them... She will have less nausea and problems. When I ask, they tell me everything is great. They might have some symptoms but it doesn't bother them so much and they have accepted the pregnancy and the responsibilities for the future, they're happy. When someone comes with an unwanted pregnancy they're more hesitant about everything they complain about all the procedures and they come with a sad face… they make a lot of excuses and often don't come to appointments and talk about other commitments that they need to work or be somewhere else. And don't comply with their prenatal controls. (Interview 13, 2019)

This interviewed participant from the Amazonas region went on to compare health-seeking behavior from a wanted versus an unwanted pregnancy in adolescents:

> ...the characteristics that she has is that she was captured by a health professional, or by a nurse or midwife and in the case where she comes in often at 3-4 months when her stomach is already growing. Where if it's a wanted pregnancy she's coming in the first month that she's not menstruating and she's coming in with her mum (Interview 13, 2019).

Another theme raised by the midwives interviewed was that the adolescent's desirability of her pregnancy will determine the relationship between baby and mother and also impact the development and health of the potential baby. An unwanted pregnancy presents many challenges to midwives in their field as it conflicts with some of the shared perceptions of the midwife. These shared beliefs that are accepted and unquestioned, coined as 'doxa' by Bourdieu (Deer, 2014), in the midwifery field include the belief of the midwife as a facilitator of childbirth and motherhood, as described in 5.1.

In the interviews, midwives were asked what their primary concerns were for adolescents with an unwanted pregnancy and what they thought the greatest risks for this group were. Many of the

interviewed midwives shared similar and overlapping concerns associated with unstable relationships, clandestine or self-medicated abortions, mental health risks, increased risk of complications at birth and during the pregnancy and not being emotionally prepared. Concerns for the baby were raised such as emotional rejection, not being able to lactate and having a painful or traumatic birth that can further negatively affect her relationship with the baby.

Midwives always spoke of the wellbeing of both the adolescent and the baby. This relates to the 'doxa' assumption that was expressed that pregnant adolescents should always give birth rather than terminate a pregnancy. Midwives spoke of complications and severe symptoms being much more common such as nausea and anemia when referring to adolescents with an unwanted pregnancy. Many mentioned that the adolescent may try to interrupt the pregnancy which means the baby might be lost but it could also mean complications for her. Nearly all interviewed midwives discussed the range of complications that could come from an adolescent having a clandestine or self-medicated abortion. A number of these midwives highlighted that these complications could also mean that the adolescent may not be able to have children in the future as a result of infections or sepsis. One midwife interviewed outlined, "look what can happen is not just the immediate physical health problems, they might have an abortion now but when they try to have children in the future perhaps they won't be able to have them" (Interview 12, 2019). Interrupting the pregnancy was a risk highlighted by all interviewed midwives. For interviewee 12, by highlighting the risk of permanent infertility there is a maternal identity attached to women that is likely to stem from their experiences in the midwifery field, but also from patriarchal societies (Roberts, 1993). Another midwife outlines "Because they're scared to come to the hospital, because of the crime [abortion]… She comes very late and the consequence is that she can die from the infection" (Interview 3, 2019). Evidently criminalizing abortion creates fear and stigma attached to interrupting a pregnancy, which can lead to negative health impacts such as delayed health-seeking behavior (Recto et al. 2018).

Maria (KI 1), expands the concerns to a range of social consequences that are associated with an unwanted pregnancy, "It's not just the risk of abortion... There is also the continuation of violence, of the poverty, the risks of abandonment of the baby definitely in the same position of the adolescent mother" (KI 1, 2019). Most of the midwives highlighted the connection between social, physical, emotional and mental health risks to an unwanted pregnancy and how these

risks are closely interconnected. One midwife described, “The emotions that come with an unwanted pregnancy influence a lot of the complications such as stress, mental health, it's going to influence physical risks or end in biological consequences and it’s very notorious...” (Interview 4, 2019). Another midwife reflects on her experience in the adolescent maternity ward in Lima, stating, “nearly all of them have depression and end up on antidepressants.” (Interview 3, 2019). Some midwives highlight that as a result of rejecting the pregnancy it can create severe physical consequences such as nausea, vomiting and eventually even a spontaneous abortion. Midwives also mentioned a lack of self-care, “they don’t eat well, they are not looking after themselves” (Interview 13). According to both samples of midwives, interviewed and surveyed, many of the risks pregnant adolescents would face would differ depending if the pregnancy was wanted or not, which was the fundamental reason midwives found this information essential when consulting a pregnant adolescent.

In the online survey participants were asked, in an open-ended format, what are their primary concerns for a pregnant adolescent and what are their primary concerns for an adolescent with an *unwanted* pregnancy. The responses to both questions have been grouped into themes and are presented in Figures 7 and 8 in the form of word clouds. The more frequently referenced, the larger the word is, thus the sizes of the words vary depending how often concerns grouped under a theme were referenced in the midwives responses. Note that many respondents listed more than one concern since concerns were presented in an open-ended format.

Figure 7: Most Frequent Concerns of Adolescent Pregnancy

What is your greatest concern when attending to a pregnant adolescent?

Answered: 85 Skipped:14 Completion: 86%

Source: Own primary data from online survey

In Figure 7

the main concerns of midwives when consulting a pregnant adolescent include physical or biological consequences (44%), followed by the behavior of the adolescent (19.5%) such as adherence to prenatal controls, compliance with prenatal medical advice, attending the hospital for childbirth and delayed health-seeking behavior. This was closely followed by the adolescents' mental and emotional state or risks (18.5%) that also included low self-esteem, her fears of childbirth, psychological and emotional immaturity. Concerns of relationships made up

10% of the respondent's concerns, this included relationships with their families, their partner or social groups. Other concerns listed included concerns of the fetus or baby (7%), the attitude of the adolescent (8%) and that she has knowledge of her signs of alarm (5%). Although there are many overlapping concerns, the concerns definitely shifted for midwives when attending an adolescent with an *unwanted* pregnancy presented in Figure 8.

Figure 8: Most Frequent Concerns of Unwanted Adolescent Pregnancy

What is your greatest concern when attending to an adolescent with an unwanted pregnancy?

Answered: 84 Skipped: 15 Completion: 85%

Source: Own primary data from online survey

As demonstrated in Figure 8, the biological concerns are less frequently referenced by midwives in comparison to Figure 7. Instead for adolescents with an unwanted pregnancy the number one concern identified by midwives was abortion or complications from abortions (37.5%). This was followed by the behavior of the pregnant adolescent (23.75%). Where midwives listed some of the following behavioural factors; "that she harms her health or the health of the fetus", "that she produces risks", "that she doesn't take the adequate care of her pregnancy", "her collaboration", "that she makes decisions that puts her life at risk", "that she does not comply with her prenatal

care", "that she becomes pregnant again", "that she makes a bad decision". The mental and emotional state was also listed as an equal concern for participants (23.75%) where conditions such as depression, suicide, psychological trauma, emotional and psychological immaturity were listed by midwives. Biological risks in this figure only came in at fourth place at 17.5%, which included references to physical, pathological risks or complications. Concerns for the baby or fetus were also more frequently referenced at 14%, in comparison to Figure 7. And relationships and the attitude of the adolescent each made up 5% of midwives' concerns. Lastly one participant identified access to care and knowledge of the pregnant adolescent.

Although there are many overlapping concerns between Figures 7 and 8 there are significant differences in the frequency of concerns listed by midwives depending on the desirability of the adolescent's pregnancy. These concerns are tightly linked to the doxa that pregnant adolescents should give birth, and thus the desirability of the pregnancy being unwanted poses a risk that shifts the midwive's concerns. Midwives perceive their role as nurturing or facilitating the connection between fetus and the to-be mother and when the the pregnancy is unwanted this is likely to put pressure on the midwives to fulfill their perceived role as facilitator of motherhood and birth. The primary concerns raised by midwives for an adolescent with an unwanted pregnancy such as abortion, mental and emotional risks and the behavior of the adolescent are concerns that may not be as easily addressed by midwives in comparison to biological concerns in an adolescent with a wanted pregnancy. Thus, from a midwife's perspective the adolescent's desirability of their pregnancy can influence the connection between midwife and adolescent, specifically when both actors may have conflicting priorities. Ultimately, midwives consider the adolescent's desirability of the pregnancy critical in shaping a good health outcome for the adolescent as well as the baby.

5.3 Perceptions and Practices of Midwives

To answer RQ 3, the wider structures that influence the midwifery field will first be identified as boundaries for midwives' practices. Subsequently the perceptions and practices will then be explored and how these are influenced by the desirability of an adolescent's pregnancy. Lastly Bourdieu's theory of practice will be used to understand how and why a midwife's practice and perception is shaped by the adolescent's desirability of their pregnancy.

5.3.1 Wider Boundaries of the Midwifery Field

When analyzing the perceptions and practices of midwives, it is important to identify other key actors that set social boundaries in the midwifery field. This includes the legal institution that provides regulations of what midwives and other health professionals can and cannot do. MINSA sets guidelines and protocols for the care of pregnant adolescents in the public health system. Both of these institutions possess power in the midwifery field and solidify social boundaries that influence the habitus of midwives when responding to pregnant adolescents. For example, MINSA provides health standards of care that are used by health professionals in all public health establishments, such as the referral of all pregnant adolescents to a psychologist on the THS. Where social boundaries are solidified, shared beliefs outlined in 5.1, are further accepted and embodied creating doxa. Ultimately the combination of resources with the shared-unquestioned beliefs (doxa) that make up part of the disposition of each midwife in the midwifery field, increase the likelihood of a number of perceptions and practices being adopted when attending to a pregnant adolescent.

5.3.2 Perceptions of Midwives

In section 5.2, it was demonstrated that the concerns of midwives for a pregnant adolescent vary depending if the pregnancy is wanted or unwanted. The adolescent's desirability of their pregnancy can be an indicator for a number of risks throughout the pregnancy. With an unwanted pregnancy being associated with a number of negative attributes, an unwanted pregnancy is undesirable for the adolescent and also the midwives caring for the adolescent. More interestingly, the interviewed midwives spoke of desirability being a state of mind that was fluid and this came from their experiences that an adolescent can change their mind of whether they want the pregnancy or not or from a state of ambivalence. The midwives were very aware that the adolescent's attitude towards her pregnancy was more often the result of the circumstances in which the pregnancy occurred as well as closely intertwined with her social capital. Social capital can provide material resources, as well as immaterial resources in the form of advice and support. Subsequently the quality of the adolescent's social network including a partner or family members and how they would perceive her pregnancy would often have a direct influence on her

attitude. Thus, the midwives would often perceive the desirability as fluid to some extent. The interviewed midwives would often connect an adolescent's negative or ambivalent feelings towards her pregnancy to relationships by describing scenarios where there would be a lack of social capital. This could range from an unsupportive family, an absent partner, violence within the family or living in a poverty-stricken household to name a few. According to the midwives, these factors could be enough to determine whether a pregnancy was wanted or not and where possible midwives would attempt to respond with a solution:

> The good thing about adolescents is that they're transparent… Some of them will ask you directly, "Señora I don't want to have it, where can I take care of it?" Yes they ask, but some don't say directly and you need to ask them, "why don't you want to have the baby? What is the reason? Because you really don't want the baby? Or because it worries you what's going to happen in the future? Or because the family will say something?" If it's one of those reasons they all have a solution and the family will understand. (Interview 7, 2019)

It's the 'habitus' of the adolescent that shapes her attitude towards her pregnancy and habitus is produced through interactions with others such as family members, partners and friends. In this sense, according to the midwives, the desirability of the pregnancy can be fluid and depends on a number of social factors, and an unwanted pregnancy in some cases, translates into something that can be problem-solved, as demonstrated in Interview 7.

5.3.3 Practices of Midwives

Fostering an acceptance of motherhood

All of the interviewed midwives, except Rosa, KI 2, discussed their work in fostering a relationship between the fetus or baby and the adolescent. Supporting an adolescent to accept their pregnancy when the pregnancy is unwanted or when the desirability is ambivalent, was a theme that was discussed by the majority of interviewed midwives. Many had experiences of adolescents changing the desirability towards their pregnancy or baby from one of rejection or ambivalence to one of acceptance. An interviewee who mostly worked in the delivery room discussed how rejection by the mother can be transformed;

> Now with a patient they have right up until the end to make up their mind... because it's normal that sometimes there is a rejection... sometimes we have girls here very young who say no but in the end they want their baby and they want to see their baby... they're very little girls but in the end they end up with the baby on their chest and it's a process. There have been some cases where basically the psychologist takes charge but I as a midwife accompany the whole process and do what I need to, talk to her, inform her, give her confidence, respect her, not blame her, advise her (Interview 4, 2019).

An unwanted pregnancy for many midwives presents many challenges in the midwifery field as it challenges some of the shared beliefs (doxa) of the social position of the midwife in this field. These unquestioned and shared beliefs determine the stability of the social structures in the midwifery field through the way they are reproduced in the midwives' perceptions and practices (Grenfell, 2014). The doxa of midwives as facilitators of childbirth and motherhood, described in 5.1, is unanimously accepted as a shared belief. Another doxa in midwifery was that an adolescent accepting their pregnancy is the best outcome. Alternative pregnancy or parenting options such as therapeutic abortion or adoption were seen as secondary or not viable options in the field of midwifery. As one midwife describes, "And the case of abortion is very hard here because what's the better option that she carries the pregnancy and cares for her baby or gives it up for adoption or she aborts and carries that trauma and guilt for the rest of her life." (Interview 3, 2019). Midwives would often highlight the consequences of interrupting a pregnancy both the physical complications that can arise as well as the guilt and psychological trauma. No midwives interviewed mentioned any positive outcomes from interrupting an unwanted pregnancy or managing an unwanted pregnancy through other alternate options such as adoption.

Many interviewed midwives spoke of their role in shifting the adolescent's desirability of her pregnancy to one of acceptance. Midwives described discussions with adolescents to uncover the motivations that led to an ambivalent or unwanted desirability of her pregnancy. In the cases where the pregnancy was identified as unwanted, most midwives described providing more time with the adolescent, approaching the adolescent with a non-judgmental attitude and where possible responding to the concerns the adolescent may have with the pregnancy. For example, if the reaction of the adolescent's parents is the primary motive of the unwanted desirability of her

pregnancy, the midwife might arrange to speak with the parents (if appropriate) to support the adolescent. The midwives would often attempt to find the root of why the pregnancy is unwanted in order to transform the desirability of the pregnancy and promote pregnancy acceptance. An acceptance of motherhood therefore was considered to be the best and even only solution to an unwanted pregnancy.

Religion and idealized motherhood

Another form of capital in which midwives would often use when responding to an unwanted pregnancy was spirituality or religion. Midwives use this as a cultural capital to connect with adolescents, for example one midwife describes, "And here I always ask if they have a faith whatever it is and it helps. The faith is very important – you find out what faith they have and you work with that" (Interview 3, 2019). Religion is introduced in the midwifery field and used as a resource. This may be a result of a gap in either resources or social structures that exists for midwives in responding to an unwanted pregnancy in the midwifery field. Where midwives may rely on religious values or spiritual beliefs as opposed to healthcare guidelines or resources in responding to an adolescent with an unwanted pregnancy. Religious views was not an area that was included in the interview or survey questions as part of this study however 10 of the 15 respondents organically introduced religion when questioned on adolescents with unwanted pregnancies. Another midwife stated the following:

> I am Catholic so I always ask, do you believe in God? What religion do you follow? And the majority will say that they are Catholic and I say if you believe in life and in God I think the only one that will make the decision is him (God) and this opportunity this experience has a fundamental reason. They need to assume the responsibility and accept the pregnancy (Interview 6, 2019).

The introduction of religion in the interviews may have been a response to the midwives' association with the confliction of abortion and religion. However, it is also evident that the midwifery field does not provide clear structure in any guidelines or protocols (MINSA, 2017) in responding to an adolescent with an unwanted pregnancy. This is translated in a range of responses in order for midwives to adhere to the doxa of - pregnant adolescents should accept their pregnancy. In the abstract above, Interviewee 6 leans on cultural capital using religion to

connect with the adolescent. Rosa, (KI 2) from 'Catholics for the Right to Decide' also elaborated on the role of religion in midwifery:

> Religion is definitely a barrier here. When we talk to health professionals they always talk about how ready they are to preserve and conserve life but I say of course the life of the woman should also be preserved but many maintain this romanticism of maternity as destiny for women and a lot of them have this perception that women should be sacrificed.. So this part is something we really need to work on, the values of health professionals. (Rosa, KI 2, 2020)

The idolization of maternity was a theme discussed by both KI's. This theme was also raised by most interviewed midwives where maternity was expressed as part of their identity and purpose as a midwife. Thus, when circumstances would conflict with these values or beliefs midwives used a number of resources to respond including religion.

Lacking alternatives to motherhood and their consequences

When midwives were asked about alternatives to motherhood, for instance, if there has ever been a case of adoption, the response would often be, "No never" and when asked if the option for adoption exists, one midwife responded, "No it doesn't exist, or at least we don't provide that option here." (Interview, 10, 2019). Midwives would emphasize the difficulties of organizing adoption services when requested or be unaware of the processes involved. Rosa, (KI 2) highlighted the failure of an adequate adoption system in Peru:

> Adoption… Of course it should be a personal decision not that somebody else decides for her, but in our country adoption is chaotic… we have a system very deficient (Rosa, KI 2, 2020).

As a result of the systematic, social and legal boundaries that restrict the range of responses midwives can have towards pregnant adolescents, adolescents are left to adhere to the social rules of the midwifery field. For pregnant adolescents with an unwanted pregnancy this means accepting the boundaries and rules to the midwifery field or accepting exclusion from the midwifery field. Accepting exclusion may occur if the pregnant adolescent does not wish to

adhere to the 'social rules' in the midwifery field, producing a 'hysteresis effect' (Hardy, 2014). The midwives interviewed acknowledged that pregnant adolescents would often be in different positions of power to exercise their reproductive autonomy in pregnancy decisions. The 'higher' position or a more powerful position would be achieved through more capital accumulated. Such as an adolescent with stronger social capital (supportive family and friends) or cultural capital (education level) might be in a better position to make more informed choices. One midwife states:

> It's important that the adolescent makes that decision to interrupt [her pregnancy] well informed and not to decide that in the heat of the moment. If they interrupt the pregnancy, well that's what happens they take that decision but it should be well-informed (Interview 3, 2019).

Many of the midwives, including interviewee 3, acknowledged that most adolescents with an unwanted pregnancy would seek services outside the formal healthcare system in order to interrupt their pregnancy. Where adolescents with an unwanted pregnancy may reclaim reproductive autonomy outside the formal healthcare or midwifery field.

Furthermore, as outlined in section 5.2, often the concerns of the midwives would differ depending on the adolescent's desirability of their pregnancy and thus the perception of the midwife towards the adolescent would shift. As risks were percieved as greater for an adolescent with an unwanted pregnancy. Nearly all interviewed midwives would adjust their practice and response depending on the desirability of the pregnancy. Interviewed midwives described spending more time with an adolescent with an unwanted pregnancy and often put more emphasis in referring an adolescent to a psychologist and other health care professionals. One interviewed midwife described her initial response:

> I always provide something positive, and provide information as much as I can, it's happened few times that they want to interrupt the pregnancy although many do want to go through with the pregnancy... and those that don't want to have the baby I'm always very respectful and I refer to the psychologist for them to evaluate and to help (Interview 4, 2019).

Psychologist referrals

Interviewed midwives described using psychologists as a resource in response to an adolescent with an unwanted pregnancy, although this referral was usually only made if there was a psychologist in the health establishment that the midwife was working in. Where there was a psychologist, midwives would also state that usually all pregnant adolescents would be referred to the psychologist for at least one consultation regardless of the desirability of their pregnancy. Where possible the practice of referring adolescents to a psychologist is embedded in the disposition of midwives as it is recommended and included as part of MINSA's health standard for pregnant adolescents. Although the health standard for pregnant adolescents doesn't mention unwanted pregnancies, midwives highlighted the importance of psychologists, if available, as a resource for adolescents with an unwanted pregnancy specifically. This resource would be used to combat many of the mental and emotional concerns that midwives described, outlined in section 5.2, but also for some midwives a psychologist would be perceived as a resource to manage or defer when faced with an unwanted pregnancy.

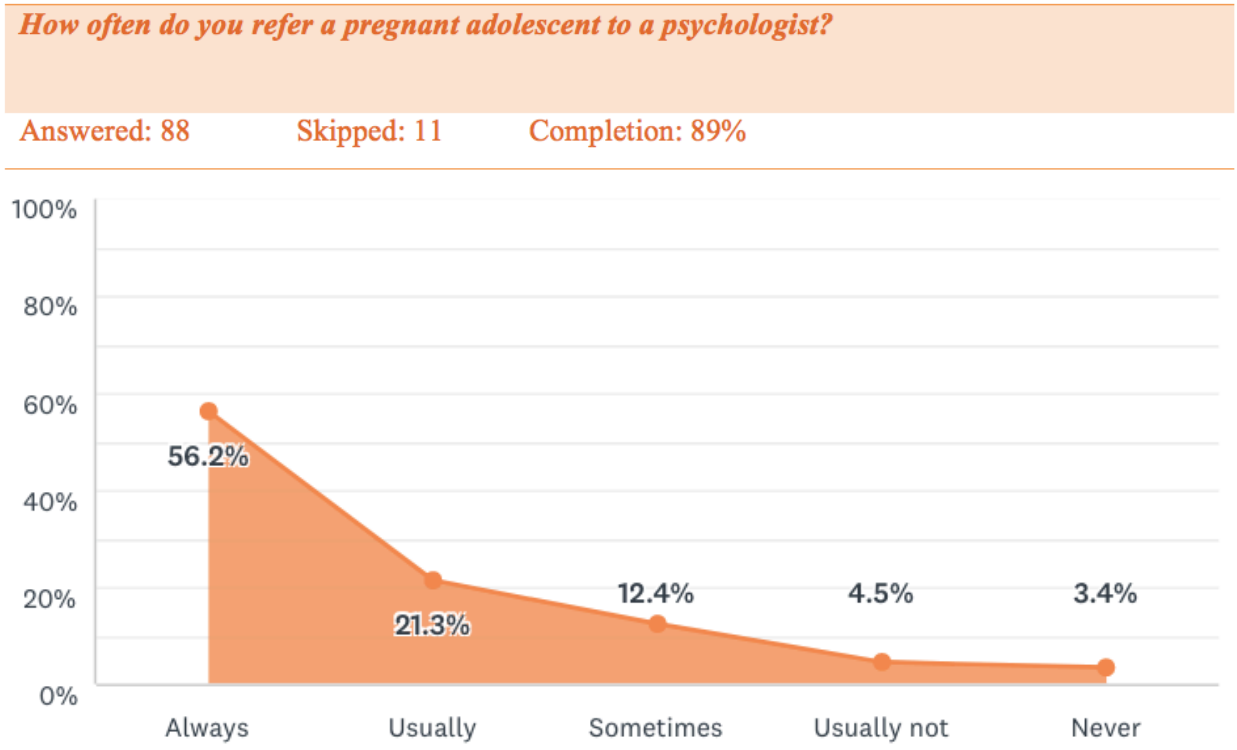
> We talk to all the adolescents and talk about all the possibilities that there are to control that pregnancy and we start talking about the steps on nutrition, how the birth will be... that's basically what we talk about, if the pregnancy is unwanted we would refer to the psychologist where the psychologist would talk to them in relation to that (Interview 8, 2019).

Interviewee 8 states that the psychologist would speak to the adolescent in relation to an unwanted pregnancy as opposed to her as the midwife. She may provide this referral as the psychologist may be better equipped to discuss the desirability of the pregnancy with the adolescent and in addition avoid discussing the unwanted pregnancy which may conflict with the midwifes social norms. Thus, the midwife is able to defend her belief or doxa that pregnant adolescents should give birth, in this circumstance by not having to challenge it. Other interviewed midwives had similar views on the importance of psychological care and would see this as a resource in responding to an adolescent with an unwanted pregnancy. For example, another midwife states:

> I always try to explain why the psychologist is important and if they have any negative thoughts they can talk to them. It is really important to counsel her of the consequences [of abortion] because it is two lives it's not just about her rights but also the rights of the baby… (Interview 6, 2019).

From the interviewed midwives it was evident that midwives were more likely to refer an adolescent with an unwanted pregnancy to a psychologist in comparison to an adolescent with a wanted pregnancy. This was also reinforced in the online survey where many of the midwives that would 'Usually' refer a pregnant adolescent to a psychologist were more likely to 'Always' refer a pregnant adolescent to a psychologist if the pregnancy was unwanted (See Figure 9 and 10).

Figure 9: Psychologist Referral for a Pregnant Adolescent

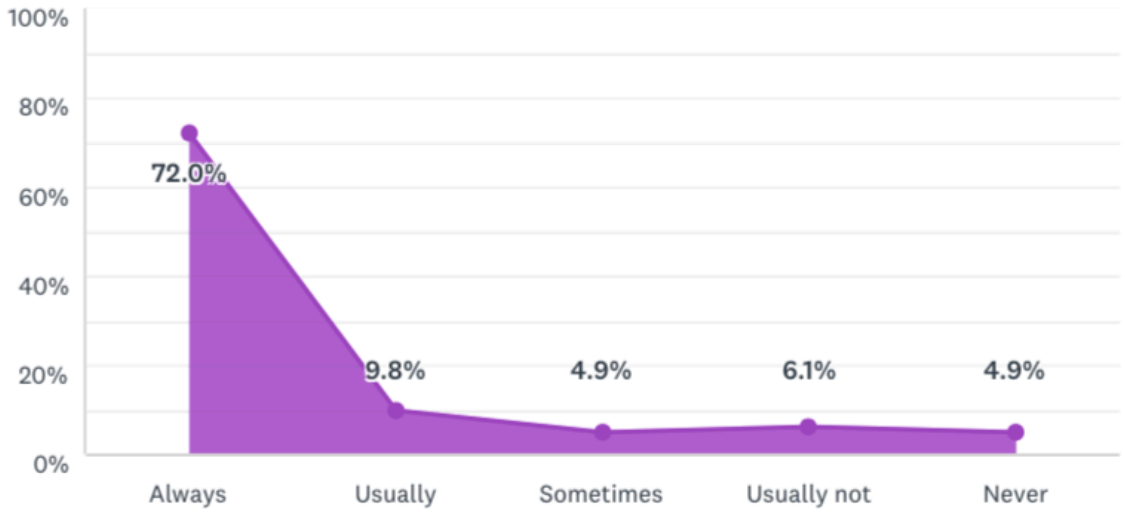


Source: Own primary data from online survey

Figure 10: Psychologist Referral for an Adolescent with an *Unwanted* Pregnancy

How often do you refer an adolescent with an unwanted pregnancy to a psychologist?

Answered: 81 Skipped: 18 Completion: 82%



Source: Own primary data from online survey

In comparing both Figures 9 and 10, it is evident that the midwife's practice of psychologist referral is considerably influenced by the adolescent's desirability of her pregnancy.

Ethical Pressures

Although, the majority of midwives would emphasize the importance of an adolescent accepting her pregnancy and their own role as a midwife in facilitating this process. Many midwives would also share their frustrations when this was not achieved. All midwives shared accounts of adolescents ending in complications and difficulties in caring for adolescents with an unwanted pregnancy. Maria (KI 1) from NSM advocates for more to be done:

> And unfortunately I tell you my testimony one time when I was at the maternity of Lima when I was interning there I was so excited to receive this baby and I say, "Señora here he is" and she says, "throw it out." She said it like that, I stayed blank, his own mum, "throw it out, I don't want to see it." Tell me what do you do in that moment. "No Señora

> here is your baby, it's your son…" That I don't know, when I don't know if she's going to throw it out. Because she was violated, because she was abandoned now you tell me if we don't need another intervention? We need another intervention (Maria KI 1).

Maria (KI 1) expressed frustration when sharing this personal experience, it was conflicting, she didn't blame the mother but instead went on to highlight the circumstances that may have led up to that point.

A midwives' practices may differ depending on their habitus made up of their personal experiences. These however are restricted to some extent by the social constructs or doxa in the midwifery field created by accepted beliefs in that field, which deems what responses are acceptable. Despite the perceptions and responses midwives might have, ultimately pregnant adolescents continue to maintain some level of power and reproductive autonomy, which the interviewed midwives mostly accepted. One midwife from Cusco shares, "I studied to provide life not to take it away. But that's my opinion and I can't deny a young person their choice." (Interview 3, 2019). The interviewed midwives all described the adolescents as active agents.

> There are some adolescents, regardless of how much you talk to them, they will go and find another way, other methods to reject the pregnancy, and those patients we don't see again, and they probably did it [interrupt the pregnancy] (Interview 9, 2019).

Lastly many interviewed midwives stressed the importance of providing the same standard of care to adolescents regardless of the desirability of the pregnancy despite acknowledging that the risks are often very different. Although the interviewed midwives tend to all want the same thing for all pregnant adolescents, not all pregnant adolescents attend their service seeking the same services and this is highlighted by interviewee 9. Ultimately, there seems to be a conflict with the degree of fit between an adolescent with an unwanted pregnancy and the midwifery field or perhaps even the larger health system. Thus, this study illustrates the experience of midwives in brushing up against the social boundaries in the midwifery field that have been established to meet the needs of some populations better than others.

6. CONCLUSION

This qualitative study analyzes the perceptions and practices of midwives in Peru in relation to unwanted adolescent pregnancies using Bourdieu's theory of practice. It demonstrates how an adolescent's desirability of their pregnancy impacts the perceptions and practices of midwives. An unwanted pregnancy was perceived negatively by midwives for the reasons that it is more likely to negatively impact the health and wellbeing of an adolescent but also limits midwives in responding to these risks. This is magnified as midwives expressed that it was harder to engage and provide care to adolescents with an unwanted pregnancy. This is connected to the lack of compatibility of an unwanted pregnancy and the social structures or doxa in the midwifery field. This study demonstrates that midwives may perceive an unwanted pregnancy as conflicting towards their identity (habitus) as midwives. Another accepted perception among midwives was that the desirability of a pregnancy was fluid. Midwives believed that they could and should shape or transform the desirability of an adolescent's pregnancy from unwanted to wanted or facilitate the acceptance of the pregnancy. It was also generally believed among interviewed midwives that pregnant adolescents should accept their pregnancy and motherhood and that this would be the best outcome for adolescents.

The theory of practice highlights how practices and perceptions are interrelated and constantly reinforcing each other, and in turn shaping social norms in the midwifery field. The mechanisms taking place including habitus of midwives, capital and doxa in the midwifery field bind together to increase the likelihood of particular practices tailored towards pregnant adolescents taking place. According to the doxa of midwives an unwanted pregnancy presents challenges in the midwifery field. The rigidity of the health system and current abortion law presents limitations that penetrate to the midwifery field that midwives must adhere to. Thus, the doxa is relative to wider fields and not only shaped by the habitus of the midwives. The doxa ultimately builds the social structures to the midwifery field creating boundaries to the midwives' perceptions and practices. Although the magnified risks that adolescents with an unwanted pregnancy face are well understood by midwives, how they respond to this circumstance is largely associated with navigating and brushing up against the social structures of the midwifery field.

This study adds to the lacking literature and empirical data gap on a widely experienced phenomenon of 'unwanted adolescent pregnancies' and highlights how wider laws and policies can impact health workers in their perceptions and practices towards this phenomenon. Considering there is a large proportion of adolescents and women that experience an unwanted pregnancy, improved structures or systems better fitted to meet this population's needs are lacking. Midwives are positioned in a fairly rigid system and consequently experience a number of challenges when responding to an adolescent with an unwanted pregnancy. According to midwives many adolescents that experience an unwanted pregnancy are often excluded from the formal health system if they do not abide by the social structures expected of them. Acknowledging that unwanted pregnancies will persist at least to some degree, more research should be explored of the social and health outcomes of current strategies and interventions used whilst ensuring satisfaction and dignity for adolescents with an unwanted pregnancy. The dignity of and respect towards pregnant adolescents is essential when undertaking any health interventions as it fosters a good relationship between the healthcare system or midwives and pregnant adolescents, which in turn promotes health-seeking behaviour and patient retention (Prakash, 2010). There could be gains in challenging embedded social norms and structures that may lead to greater possibilities for adolescents within the midwifery field, as the constraints are neither universal nor static.

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APPENDICES

Appendix 1: Online Questionaire

[Original in Spanish]

Background

1. Do you identify as:
- a) Male
- b) Female
- c) Non-binary

2. What is your age?

3. Province:

4. What is your profession?
- a) Midwife
- b) Another Health Profession [Instantly excluded from the study]
- c) Another Profession [Instantly excluded from the study]

5. How long have you worked as a midwife? [years]

6. Do you work in a private or public institution?
- a) Public
- b) Private

7. What type of health institution do you work in?

8. Establishment level:

9. Does your workplace have a protocol to respond to pregnant adolescents?
- a) Yes
- b) No
- c) Unsure

10. Have you attended a pregnant adolescent from 15 to 18 years olds?
- a) Yes, in the last month
- b) Yes, in the last 3 months
- c) Yes, in the last 6 months
- d) Yes, more than 6 months ago
- e) Never
- f) Unsure

Adolescent Pregnancy

11. During adolescent pregnancy care, what is your biggest concern related to the adolescent's health?

12. How often do you refer a pregnant adolescent to a social worker?

a) Always
b) Usually
c) Sometimes
d) Usually not
e) Never

13. How do you refer a pregnant adolescent to a psychologist?

a) Always
b) Usually
c) Sometimes
d) Usually not
e) Never

14. Is there a differentiated service for pregnant adolescents in your work?

a) Yes
b) No
c) Unsure

15. Do you identify if the pregnancy is wanted or unwanted when consulting a pregnant adolescent?

a) Yes I always ask
b) Usually
c) Unsure
d) Usually not
e) No, never

16. Do you think it is important to know if the pregnancy is wanted or not when caring for an adolescent that is pregnant?

a) Strongly agree
b) Agree
c) Unsure
d) Disagree
e) Strongly Disagree

Adolescent with an Unwanted Pregnancy

17. Have you ever attended to an adolescent with an unwanted pregnancy?

a) Yes, in the last month
b) Yes, in the last 3 months
c) Yes, in the last 6 months
d) Yes, more than 6 months ago

e) I'm not sure
f) No, never

18. What is your greatest concern when attending to an adolescent with an unwanted pregnancy?

19. During pregnancy, what do you think are the greatest risks for adolescents with an unwanted pregnancy?

20. How often do you refer an adolescent with an unwanted pregnancy to a psychologist?

a) Always
b) Usually
c) Sometimes
d) Usually not
e) Never

21. An adolescent with an unwanted pregnancy has a higher risk of maternal mortality and morbidity compared to a wanted pregnancy:

a) Strongly agree
b) Agree
c) Unsure
d) Disagree
e) Completely disagree

22. An adolescent with an unwanted pregnancy is entitled to information on sexual and reproductive health:

a) Strongly agree
b) Agree
c) Unsure
d) Disagree
e) Completely disagree

23. An adolescents with an unwanted pregnancy has the capacity to make decisions about her own sexual health:

a) Strongly agree
b) Agree
c) Unsure
d) Disagree
e) Completely disagree

24. Have you ever attended an adolescent seeking to terminate an unwanted pregnancy?

a) Yes, in the last 3 months
b) Yes, in the last 6 months
c) Yes in the last 12 months
d) Yes more than 12 months ago
e) Unsure
f) No, never

Therapeautic Abortion
25. Therapeautic abortion may be an option in cases where the life or welfare of the mother is at risk of permanent damage: a) Strongly agree b) Agree c) Unsure d) Disagree e) Completely disagree **26. I never provide information about therapeautic abortion due to the legal framework that exists:** a) Strongly agree b) Agree c) Unsure d) Disagree e) Completely disagree **27. Does your workplace provide therapeautic abortions on site when necessary?** a) Yes b) No c) Unsure **28. Do you know where an adolescent could access a therapeautic abortion when necessary?** a) Yes b) No c) Unsure **29. If the pregnancy seriously affects the mental or emotional health of adolescents, the regulations consider therapeautic abortion as a possibility:** a) Strongly agree b) Agree c) Unsure d) Disagree e) Strongly disagree

Appendix 2: Interview Guide

[Original in Spanish]

Introduction to the Study

a) Firstly thank-you for your time today and agreeing to take part in this study.
To present myself, my name is Tessa Stockburger I am a student at Lund University in Sweden and also a current intern at the Population Fund of the United Nations. This study is with midwives from a range of different health establishments including primary healthcare centres, hospitals and tertiary level health facilities.
I am originally from Australia and Spanish is not my native language so if there is something you don't understand or would like me to repeat please let me know.
To start off I have an executive summary of the study which provides you information of what the study is about, who is involved, the objectives and background. After you have read through this, I have a consent form, a copy for me and for you and if it all sounds good to you, we will both sign and then go ahead with the interview. Is this ok for you?

b) Executive summary is provided, discussed and any questions answered.
c) Consent form read, understood and if agreed upon, signed.
d) *I know it's mentioned in the consent form but I would just like to ask again if it's ok that I audio record the interview and if yes, if you're ok if I start it now?*
e) The Interview

Section A: Background

1. To start off could you present yourself and tell me a little about yourself, your age, work experience, current workplace?

1.1 Is your current workplace public or private?
1.2 How long have you been working at your workplace?
1.3 What is your role at your current workplace?

Section B: Adolescents

[Define adolescents]

2. What do you like about working with adolescents?
3. Do you believe adolescents have the capacity to make decisions on their own sexual health?
4. What do you think are the biggest barriers for adolescents in accessing sexual and reproductive health? And why?

Section C: Adolescent Pregnancy

5. What is your opinion of adolescent pregnancy here in Peru?

6. Have you ever consulted a pregnant adolescent 15-19?
   If yes:

6.1. Approximately how many pregnant adolescents have you consulted in the last month?

7. Normally when a pregnant adolescent comes into your workplace who is the first health professionals that they will see in a consultation?

8. Could you describe some of the first processes a pregnant adolescent will experience when entering your workplace for the first time?

9. Does your workplace have the adequate resources and protocols to meet the sexual and reproductive health needs of pregnant adolescents?
   If yes:

9.1. What kind of resources or protocols?

10. What other health professionals are you likely to refer a pregnant adolescent that you see?
10.1 Do you ever refer a pregnant adolescent to a psychologist? (inside or outside your workplace)
10.2 Do you ever refer a pregnant adolescent to a social worker? (inside or outside your workplace)

11. What are your greatest concerns when you attend a pregnant adolescent during her pregnancy? And why?

12. What do you think are the biggest risks for a pregnant adolescent during her pregnancy? And why?

Section D: Adolescents with an Unwanted Pregnancy

We know that the majority of adolescent pregnancies are not planned and of these unplanned pregnancies we no many of them are also unwanted. In these next few questions I'd like to ask you specifically about unwanted pregnancies among adolescents. [Define unwanted pregnancy]

13. When you attend to a pregnant adolescent do you identify if the pregnancy is wanted or not?

14. Do you think it is important to know if the pregnancy is wanted or unwanted for an adolescent? Why or Why not?

15. How many times in the last 3 months have you consulted an adolescent with an unwanted pregnancy?
15.1 If yes, can you describe how you respond to an adolescent with an unwanted pregnancy?
15.2 If yes, What information would you provide that adolescent?

16. What is your opinion of unwanted pregnancies among adolescents in Peru?

17. Are there any protocols or any resources in your workplace specifically regarding unwanted pregnancies?

18. What are your greatest concerns when attending to an adolescent with an unwanted pregnancy? And why?

19. Do you think the risks are different for an adolescent with an unwanted pregnancy as opposed to a wanted pregnancy?
19.1 Is there anything you or your workplace does to address or avoid those concerns or risks?
19.2 Do you refer an adolescent with an unwanted pregnancy to any other health professionals?

20. Do you think an unwanted pregnancy affects the mental health of an adolescent? How and why?

21. How might an unwanted pregnancy affect the life of an adolescent?

22. Have you ever consulted an adolescent that has wanted to interrupt her pregnancy?
22.1 If yes how did you respond to that?

23. Do you think the services or attention provided should be different for an adolescent with an unwanted pregnancy versus an adolescent with a wanted pregnancy? Why or why not?

Section E: Therapeautic Abortion

The next few questions will be in reference to therapeautic abortion here in Peru.

24. What is your opinion on therapeautic abortion and the current protocol here in Peru?

25. Do you know where an adolescent or adult would be able to access a therapeautic abortion when it might be necessary?

26. Do you think information of therapeutic abortion is important? Why or why not?

27. Do you think there are barriers for someone accessing a therapeutic abortion when it is neccesary? If yes what?

Section F: End of Interview

28. That's the end of the interview, are there any other comments, thoughts or experiences that come to mind or that you would like to add related to anything we've spoken about today?

Thank-you so much for your time today. Are there any questions you would like to ask me?

Appendix 3: Executive Summary of Study

LUND UNIVERSITY

RESUMEN DE LA INVESTIGACIÓN

Actitudes de las y los obstetras en la atenciòn de la salud sexual y reproductiva para adolescentes embarazadas en Perú

I. ANTECEDENTES

En Perú, el embarazo adolescente continúa siendo un problema de salud publica, donde la variable del embarazo coloca a la adolescencia en una posición mucho más vulnerable frente a una serie de riesgos para la salud. Los embarazos adolescentes son mucho más propensos a ser no planificados y no deseados, lo que agrava los riesgos para la salud física y mental. Además, las adolescentes también se enfrentan a una serie de barreras para acceder a los servicios de atención de la salud sexual y a la información, como el estigma, la discriminación y los factores institucionales estructurales. En el contexto de Perú, las/los obstetras son el recurso humano de salud que proporcionar información sobre salud sexual a adolescentes embarazadas. Por lo tanto, obtener una mejor comprensión de las ***actitudes de las/los obstetras*** es fundamental para fortalecer mejor las necesidades de salud sexual y reproductiva de los adolescentes en Perú.

II. OBJETIVO

La propuesta de tesis está enfocada en embarazos adolescentes y el rol de la/el obstetra. El objetivo de la investigación es identificar si actitudes de las/los obstetras influyen la entrega de información de salud sexual y reproductiva proporcionada a las adolescentes embarazadas. Esta información y evidencia pueden contribuir a los esfuerzos para comprender mejor cómo mejorar el acceso a la atención sexual y reproductiva para adolescentes embarazadas. También se enfocará en conocer si las adolescentes embarazadas reciben atención psicológica y apoyo social.

IV. METODOLOGÍA

Este estudio está centrado principalmente en obstetras en contacto con adolescentes embarazadas. Hay dos formas de metodología en esta investigación: 1) entrevistas personales y 2) cuestionarios anónimos en línea.

Mediante el uso de un cuestionario en línea, este estudio tiene el potencial de incluir una proporción más amplia de obstetras fuera de Lima para llegar a las/los obstetras que trabajan en entornos más rurales. El cuestionario será anónimo.

V. ÉTICA

Este estudio será tratado con el más alto nivel de sensibilidad con una serie de consideraciones éticas incluidas. No se buscará ni documentará la información de identificación de los pacientes de las obstetras y todas las entrevistas serán voluntarias. Además, las encuestas en línea se completarán de forma anónima con el consentimiento solicitado en línea. Esta propuesta de investigación fue recibida y aprobada por el Departamento de Salud Pública de la Facultad de Medicina de la Universidad de Lund (Suecia) y cumple estrictamente con la Declaración de Helsinki (1997).

Appendix 4: Consent Form

CONSENTIMIENTO INFORMADO

Estudio: Actitudes de las/los obstetras en la atención de la salud sexual y reproductiva de adolescentes embarazadas en Perú

Consentimiento para participar en este estudio

Yo……, acepto voluntariamente participar en este estudio de investigación.

- Entiendo que incluso si acepto participar ahora, puedo retirarme en cualquier momento o negarme a responder cualquier pregunta sin consecuencias de ningún tipo.
- El propósito y la naturaleza del estudio me han sido explicados por escrito y he tenido la oportunidad de hacer preguntas sobre el mismo.
- Entiendo que la participación implica una entrevista cualitativa cara a cara.
- Entiendo que no recibiré compensación por mi tiempo o participación en este estudio.
- Acepto que mi entrevista se grabe en audio.
- Entiendo que toda la información que proporcione para este estudio será tratada de manera confidencial.
- Entiendo que en cualquier informe sobre los resultados de esta investigación, mi identidad permanecerá anónima. Esto se hará cambiando mi nombre y ocultando cualquier detalle de mi entrevista que puede revelar mi identidad o la identidad de las personas de las que hablo.
- Entiendo que los extractos disfrazados de mi entrevista pueden citarse en documentos publicados.
- Entiendo que soy libre de contactar a la investigadora principal involucrado en la investigación para buscar aclaraciones e información.

Tessa Stockburger
Investigadora Principal Universidad de Lund, Suecia
Pasante de Fondo de Población de Naciones Unidas Perú
+51 988 297 093
Stockburger@unfpa.org

Firma del Participante…… Fecha……

Yo, Tessa Stockburger confío en que el participante está dando su consentimiento informado para este estudio.

Firma de la Investigadora Principal …… Fecha……

Appendix 5: Log Record of all Interviews

No.	Gender	Date of Interview	Workplace	Place of Interview	Length of Audio Recording
1	F	3.12.19	National Maternal Perinatal Institute	UNFPA office	01:10:53
2	F	07.12.19	National Maternal Perinatal Institute	Workplace of Interviewee	00:59:00
3	F	07.12.19	National Maternal Perinatal Institute	Workplace of Interviewee	02:08:32
4	F	09.12.19	National Maternal Perinatal Institute	Workplace of Interviewee	01:21:46
5	F	10.12.19	National Maternal Perinatal Institute	Workplace of Interviewee	01:24:52
6	F	12.12.19	Health Establishment	Cafe	01:31:57
7	F	12.12.19	Education	UNFPA office	01:14:32
8	M	14.12.19	Hospital 1	Café	36:34:00
9	F	14.12.19	Hospital 2	Workplace of Interviewee	01:34:28
10	F	16.12.19	National School of Midwifery	Workplace of Interviewee	02:17:04
11	F	16.12.19	Hospital 3	Home of interviewee	00:36:15
12	F	19.12.19	Hospital 2	Workplace of Interviewee	01:17:43
13	F	19.12.19	Hospital 2	Workplace of Interviewee	0:55:30
14	F	09.01.20	Catholics for the Right to Decide	Workplace of Interviewee	01:08:03
15	M	19.12.19	Health Establishment	Phone Interview	01:36:08

Key Midwife Informant F: Female M: Male

Source: Own Primary Data

Appendix 6: Detailed List of all Online Entries

NO.	Survey Entry Date	Gender	Age	Region	Yrs Exp	Public /Private	Level of Health Est.	Completion	Workplace
1	9.01.2020	F						Disqualified	
2	9.01.2020	F	25-34	Lima	5	Public	N/A	Completed	Education
3	9.01.2020	F	25-34	Lima	3	Private	Secondary Health Service	Completed	Clinic
4	9.01.2020	F	35-44	Lima	10	Private	N/A	Completed	Study Centre
5	9.01.2020	F	25-34	Lima	5	Private	Primary Health Service	Completed	Polyclinic
6	9.01.2020	F	55-64	Lima	29	Private	Primary Health Service	Completed	Private clinic
7	9.01.2020	F	<25	Piura	1	Private	Primary Health Service	Completed	Health Establishment
8	9.01.2020	M	35-44	Piura	18	Public	Primary Health Service	Completed	Health facility
9	10.01.2020	-	-	-	-	-	-	Disqualified	-
10	10.01.2020	F	55-64	Ayacucho	39	Public	Primary Health Service	Completed	Maternal and Infant care
11	10.01.2020	F	45-54	Ucayali	9	Public	Primary Health Service	Completed	Health Centre
12	10.01.2020	F	65<	-	-	Private		Incomplete	Hospital
13	10.01.2020	F	45-54	Pasco	18	Public	Primary Health Service	Completed	Health Facility
14	10.01.2020	F	55-64	Pasco	28	Public	Primary Health Service	Incomplete	Hospital
15	11.01.2020	F	25-34	Lima	15	Public		Incomplete	CEM/ MIMP
16	11.01.2020	F	35-44	Lima	15	Public	Primary Health Service	Completed	Establishment
17	11.01.2020	F	25-34	Lima	6	Public	Primary Health Service	Completed	
18	11.01.2020	F	45-54	Lima	20	Public	Primary Health Service	Completed	Clinic
19	11.01.2020	F	45-54	Lima	10	Public	Primary Health Service	Completed	Clinic

20	11.01.2020	F	45-54	Lima	15	Public	Tertiary Health Service	Completed	Clinic
21	11.01.2020	F	25-34	Lima	7	Public	Primary Health Service	Incomplete	Maternal Centre
22	11.01.2020	F	45-54	Lima	10	Public	Primary Health Service	Completed	Health facility
23	11.01.2020	F	25-34	Puno	11	Public	Primary Health Service	Completed	Health Establishment
24	11.01.2020	F	35-44	Cusco	13	Public	Primary Health Service	Completed	Clinic
25	11.01.2020	F	45-54	San Martin	15	Public	Tertiary Health Service	Completed	Health facility
26	11.01.2020	F	55-64	Huancavelica	31	Private	Primary Health Service	Completed	Consulting
27	11.01.2020	F	35-44	Ica	11	Public	Secondary Health Service	Completed	Health Establishment
28	11.01.2020	F	45-54	Arequipa	25	Public	Primary Health Service	Completed	Health Establishment
29	11.01.2020	F	45-54	Arequipa	20	Public	Primary Health Service	Completed	Health facility
30	11.01.2020	F	45-54	Puno	18	Public	Primary Health Service	Completed	Health Establishment
31	11.01.2020	F	45-54	Puno	24	Public	Secondary Health Service	Completed	Hospital
32	11.01.2020	F	35-44	Puno	10	Public	Primary Health Service	Completed	Clinic
33	11.01.2020	F	45-54	Madre de Dios	8	Public	Primary Health Service	Completed	Health Establishment
34	11.01.2020	F	25-34	Cusco	2	Public	Primary Health Service	Completed	Health facility
35	11.01.2020	M	35-44	Arequipa	12	Public	Primary Health Service	Completed	Clinic
36	11.01.2020	F	45-54	Lima	20	Private	NA	Completed	NGO
37	11.01.2020	M	35-44	San Martin	15	Public	Primary Health Service	Incomplete	Health facility
38	11.01.2020	F	55-64	Tacna	30	Public	Primary Health Service	Completed	Health Centre

39	11.01.2020	F	55-64	Piura	29	Public	Primary Health Service	Completed	Health Establishment
40	11.01.2020	F	25-34	Ucayali	8	Public	Secondary Health Service	Completed	Hospital
41	11.01.2020	F	45-54	Lima	10	Private	-	Completed	Consulting
42	11.01.2020	F	45-54	Cusco	25	Private	Tertiary Health Service	Completed	Hospital
43	11.01.2020	F	<25	San Martin	2	Public	Primary Health Service	Incomplete	Health Establishment
44	11.01.2020	F	35-44	Lima	4	Public	Primary Health Service	Incomplete	Health Centre
45	11.01.2020	F	25-34	San Martin	9	Public	Primary Health Service	Completed	Hospital
46	11.01.2020	F	45-54	San Martin	30	Public	Primary Health Service	Completed	Hospital
47	11.01.2020	F	45-54	San Martin	20	Public	Primary Health Service	Completed	Health Centre
48	11.01.2020	F	35-44	San Martin	14	Private	-	Completed	Consultation
49	11.01.2020	F	25-34	San Martin	2	Private	-	Incomplete	-
50	11.01.2020	F	25-34	Lima	11	Public	Primary Health Service	Completed	Health Establishment
51	11.01.2020	F	25-34	San Martin	3	Public	Primary Health Service	Completed	Health Establishment
52	12.01.2020	F	45-54	Lima	20	Public	Level 2- 1	Incomplete	Hospital
53	12.01.2020	F	55-64	Lima	20	Private	Primary Health Service	Incomplete	Health Establishment
54	12.01.2020	F	55-64	San Martin	30	Public	Primary Health Service	Completed	Health Centre
55	13.01.2020	F	65<	Lima	33	Public	Tertiary Health Service	Incomplete	Health Centre
56	13.01.2020	F	45-54	Callao	12	Private	-	Incomplete	-
57	14.01.2020	F	45-54	Ucayali	15	Public	Primary Health Service	Completed	Health Centre

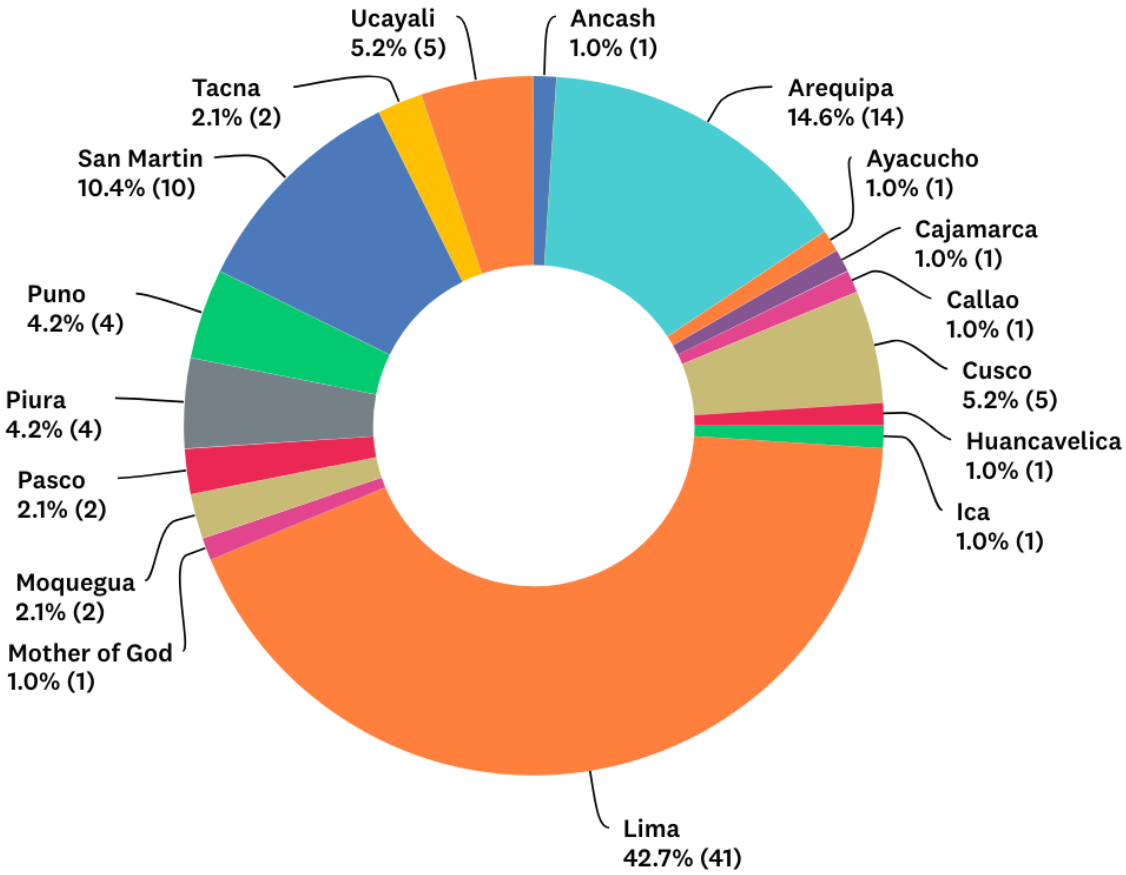
58	14.01.2020	F	45-54	Arequipa	-			Incomplete	
59	14.01.2020	F	25-34	Arequipa	3	Public	Primary Health Service	Incomplete	Health Centre
60	14.01.2020	F	45-54	Arequipa	20	Public	Primary Health Service	Completed	Health Centre
61	15.01.2020	F	35-44	Lima	6	Public	Primary Health Service	Completed	Health Centre
62	15.01.2020	F	45-54	Lima	1	Public	Secondary Health Service	Completed	Health Establishment
63	16.01.2020	F	35-44	Ancash	12	Public	Tertiary Health Service	Incomplete	Hospital
64	16.01.2020	F	45-54	Cusco	20	Public	Secondary Health Service	Completed	Health Establishment
65	16.01.2020	F	35-44	Lima	-	-	Professional Association	Completed	CRO III
66	16.01.2020	F	55-64	Lima	25	Public	Tertiary Health Service	Completed	INMP
67	16.01.2020	F	45-54	-	20	Public	Secondary Health Service	Completed	Hospital
68	16.01.2020	F	55-64	Lima	30	Public	Primary Health Service	Completed	Health Centre
69	16.01.2020	F	35-44	Moquegua	10	Public	Primary Health Service	Completed	Health Establishment
70	16.01.2020	F	35-44	Cajamarca	15	Public	Primary Health Service	Completed	Health Establishment
71	16.01.2020	M	45-54	Ucayali	19	Public	Secondary Health Service	Completed	Hospital
72	16.01.2020	F	55-64	Lima	25	Public	Primary Health Service	Incomplete	Health Establishment
73	16.01.2020	F	55-64	Tacna	31	Private	Primary Health Service	Completed	Consultation
74	16.01.2020	F	45-54	Lima	23	Private	Secondary Health Service	Completed	Clinic
75	16.01.2020	F	35-44	Lima	15	Public	Primary Health Service	Completed	Health Establishment
76	16.01.2020	F	35-44	Lima	20	Public	Tertiary Health Service	Completed	Health Centre

77	16.01.2020	F	35-44	Lima	20	Public	Primary Health Service	Completed	Maternal Centre
78	16.01.2020	F	55-64	Lima	30	Public	Primary Health Service	Completed	Maternal and Infant care
79	16.01.2020	F	45-54	Lima	20	Public	Primary Health Service	Incomplete	Health Establishment
80	16.01.2020	F	55-64	Lima	30	Public	Tertiary Health Service	Completed	Health Centre
81	16.01.2020	F	35-44	Lima	15	Public	Primary Health Service	Incomplete	Health Establishment
82	17.01.2020	F	55-64	Piura	25	Public	Primary Health Service	Incomplete	Health Centre
83	17.01.2020	F	55-64	Lima	31	Public	Primary Health Service	Completed	Health Establishment
84	17.01.2020	F	45-54	Lima	22	Public	Primary Health Service	Completed	Health Establishment
85	17.01.2020	F	65<	Lima	36	Public	Tertiary Health Service	Completed	Health Centre
86	17.01.2020	F	55-64	Lima	28	Public	Primary Health Service	Completed	Health Establishment
87	17.01.2020	F	45-54	Moquegua	27	Public	Primary Health Service	Incomplete	Health Centre
88	18.01.2020	-	35-44	Ucayali	13	Public	Secondary Health Service	Completed	Hospital
89	18.01.2020	F	55-64	Lima	27	Public	Tertiary Health Service	Completed	Hospital
90	18.01.2020	F	45-54	Arequipa	6	Public	Primary Health Service	Completed	Health facility
91	19.01.2020	F	45-54	Arequipa	20	Public	Primary Health Service	Completed	Clinic
92	20.01.2020	F	55-64	Lima	28	Public	Tertiary Health Service	Completed	Hospital
93	22.01.2020	M	35-44	Lima	5	Public	Primary Health Service	Completed	Health facility
94	22.01.2020	F	45-54	Arequipa	15	Public	Primary Health Service	Completed	Health facility
95	22.01.2020	F	25-34	Arequipa	3	Public	Primary Health Service	Completed	Health Centre

96	24.01.2020	M	45-54	Cusco	16	Public	Primary Health Service	Completed	-
97	24.01.2020	F	25-34	Arequipa	5	Public	Primary Health Service	Completed	Health Establishment
98	25.01.2020	F	45-54	Arequipa	24	Public	Primary Health Service	Completed	Health facility
99	26.01.2020	F	25-34	Arequipa	2	Public	Primary Health Service	Incomplete	Health Centre
100	28.01.2020	F	45-54	Arequipa	10	Public	Primary Health Service		Clinic
101	28.01.2020	F	45-54	Lima	16	Public	Primary Health Service	Incomplete	-

Disqualified

Appendix 7: Regional Location of Online Survey Respondents



Source: Own primary data from online survey
Note some regions are not represented.