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Pregnancy Management Strategies and Childbirth Experiences of Internally Displaced Women in Barranquilla, Colombia

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Abstract

This ethnographic study aims to illuminate the experiences of pregnant and new mothers in poor areas of Colombia with respect to pregnancy and childbirth. Ethnographic observations including key informant qualitative interviews were performed by the primary investigator in four different neighborhoods in and around the city of Barranquilla, Colombia, over the course of 3 months. A total of 24 women were interviewed, and additional interviews were held with Colombian medical students, religious workers and not-for-profit healthcare leaders. I seek to better understand the perspectives of these internally displaced women in terms of contraception use including the sense of necessity of planning pregnancy as well as the mechanism of action related to each type of contraception. I explore the trajectory of complications experienced by the women, including the first signs of pregnancy and the way they managed the healthcare system to resolve the issues they had with pregnancy. Health education and body awareness were also discussed with relation to what women considered to be "normal" pregnancy experiences. Finally, the violence faced by many of the younger women was examined. Data was analyzed focusing on the personal experience of the women as they shared their health risk perceptions in relation to pregnancy and childbirth. I examined the maternal perceptions of healthcare as well as the structural constraints on prenatal healthcare-seeking behaviors. My point of view as a medical student from the United States became an important perspective in appreciating the pregnancy management strategies of women in Barranquilla.

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"When one is displaced, one loses the feeling of being Colombian, a citizen with rights and responsibilities." (Sanford, 2004)

Background

Definition of Internal Displacement

In order to truly understand the difficulties of delivering healthcare to those who are internally displaced, it is necessary to define the population and understand their global location. Internally displaced persons, or IDPs, are defined as "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border" (Guiding Principles on Internal Displacement, 2010: Introduction, para. 2). It is important to note the two parts of the definition; first that the displacement is involuntary and against the will of the individual. This increases the trauma of the migration, which is often caused by violations of human rights or armed conflict. Second, that these individuals are displaced within their own country of origin, meaning they are unable to find refuge in another country. In addition, they are still entitled to protection by the state, but are often deprived of these privileges for any number of reasons. The status of the country's government has a significant impact on the delivery of these services (Internal Displacement Monitoring Centre, 2010).

The Colombian government defines this group as follows: "A person is deemed displaced when he or she has been forced to migrate within the national territory, abandoning his or her normal residence or regular economic activity because his or her life or physical integrity,

security, or personal liberty are at stake or are threatened" (Cano, 2007, p. 9). Many of the reasons these individuals are threatened include being frightened of their situation or surroundings, having been directly threatened, having had one of their family members drafted into the armed group, or having had a family member assassinated, kidnapped, or disappear (Cano, 2007). The majority of the displaced population move as individuals or families, while it is less common for mass displacements to occur. It is often safer for them to flee in smaller groups for fear of retribution. Consequently, these families lose touch with many of their friends and neighbors and are even more alone in the outskirts of larger cities (Krause, 2003).

History of Violence Leading to Forced Displacement

The South American country of Colombia has the largest population of internally displaced people second to Sudan, totaling 3 million individuals (United Nations Refugee Agency, 2009). It is difficult to estimate the true number of IDPs, as the International Red Cross estimates a 30% under-registration rate, but at least 11.6% of the urban population in Colombia is considered to be displaced (Carrillo, 2009).

The internally displaced communities of Colombia began to grow over 50 years ago, when guerilla forces fueled by drug trade began fighting with the national government armed forces. The internal conflict in Colombia is "one of the three longest-lived conflicts in the world," third only after the Israeli-Palestinian and India-Pakistan conflicts (Riaño-Alcalá, 2008). A well-known guerilla group called the FARC (Revolutionary Armed Forces of Colombia) has been accused of kidnappings, using child soldiers, inhumane treatment of hostages, attacks on healthcare professionals and facilities, as well as using weapons to forcefully displace families (Friedland, 2002). A commonly told story is that guerillas take over a village and steal food and supplies, forcing the community members to hand over their necessities. Soon after, a

paramilitary group arrives, accuses the community of supporting the guerillas, and kills many members of the village publicly, inducing fear in the rest of the community. They are then forced to move to protect their families, but lose their land and livelihood in the process (Veeken, 1998). As mentioned earlier, the majority of the IDPs are displaced as individuals or small families, and mass displacements do not commonly occur. The smaller groups make individuals feel safer which, consequently, causes them to lose touch with many of their friends and families, making life in the city even more isolating (Krause, 2003). Internally displaced persons (IDPs) living in cities have many obstacles to overcome; because many of them were farmers in their previous homes, they have few skills that are desirable in the city. They are forced to find other jobs to support their families, which offer low wages that are unreliable.

Once a family is displaced, they often move to the outskirts of the nearest city. The Colombian government is trying to register all of the displaced persons in order to survey the issue as well as distribute government aide. Partially owing to the high rate of poverty, 99% of IDPs are living in poverty and 85% of those live in extreme poverty. This data show that IDPs have a great deal of suffering among them. Because they have distrust in the government from their displacement, many of them are unwilling to register and then obtain the services offered to them. Additionally, approximately 80% of IDPs register individually, making it even more difficult to provide care to these populations en mass. Those who remain unregistered are considered the same as the general poor population of Colombia and are not able to receive the standard three- month supply of aid provided. Even those who do receive aid are in danger, as other poor individuals surround the government offices that provide the items and will steal from the vulnerable IDPs (Carrillo, 2009).

Healthcare Delivery System

In Colombia, those who can afford health insurance are able to purchase it through a private company. However, this population is quite small and leaves a majority of people without access to healthcare. The extremely poor are covered by governmental insurance called SISBEN, which covers only the most basic level of care and often leaves patients waiting outside of hospital doors hoping to receive care. Stories have been reported of women giving birth on the hospital doorstep because they were not allowed inside without the ability to pay. Many of these poor individuals are identified as IDPs and face a particularly difficult struggle.

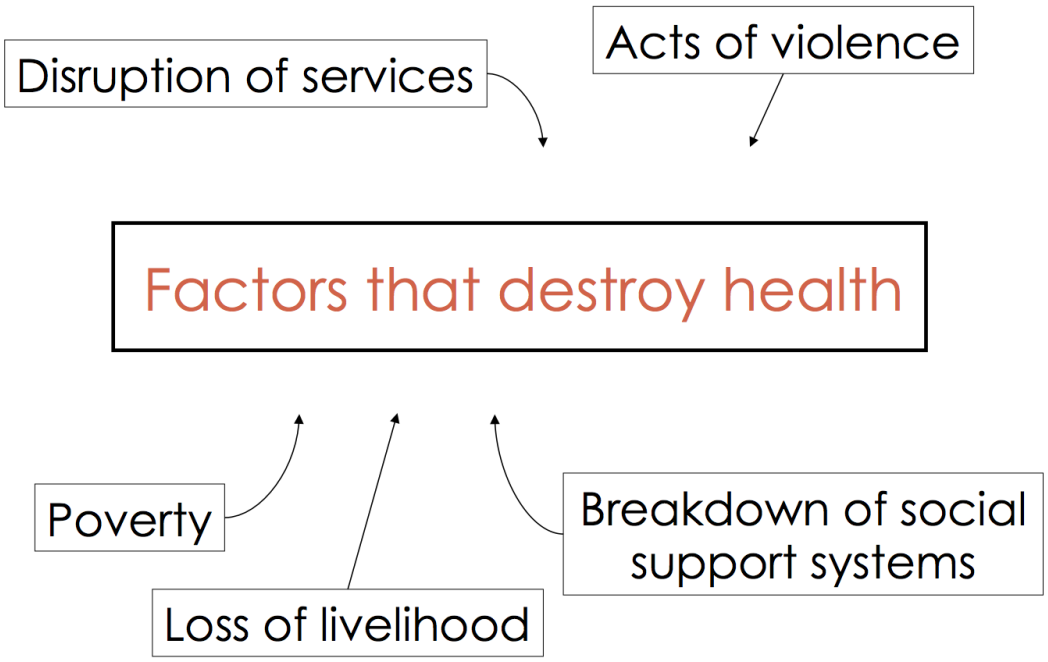
The obstacles that internally displaced persons (IDPs) living in cities must overcome are many. As mentioned, their previous skills of farming are rendered useless in a large metropolitan area. Their only choice is to find jobs which may require no experience in order to support their families. Such jobs offer low wages, are unreliable, and are difficult to find. A man in Cartagena explains his situation as "We survive, but no more than that, I earn 5000 pesos ($2.52) a day by selling chips in town, but there are days when I don't earn a penny" (Veeken, 1998, p. 1649). Many young girls are forced into prostitution, against their will (Alzate, 2007). These stories are found among many displaced families and can negatively affect their health due to malnutrition.

According the World Food Programme, 60 percent of Colombian IDPs living near large cities are experiencing food insecurity. Those living around smaller cities have a slightly worse situation, with 71 percent experiencing food insecurity. The study also uses anemia as an indicator of nutrition status, and the results are concerning. Of displaced children, 67 percent under the age of 2 suffer anemia, while 60 percent of pregnant women are anemic. This reflects the unreliable food sources that are available to displaced people, and indicates that these

populations are not eating enough protein to keep them healthy. Because of malnutrition, the prevalence of stunting in children is 23 percent, compared to the 12 percent national average (World Food Programme, 2008).

Impact of Displacement on Reproductive Health

There are many effects of displacement on health, but five specific aspects significantly affect reproductive health. The figure below lists the factors and their impact on the internally displaced.



When individuals are displaced, they often move to slums or refugee camps, or they are dispersed throughout major cities or rural areas. Although the location of the displaced may vary, most all IDPs have difficulty locating and accessing healthcare services. They are forced to live in an unknown area, where services do not exist or are difficult to access (WHO, 2000). For example, those IDPs living in Colombia are often displaced due to armed conflict. The

government offers these individuals a special healthcare program and other aid. However, in order to receive this aid they must provide documentation of their displacement and sign up through the government. This presents two problems for the IDPs: first, many of their homes were burned or they were displaced without any opportunity to bring their personal belongings with them. Therefore, when the government requests these documents, the IDPs do not have any way of providing them, and it is unsafe to return to their homes in order to retrieve them. Secondly, because of the complex conflict occurring in Colombia, many IDPs are frightened of becoming a registered IDP for fear of being located in their new homes by those who displaced them originally (Friedland, 2002). IDPs in other countries often experience similar barriers to accessing healthcare, which negatively impacts their health status.

Second, IDPs are the victims of countless acts of violence. More specifically, women often suffer the majority of violence which directly impacts reproductive health. The increased rate of rape among these women causes an increase in the fertility rate and unwanted pregnancies, among other reproductive health issues. Men also place pressure on women to have more children, asserting their power over women. These increased fertility rates in an already difficult healthcare system makes motherhood increasingly dangerous, not to mention the danger of the increased rate of unsupervised abortions. A lack of access to reproductive healthcare and contraception also increases the fertility rate and unwanted pregnancies (WHO, 2000). In Colombia, young internally displaced women (aged 13-19) have the highest pregnancy rate in the country, with 30% of young women being pregnant as compared to 20% of their resident comparisons. In addition, 36% of displaced women report being forced to have sex with unknown men. Still more concerning, one report concluded that "IDP women did not know that

they had the right to refuse sexual relations with their partners" (Alzate, 2007). Again, similar issues are encountered throughout the world by IDPs.

It is widely known that those living in poverty have poorer health outcomes when compared to those with more resources. Poverty also prevents IDPs from having the capacity to pay for healthcare services when housing and food are more important in these situations. The spread of disease can also increase in those living in poverty, such as sexually transmitted infections (STIs) and HIV (WHO, 2000). IDPs are especially subject to poverty because many of them lost everything they owned during displacement. They are then forced to move to a new place, where it is difficult to find work among hundreds or even thousands of other IDPs looking for jobs. Still others are displaced from rural areas, where they made their livelihood farming, and must move to urban areas in which they have no marketable skills. These situations are directly linked to the loss of livelihood experienced by IDPs. Both poverty and loss of livelihood negatively impact the reproductive health of these populations (Alzate, 2007).

The last factor that disrupts reproductive health in IDPs is the breakdown of social support systems. IDPs are removed from their homes and also families, friends, and societal support. Social networks are essential for individuals to be able to deal with crisis in their lives, and living without that support can be detrimental not only to mental health with an increase in depression, but also to reproductive health. It has been found that women have a sense of overwhelming loss after displacement, and often try to fill this feeling with having more children. Again, fertility rates increase and reproductive health is jeopardized. Loss of social networks is especially hard on adolescents, who rely on these networks to develop into adults. Losing this aspect of development can cause increased risky behavior, resulting in unsafe sexual

activity, substance abuse, and violence, all of which negatively impact reproductive health (WHO, 2000).

However, there have been more barriers to delivering care than successes. Part of the difficulty is the wide distribution of Colombian IDPs. As shown in the map below, IDPs are living throughout the country and are not easily located

(Internal Displacement Monitoring Centre, 2010).

As previously mentioned, most Colombian IDPs are displaced in small groups, making it more difficult to locate large groups of newly displaced individuals to whom to deliver care. Also, the resistance of IDPs to register with the government is yet another barrier to delivery of healthcare. The lack of awareness of the significance of the problem is also a concern, with many international organizations focusing on other countries in Africa and the Middle East (with good reason), but neglecting to help Colombia. In terms of healthcare delivery, the unstable national healthcare system is continually changing and experiencing a lack of funds, causing even more IDPs to fall through the cracks of the system and fail to receive care. In addition,

IDPs are unaware of the services to which they are entitled. Alzate notes that "not knowing that one is entitled to a right is a great obstacle to claiming it, and ignorance about rights in endemic among internally displaced women" (Alzate, 2007, p. 138). Unfortunately, because this situation has been ongoing since the 1960's, much of the emergency aid has dwindled. Many aid groups do not consider the situation of the displaced in Colombia as an emergency situation anymore. Therefore, necessary items like the MISP (Minimum Initial Service Package) for pregnant mothers are not being distributed. As Krause and her research team found, "there is no distribution of MISP kits, including clean delivery supplies to pregnant women or safe delivery kits to hospitals. A number of women told assessment team members stories of being turned away from hospitals for childbirth, including for emergency services" (Krause, 2003). The aid group Profamilia in Colombia, responsible for much of the reproductive healthcare for IDPs, is just one of many groups that are not offering these MISP kits to women in need. It is clear that even though these displacements are occurring in small groups over a long period of time, these IDPs are still living in emergency situations and need to be helped as such.

The reproductive health of IDP women is of special concern because of their increased risk for reproductive health issues. Families are often led by only one individual, and 91% of the time that individual is female. Therefore, women have significant pressure in which to care for their often large families alone (Carrillo, 2009). Overall, only one out of five IDPs who are sick use medical services according to one study (Ruiz-Rodriguez, López-Moreno, Avila-Burgos, & Acosta-Ramírez, 2006). Female IDPs are also at an increased risk of gender-based and sexual violence, due to what one researcher called increased dominance and aggressiveness among displaced men. This leads to pressure on women to give birth to "replenish" the population or replace children who were lost, resulting in an increased pregnancy rate. Unwanted pregnancies

are more prevalent due to decreased access to contraception and younger women becoming sexually active as a source of income (WHO/RHR/00.13). One study noted that young IDPs have the highest pregnancy rate in the country, with 30% of young women (aged 13-19) being pregnant as compared to 20% of non-refugee comparisons. The high rate of pregnancies could be attributed to the finding that 81% of young IDPs do not use contraception. As mentioned earlier, one report concluded that "IDP women did not know that they had the right to refuse sexual relations with their partners."

Reproductive health is a major issue for the internally displaced, particularly for adolescents. Young IDPs have the highest pregnancy rate in the country, with 30% of young women (aged 13-19) being pregnant as compared to 20% of their resident comparisons. This is likely a result of the fact that 81% of young IDPs do not use contraception. These adolescents are also at an increased risk for HIV/AIDS because of their practice of unsafe sex, but it is unclear how many IDPs have the disease (Alzate, 2007). Profamilia, a local NGO responsible for reproductive healthcare, charges for HIV testing and as a result most IDPs will not get tested. Discrimination against those with HIV/AIDS in Colombia is an issue, with many reports of hate crimes by the FARC as well as other military groups. The FARC actually tests its soldier recruits for the disease, and unfortunately will kill those who test positive (Friedland, 2002). The increased violence among the displaced is one cause of increased risk of contracting AIDS, but sexual assault is also all too common among women IDPs. Many are forced to take up prostitution as their only means of earning money. Even those who do not choose prostitution are at risk, with 36% of displaced women report being forced to have sex with unknown men (Alzate, 2007). Once these women become pregnant, they again face adversity in receiving proper healthcare. Although IDPs are supposed to receive free healthcare, most do not and must

pay to deliver their babies in a hospital. While the cost is difficult enough, they must also be accepted by the hospital because of overcrowding issues. They must arrive between 1 and 2 a.m. in order to save a bed for themselves, and some have been forced to give birth at hospital doors (Friedland, 2002). Access to care is a major issue for adolescents and pregnant women who are displaced, and obviously has a major effect on their health outcomes.

Female IDPs perceive gynecological problems as one of their most concerning health issues. They feel that they are unable to access healthcare because of economic situations and increasing home responsibilities (Mogollon-Perez et al., 2006). In addition, there is inadequate funding for IDP healthcare, and many displaced women have trouble entering the Colombian Social Security system that is supposed to cover their health expenses (Mogollon-Perez et al., 2008). Consequently, only one out of five IDPs who are ill uses medical services. Distance from the displaced communities also presents a burden on access for these individuals (Ruiz Rodriguez et al., 2006). For children, poor access to healthcare results in inadequate vaccination coverage. Only 22.9% of children in one study had been fully vaccinated as recommended. Those who were insured had a 2.4 times higher likelihood of completing vaccinations, but only 21.2% of these IDPs were insured (Ruiz-Rodriguez, Vera-Cala, & López-Barbosa, 2008). Another study confirmed the lack of insurance among IDP children, finding that 77.9% of children did not have the Social Security to which they are entitled. Often, displaced families lose their Colombian identification documents when they are forcefully removed from their homes. When they finally settle in a new area, they refuse to register as an IDP because they are concerned that the paramilitaries will find them. This is a valid concern, as some hospitals report militia members demanding a list of all registered IDPs. As a result, the free healthcare that IDPs are entitled to is not utilized (Friedland, 2002). Still other IDPs are unaware of their right

to free healthcare. Although the Colombian government often does not have adequate funding for the IDPs, if IDPs are not enabled to claim their rights they will never receive any of the healthcare that they deserve (Alzate, 2007).

It is clear that being an IDP in Colombia brings many more issues than benefits. Poor nutrition status, inadequate reproductive healthcare, and difficult access to medical professionals are just a few of the topics that deserve improvement. Progress could be made with increased education and empowerment among IDPs to help them realize the rights to which they are entitled. As mentioned previously, Alzate notes that "not knowing that one is entitled to a right is a great obstacle to claiming it, and ignorance about rights in endemic among internally displaced women" (Alzate, 2007, p.138). Empowering these women is essential to helping them improve their situation. While the violence and civil war in Colombia is the source of these issues, it is nearly impossible to fix that situation at this time. Even if peace were to be accomplished, three million Colombians would still be displaced and would face the same adversities even without violence. The situation is dire, and the unseen millions of displaced Colombians need to be recognized before they can be assisted.

The issues faced by IDPs that will be focused on in this paper include the necessity of contraception use, and the mechanism of action of different types of contraception. As mentioned, increasing rates of pregnancy especially among young IDPs is an issue. The trajectory of complications experienced during pregnancy is more common among IDPs, and the management strategies employed by IDPs are often different from those of more stable women in Colombia. Access to health insurance, transportation, and monetary funding for prenatal and postnatal healthcare are all obstacles for IDPs. The level of health education in IDPs is not entirely clear, and needs further research to determine what areas are lacking in respect to

pregnancy and prenatal health concerns. The setting of violence in which many IDPs have been raised most certainly affects the way they experience relationships. More specifically, domestic violence can be more pronounced within IDP relationships, often resulting in men beating women without much consequence. These obstacles have been well documented in the literature, and affect the pregnancy management strategies and reproductive experiences of IDP women.

Statement of Purpose

Using participant observation and qualitative interviews of key informants, this research aims to illuminate the experiences of pregnant women and new mothers in poor areas with respect to pregnancy and childbirth. I seek to better understand their point of view in terms of contraception use including the sense of necessity of planning pregnancy as well as the mechanism of action of the types of contraception. I explore the trajectory of complications experienced by the women, including the first signs of pregnancy and the way they managed the healthcare system to resolve the issues they had with pregnancy. Health education and body awareness were also discussed with relation to what women considered to be "normal" pregnancy experiences. Finally, the violence faced by many of the younger women was examined. Data was analyzed focusing on the personal experience of the women as they shared their health risk perceptions in relation to pregnancy and childbirth. I examined the maternal perceptions of healthcare as well as the structural constraints on prenatal healthcare-seeking behaviors. My point of view as a medical student from the United States became an important perspective in appreciating the pregnancy management strategies of women in Barranquilla.

Research Setting

Ethnographic observations including key informant qualitative interviews were performed by the primary investigator in four different neighborhoods in and around the city of Barranquilla, Colombia. With a population of approximately 1.2 million people, Barranquilla is the fourth largest city in Colombia. The neighborhoods included *El Por Fin*, an area in Barranquilla known as a place where displaced groups settled in the late 1980's. At that time, the area contained "free land," which allowed families to settle and build a house. They often began to steal water, electricity, and other utilities from surrounding areas, creating a new neighborhood. I was told that this area was guarded by the neighborhood's own make-shift police force, only allowing entry of the residents until approximately 2006. It is known as a dangerous area, as social workers and philanthropists have had their personal items stolen while trying to help the people of *El Por Fin*. In contrast, interviews were also conducted in a rural town called *Pital de Megua*. The town, while just as poor as *El Por Fin* (both considered to be in the lowest "*estrato*"[1]), is said to be much less dangerous due to its increased distance from the city center and its better sense of community. The third location, *Olaya*, was in the highest *estrato* of 3, although women facing economic hardships were still prevalent in the area. Lastly, *La Casa de Jovenes Embarazadas* (the house of pregnant girls) was in a nicer area of Barranquilla, considered an *estrato* 4, however the girls living within the house were in *estrato* 1. These girls were considered orphans by the Colombian government and therefore would be facing extreme economic and social hardships without the help of the house.

I was informed by the locals that displaced people lived in all four areas in which I performed the qualitative interviews. However, it is not customary to speak openly about

[1] *Estrato* is the term used to describe the socioeconomic level of an area within the city Estratos range from 1-6.

displacement. I learned quickly during my experience in Barranquilla that using the term "IDP (internally displaced person)" to describe an individual or group of people is not common, and often has to be further explained for Colombians to even understand the concept. While I do believe that I gathered information from IDPs, classifying the women as such proved to be impossible.

Methods

Ethnographic fieldwork lasted 3 months during which I conducted key informant interviews with 24 women in four neighborhoods in and around the city of Barranquilla, Colombia. Before leaving the United States, I obtained Institutional Review Board approval from Wright State University. Ethnographic fieldwork began with participant observation of the medical care provided by the Cruz Roja for the first four weeks to further understand the context and the care provided by this program. I then traveled with Colombian women who introduced me to pregnant and recently pregnant women in each neighborhood. After introducing myself, I explained the goals of my research and the type of questions I would be asking, in addition to receiving verbal consent from each participant. I conducted in-depth interviews one-on-one with each woman, inquiring about their pregnancy experience, use of prenatal care, attitudes toward pregnancy and contraception use, as well as their pregnancy management strategies, structural boundaries to access care, and obstacles they experienced as women of low socioeconomic status in Barranquilla. All qualitative interviews were performed within the homes of the women, without men nearby to ensure the safety of the women and to give them the opportunity to speak honestly. The qualitative interviews were conducted in Spanish, the national language of Colombia. I am not a native Spanish speaker, but have been speaking the language for over 14

years and was able to converse fluently with the women. Names of the women used within this paper have been changed to ensure their anonymity.

Additionally, I interviewed medical students, religious workers and not-for-profit healthcare leaders, collecting information of their perceptions regarding internally displaced women and opinions of how they accessed prenatal care. I gathered information from their point of view of how these women were able to manage their pregnancies as well as on the topic of internal displacement and its effect on health.

Qualitative interviews were transcribed verbatim and then coded by the principal investigator by using Dedoose®, a program designed for qualitative data analysis and mixed methods research. Data was analyzed focusing on the personal experience of the women as they shared their health risk perceptions in relation to pregnancy and childbirth. I examined the maternal perceptions of healthcare as well as the structural constraints on prenatal healthcare-seeking behaviors. Sample questions are included below, and were used as guidelines for the interviews. I often asked the questions in simpler terms, depending on the woman whom I was interviewing.

Questions focused on reproductive health:

1. When you became pregnant, what were some of your worries?
2. Were you able to see any healthcare professionals during your pregnancy?
3. Who did you have to help you during pregnancy?
4. How do you feel about the care you received?
5. When remembering the birth of your child, what was it like?
6. Ideally, how would you have liked to deliver your child?
7. If you have had multiple children, what were the differences between the births of each?
8. What type of services would you use in terms of reproductive healthcare?

General questions:

1. How do you feel about prenatal healthcare?
2. What are the costs of various treatments here? Are they reasonable?
3. How long have you lived here?

4. What are some of the challenges you face as a woman living in Barranquilla?
5. If you could change anything about your life, what would you change?
6. What are some of your hopes for the future?

Characteristics of Sample

The 24 women in the study sample ranged in age from 14 to 38, with a mean age of 25. The majority of women were living in areas of Barranquilla that are labeled *estrato* 1-3, meaning the lowest three levels of socio-economic status. The city of Barranquilla is separated into neighborhoods and labeled anywhere from 1-6, with 6 being the highest social class. Those women living in an *estrato* 1 through 3 were likely coming from families who were displaced due to drug violence throughout the country. The majority of households were economically vulnerable without a stable income. Opportunities for the women to earn money while still caring for their children were inadequate, and most relied on the male figures in their family or the government for monetary support. Many women had to quit their jobs (mostly housecleaning or selling small items on the street) when they became pregnant and then were not able to find work. Almost all relied on government health insurance for their pregnancy needs. The extent of the coverage provided by this insurance is unclear, and varied among each individual as to what services they could receive without monetary charges required.

Case Studies

Case study: Perceptions of Displacement

Throughout my investigation before I went to Colombia for my field research, I searched for articles and information on a specific group of people – the internally displaced people or IDPs. I read about their struggles to find identity in a new location, the issues they faced with finding new careers in the cities as opposed to their previous farming lifestyle. I tried to understand their fears of accepting government aid in the midst of running away from the

government. I looked forward to arriving in Barranquilla and going straight to the IDP communities, so that I could experience and observe firsthand their obstacles of being an IDP and how they came to overcome these obstacles.

However, soon after I arrived in Barranquilla I began to learn the higher complexity of the IDP term. I asked my host family, my friends who were medical students, and the employees at the Cruz Roja to explain to me everything they knew about IDPs. To my surprise, most of them had never heard the term before. I found that even if there were groups of IDPs, they would not refer to themselves as such. The individuals I spoke with in the higher *estratos* of 5 or 6 thought that IDPs probably lived in "the poor neighborhoods," but they stated they were only assuming that they were living there and there was no way to be sure. The women who I interviewed in each of the four areas would tell me where they had moved from, but many stated that it had been many years since they moved. Still others stated that their parents may have been from another part of the country, but they didn't consider themselves to be from anywhere but Barranquilla. All these observations seemed to me to indicate that the term IDP is an "outsider" term if you will – those of us who are withdrawn from the situation want to name a group of individuals who don't actually consider themselves a part of said group.

Catalina, the director of the house of pregnant girls, was one of the only women who attempted to give me a straight answer on where the IDPs lived. She also was well informed on the political situation they face and how they seek to overcome the obstacles of displacement. Her explanation is summarized below, with additional information applying directly to the girls living in the house.

Interviewer: "Are any of these girls children of displaced people?"

> *Catalina: "At this moment, none of the girls that we have here are children of displaced people. If you went to even larger cities, such as Bogotá, you would probably find them there because the people who have been displaced often think that if they live closer to where the government is, they will have better chances of receiving aid and opportunities. And it is true that there are some opportunities there, but the problem is that the people are far too many. So smaller cities will see some displaced people, but they are likely to go and stay with family members. People from the country that move to the city tend to seek out the help of relatives who live there. Families here in the coast are known to be very likely to help each other out. What we have is a population of children who come from homes where the adults are living in "unión libre" (living together, not married), where the dad goes one way, the mother goes the other way, often they each find other partners of their own, and that whole dynamic brings about the issues that the girls have to deal with, such as lack of responsibilities. Besides that, then we have the economical crisis that these families have to face, which often drive young girls to prostitution or to leave their homes to move in with their boyfriends since at home there often isn't anything for breakfast or lunch - these things carry a lot of weight."*

Catalina's point of view of the IDP situation in Barranquilla is only one experience. However, it became clear to me that it was possible that the women I interviewed may not be specifically IDPs themselves, but it was quite likely that their families had been displaced in the early 1980's or before. Regardless of their specific histories, it was clear that they were all significantly affected by the violence and social situations in Colombia that lead to displacement of thousands of families. Displacement was still affecting their lives.

Contraception use and cultural norms

In my experience working with women in the United States in a healthcare setting, it is expected that women of childbearing age will either be using contraception, be actively trying to conceive a child, or have another specific reason for not using birth control. Contraception after a woman has birth in Dayton, Ohio, is part of her discharge planning from the hospital. Obstetricians/gynecologists, family doctors and internal medicine physicians look at contraception as part of a woman's "normal" medications. As a woman attending a university in the United States, there were few, if any, of my peers that were not using some type of contraception.

It is with these experiences and perceptions of contraception that I spoke with Colombian women who were either pregnant or had recently had a child about their family planning methods. As often while traveling, a person can attempt to keep preconceptions out of her mind but this is often impossible, as such preconceptions make up her life view. This can result in a new world view, wherein preconceptions are combined with new experiences. I would ask all the women I interviewed if they were using or planned on using contraception. Most women had an idea about what type of birth control they would like to use, although only two of the women were currently using some type of contraception. Many stated they planned on obtaining birth control in the future, and were able to explain where and how to access such services. One woman whom I will refer to as Maria stated that she had already received information about the different types of birth control and explained the options she had, including oral contraception pills, intramuscular injections and condoms. Maria felt that it was easy to access these treatments and thought that they would be covered under her insurance (the government provided insurance, SISBEN). It seemed that the women had access to all of the same types of contraception offered here in the United States. The two women who were currently using birth

control were using a type of implant (brand names include Implanon and Norplant). These can be used for up to three years and provide effective birth control without the use of injections or pills. It was clear that many women understood not only the different types of contraception but were also able to access it.

Case Study: Mechanisms of action of contraception

As I discussed contraception in-depth with the women, I began to observe that they may not have much knowledge on how the different types of contraception work. In medicine, we call this the "mechanism of action" of a medication. I spoke with one woman whom I will refer to as Johana about the intrauterine device (IUD) that she had been using as contraception for the past seven years. At the age of 38, she had a total of eight children, with her youngest child being 10 months old. She explained to me how she had her IUD placed seven years ago and was told that it would prevent pregnancy for a total of 10 years. Johana did feel that it was not as effective as she expected – she had had four children with the IUD still in place. She went on to explain that the doctors told her after her first pregnancy with the IUD that it was no longer in her uterine cavity, it had moved into her abdominal cavity. The physicians confirmed its location using an ultrasound, but did not recommend a removal of the device. Furthermore, it seemed that they had not explained to her that the IUD was no longer functional if it was not within the uterine cavity. Johana continued to believe that it was a reliable source of contraception, and subsequently became pregnant three more times. This illustrates her lack of body awareness and understanding of reproductive health in terms of IUD contraception. Perhaps she was unaware due to lack of explanation from her healthcare providers, or simply a general health education deficiency. During our conversation, she requested an explanation from me about why it was not preventing pregnancy for her and it seemed that I was the first one to

take the time to make sure she understood the mechanism of action of an IUD. She said that the physicians always told her "please do not get pregnant again because you are old!" and yet, she was not given other options for contraception.

A woman whom I will refer to as Margarita explained to me many different types of birth control that were offered to her at various clinics in Barranquilla. She was very well versed on the types, however not as well informed when she explained the way each one worked to prevent pregnancy. Her last pregnancy was a "surprise" to both her and the baby's father. Margarita's explanation of contraception is summarized below:

> *"I'm not using any birth control right now. I don't want to use an IUD, and I told them at Profamilia that I didn't want that. They gave me some pills to take, but I don't like the hormones in these pills. I heard that there are other pills that can lessen my menstrual symptoms that do not have hormones."*

I asked her what types of contraception, if any, she had used in the past.

> *"I used to be on the rhythm method. I got pregnant while using this method."*

Earlier in the interview, she had told me that she had irregular menstrual cycles for the past several years. I mentioned that the rhythm method is only useful and successful if a woman is having regular menstrual cycles. Margarita replied:

> *"I didn't think it mattered whether or not you had regular periods. I thought everyone could use the rhythm method."*

She had been using the method by having sexual relations at the same time each month as her menstrual cycle indicated. For example, she would only have intercourse for the 2 weeks after her period ended to prevent conception. Margarita and I talked more about types of birth control, and she explained to me that the copper IUD had the same mechanism of action as a hormonal

birth control patch. She mentioned that Profamilia (a local women's health clinic) recommended Implanon (a hormonal implant placed in a woman's arm just under the skin). She did not want this type of contraception because she was concerned it would affect her heart due to the close placement to her "veins."

Margarita's experience demonstrates many aspects of healthcare delivery and a woman's understanding of her healthcare as well as her body. She was obviously well informed on the types of birth control, but perhaps not educated correctly or fully on the mechanism of action, risks, or benefits of many of the options. She was also unaware of basic anatomy in terms of how body systems are connected or separated with respect to the hormonal implant.

As I spent more time in Colombia, I often became frustrated with the lack of planning as it related to meetings, meal times, social gatherings and other activities of daily life. I often joked that "making plans" in Colombia was the same as not making plans in the United States. I carried with me a small calendar to write down appointments and interview dates so as to keep myself organized, but quickly found that no Colombian ever carried a calendar with them. Dates were not commonly discussed; rather plans were made the day of the event. Even when plans were made, they were usually changed at least three times before the event actually occurred. It is with this knowledge that I began to think about my culture of planning, making appointments, and showing up on time. The concept of family planning fits neatly into my culture of planning – making sure everything happens "according to plan" is a fundamental moral value for many North Americans. However, this concept of planning is not an everyday occurrence in Colombia; therefore it is not hard to imagine why planning a pregnancy is yet another event that is not scheduled. While it may seem irresponsible to a North American young female like me to leave pregnancy up to chance, this is likely due to my concept of planning that transcends

appointments and also applies to childbearing. Perhaps, for a woman living in the Caribbean city of Barranquilla, where life is on the beach and less structured, a pregnancy is yet another surprise that is meant to occur without pre-planning. With a strong Christian background, many women also view pregnancy as a gift from God, and therefore something that does not need planning. The concept of "God's plan" is strong, and the relationship of a woman's responsibility or power over that plan varies among women. One friend of mine who is a medical student in Colombia who uses birth control consistently is a Christian, and yet she would like to plan her pregnancies. She feels that God's plan for her is to plan when she has children. Shifting my point of view to better understand Colombian's way of life was the only way to better grasp their perspective on family planning.

Case Study: Trajectory of complications

Many women who I interviewed had numerous complications with their pregnancies. While I expected these complications to be somewhat common, I did not expect to find the women presenting the way they did with these complications. I also did not expect the reactions that each woman had to their complications. Hearing stories about the issues they had with their pregnancies showed me that not all women encounter health problems in the same way. Some were told by a physician that they had a problem without having ever complained of anything. Still others would present to a healthcare professional for one thing and end up with treatment for an illness completely unrelated to their original complaint.

One woman whom I will refer to as Natalia in the community of El Por Fin had multiple complications that stemmed from her original complaint of a vaginal infection. Natalia's story is summarized below:

> *"My pregnancy went well, I had a vaginal infection at the beginning and I was also leaking amniotic fluid - this concerned me and I didn't understand what was happening. It was my sister who convinced me to go to the emergency room. Once I got there, they told me that I had a urinary tract infection. It was also at that time that I found out that I was six months pregnant. My stomach did not change sizes, I didn't have any sickness of pregnancy, and I always had irregular periods so I couldn't have known that I was pregnant. They did all of my prenatal care in the emergency room at that time, and gave me pills for the infection. I am still taking the pills now, 6 months later. I am not sure what type of infection I have, but just that I have to keep taking the pills. I do not feel sick, but I continue to have vaginal discharge from the infection. I do not know if it will go away. Later in pregnancy I was having arm pain and a headache, and at my prenatal appointment they said my blood pressure was 280/170. They took me right away for a c-section after that."*

I asked if she was having high blood pressure at her previous appointments and she responded:

> *"Yes, I had high blood pressure for the last three months of pregnancy. They told me to take my blood pressure at home three times per day. They did not give me any treatment for it. They kept me in the hospital for 5 days after I gave birth; it cost a total of 150,000 pesos. The baby's father helped me pay for it."*

There are multiple surprising aspects of Natalia's story for me. The most striking is the confusion she seemed to have regarding her infection, pregnancy complications, and seriousness of the problems she faced during pregnancy. Her explanation of high blood pressure worried me, as she and her baby could have suffered severe health problems due to blood pressure readings that high. It amazed me that although she was told to take her blood pressure at home

and she found it to be elevated often, no further instructions were given to her regarding the safety of her and her baby. It is also possible that instructions were given to her, but they were too complex or difficult to perform and she either could not complete them or forgot how to do so. Overall, she told the story in such a way that conveyed no sense of concern – it was as though she was recounting a sporting event, not a medical emergency that could have affected her life and the life of her child.

This was not uncommon among the women I interviewed. It is unclear whether this calm point of view is due to a lack of explanation from the healthcare professionals as to the gravity of the situations or if it is a cultural norm to be optimistic and seemingly unconcerned about complications. In my experience in Colombia, I have always found its people to be unusually happy considering their circumstances. From the point of view of a North American, where we have been often told of the violence and unrest in Colombia (which is most certainly true), I expected the first time I visited Colombia to find a country of people who have been broken down due to violence. However, I find over and over again that the people of Barranquilla have an amazing ability to put the past behind them and look toward the future with optimism. When you greet a Colombian and ask how they are doing, they often respond "very well, thanks to the work of God." Although some may dismiss this as simply a saying, to me it is an example of their trust in another power and their feeling that all the good things they are able to experience are not of their own doing. In the same way, these women simply were satisfied that things had "turned out okay" and dismissed the complications – not because they were inconsequential but because they thankfully did not alter the ultimate outcome. Lastly, I often found that these women were not used to anyone asking them questions about their feelings. Explaining the emotional experience of pregnancy and childbirth was something reserved for only the closest

friends. Keeping a positive attitude and focusing on the positive outcomes were more important to these women.

Body image & awareness

Most of the women I interviewed explained to me how they found out they were pregnant. The home pregnancy test is not commonly used by the women in my interview population. Even Colombian women in the upper middle class are not routinely using home pregnancy tests. I had difficulty finding them in local grocery or drug stores. It is more common for women to see a physician at a local clinic to confirm that she is pregnant, as opposed to finding out on her own at home. When I myself became pregnant and called my in-laws in Colombia to share the news, they didn't understand how I had found out on my own before going to a doctor's appointment. Of the women I interviewed, only three felt they found out "late" about their pregnancies even though many others were in their third or fourth month before confirmation that they were pregnant. Still others never have prenatal care, and therefore stated they had never had a pregnancy test to confirm. As above in the trajectory of complications case study, Natalia found out she was pregnant after presenting to the emergency department due to what she considered to be a "vaginal infection." Another pregnant woman found out because she was "having trouble walking up stairs at work" – she was working as a maid in a home and was forced to quit due to her pregnancy. One of the younger women told me that she found out she was pregnant at 4 months because her mother told her she was.

In terms of body awareness, many women were being treated for infections or had extra tests that were done in the hospital by a physician and they were not aware of why the tests were done. One girl explained to me that she was in hospital for four days after the birth of her child waiting for the results of an extra test that was done. To this day, she does not know exactly

what it was for but she states she “is fine now” and is not concerned. Still another woman had an infection during her pregnancy and is still taking the antibiotics for vaginal discharge which she states has not gone away. She's not sure when she is to stop taking the antibiotics - she was either not told or did not fully understand what type of infection she's experiencing. Again, it is unclear whether this is the fault of the healthcare professional for not fully explaining each woman’s issue, or if it is due to the educational background of each individual woman. Most likely, it is a combination of these issues.

Case Study: Health education and the concept of “normal”

Of all the women I interviewed, not one stated that she had a complicated, difficult, frightening or problematic pregnancy. Johana stated that “the doctors told me I was high risk because of my age,” but did not seem concerned about how the pregnancy progressed. Even those women who explained that they had high blood pressure or other complications like swelling, headaches, bleeding, infections or loss of amniotic fluid still stated that their pregnancies were “normal.” As Natalia explained, her pregnancy “went well,” but was complicated by infection that required antibiotics, high blood pressure and the urgent need of a cesarean section. Johana, who was told she was high risk due to her advanced age of 38, also felt her pregnancy went well. She however had “many infections” which required antibiotics and recurred three months later, requiring another course of antibiotics. She also told me that “the doctors did extra tests because I was old, and then told me not to have any more children.” One woman explained that she was also having a normal pregnancy although she was experiencing an infection from toxoplasmosis. Indeed, this infection is more common in Colombia, but it is considered to be a very high-risk pregnancy should a woman obtain this infection in the United States. At the time of the interview, she was seven months pregnant and said that she didn't

think her baby had any infection and that the doctors think the baby is going to be okay. She continues to take antibiotics for the infection, which is often spread by having cats in your home. When I asked if she still had cats in her home, she exclaimed "I have thousands of them!" It appeared that her physician had not explained the transmission of infection, and it is possible that she could be re-infected by the same cats.

The number of complications of the pregnancies in women I interviewed was astounding from my perspective. Almost every woman I interviewed said that they had some sort of issue during their pregnancy although they never stated they had a difficult pregnancy. The majority of women described their pregnancy as "normal," or stated that their pregnancies went "well" or "very well." It is unclear whether the women were unusually optimistic about how their pregnancies progressed, or that since most women experienced complications, having complications became the "normal" for them. One woman, whom I will refer to as Elaine, did not go to any prenatal care appointments during her most recent pregnancy because she said she didn't want to go to prenatal appointments. During her first pregnancy, Elaine did use prenatal care but for her subsequent four pregnancies she determined she did not need any prenatal care. She did however give birth to each of her children in a hospital. She states that she doesn't feel she needed any treatment during her pregnancy even though she had some complications. Elaine's youngest son was born at seven months (two months premature). She still feels that she had a pregnancy that went well without complications.

Another woman I talked to whom I will refer to as Flor said that her only problem with pregnancy was that she struggled with her weight after the baby was born. At the time of the interview, she was trying to obtain a job but said no one would hire her because she was overweight. She states that she gained over 50 pounds during her pregnancy and she said this is

because she ate a lot. She would eat a loaf of bread and a half a liter of milk every night at 2am in addition to her normal meals during the day. Although this is considered to be a concerning amount of weight gain during one pregnancy, she stated that all of her prenatal appointments were normal. In addition, during the birth of Flor's second child she had a hemorrhage after a cesarean section after which she needed to have a blood transfusion. She also had to pay an extra cost for the C-section (as opposed to the less expensive vaginal delivery) and had trouble finding the money. She had to pay for each item used during the surgery: gloves, gowns, syringes, surgical instruments, medications and other items. In order to gather the money to pay the hospital, Flor had to pawn different items from her house including the microwave and refrigerator. She had to pay back the same amount of money plus 10% interest due to her inability to pay the bill on time. These payments were in addition to the coverage given to her by the government insurance, SISBEN. Even after all of these obstacles that occurred, Flor still felt that her pregnancy and delivery were normal.

A woman whom I will refer to as Dolores, who had one son, said her pregnancy also went very well. However, she did not go to any prenatal appointments and also had to have an emergency C-section due to high blood pressure. Dolores was unable to continue prenatal appointments due to the expense. She first went to Profamilia but it became too expensive for her and she stopped going. She said that the government insurance used to provide prenatal appointments for free but they stopped offering them at the clinic where she lived. The expense of transportation into the city, a lost day of work, and issues organizing childcare for other children are further obstacles for women attempting to access prenatal care.

I was again surprised when yet another woman, whom I will refer to as Clara, explained to me that her two pregnancies were also "normal" although she actually had multiple

complications. Her first child was born prematurely. She also experienced a kidney infection and she had to stay in the hospital for observation for eight days due to this infection. A woman whom I will refer to as Paola, 29 years old, explains to me that she had a normal pregnancy other than high blood pressure and a very long labor. She said that her labor took so long that the doctors became concerned about her and the baby's health. After delivery, it was found that her daughter had aspirated amniotic fluid and had to stay in the hospital for a lung infection for an extra five days. Paola also experienced significant swelling and a subsequent cesarean section during her second pregnancy because of the long labor and possible preeclampsia. Another young woman explained to me that the birth of her child went well although she had high blood pressure in the cesarean section. She also had to stay in the hospital for four extra days because she was waiting for another test to be done. She doesn't know exactly what this test was for but states that now she is fine. These examples illustrated the many complications and health issues the women had to face during their pregnancies, and yet they were still of the opinion that things were “normal” or “went well.”

Case Study: Violence among young pregnant women.

I also interviewed some younger women living together in a home for pregnant girls who needed a safe place to stay. Initially concerned that these girls would have less to share due to their young age or shyness, I quickly found that they were willing to share not only their stories but also the emotions they experienced during pregnancy. It was a drastic difference from the stories focused on medical details that the older women shared with me. I often would ask the women what obstacles or concerns they had as a pregnant woman living in Barranquilla. The majority of the women would say “none.” I would have to ask twice if I wanted to obtain even a short answer of obstacles the women faced. However, the younger girls shared many concerns.

Sofia said that violence is a problem "especially for pregnant women in Barranquilla." She couldn't explain why she thought this was, but was adamant that it was happening. Sofia clearly understood the pressures on young girls, as she had experienced them herself.

A 19-year-old girl, whom I will refer to as Mayo, told me how she experienced violence during her pregnancy. Because of her history of being placed in violent situations, she said that the house for pregnant girls was the only place she really felt safe. Mayo's story, told in her own words, is below.

> *"I was working on buses selling small things when I found out I was pregnant. I then decided I would come back to Barranquilla where the baby's father lived so that we could be together. When I got back to him, he said that the baby wasn't his – that it was someone else's. He was very upset. When I actually had the baby, he saw him and knew that he was his son. He didn't want to stay with me though, because he was now living with another woman and he wanted to keep the baby. He wanted to put the birth certificate in the name of him and his new girlfriend. I had the birth certificate in my name. I went to his house to show him the birth certificate, and he was mad – there was a fight. That's when the police who take care of young people came and took me away. I was afraid he was going to hit me during the fight, he has before. But I feel safe here now. He tried to make me look like a bad mother so that he could have the baby. I was without my son for awhile while the police investigated us, but my son will stay with me."*

Another girl whom I will refer to as Laura explained to me how she ended up in the house of pregnant girls. She also arrived there due to violence involving her baby's father. Laura began living with the baby's father at the age of 12 when she was pregnant with her first child. At that time, she didn't know she was pregnant for four months until she was experiencing symptoms

and her mother told her she was pregnant. She then ended up fighting with her boyfriend during that pregnancy but received no help at that time. When she became pregnant again, she continued to live with this boyfriend. She states that he was beating her so she finally called the police and they came to the home. They determined that she could no longer live with this man and took her away in order to live in the house of pregnant girls. Laura told me that right now she's afraid to leave but she doesn't know why. She believes that once she doesn't live in the house anymore she might start using drugs again (a problem she dealt with in the past). She thinks that if she continues to study she won't start using drugs again, but she will be taking care of her children alone and is not sure that she can handle the responsibility and stress of being a mother.

I spoke with the director of the house of pregnant girls (whom I will refer to as Catalina) about the issue of violence among young women in Barranquilla. My questions as well as Catalina's responses are summarized below.

Interviewer: "Can you tell me about the girls? How did they find this place? How do they get here?"

Catalina: "The ICBF (Insituto Colombiano de Bienestar Familiar) brings them here. These are girls who have been economically, sexually, socially abused. Their children are caused by rape, drugs, or prostitution. Why aren't they with their families? Many times they are abused by their own stepfathers, or their mother's companion. Some other times, their mothers let them roam free with their boyfriends; these are girls who know nothing about responsibilities because no one in their homes has taught them about it. Then when they find themselves in this situation, with this tremendous responsibility, they begin being mistreated by their mother's companion. Why aren't they at their own home?

Because if the stepfather is the one who has abused them, the mother is incapable of standing up for their daughter; she never says "you must respect my daughter." That is the case most of the time, and here we have many examples like that. The ICBF doesn't really take into account the poverty level; they are mostly concerned about the safety of the baby, and of the mother, who in this case is also a child. That is the reason why the ICBF brings them here.

"There are two girls with whom you spoke - the one is here because her mom cannot afford to keep her at home, and to pay for school and transportation and such. The other girl is here because the mom is only 16 and the girl's mother has taken advantage of them to acquire some level of economical benefit. This is likely occurring through prostitution either to strangers or even to the mother's own partner/companion."

"For us it is very important to protect minors. These girls stay until they get to be emotionally and economically stable, which usually takes 3, 4 or 5 years. At that time, when they are strengthened in all aspects and they are able to go and live elsewhere, we try to get them to back to their families whenever possible. If not, they move out and continue moving forward. The problem is that if they leave too early, when the child is 6 months or a year old, it is very likely that they will get pregnant again shortly thereafter. This is because they won't be economically stable and there will be a man who will approach them and tell them that he will take care of the baby, and he will help her. However, the moment they get pregnant again the man is gone. At that time then she has to deal with not one child, but two."

Interviewer: "What is the age range of the girls who stay here? Who is the youngest?"

Catalina: "13 or 14. There is a girl who claimed she was 16 but that I thought she looked much younger. The other staff here thought the very same thing about her, so we took her to "Medicina Legal" and they confirmed that in fact she was 16. All of us thought for sure she was much younger, 12-13 years old, because of her delicate face and all, but she was older. In contrast we have this other girl who is 14 and has a 10-month-old child, who looks to be much older than she is. The reason why this 14-year-old girl looks this way is because of what she's been through. She hasn't been abused but she has certainly been mistreated by her mother. She now has the body of a woman, and not as much of a child anymore."

Discussion

The conversations I was able to have with these women altered my perceptions of Colombian women, IDPs, and the way women in low socioeconomic situations must navigate the obstacles of pregnancy. I arrived in Barranquilla as a female American medical student who hoped to better understand the point of view of female IDPs regarding various reproductive health topics. Specifically, discussions focused on the following topics: contraception use, its necessity, and mechanism of action, the trajectory of complications including the way women handled issues of health during pregnancy, health education, body awareness, the concept of "normal" pregnancy in the midst of complications and finally, violence experienced by women in Barranquilla.

It was clear that the women I interviewed were well informed on the different types of contraception as well as how to access them. However, they were not as well educated about how each type functioned to prevent pregnancy. I was amazed at how few women, even with their knowledge of the many types of birth control and relative ease of access, were choosing not

to plan their pregnancies. I came to the conclusion that my perceptions of family planning are those of a young North American female, who comes from a culture of schedules and future planning, in which pregnancy is yet another life event that should be booked ahead of time. In contrast, Colombian women are living in a city where plans are made after events have already occurred, where calendars, appointments, and date books are foreign concepts. In the midst of their unscheduled lives, pregnancy is yet another welcomed surprise that does not need forewarning.

As a medical student, I have spent over four years learning how to communicate with patients to achieve the best health outcomes in terms of their care. If I am not able to share health information in a way that patients can comprehend and therefore accomplish, then I will not be a successful healthcare provider. Many of the women I interviewed had many pregnancy complications that they attempted to explain, although it became clear that they were not well educated on the topics relating to their health. It is unclear whether this was due to a lack of general health education or a deficiency in the explanation they received from doctors and nurses in the area clinics and hospitals. The level of body awareness with respect to infections or pregnancy symptoms also left much to be desired. Women often relied on others to inform them that they were in fact pregnant. This lack of understanding may have contributed to their optimism regarding the many grave complications they experienced during pregnancy, which they considered "normal." However, I was also struck by the general positive attitude of the women with respect to their pregnancy complications. This attitude was universal in the midst of violence, economic troubles and health issues that were everyday experiences for these women. Perhaps because complications were so ubiquitous, complications became the new "normal" for

pregnancies. None of the women I spoke with described her pregnancy as difficult, overwhelming, or complicated.

Within that sense of optimism, the older women rarely had anything to say when I would ask them what types of obstacles they experienced as a woman living in Barranquilla. Most answered that they didn't feel like any part of their life was more difficult due to their gender role or socioeconomic status. I got the feeling that these women were not normally asked questions about their emotional point of view. In contrast, young women in the United States are often called upon to express their opinions on a variety of aspects of their lives. It is comfortable for me and my female peers to speak about our concerns, hopes, and dreams. Although I expected it to be more challenging to ask such questions of younger Colombian women, I was proven wrong by their honesty. The younger women explained to me the violence they often experienced in Barranquilla, and how it is especially dangerous for pregnant women to live in the city. They shared their hopes for a better future, a future with more peaceful domestic relationships and completed educations that would allow them to achieve more in life. The young Colombian women clearly understood the pressures placed on female IDPs and had hopes to overcome those societal pressures.

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Appendix A: Public Health Competencies Met

Specific Competencies
Domain #1: Analytic Assessment Skill
Defines a problems
Determines appropriate uses and limitations of both quantitative and qualitative data
Selects and defines variables relevant to defined public health problems
Identifies relevant and appropriate data and information sources
Evaluates the integrity and comparability of data and identifies gaps in data sources
Applies ethical principles to the collection, maintenance, use, and dissemination of data and information
Partners with communities to attach meaning to collected quantitative and qualitative data
Makes relevant inferences from quantitative and qualitative data
Obtains and interprets information regarding risks and benefits to the community
Applies data collection processes, information technology applications, and computer systems storage/retrieval strategies
Recognizes how the data illuminates ethical, political, scientific, economic, and overall public health issues
Domain #2: Policy Development/Program Planning Skills
Collects, summarizes, and interprets information relevant to an issue
Decides on the appropriate course of action
Domain #3: Communication Skills
Communicates effectively both in writing and orally, or in other ways
Solicits input from individuals and organizations
Uses the media, advanced technologies, and community networks to communicate information
Effectively presents accurate demographic, statistical, programmatic, and scientific information for professional and lay audiences
Attitudes
Listens to others in an unbiased manner, respects points of view of others, and promotes the expression of diverse opinions and perspectives
Domain #4: Cultural Competency Skills
Utilizes appropriate methods for interacting sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, racial, ethnic and professional backgrounds, and persons of all ages and lifestyle preferences
Identifies the role of cultural, social, and behavioral factors in determining the delivery of public health services
Develops and adapts approaches to problems that take into account cultural differences
Attitudes
Understands the dynamic forces contributing to cultural diversity
Understands the importance of a diverse public health workforce

Specific Competencies
Domain #5: Community Dimensions of Practice Skills
Establishes and maintains linkages with key stakeholders
Collaborates with community partners to promote the health of the population
Identifies how public and private organizations operate within a community
Accomplishes effective community engagements
Identifies community assets and available resources
Develops, implements, and evaluates a community public health assessment
Describes the role of government in the delivery of community health services
Domain #6: Basic Public Health Sciences Skills
Defines, assesses, and understands the health status of populations, determinants of health and illness, factors contributing to health promotion and disease prevention, and factors influencing the use of health services
Understands the historical development, structure, and interaction of public health and health care systems
Identifies and applies basic research methods used in public health
Applies the basic public health sciences including behavioral and social sciences, biostatistics, epidemiology, environmental public health, and prevention of chronic and infectious diseases and injuries
Identifies and retrieves current relevant scientific evidence
Identifies the limitations of research and the importance of observations and interrelationships
Attitudes
Develops a lifelong commitment to rigorous critical thinking
Domain #7: Financial Planning and Management Skills
Develops and presents a budget
Prepares proposals for funding from external sources
Manages information systems for collection, retrieval, and use of data for decision-making
Domain #8: Leadership and Systems Thinking Skills
Identifies internal and external issues that may impact delivery of essential public health services (i.e. strategic planning)