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"We keep quiet": exploring the context of pregnancy intention in a low-resource community in Ecuador

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Abstract: *Unintended pregnancies are both a consequence and a cause of socioeconomic inequality. Family planning prevents unintended pregnancy and reduces health disparities. The purpose of this study is to describe the structural, social, economic context of pregnancy intention in a peri-urban, diverse, low-resource community in Ecuador. A qualitative descriptive methodology was used. Semi-structured individual interviews were performed with 19 female participants of reproductive age. Interviews were professionally transcribed in Spanish, translated into English, and analysed in MAXQDA using content analysis. The majority of pregnancies were reported as unintended and four themes emerged to describe the context. (1) Women's autonomy is limited by men, (2) Women keep quiet, (3) Systems failed women, and (4) Building resilience. Health systems, gender-based violence, limited education and financial means, and policies yet to be enforced served as barriers to both empowerment and family planning. In spite of this, many women were able to transition into safety, and prevent or delay pregnancy with new partners. Ecuador has made significant economic gains in the past two decades, but these findings suggest that inequality persists in some regions of Ecuador. The women in this study report needing to feel safe, productive and valued to plan their families. Public health professionals need to involve multi-sectors in solutions to reduce health disparities and address determinants of maternal/child health including gender-based violence, economic and systemic limitations.*
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Introduction and background

Latin America has the highest rate of socioeconomic inequality in the world, which creates unjust and avoidable inequities in health and well-being.[1] Ecuador seemingly reversed this trend in Latin America when, over the last several decades, it increased oil exports and investment in social, health and poverty-reduction programmes.[2] But this progress was not sustained, in 2014 oil prices fell, investments in social programmes decreased. This led to greater inequality and affected the health and well-being of people living in poverty.[2] Reproductive health services are sensitive to disruption and rationing during economic downturns. This is of particular concern regarding the access to contraception, as unintended pregnancy is both a cause and a consequence of inequality that perpetuates the cycle of poverty.[3,4] Women with lower levels of education and economic means or those marginalised by race, ethnicity, social class and violence have greater challenges accessing and using contraception.[5–11] The consequences of this include fewer educational and economic opportunities for both the mother and her offspring, as well as a greater likelihood of adverse maternal and child health outcomes which impose greater long term direct and indirect costs for the family.[3,9,10,12,13] The context of inequality in a community can also be related to pregnancy intention. Teen pregnancies (of which the majority are unintended) tend to occur where income inequality is high.[14] Living in a community with high rates of gender inequality also can significantly increase a woman's odds of having an unintended pregnancy.[15]

Promoting socioeconomic equality of women involves understanding context-specific barriers women face in controlling whether and when to become pregnant. In 2008 Ecuador adopted a human rights-based approach to reproductive health. The amended constitution acknowledged all adults and adolescents have "the right to make free, responsible and informed decisions about their health and reproductive life and to decide when and how many daughters and sons to have" (Art. 66, section 10).[16] However, creating effective policies, dissemination, and training about these rights has been slow and inconsistent, especially for adolescents and young adults living in impoverished communities.[17] Language regarding abortion was notably absent in this human rights framework. Since 1938, abortion has been largely illegal except if the life of the pregnant women was in danger or if a rape happened to a woman with mental disabilities.[18] In 2014, 15.6% of all maternal deaths in Ecuador were related to unsafe abortion.[19] In the same year, the Ecuadorian government approved a new section to the penal code indicating that women and health care providers could be sentenced to two years in prison for having an elective abortion or assisting with one.[20]

Ecuadorian women over the age of 18 who are married or in a long-term union report that their contraceptive needs are largely met, only 9% reported an unmet need.[21] The overall contraceptive prevalence rate for this population was 72.5%, and more than half (58.2%) report using modern contraception methods.[22] This data does not reflect the unmet contraceptive needs for younger women/adolescents or those who are unmarried and not in a long-term union. The data also does not reflect the complexities of obtaining and using contraception consistently, as women may have access to contraception but either cannot exercise this right due to stigma, coercion or violence, or the methods they preferred were not available. A 2014 United Nations report found that women in Ecuador with lower levels of education and in the lowest quartile for income had over five children on average whereas the overall fertility rate is 2.4.[23] Ecuador has the second highest percentage of teen births in South America, with 20% of girls aged 15–19 having more than one child in the household. In addition, 70% of women in Ecuador report experiencing intimate partner violence, which is associated with both higher rates of unintended pregnancy and one of the highest expenditures in healthcare services for the country.[23–25]

Purpose

The purpose of this study is to describe the structural, social, economic and cultural context of women's reproductive health and how these factors influence pregnancy intention in a low-resource, peri-urban community in Ecuador. The long-term goal of this work is to generate essential data needed to inform further research and design interventions to reduce health disparities and inequality by removing barriers to family planning.

Methods

Study design and setting

The Universidad de San Francisco, Quito, Ecuador (USFQ) Bioethics Board approved our study, followed by approval in the United States by the University of Kentucky Institutional Review Board (IRB). The study followed a qualitative descriptive approach with feminist and ethnographic overtones, which is a suitable methodology where the primary focus is the description and experience of women.[26] The in-depth, semi-structured interviews were conducted in a peri-urban community within the province of Santo Domingo de los Tsáchilas, Ecuador. The community has experienced rapid growth over the last 20 years and is accessible to the neighbouring city by bus, but services such as roads, electricity, and piped water are limited. The interviews took place in three adjoining neighbourhoods served by a private clinic funded by an Ecuadorian foundation. This community was selected because there was an established, ongoing university-affiliated relationship with the foundation, the clinic's medical providers, and staff.

Prior to interviewing women for the current study, 12 health providers and community leaders were interviewed by the principal investigator (PI) and research assistant (RA) to better understand the context of reproductive health and family planning. These 12 interviews were included in the same IRB to gather preliminary data to inform the research team and the final version of the semi-structured interview guide with women of reproductive age. They included public officials (Ministry of Health and elected offices), physicians, the faith community, community health workers, and nurses. The Conceptual Framework of Preconception Care developed by Bhutta et al. in 2011 to identify underlying, intermediate, and immediate issues before and between pregnancies to improve

birth outcomes was translated into Spanish and used as a guide for these preliminary interviews.[27] The health providers and community leaders described the maternal and child health issues they believed were due to a lack of family planning. Specifically, they described women who had closely spaced pregnancies, high rates of anaemia, poor nutrition, disabilities, women having more children than they wanted or that they could adequately care for, and high rates of teen pregnancies.[28] They described the barriers they believed inhibited women from seeking family planning as arising from the influence of male chauvinism and gender-based violence, religion, stigma of seeking contraception when young or unmarried, challenges with health literacy, and inadequate access due to poverty. In addition, the community leaders described challenges related to social support due to the migratory nature of the neighbourhoods, as many families had recently moved from rural areas, Columbia, and coastal communities.[28] These topics were reflected in the interview guide which was pilot tested with three Ecuadorian women of reproductive age.

Data collection

Stratified and purposive sampling strategies were used to ensure relatively equal representation of women in each of the three neighbourhoods with a range of ages and races/ethnicities that represented the community. The community leaders provided the study team with women's groups or meeting places to initiate recruitment. Two of the three communities had women's groups established by the government for economic development. Between June and December of 2016, 19 women ($n = 19$) were recruited and interviewed. Inclusion criteria included being a female of reproductive age (18–45 years) and residing in one of the three communities. Exclusion criteria included being pregnant or inability to speak Spanish, as there was no immediate access to interpreters of indigenous languages. While there are some inconsistencies regarding the reporting of intention status during pregnancy versus after the birth,[29] the study team decided to explore only the retrospective assessment in the scope of this study as including pregnant women would have required greater scrutiny by both the US and Ecuadorian IRB in terms of protections for "vulnerable" populations.

A university student from the adjacent city was trained as the research assistant (RA) to uphold a naturalistic paradigm. The RA was also a co-author and part of the research team. She completed all study-related training, including an online course in qualitative methodology, Collaborative Institutional Training Initiative (CITI) programme, and a certification as a Spanish-English translator. Furthermore, the local partnering foundation endorsed selection of this RA due to her Ecuadorian status and community engagement experience. All of the participants were contacted by the RA and screened for eligibility. If eligible, the purpose of the study was explained, and consent obtained by the RA.

The interviews took place in private rooms in community centres and churches, in mutually agreed upon locations, and lasted approximately 45 min. A semi-structured interview guide with open-ended questions and prompts was developed from the prior interviews with leaders. Brief demographic characteristic questionnaires were completed after the interviews took place. All interviews were audio-tape recorded, translated, and transcribed by certified translators. Participants were compensated $10 USD (which is the currency of Ecuador) for their time.

The interview guide began with general questions regarding the health of women and children in the community, how long the participants have lived there, what brought them to the area, encouraging them to be comfortable and open to share their story. Next, the questions were more personal, about their own health and health care, and the health of their family, which led to asking about their children and details about their pregnancies. This led to questions regarding how they learned about reproduction and conception, first sexual experiences, relationships, challenges with birth control or reproductive health, pre-conception care, and finally details about the planning or intention of each of their pregnancies. The reproductive planning question included prompts for cultural influences (gender roles, religion, family pressure and norms). The remainder of the questions focused on their ideal family planning situation, reflecting on the past, advice for their children/grandchildren and in the future.

Data analysis

Analysis of the interviews included an iterative process in which the audio recordings were all de-identified (assigned a number) and added to a private Dropbox file for the research team access within one to two days of the interview. The

research team was made up of the three authors, two of whom are native Spanish speakers and fluent in English, the Ecuadorian RA/student and a Chilean midwife certified in Ecuador and Associate Professor in the United States (US). The third member is the principal investigator (PI), her first language was English; although she is highly proficient in Spanish, she is not fluent. The PI has worked with the Ecuador partners since 2009 and is an Assistant Professor in the United States. Ideally the study would have been completed entirely in Spanish so that translation did not influence the trustworthiness and credibility of the data, but due to the PI's lack of fluency in Spanish, a cross-language methodology was used.[30] The team would listen to each recording, keep field notes, discuss each interview, clarify any interpretation issues to assure conceptual equivalence, and recommend different interviewing approaches and prompts to elicit greater depth of future interviews. This was a very useful process to understand the environment and the emotion. For example, the audio recordings might include the surrounding animal noises and loud construction, the speaker's pauses, as well as their expressions of joy and sorrow. The team was very deliberate in discussing and reviewing interpretation and translation issues throughout the process. The first four interviews were transcribed and translated by the RA to assure the PI (non-fluent) was understanding the context, and her field notes aligned with the team. When each of the three communities was well represented and the women were reporting similar experiences, the research team determined saturation at 19 women.

After all interviews were transcribed in Spanish and translated into English, content analysis was done by coding categories largely derived directly from the data.[31] This process entailed reading and re-reading English transcripts with open coding by hand in the margins, merging field notes, and collaborating with the RA to include her codes from the first four interviews. These initial codes were then used to develop a coding schema in MAXQDA version 12. More codes were added as needed, and several quotes had more than one code and category. Next, earlier interviews were reviewed to see if they also needed to include the newer codes, which was followed by identifying broader categories. MAXQDA was also used to organise the demographic characteristics by participant and categorise information by communities, and later to cross reference codes and merge into categories and themes. Other approaches to the content analysis included peer debriefing to reflect initial categories and themes with the community health nurse and community health worker who work closely with families in the same communities. The data were then merged into four primary themes. Table 1 illustrates examples of the content analysis.

Findings

Description of sample

Nineteen participants were interviewed and the women in the study were from diverse backgrounds. The most populous race/ethnicity in Ecuador are Mestizos (72% of the population), who are considered to have a mixed heritage of indigenous and white (Spanish or European descent).[32] Other race/ethnicities in Ecuador include Montubios (7%), which refers to coastal aboriginal (indigenous) heritage, African or Afro-Ecuadorians (7%), native South American indigenous groups (7%), and white/European descent (6%).[32] Nine of the participants self-identified as Mestizo and 10 represented a minority race or ethnicity in Ecuador (Table 2). There were five Montubio women, three Afro-Ecuadorian, and two who identified as indigenous (one Tsáchila, the indigenous group the city was named after, and one originated from an Amazonian group). All of the women spoke Spanish as their first language and the study team did not exclude anyone due to language. The RA did exclude one potential participant who was pregnant.

Most of the women did not finish high school and nine had elementary education or less. Most women were in a relationship with a man; three reported being married, 10 were in a "free union" which they described as cohabitating with partners, and six were single. The team asked about employment status outside of the home and 13 reported being unemployed, but in the interview, many reported informal or inconsistent work. Several reported looking for employment and working in the home with children or grandchildren (five of the participants discussed being grandmothers). Of those who reported being formally employed, the range of their incomes were from $120 to $140/month. Women who reported informal work had variable monthly incomes. Informal jobs included picking up scrap metal, selling items such as cell phone cards, cleaning products, and snacks at the bus station. Those cohabitating reported partner's incomes ranging from $50 to $480/month, but

Table 1. Content analysis example

Quote	Code	Category	Theme
"*When I was about fourteen, that was the first time I was forced to … I was robbed of what I was.*" [Participant no. 4, age 25]	Rape at young age	Reproductive coercion Violence	Women's autonomy is limited by men
"*It was also because I was an adolescent and he was quite older, like 10 years.*" [Participant no. 10, age 28]	Dating older men	Men have the power	
"*I decided to separate after one time that he started the mistreatment. Because what I say is, I mean, if I accept this it would get worse.*" [Participant no. 3, age 31]	Separated due to IPV Aware of rights	Moving forward after violence Empowered	Building resilience
"*I tell him no, I have my own money. I'm going and if they invite me to go somewhere we go even if I have to use my own money, because you can't trust somebody else's pocket.*" [Participant no. 15, age 40]	When women go back to work Control of personal finances	Standing up to men Social support	

many did not have consistent employment. Most women would recall income estimates week to week, and many did not know their household income as they did not know how much their partners made. The woman who reported her husband's income as $480/month was the only participant who stated that the household income was enough to support the family.

The participants had a total of 70 pregnancies, with a range of 1–8 pregnancies each, 47 of which were reported as unplanned and 13 of which were aborted. In Spanish the word "*aborto*" can mean elected or spontaneous abortions (generally referred to as a loss or miscarriage) and we did not ask them to specify. All but one woman reported having at least one unplanned pregnancy, most reported having two or three unplanned pregnancies. All the participants had children, aged five months to 30 years. Of all the living children, eight were identified as closely spaced pregnancies (short inter-conception period) with gaps of less than 18 months. The range in ages at the first pregnancy was 14–30 years old. All but three were 18 or younger when they had their first pregnancy, and four participants were 15 years or younger (Tables 2 and 3).

When asked about pre-conception care or practices, only one woman reported changing her health behaviours to prepare for pregnancy, she took prenatal vitamins because she was having a difficult time getting pregnant with her third baby. Other women in the study reported trying to eat more healthily during pregnancy when possible, but no pre-conception behaviours were noted. Many of the women reported using some form of contraception or prevention when they got pregnant. These methods were withdrawal, breast-feeding, the pill, the injection, and using a post-coital douche.

Themes

Four themes emerged from the qualitative data; *(1) Women's autonomy is limited by men, (2) Women keep quiet, (3) Systems failed women* and *(4) Building resilience*.

(1) *Women's autonomy is limited by men*

The first theme was related to how women reflect on their early relationships, and most of the comments were in reference to their partner's dominance. This was reported as coercion, violence, fear, and male chauvinism. They described narratives of men who limited access to social environments outside of the home, incited shame and embarrassment, and limited their growth and potential in the early years. Refusing to wear a condom or encouraging women not to use contraception is a common occurrence: "*sometimes you tell your boyfriend or husband to use something, but they are male chauvinist and they don't want to wear it [condom]. And when it is*

Table 2. Demographic characteristics of participants (*N* = 19)

Characteristic	*N*
Race/ethnicity[a]	
Mestizo	9
Afro-Ecuadorian	3
Montubio	5
Indigenous	2
Marital status	
Married	3
"Free union"/cohabitating[b]	10
Single	6
Unemployed	13
Highest level of education	
< Elementary	1
Completed elementary	8
< High school	3
Completed high school	5
College graduate	1
	Range
Current age	20–45
Pregnancies per woman	1 to 8
Ages of children	<1–30
Age of first pregnancy	14–30

*E*xplanatory notes:

a. Mestizos are considered a mixed heritage of indigenous and white (Spanish or European descent). Montubio people are of a coastal aboriginal (indigenous) heritage. Afro-Ecuadorians are of African descent/black. Indigenous people are groups native to South America.[32]

b. Free unions are those who are cohabitating. In Ecuador those in long-term free unions were mandated to register as married with the municipality, so during the interviews several reported free union but have not registered and they not sure how to report their status.

Table 3. Reproductive characteristics in relation to total number of pregnancies (*N* = 70)

Unplanned pregnancies	47
Total number of abortions**	13

** The word in Spanish is the same for elective and spontaneous abortions. Some elaborated on whether they were elected or spontaneous, but the team did not specifically ask this.

your first time, you don't even realize you can get pregnant" … .[later she described how being financially dependent on her partner did not give her the power to refuse] "*he won't take care of me if I don't have kids with him*" [participant no. 8, age 28]. Another woman believed the father of her first baby wanted her to drop out of school and get pregnant, "*he didn't let me [use contraception] so that I would have a baby, and not study*" [participant no. 9, age 21].

They referred to the double standards of fidelity,

"my husband is a skirt chaser and I think he has transmitted the diseases to me, but I cannot tell him … like, I mean I can't refuse [sex] because he says that if I refuse it is because I have another man, so that's what happens to me." [Participant no. 1, age 39]

One woman reflected on the general lack of power of women in the community, "*Like we don't have a voice or opinion, but they [men] decide what gets done*" [participant no. 9, age 21].

There was a collective "we" as women and mothers, as the participants referred to the culture of community at times and their own personal experience with men in the next breath. One woman described some men in her community as "*always there, taking away our opportunity to grow and become someone in life, achieve more than what we already have*" [participant no. 16, age 36]. The experiences with either their own partners or some of the men in their community were classified as "*machismo*", described as pervasive male chauvinism with some including narratives describing psychological or physical violence. Most of the participants reported their personal experience with this as something that occurred in the past, when they were younger

rather than in current relationships. However, some women were just hopeful that their partners had changed or that the psychological or physical violence would not happen again. When prompted to describe factors in their community that influence unplanned or unwanted pregnancies, the common narrative was again that of *machismo*. The majority of the participants described *machismo* as contributing to the persuasion of teen girls to have sex, violence or coercion leading to unplanned or unwanted pregnancy, and generally reducing the self-esteem of women and the control women have over their own lives. Several women also described a process of social change or progress regarding the decreased acceptance of machismo, and how some men were threatened by this change, some fought back and some accepted it reluctantly.

During peer debriefing, the team discussed the theme of "tensions" related to adaptations to new policies and norms protecting women, which shifted the power dynamic in their homes and communities. The community health nurse described this as not strong enough, what she sees in the community is fear and men limiting the actions of women. She elaborated that there is a fear of change, being controlled, losing power, being silenced by violence, reaction from partners when they demand their rights, and fear of moving forward without their partners. After further review of the participant's words and codes, the team was in agreement that fear limited autonomy and these items were recoded.

(2) *Women keep quiet*

Fear was compounded by shame and lack of trust and support by other women in the community. For the most part, women reported not having trusting relationships or enough social support, and many had left their multigenerational familial support by migrating to this area. One participant from a rural area who had moved away from her family said, "*the truth is that I used to confide in my mother, but now that I live here I don't tell anyone my personal things*" [participant no. 8, age 28]. Many women described lack of trust:

"t's just that sometimes you talk to someone, and they say, no, I won't tell anyone, but later the news has spread, and people come asking at home. If something has happened to me, fine, I just keep it to myself." [Participant no. 11, age 26]

There were lighter moments in the interviews as well, when women joked about their carelessness and negligence in getting pregnant, but even still, they consistently blamed themselves. Instead of the couple being careless when they had sex, women took the sole responsibility for not planning. Many women had similar statements to this woman, "***I** just didn't look for ways to prevent it … **I** was pregnant again … In those days **I** was careless, and I got pregnant*" [participant no. 17, age 38]. When men refused to wear condoms, it was the woman's responsibility not to get caught up in the moment, to plan ahead, get an appointment, and get on the pill a month in advance. One woman described this as a regional issue, "*where we live, it does seem that it is mostly a woman's responsibility, you are the one that has to use methods, you have to do this*" [participant no. 9, age 21]. Another woman described men in general as not getting "*tied down because of a child*" [participant no. 16, age 36], so they are less motivated to use or discuss contraception as their lives are less affected by parenting.

Pregnancy and child-rearing were the women's primary responsibility, and even when they were in violent relationships or their partners were unfaithful, they felt pressure to keep the family intact and when they could no longer do this, they had a great deal of shame. They were afraid of gossip in the neighbourhood and of disappointing their mothers.

"Sometimes you don't split up because you are afraid, you don't split up because what neighbors may say, that was my case. I would tell my mother, once again I have to start over, how embarrassing, what will people say, what will the neighbors in front of us, to the side and the other side say. I mean, that stops you too, but nevertheless the aggression increased. I mean, you either decide to denounce, to speak up or you keep quiet. But if you keep quiet, it becomes your problem, because nobody on the outside knows what goes on inside the home. But we keep quiet for different reasons, fear, shame, because you don't want the family to know, because there are always people that criticize you. I mean, they don't come to offer support but to be critical. That is why you keep quiet." [Participant no. 16, age 36]

Most of the participants who articulated similar sentiments were describing situations to justify keeping quiet, not only out of shame but for the sake of their children. Most of the women had

extremely loving and positive comments about their children, and often prioritised the children's health, safety and well-being over their own. At the same time, older women had regrets about the number of children they had, and the ones who had teen pregnancies reflected about the premature loss of their own childhood and how they were unprepared to be mothers. Many lamented not consciously making decisions about the size of their families or timing of pregnancy, and being allured by companionship and intimacy with hopes of escaping poverty rather than choosing a compatible life partner. Women reported enjoying work (either in the past or currently) and having a larger social circle prior to child-rearing, most had to quit work to stay at home and keep their children and teenagers safe. Then they had a difficult time re-entering the work force, which made them more dependent on their partners and took a toll on their self-esteem. Many women reported persisting in spite of poverty, violence, and abuse; they persevere for the sake of their families. They described their daily tasks in great detail, of how much rice they can buy, how they make do in lean weeks, and tricks to save money on children's clothing or materials for school and keeping their families together.

(3) *Systems failed women*

Women discussed the challenges of the structures in place to promote health and wellbeing. There is a free Ministry of Health primary care system in Ecuador, which includes family planning services. According to our health provider interviews, this system functions well in some regions but is overwhelmed in areas with high poverty rates. Women reported challenges accessing the public system of primary care in the community where the interviews took place. There were challenges getting appointments and medication, and several reported no public transportation to the clinic. Many women reported just giving up after being redirected to other facilities across town, waiting all day, and that many of the clinics are not on a bus line. One woman described her frustration with the public health clinic, "*I would call and call, and they would tell me they did not have appointments, that there were no appointments … what can I do?*" [participant no. 11, age 26]. Women cannot get appointments for non-emergency health concerns for themselves or their children, nor can they rely on consistent contraception from the public system. They reported not being able to stay on the same birth control due to shortages and getting pregnant when switching methods. This strained system failed to provide timely health care for women who wanted to avoid pregnancy. Several acknowledged they didn't want to be pregnant, got an appointment to start birth control but by the time they were seen they were already pregnant. One woman said of the public clinic, "*you have to beg for a pill*" [participant no. 17, age 38] or, if you have any money, go to the pharmacy and try to figure out which medicine to purchase. They reported stigma and taboo when trying to utilise family planning services when they were unmarried, young, and did not have children yet.

There were extremes of system failures too, from trafficking of young girls into prostitution rings, to not upholding the laws regarding child support and protections for women who face intimate partner violence. One woman described how, when she was 13 years old, a man started hanging around and at first he was nice to her, then he threatened to kill her and her family, he forced her to leave to make money from her as a prostitute (which is legal in Ecuador for women over the age of 18 years). "*He got me a fake ID, fake papers of a nineteen-year-old [registered me] … so I work almost a year in this*" [participant no. 4, age 25]. She was relieved to find out she was pregnant so that he let her go home. Women who wanted to have a tubal ligation were required to have their husband's signature to get this procedure. And women who did not have a partner were often denied. In one case, a woman with a serious health history reported

"the doctor told me I was at risk[of death] to have a fourth baby … .because he didn't want to [sign the tubal papers] … I had my tubes tied, the doctor almost had to force him to sign, because without his signature I couldn't get the tubal ligation." [Participant no. 9, age 21]

According to previous interviews with health providers, the practice of requiring a partner's signature is illegal in Ecuador, but it is still in practice in many parts of the country.[28]

In addition, the school system had several challenges for adolescents and mothers. First, there was very little education regarding health, the body, and sexual education. When asked about how women learned about sex and pregnancy, it was common to reply that they didn't remember ever learning about it, "*no, no, no … before getting*

pregnant with my baby girl I knew nothing about that" [participant no. 4, age 25]. This was considered taboo to discuss in the home as well, although several are now talking about it with their own children. Women reported wanting to learn more about this in school with their peers, rather than from experience. Several women discussed sexual health education in the schools as either non-existent or not effective. One woman who was pregnant at 16 said she learned very little about sexual health "*in school, but just superficially, and since one is curious, restless, wants to know … [learned] more through experience*" [participant no. 6, age 34]. The public primary and secondary schools in this area are in session for a half-day, the children are not served a meal, and very few affordable and safe childcare programmes are available. One woman described this as a barrier to working, as compared to an area where she used to live, "*if we knew there was childcare until 4 PM, it would be great to have here*" [participant no. 6, age 34]. Another woman described why she quit her job to protect her teenage son, "*I would realize that if I went to work, my son is going to be there [home alone] all morning, and what could happen? His friends would come in and who knows … .no, no*" [participant no. 14, age 45].

(4) *Building resilience*

The last theme reflects comments from women who were no longer "keeping quiet", but were empowered to demand their rights. Many of these women were in their mid-thirties and early forties when they were able to build resilience. They reported severing ties if their partner did not change violent behaviours and most found new partners who are "good" men. Overall, this led to greater ability to make strategic life choices, including planning pregnancies, and to pass on family planning advice to their daughters. One woman told a detailed story about a woman's advocacy organisation in the adjacent city passing out fliers about the rights of women to be free of violence and having the right to sexual consent. Because of that she described coming home with the flier: "*I presented a demand against him … I mean, he's afraid, he no longer insists like before*" [participant no. 1, age 39]. Later in her interview she recalled that after the confrontation she was better able to plan when she wants to get pregnant. Another powerful statement about women moving forward was from a woman who reflected on her life and the moment she decided to end her relationship: "*so you are submissive, you have to be dependent on what he says. But that is a period, until you* ***wake up*** *… not anymore."* [participant no. 14, age 45]

Many women described a "good man" paradigm, as those who allow women to work and to leave the house to go shopping and have friends. One woman recounted with pride a conversation with her current partner:

"You met me when I was working, and you aren't going to prohibit me from working. Because I can't be waiting to get money from you … So we understood each other, he worked on his stuff, and I worked on mine." [Participant no. 13, age 34]

In addition, these "good men" assist financially and emotionally with the children (even if they were not theirs by blood), they don't fight, and they allow women to use birth control and plan future pregnancies. In addition, several women laughed as they described their realisation of what it was like to find pleasure in their intimate relationships, they learned *"what it* ***really*** *was, to have sex and all of that*" [participant no. 10, age 28] in the context of a safe, loving relationship.

Although the women were all still living in impoverished communities and most reported they did not have enough funds for their basic needs, they seemed to be reflecting on more difficult times in the past. But moving forward they seemed optimistic, were investing in their children, accumulating social capital and hoped this would pay off. In reference to her three children, one woman stated "*they are my life. I hope they don't turn their backs on me someday*" [participant no. 14, age 45]. Many women had no other safety nets, felt as if they had given up their youth for their children, and were hoping that their children would take care of them as they age.

The participants in the study also had advice for their children, primarily their daughters, based on their early relationship experiences. This included advice to "*have a childhood*" [participant no. 9, age 11], wait to have a boyfriend, wait to have sex, finish their education, use contraception, and insist the boyfriends treat them well. One described a conversation with her daughter in which she said "*Honey, you first have to get prepared in life, use caution, even to have sex, it has to be with someone who will help her* ***be someone***" [participant no. 12, age 45]. Many of the women interviewed wanted to better provide for their children, so some were taking handicraft courses,

trying to learn new skills, and for those who wanted more children, most seemed able to delay future pregnancies until their financial situation improved.

Contrasts between the women's perspectives and the prior interviews with leaders

Most of the community leaders' and health providers' perceptions about barriers to family planning in the community were accurately reflected in the later interviews with women. However, the leaders assumed that religion would play a larger role for the women, specifically in decision making about using birth control, who decides how many or when to have children, expectations as to the number of children, fatalism (fate or destiny to have children/up to God) and the need to stay in violent relationships/marriages. But the findings did not support this, the study team asked women specifically about religion's role in family planning if the participants did not allude to it as part of an open-ended question about cultural influences. No one reported that religion, faith or fate played a role in limiting birth control, the timing or number of children they had, pregnancy decisions or staying in relationships. The women in the study did rely on their faith when escaping violence, raising their children and starting over with limited resources.

In addition, several of the community leaders advised the study team not to inquire about elective abortions. They referred to these as rare occurrences, that these were considered very controversial as they would have to disclose an "illegal act" and thus would not be able to discuss it freely and there is potential for prosecution. As the pre-determined focus of this study was on identifying barriers related to unintended pregnancy, rather than unintended birth, the study team decided not to expand the scope of the interviews. But experiences with elective abortions came up naturally, when the RA asked how many times participants had been pregnant. Several women openly discussed attempted and failed abortions in addition to those that successfully terminated their pregnancies.

Limitations

The interviews were limited to women available during daytime hours, and this could have restricted our sample to those who had already experienced pregnancy, had inadequate child care, and were working in the home, although this was not part of the inclusion criteria. The participants also were women who were the most visible and engaged in community activities, some were already seeking skills and job training, and many were connected to a church. Their experience may not have been fully representative of those less engaged in community activities. Another limitation is that the data about adverse outcomes is based on unintended pregnancies or births, but the participants used the term "*planificación familiar*" (family planning) to refer to planned or unplanned pregnancy, rather than pregnancy intention. Unintended pregnancy is defined as unplanned, mistimed or unwanted pregnancy and we did not specifically inquire about wantedness or timing.[33] We also did not inquire about acceptability or happiness about the pregnancy, which some researchers have argued are more closely associated with health outcomes of both mother and child.[34,35] However, many women did refer to their happiness and ease when they had planned pregnancies later in life as compared to unplanned. They reported feeling more financially prepared, ready as a parent, and glad to have made the decision as a couple.

The cross-language methodology of interviewing in Spanish but analysing in English also served as a limitation in the interpretation of the results. Although we tried to account consistently for the effects of the translator, inevitably some the nuances and richness of the dialogue were lost in translation and this could influence the trustworthiness and credibility of the data.[30] For example, when women discussed violence and poverty they used the Spanish word *vergüenza*, which can be translated as either shame and embarrassment in English. During the interviews, we did not clarify this nuance with the participants. The research team attempted to accurately resolve this through discussions with community partners and determined that, when the word was used in a public nature, it was translated as embarrassment, and when it was private or women alluded to a situation that was morally reprehensible, it was translated as shame.

Discussion

Women in our study reported living in poverty, not having consistent access to services they desired, experiencing gender-based violence in their relationships or witnessing this in their communities. Most women reflected upon living in a society where their gender is associated with taking responsibility for the family without the systems or

resources to fully support this role. The majority of pregnancies were unplanned for a variety of reasons. Living in a region with fractured systems, violence and the chaos of poverty compounds the difficulty in just day-to-day living and constrains life choices and options.

The findings reveal many narratives regarding the negative attributes of men, as contributing largely to the erosion of women's power to plan a pregnancy. However, men were also victims of many of the social and system failures in this community. Globally, men have often wanted to be part of the solution to promote both family planning and gender equality, as were the "good" men in this study.[36] Future research in this area should include the perspective of men to better understand the context of family planning, sexual and reproductive health promotion. Additionally, future research related to failed abortions and unwanted birth is warranted in this community, as unwanted birth after denial of abortion can lead to greater psychosocial risks and economic hardships for the mother, her existing children and infant.[37,38]

Many of the women in the study did not consciously make a reproductive life plan, decisions about pregnancy timing or their ideal family size. Decisions were often more about the immediacy of finding a companion and intimacy, not in the framework of a childbearing decision. Those who did want to access consistent contraceptive care were often challenged by stock-outs and rationing. Women in the study who expressed the desire to have more children wanted to wait until their financial situation improved, so they were able to adequately provide for their current children, and when they had "good" men in their lives. This is not necessarily a common scenario in their own communities, and a few participants joked that this was not likely happen, so they will not have more children.

Previous researchers have found that the binary intention paradigm of planning or not planning a pregnancy is not a salient concept in communities where planning pregnancies is not a social norm, and that conditions have to be met for planning pregnancy which are not seen as realistic in that social environment.[33,39] There are several additional challenges noted by researchers with the binary measurement of pregnancy intention, one of which is that it fails to determine the contraceptive care the woman desires or prefers.[40] Another weakness of the binary measure is the oversimplification of a complex set of decisions or influences; even if women in our study had a clear preference to prevent pregnancy, they felt trapped or inhibited by their circumstances. Many women have the desire to plan or avoid pregnancy, however their power to act on this desire is limited by the social, economic, and systemic limitations of their environments.[33]

Another method to examine the context within which pregnancy intention occurs is through the broader lens of reproductive autonomy, which examines the power women have to decide whether and when to become pregnant.[41] Reproductive autonomy is part of the larger construct of women's empowerment, which is often inversely related to unintended pregnancy, and has the potential to greatly improve the lives of women and families.[41,42] The United Nations Sustainable Development Goal 5 recognises that women's empowerment and gender equality, which includes the promotion of reproductive autonomy, is vital to eradicate poverty and inequality.[43] Expanding the conceptualisation of the issue to one of reproductive autonomy shifts the burden from one placed largely on the shoulders of women to one in which health care systems, policy evaluators and lawmakers are more accountable.[40]

Recommendations and conclusions

Results from this study suggest that to promote reproductive autonomy women need not only to have consistent access to contraceptive care, but concurrently to feel safe, productive, and valued across the life course. To move towards this ideal scenario, greater investments in system-level determinants of health and policies that uphold the rights outlined in the Ecuadorian constitution are needed to reduce the structural barriers related to reproductive autonomy.

Our study elucidated that women need to feel safe, not only free of violence and coercion in their intimate relationships, but also to be empowered in their communities to make decisions about their families. Ecuador's constitution established protections regarding gender-based violence in 2008, including the right to be free from violence in private and public life and this includes physical, psychological and emotional violence.[16] However, the regulatory instrument that enforces and prosecutes violent acts as a crime has a higher threshold of what is considered violence, emphasising severe physical violence. The woman would have to

demonstrate to a certified legal doctor that she requires more than four days of sick leave as a result of the violence.[18,44] Investigations by the Red Cross in Ecuador revealed police often do not have adequate training to understand the complexities of gender-based violence and they identified a lack of integrated policies to provide support to survivors of violence.[44] The enforcement mechanisms which uphold the ideals in the constitution need to be reformed and streamlined to assure women are free from violence, have stronger safety nets for the survivors of violence, and have consistent access to the tools and methods to expand reproductive autonomy.

Women in the study who felt productive and built resilience were working outside of the home or had some control over household finances. Investing in education could address some of the determinants related to employment opportunities for both the mother and child, which would in turn empower women to have more control over their desired fertility. In low-income regions, every dollar invested in girls' education generates health benefits and earnings equivalent to 10 dollars.[45] Moving from a half-day school session (without a meal) to all-day with a meal in this area has the potential to promote children's safety, improve their nutritional status, improve economic opportunities for girls, provide additional time for sexual and health education, and allow mothers to work.

Valuing women has great potential to improve reproductive autonomy. This includes being valued by their partners, by health, social service and justice systems, valued for their contributions to society, and valued by their families, neighbours and communities. Generally, being valued entails being surrounded by people and systems who invest in them to "*be someone*". One way to invest in women is through microfinance as a means of poverty alleviation. There is evidence globally that microfinance opportunities paired with health education and entrepreneurship training can improve empowerment, social support and cohesion, as well as reproductive health outcomes for women.[46] Currently, there are microfinance opportunities for low-income women in Ecuador and the findings from this study have encouraged local community partners to promote these opportunities and assist women with applications.

Ecuador has made significant social and economic gains, but these findings suggest that inequities persist in some regions. There needs to be a focus on expanding reproductive autonomy by empowering girls and women of reproductive age through all three mechanisms: providing safe environments, economic opportunities, and adding value to their gender and role in the community.

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Résumé

Les grossesses non désirées sont à la fois une conséquence et une cause des inégalités socio-économiques. La planification familiale évite les grossesses non désirées et réduit les disparités dans la santé. L'objet de cette étude est de décrire le contexte structurel, social et économique de l'intention de grossesse dans une communauté périurbaine, diverse et à faibles ressources en Équateur. Une méthodologie descriptive qualitative a été utilisée. Des entretiens individuels semi-structurés ont été menés avec 19 participantes en âge de procréer. Les entretiens ont été transcrits de manière professionnelle en espagnol, traduits en anglais et analysés dans MAXQDA en utilisant l'analyse de contenu. La majorité des grossesses ont été qualifiées de non désirées et quatre thèmes ont émergé pour décrire le contexte: 1) l'autonomie des femmes est limitée par les hommes; 2) les femmes se taisent; 3) les systèmes déçoivent les femmes; et 4) renforcer la résilience. Les systèmes de santé, la violence sexiste, le manque d'éducation, la limitation des moyens financiers et les politiques pas encore appliquées faisaient obstacle à l'autonomisation des femmes et à la planification familiale. En dépit de cette situation, beaucoup de femmes avaient pu faire la transition vers la sécurité et prévenir ou reporter une grossesse avec un nouveau partenaire. L'Équateur a accompli des progrès économiques substantiels ces vingt dernières années, mais ces conclusions suggèrent que les inégalités persistent dans certaines régions du pays. Dans cette étude, les femmes affirment qu'elles doivent se sentir en sécurité, productives et appréciées pour planifier leur famille. Il faut que les professionnels de la

Resumen

Los embarazos no intencionales son tanto consecuencia como causa de la desigualdad socioeconómica. La planificación familiar previene el embarazo no intencional y reduce las disparidades de salud. El propósito de este estudio es describir el contexto estructural, social y económico de la intención de embarazo en una comunidad periurbana, diversa y con escasos recursos en Ecuador. Se utilizó una metodología descriptiva cualitativa. Se realizaron entrevistas individuales semiestructuradas con 19 mujeres participantes en edad reproductiva. Las entrevistas fueron transcritas profesionalmente en español, traducidas al inglés y analizadas en MAXQDA utilizando análisis de contenido. La mayoría de los embarazos fueron reportados como no intencionales y cuatro temáticas emergieron para describir el contexto: 1) La autonomía de las mujeres es limitada por los hombres, 2) Las mujeres guardan silencio, 3) Los sistemas les fallaron a las mujeres, y 4) Desarrollo de resiliencia. Los sistemas de salud, la violencia de género, educación y medios financieros limitados, y políticas aún por aplicar sirvieron como barreras al empoderamiento y a la planificación familiar. No obstante, muchas mujeres pudieron hacer la transición a la seguridad y evitar o aplazar un embarazo con una pareja nueva. En las últimas dos décadas, Ecuador ha logrado considerables ganancias económicas, pero estos hallazgos indican que la desigualdad persiste en algunas regiones de Ecuador. Las mujeres en este estudio expresaron que necesitan sentirse seguras, productivas y valoradas para poder planificar su familia. Los profesionales de salud pública necesitan incluir múltiples sectores en

santé publique associent plusieurs secteurs aux solutions pour réduire les disparités de santé et s'attaquer aux déterminants de la santé maternelle et infantile, y compris la violence sexiste ainsi que les limitations économiques et systémiques.

las soluciones para disminuir las disparidades de salud y abordar los determinantes de salud materna/infantil, tales como la violencia de género y las limitaciones económicas y sistémicas.