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The sociological dimensions of induced abortion in developing countries are not well understood. Because abortion is illegal in many of these countries, research has been limited in both quantity and scope. In most of Latin America, for example, research has been confined mainly to surveys conducted from an epidemiological or demographic perspective (see Gaslonde Sainz, 1976; Potts, Diggory, and Peel, 1977; Requeña, 1968, 1970; van der Tak, 1974). Studies relating the incidence of abortion to sociodemographic variables such as residence, marital status, and parity have helped reveal the characteristics of women who undergo abortion as well as its extent (see, for example, Agualimpia et al., 1968; Armijo and Monreal, 1968; Gomez Ferrarotti and Garcia Varela, 1964; Hall, 1965; Mendoza-Hoyos, 1968; Tabah and Samuel, 1962). While continued research of this kind is necessary, research is also needed to elucidate the *ways* in which various factors may influence the decision to terminate a pregnancy. For a better understanding of the processes by which women make decisions related to their fertility is a prerequisite to designing services that meet women's needs.

As a number of writers have shown, fertility decision-making is a dynamic process. Although factors such as attitudes toward fertility control, socioeconomic situation, age, and expressed desire for additional children may be relevant, they alone do not predict fertility behavior; women with similar stated family-size desires and attitudes, for example, do not necessarily make the same decisions regarding contraceptive use, pregnancy, or abortion. Going beyond the variables investigated in standard KAP surveys, Hass (1974) and Luker (1977) developed models explaining fertility decisions in terms of the perceived costs and benefits of contraception and pregnancy. Because these perceptions may change over time, any specific decision must be seen in the light of a woman's circumstances at the time of the decision. Thus, the decision whether to continue a pregnancy is related to a woman's situation once she becomes pregnant (see Downs and Clayson, 1972; Fawcett and Arnold, 1973; Hass, 1974). Her previous intentions (for example, whether the pregnancy had been planned or was the result of unintentional contraceptive failure) do not always explain her later behavior.

The Study

In an effort to understand the process by which some women seek to terminate a pregnancy, while others in apparently similar situations do not, we conducted in-depth interviews with women who had had a pregnancy they reported as unwanted. The interviews took place in Cali, Colombia, a commercial and manufacturing center and the country's third largest city. Our fieldwork covered a period of 17 months (July 1974-November 1975); interviews were conducted between January and November 1975. All interviews were conducted by the investigator or her Colombian assistant and all but three took place in a government-sponsored neighborhood health center.

Participants were asked to reconstruct the circumstances under which they decided the resolution of a pregnancy they said was unwanted from the time of conception; the study is therefore a retrospective examination of the factors operating at the time the women made pregnancy decisions. The interviews were open-ended, with respondents being given the opportunity to discuss issues at length. A prescribed set of topics was covered,

however. The interview guide consisted of five sections: general background (including questions on sociodemographics, family structure and household composition, a genealogy, employment and migration histories, and extent and nature of interaction with relatives); attitudes and values (especially about sex roles, changing norms, and views on family size, sex, and contraception); projective stories (hypothetical incidents describing intrafamily conflicts to help articulate the range of norms for decision making in general); decision making (descriptions of the social contexts in which actual major and day-to-day decisions are made; unwanted pregnancy and abortion (questions concerning preabortion/unwanted pregnancy attitudes and behavior, the abortion decision, and the postabortion experience, with special attention in all cases to the role of relatives and friends).

Setting and Respondents

Colombia is one of the many Latin American countries where abortion is illegal yet apparently widespread. Because of its illegality, reliable statistics are not available. Estimates reported in the press range from 200,000 to 500,000 abortions annually, a minimum rate of 41 per 1,000 women of reproductive age (*El Espectador*, 13 Feb. 1975; *Cromos*, 27 Feb.–3 Mar. 1975; *El Occidente*, 7 Oct. 1975). A survey by Gaslonde (see Gaslonde Sainz, 1976) in Bogota reported a rate of 22–25 per 1,000 women aged 20–34 in the mid-1960s. Even a rate of 22 per 1,000 is relatively high (for example, a rate of 23.3 per 1,000 women aged 15–44 was reported for the United States in 1976, when abortion was legal [Tietze, 1977, Table 2]). The complications of abortion are a serious health problem; in Bogota, 50 percent of maternity beds are occupied by women with abortion complications (Brown and Newland, 1975); in Cali, abortion complications are the most frequent cause of mortality among women of childbearing age (Mendoza-Hoyos, 1968).

Most of the women interviewed lived in one of three invasion barrios[1] that surround the health center, which is located at the foot of the oldest and largest of the barrios (for more complete discussion, see Browner, 1976). Although these barrios do not contain Cali's most destitute population, its people think of themselves as poor. The working women are typically employed as domestics or other service employees. Men work outside the industrial sector, most commonly as laborers or service workers. Objectively, too, the barrio's residents are poor. Malnutrition is common enough among children to qualify the health center's catchment district for a government-subsidized surplus food program. On a five-point scale designed to rank Cali's barrios by socioeconomic status, the three barrios were rated in the two lowest groups (Bertrand, n.d.).

Problems in Finding Respondents

The illegality of abortion and negative attitudes toward it in Colombia made it initially difficult to contact many women willing to discuss their own induced abortions. Between August and November of 1974 efforts were made to recruit respondents through the informal networks of the investigator and her assistant.[2] Thirty-three doctors and nurses connected with the health center or the university hospital were asked if they knew of anyone who had had an induced abortion and would be willing to discuss it in the context of the study. Only ten said they were acquainted with potential informants: one person knew of three, the others, one each. Of these 12 women, 5 refused to participate, saying they would find an interview embarrassing, 2 had moved to another city, and one denied she had ever had an abortion. Just 4 respondents were recruited in this way. (For further discussion of the methodological difficulties involved in the study of illegal abortion, see Gaslonde Sainz, 1976.)

The difficulty of finding informants forced us to develop other recruitment techniques. The first means was through the health center. Women who came to the center's gynecology clinic for the first time were routinely asked about their previous pregnancies and the outcomes (live birth, stillbirth, or abortion, with no distinction made between spontaneous and induced). For the purpose of our study, women were also asked if any of their preg-

1. Invasion barrios are established by landless migrants who, in a unified effort, seize state land to build homes and create a community. Legal title to the land may subsequently be sold to those who are occupying it.

2. Throughout the field study period, the author was employed as research associate at the School of Medicine of the Universidad del Valle in Cali, a position that afforded ready access to physicians and nurses associated with the medical school and the university hospital. In addition, the author carried out participant observation in the neighborhood health center after having been presented to staff and patients as a researcher studying pregnancy and abortion.

nancies had been unwanted.[3] Those who reported an unwanted pregnancy or an abortion were referred by a nurse to the investigator or her assistant, and if she was willing to participate, she was given an appointment to return for an interview. Finding respondents who would discuss unwanted pregnancies, whether they ended in "spontaneous" abortions or live births, was not difficult. In a population where contraceptive use was not widespread, there was little stigma attached to unwanted pregnancies, and many women considered miscarrying an unwanted pregnancy a fortunate turn of fate.

The second means of recruitment was through referrals from women who were participating in the study. At the close of each interview, informants were asked if they knew anyone who had had an unwanted pregnancy that had ended in either abortion or live birth. We told them we were especially interested in talking with women who had voluntarily interrupted a pregnancy. This less direct method of recruitment proved to be an effective means to locate women; 72 of the study's participants (67 percent) were recruited in this way.

Characteristics of Respondents

The study population consisted of 108 women who had had at least one pregnancy that they described as unwanted at the time of conception. Data were collected on 123 unwanted pregnancies, with 87 women providing information on one pregnancy, 12 women providing information on two pregnancies each, and 4 offering data on three each. Of the 123 unwanted pregnancies, 42 were ended by surgical intervention, 44 aborted either spontaneously or with the use of folk remedies, and 37 ended in live births.

Given the design of our study, we did not expect our group of respondents to be completely representative of the barrios' population. Nevertheless, on a number of sociodemographic characteristics, the study group turned out to be fairly similar to a sample of women who visited the health center's gynecology clinic for gynecological checkups, genitourinary disorders, and to obtain contraceptives. (Data on some of these characteristics are shown in Table 1.) The women interviewed in our study ranged in age from 17 to 52 at the time of the interview and were only slightly younger as a group than the sample (mean age 31.1, compared to 32.8 for sample). The majority in both groups were married or living in stable unions, although a larger proportion of the women in the study population were single or separated. There was no statistically significant difference between the two groups with regard to the number of times they had been pregnant (5.1 for sample; 4.7 for study group), their number of live births (4.4 in the sample; 3.6 in the study group); or the number of abortions they reported (0.7 in the sample; 1.0 in the study group).

The study population was, on the whole, literate: 78 percent reported between one and five years of formal study, about the same as the national average (DANE, 1975, p. 32). Most had lived in the city a long time: 64 percent had been born in Cali or accompanied their parents' migration while they were still young. Eighty percent had worked for

TABLE 1 Comparison of study group and clinic sample on selected characteristics: Cali, Colombia

	Health center sample		Study group	
Characteristic	Number	Percent	Number	Percent
Residence				
3 barrios[a]	202	75.7	69	63.9
Other barrios	45	16.9	23	21.3
Middle class and above	20	7.5	16	14.9
Total	267	100.1	108	100.1
Marital Status[b]				
Married	224	59.6	50	47.6
Consensual union	116	30.9	24	22.9
Separated or single	36	9.6	31	29.5
Total	376	100.1	105	100.0
Ever-use of Contraceptives[c]				
No	155	46.1	34	36.1
Yes	181	53.9	60	63.9
Total	336	100.0	94	100.0

NOTES: Based on 10 percent random sample of 3,910 users of gynecology clinic between January 1973 and August 1975 and all 108 women in study group.

Data not available for all women on all characteristics.

[a]The 3 barrios surrounding the health center.

[b]Marital status as of time of interview.

[c]Oral contraceptives and IUDs only.

3. The intake form, administered by an auxiliary nurse, asked "What was the date of your last menstrual period? How many times have you been pregnant? How many live births have you had? How many stillbirths? How many abortions? What was the date of your last birth or abortion? What form of contraception do you presently use?" We added the question, "Would you describe any of your pregnancies as unwanted at the time you became pregnant?"

wages at one time, although most discontinued wage work when they began a resident conjugal union or became pregnant. At the time of the interview, just over 30 percent were employed for wages; the majority of these were separated or single. Of their husbands, 64 percent were employed as laborers, 13 percent as service workers, 9 percent as vendors, and 8 percent each as office workers/proprietors and professionals.

Most of the women had used contraception at some time in the past but many subsequently abandoned it. Whereas 64 percent had used oral contraceptives or an intrauterine device at one time, only 36 percent were using one of these methods at the time of the interview. An additional 6 percent were currently using rhythm or suppositories. In 50 percent of the unwanted pregnancies, women said they were using a contraceptive when they became pregnant, and the overwhelming majority (88 percent) attributed the pregnancy to failure of the contraceptive method. According to respondents, failures from pills and IUDs were responsible for 27 of the unwanted pregnancies; the remainder followed use of rhythm, suppositories, or coitus interruptus. When those not presently using contraceptives were asked their reasons, many said they did not trust them, since they had been using them when they became pregnant the previous time. Others voiced fears about immediate or potential side effects, especially headaches, circulatory problems, and fear of cancer.

Outcome of Pregnancy

Pregnancies were classified by the actions women said they took to end them rather than by the pregnancy's actual outcome. The scheme used, which is described below, is therefore a measure of intent rather than result. Since it is medically difficult to distinguish between a spontaneous and an induced abortion, we avoid this distinction. In addition, we circumvent such questions as whether the woman was "really" pregnant to begin with or the extent to which her actions "caused" an abortion to take place. Our interest is in the woman's decision and action with respect to a pregnancy.

We divided the 123 reported pregnancies into the following categories:

No attempt (N = 28) describes pregnancies women classified as unwanted from the time of conception, although they made no attempt to intervene in the pregnancy's course.

One minor intervention (N = 31) describes one-time use of herbal teas or douches, commercially manufactured pills or injections sold specifically to cause abortion, self-inflicted trauma, and preparations not explicitly abortifacients but said to be effective if used in proper combination under the appropriate conditions (e.g., boiled beer mixed with aspirin taken three consecutive days upon rising).[4]

Multiple minor interventions (N = 22) refers to pregnancies in which women used several of the remedies described above, sequentially or simultaneously.

Major intervention (N = 42) describes pregnancies terminated by surgical means such as catheter or dilation and curettage.

Determinants of Decision Making

We examined the relationships between a variety of social factors and the actions the women took to end unwanted pregnancies. There was a tendency for women with greater economic resources to take major or several minor steps to end the pregnancy, while those with fewer resources were more likely to take no action or cease attempts to terminate the pregnancy after one minor intervention (see Table 2). It is noteworthy, however, that few women in any of the economic groups gave economic reasons for not wanting to continue the pregnancy. Instead they were likely to give "marital problems" (e.g., "my husband left me or seemed about to do so") or "social" reasons (e.g., "I had all the children I wanted"; "My youngest was just a year old") for not wanting to continue that particular pregnancy.

The woman's age at the time of the unwanted pregnancy had no consistent relation to the actions

4. Use of "folk" remedies (referred to above as "minor intervention") to influence the outcome of an unwanted pregnancy is common practice among Cali women. For the study group described here, in 92 of 123 unwanted pregnancies (75 percent) the women made at least one such "minor" attempt. These "minor" attempts consisted of: herbs (in 27 percent of cases); injections (24 percent); combined herbs and injections (18 percent); combined herbs and commercial preparations (e.g., beer, rum, aspririn) (9 percent); combined herbs and pills (6 percent); combined herbs, pills, and commercial preparations (6 percent); pills only (2 percent); commercial preparations (2 percent); lifting heavy objects (2 percent); and taking contraceptives (1 percent).

she took, although younger women were slightly more likely to take strong steps.

A greater proportion of the women who ultimately took strong steps to end the pregnancy reported use of birth control prior to becoming pregnant (see Table 2). This finding is consistent with Requeña's model of fertility behavior in Latin America (1970), in which he suggests that women who are motivated to regulate family size will rely on contraceptives but in the event of contraceptive failure will turn to abortion as a back-up method of fertility control.

The Role of Kin

While the functional importance of kin ties in urban Latin America in terms of such basic social activities as economic assistance, help with child rearing, and important ritual events has been amply documented in recent years (Bryce-Laporte, 1970; Hammel, 1961; Lewis, 1952, 1973; Peattie, 1968), their role in fertility decision making had not, to our knowledge, previously been considered. This question was of particular interest to us since a relationship between family organization and fertility has long been suggested, but the question has not been examined in much detail (see Freedman, 1961-62; Burch and Gendell, 1971). It seemed as if an analysis of the nature of urban kinship relations might help in providing an understanding of the fertility decline that seems to characterize urbanization.

Observers have stated that in sexually segregated societies, women get significant support, emotional and otherwise, from relatives other than husbands (Brown, 1975; Datan, 1977; Dwyer, 1977; Lomnitz, 1977; Peattie, 1968). The system of sex role organization in Latin America is highly segregated: many men carry out much of their lives away from home and return home mainly at mealtime and to sleep; women's activities are concentrated in the household (Lomnitz, 1977). Cross-sex interaction, even between spouses, is said to be very limited, and reports have indicated that intimate matters such as sex or family size preferences would rarely be discussed (Hill, Stycos, and Back, 1959; Stycos, 1968). At the same time, women apparently do get significant social support from female relatives.

We hypothesized that it would be within the female kinship network that abortion decisions might be made. This, however, was not the case. According to our respondents, social resources other than a woman's partner had no discernible influence on the actions the women took in the case of an unwanted pregnancy. The woman's type of social network had no demonstrable effect on the actions taken to end the unwanted pregnancy. Women who lived with kin or who visited frequently with relatives outside their households were no less likely to end the pregnancy than were women with less intense family ties (see Table 2).

TABLE 2 Actions taken to end pregnancy and characteristics of women: Cali, Colombia

	Type of Action			
	Major or multiple minor		One minor or none	
Category	Number	Percent	Number	Percent
Marital status				
Single	5	83	1	17
Separated	16	67	8	33
Consensual union	20	57	15	43
Married	23	40	35	60
Number of pregnancies[a]				
1	13	65	7	35
2	9	50	9	50
3	11	52	10	48
4	10	53	9	47
5	10	52	11	48
6+	11	48	12	52
Interaction with kin[b]				
Frequent interaction	25	48	27	52
Infrequent interaction	39	57	30	43
Monthly household income[c]				
0–1,500 pesos	18	50	18	50
1,501–2,500 pesos	13	43	17	57
2,501–7,000 pesos	15	68	7	32
Age				
≤20	13	57	10	43
21–25	18	60	12	40
26–30	14	41	20	59
31+	19	53	17	47
Contraceptive use[d]				
Yes	35	59	24	41
No	25	42	34	58
All women[e]	64	52	59	48

[a]At time of unwanted pregnancy.
[b]Frequent interaction = Lives with at least one relative in addition to husband and children (or children, if husband does not live in household) and/or visits at least one relative outside the household at least once a week.
Infrequent interaction = Lives in nuclear or broken nuclear household and does not visit with anyone outside the household as often as once a week.
[c]The 1975 exchange rate was approximately 28 Colombian pesos to the US dollar.
[d]At time of unwanted pregnancy.
[e]Data not available for all women on all characteristics.

The respondents' domestic groups tended to be nuclear, and even within larger households they usually formed subunits along nuclear lines.[5] Decisions were generally made within this subgroup. In only 10 percent of the cases did women even tell relatives of their initial suspicions of pregnancy or that an abortion was being contemplated. Most women stated that their relatives were unwilling to accept long-term responsibility for children that were not their own, especially when economic resources were limited (as they are in most barrio families). Less than 10 percent of women with minor children had any children living with relatives in other households at the time of the interview. Nor did most women engage in extensive cooperative domestic activity with relatives or friends—although they did exchange babysitting, help with housework, and financial loans in emergencies or times of short-term need—so that long-term assistance from relatives with domestic responsibilities was not available to most women. Among this group, the kinship network apparently did not play the role frequently ascribed to it. Most respondents did not look to relatives for financial support for either the abortion or childraising, and most did not even discuss their decision with relatives (perhaps to avoid possible censure or attempts to prevent an abortion—for although relatives might not be willing to support the child, they might also disapprove of the abortion).

The Role of the Man

The women in our study reported that it was the response of the man and not that of other kin that had a direct bearing on their decision. They usually discussed their plans with their partner before they took any action, and his response to the pregnancy was often the single most important factor influencing outcome. For many women, the man's denial of paternity or a suggestion of abortion indicated that he would not accept responsibility for the child. The understanding, then, was that if she wanted the child, the woman would have to manage without the man's material or emotional support. In 16 percent of the cases, the woman refrained from telling the man of the pregnancy so she would be free to proceed with an abortion. If she did tell him, she usually did so because she intended to go along with his wishes about the pregnancy's outcome. In nearly 80 percent of the cases, where the man accepted the pregnancy or was indifferent to its outcome, the woman made no attempt or just one minor attempt to end it, despite the fact that the pregnancy had been unwanted. If the man advised an abortion, in 70 percent of the cases the woman took major or several minor steps toward pregnancy termination.

The Conjugal Contexts of Abortion Decisions

The results of our interviews indicated that the less stable the marital situation, the more attempts, and the more drastic the attempts, to end the pregnancy.

For the purposes of our analysis, four types of conjugal unions were identified: *Single* describes never-married women who were living in their parental households when the unwanted pregnancy occurred. *Married* women were in unions legally recognized by the Colombian government and the Catholic Church. Until 1974, all marriages required both church and civil ceremonies, a fact that precluded the possiblity of divorce. In 1974 a law recognizing the legality of civil marriage alone was passed, although divorce is still not widely available. *Consensual unions* are resident free unions, a common variant of marriage, especially among couples in the poorer socioeconomic groups, who often lack the financial resources needed to have a wedding. In addition, women in consensual unions frequently report that they prefer this arrangement to legal marriage because it allows them greater freedom to leave an unsatisfactory union in the absence of legal divorce. The 31 percent incidence of consensual unions in the health center sample (see Table 1) gives some indication of the extent of this pattern. *Separated* women were married or had lived in a resident consensual union, but at the time of the unwanted pregnancy they were living apart from their spouse. (No distinction is made here between legally married and consensually mated separated women.) The term is not used in the technical sense of legal separation or divorce, since the latter is not generally practiced, and few women or men went to the trouble of obtaining a church-sanctioned separation, since re-

5. Of the women in our study, 70 percent lived in nuclear households (defined as woman, man and unmarried children or woman and unmarried children). These figures are consistent with those reported by Harter and Bertrand (1977), who collected kinship data in 1972 from a sample of 1,296 households and found that 64 percent were nuclear and 12 percent nuclear without husbands.

marriage was not a possibility for them.

While these categories describe the conjugal statuses of the women in the study population, their partners do not necessarily fall into comparable groups. Throughout Colombia there is said to be a large number of men in all social classes who maintain simultaneous conjugal ties (including economic, sexual, and social services) with two women. Children are usually borne from both unions. Data on the actual extent of this practice, however, are not available. In other cases, serial unions are practiced and the man will maintain two households for a transitional period while he gradually terminates his ties with one household and solidifies them with another.

We found that among the women in our study, the likelihood that actions would be taken to terminate a pregnancy could be explained to a substantial degree in terms of three conjugal situations: (1) unions of sexually active women who continue to live in their parental households; (2) unions of women who are separated from their partners; and (3) marriages or resident consensual unions undergoing sufficient strain to place the future of the union in question.[6] The types of actions taken to terminate a pregnancy and their associations with marital status are shown in Table 2 and Figure 1.

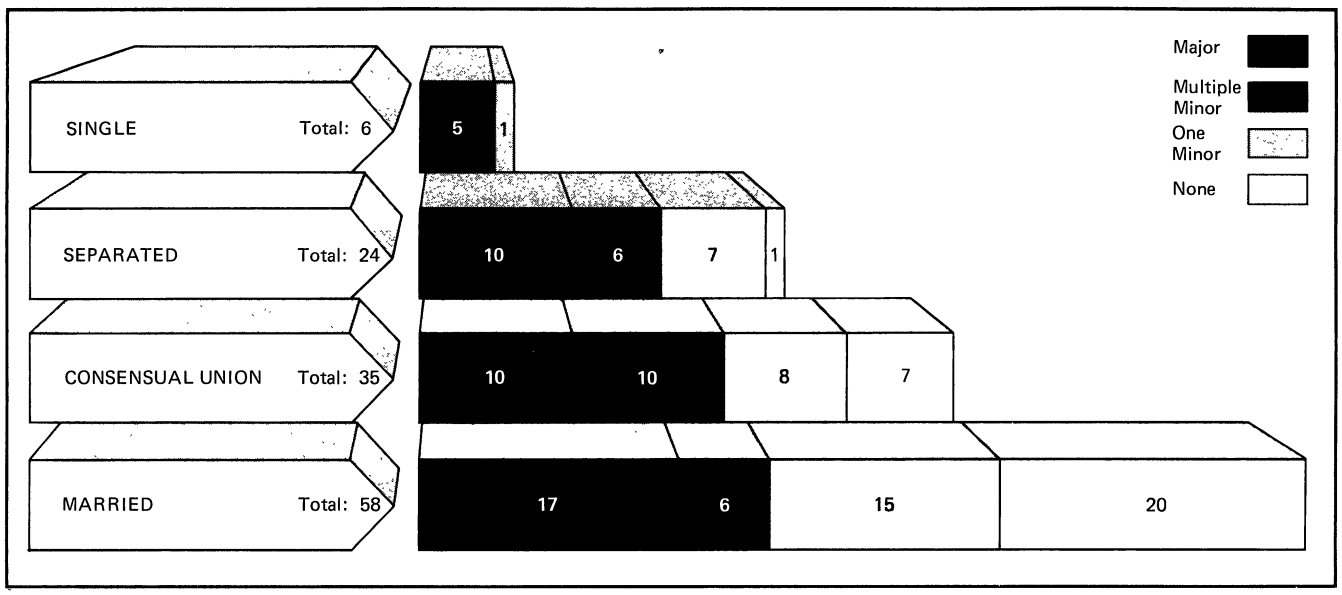
6. We note that there is a slightly higher proportion of single and separated women in our group than in the clinic sample, and that the same trends might not be as clear in a completely representative sample. A greater reluctance of married women to discuss unwanted pregnancies and to report actions to terminate pregnancies may influence the findings.

Single Women

All six single women took active steps to end their pregnancy, and five of them took a major step. Among Cali's working and lower classes, many women become pregnant prior to marriage but few intentionally single mothers are found. It is not always possible or practical for a resident conjugal union to be established, and the single women in our study who found themselves in this situation took strong steps to end the pregnancy. Our interviews indicated that sometimes a union was not established because the woman felt she was too young or was otherwise unready. In other cases, the woman feared that a union with the particular man did not stand a good chance for success. In some instances the woman was willing to establish a union, but she was abandoned by the father of the baby. Below are two illustrations of cases in which an abortion was induced because a union could not be established.

When Faviola was fourteen she began to spend time with a workman who lived nearby. They became lovers and soon afterward, Faviola missed a period. Afraid to tell her parents because she feared their anger and her lover because she feared he would force her to marry him, she went to a local midwife. The midwife prescribed that a pear be coated with a solution of potassium permanganate and introduced deep into the vagina. One single treatment induced menstruation. Al-

FIGURE 1 Marital Status at time of pregnancy, by actions taken



though the courtship continued, the couple did not resume sexual relations until marriage.

Rosa Inez migrated to Cali from the south to work and to escape the boredom of the country. She moved in with her sister's family and found a job selling lottery tickets. Within a year she met a man who began to visit her regularly. After three months of courtship, Rosa Inez became pregnant. A week after telling her lover of the pregnancy, he left town.

Interviewer: What did he say when you told him you were pregnant?

Rosa Inez: He said we would have the baby. And then he left town.

Interviewer: Did you want to have the baby?

Rosa Inez: Yes, but how could I since he's gone?

Interviewer: So at first you thought you would have it?

Rosa Inez: Well, he said he would take me to another city to live with him. But after he said that he left. So I took some things to get rid of it.

Interviewer: Did he ever say that you should abort?

Rosa Inez: At first he did. Later he asked me if I wanted to have it. I said I wanted the baby if he was going to marry me, but if he wouldn't then I didn't want to have it alone. So he said, "Well then, get rid of it." And then he left. . . .

Women Who Are Separated

Women who became pregnant while living apart from a man were more likely to take active steps to end a pregnancy than were women who were living with their husbands (see Figure 1). Most of these women had already borne children. Some of the separations were temporary, with some economic, social, and sexual ties retained. In other cases, separate residences were a permanent arrangement, and many of the men lived with another common law or legal wife. A substantial number of women who were separated were employed outside their homes (42 percent of these women were working at the time of the interview, as compared with 23 percent of those who lived with their husbands). Working women with small children had arranged for their care by either their own older children or other relatives. Occasionally, mothers boarded their young children with relatives on a semipermanent basis, but this was not a popular pattern. If they could, women preferred to form joint households with willing relatives until a more permanent conjugal union could be established.

For the women dependent primarily on their own earnings the prospect of a pregnancy posed an especially severe threat to them and their other dependent children. Those dependent on voluntary contributions from a man not living in the household were also in a precarious situation, since there was little possibility of external enforcement of his obligation. Continued support is purely a function of the man's sense of personal responsibility and therefore subject to caprice as well as the objectively marginal economic situation many such men find themselves in. Although women can obtain a court order requiring a spouse who has abandoned the household to make child support payments, enforcement is essentially nonexistent. The experience of one separated woman is a typical example:

At the age of twenty Lucinda set up a common law household with Fernando. He had left his legal wife and children in Medellín and come to Cali in search of better work. Five years later, Fernando brought his first family to Cali and resumed residence with them. He said he would continue to support the four children he and Lucinda had had together, but said that she, too, should get a job. At first Fernando came weekly, bringing money and spending a night or two with Lucinda and their children. When he stopped making regular visits, Lucinda became the household's main breadwinner, although she still picked up his weekly contribution, travelling by bus to his house to do so.

Shortly after the separation, Lucinda began taking oral contraceptives against Fernando's wishes. Despite these precautions, she became pregnant again. Lucinda saw no alternative other than induced abortion. She could not work with a newborn infant to care for and she could not afford regular child care. Her only relative in Cali was a brother with a large family of his own, whom she could not depend on for substantive help. Lucinda asked a friend for the location of an abortion practitioner and within a week the surgery had been performed. She never consulted her husband because she knew he would forbid the abortion, even though his support was neither adequate nor reliable.[7]

Consensual Union or Marriage

Women in resident consensual unions took stronger steps to end unwanted pregnancies than did married women, as Table 2 and Figure 1 show. One apparent reason is that consensual unions were, in fact, less stable than legal marriages. While only 7 percent of women who had been married at the time of the unwanted pregnancy were no longer living with their husbands at the

7. The reasons Colombian men, like other Latin men, are said to oppose contraceptives and abortion have been extensively explored. See Back and Hass (1973) for a useful review.

time of the interview, 35 percent of the women in consensual unions were separated from that spouse. But the reasons cited by women in these two categories for seeking to end unwanted pregnancies were similar. The most important reason was marital stress of significant enough dimensions that the woman felt the relationship's future was not assured. The impetus for dissolution may have come from either the man or the woman, and the pressure to terminate the pregnancy may have come from either side. These were the only conjugal contexts in which a man could in effect force the woman to have an abortion, in part because a wife may be likely to accede to her husband's overt demands, but also because the man might threaten to leave or withdraw economic support if she refused to do so. Because an economic bond existed prior to pregnancy, these women might be even more financially vulnerable than those who were separated and accustomed to relying on their own earnings with occasional outside help. When explaining their reasons for abortion, women in previously stable unions emphasized the fact that they would have soon found themselves on the labor market in a relatively unemployable condition.[8] Although at the time of the pregnancy the union may not have yet been formally broken, women considered their likely future when deciding the pregnancy's course. As one woman in a consensual union explained her decision to have an abortion:

> He was drinking so much in those days. He was drinking and of all the time with another woman. And I thought, "Really, we're not even married yet." It seemed like he was going to leave me and the two little ones totally at loose ends and go off and marry the other one. I had to do something.

Husbands were most likely to suggest an abortion when they were thinking of leaving. Some had already established other households, and their new wives frequently also had young children. Because of the strain of maintaining an active economic commitment to two households, men would encourage only the pregnancy of the woman they cared to live with, regardless of whether she was a legal or common law wife.

8. Recent changes in Colombian labor law requires that maids—one of the few jobs available to women in these barrios—have maternity fees paid by their employers along with other health costs as they arise. As a result, prospective employers are often unwilling to hire pregnant women. They wish to avoid the maternity costs and they do not want to lose the services of the employee once the baby is born. Job seeking maids are required by law to inform employers at the time they are hired of their pregnancy status. Concealing one's pregnant condition constitutes legal grounds for dismissal.

Conclusions

Our initial hypothesis, that a woman's relatives would play an important role in post-conception decision making, was not borne out by our interviews. In the group we studied, relatives were not asked—nor would they in most cases have offered—the kind of economic support necessary for child care and child rearing. Nor were relatives generally called upon for emotional support and advice in whether to continue the pregnancy. Instead, it was the partner from whom women sought both financial and emotional sustenance. Our interviews strongly suggested that the increased trend toward nuclear families in a rapidly urbanizing part of the world was already a reality for the women in our study. One implication of this trend was that primary responsibility for children rests exclusively with the parents and not with the larger kin group.

For most women in our study, conjugal stability was therefore the critical factor in accepting or terminating a pregnancy. A woman was more likely to continue a pregnancy if it occurred during a stable relationship, even though she defined the pregnancy as unwanted. In contrast, if a woman did not see a stable relationship in her future, she was likely to initiate abortion activity. This was the case not only for women who were single or separated when they became pregnant, but also if a separation seemed imminent or if the economic base was otherwise disrupted through, for example, the husband's initiating the support of an additional sexual partner. Women not in stable relationships tended to seek to terminate the pregnancy unless they secured a promise of regular assistance from the father.

The pattern of allowing the type of relationship with the father—if not the man himself—to decide the pregnancy's course seems consistent with the fact that pregnancy effectively disenfranchised a woman from independent employment. In fact, our interviews indicated that a sizable proportion of abortion decisions may be understood in terms of the woman's relationship to the economic system. When the relationship's viability was threatened, she sought to terminate an unwanted pregnancy. It

was the perception of a threat, moreover, rather than the threat *per se* that was the key to understanding a woman's evaluation of her situation and her timing of an abortion. In view of the finding that women with smaller incomes tended to take fewer steps to terminate a pregnancy, income level itself did not seem to influence women to seek abortion. The determining factor seems instead to have been anticipated economic disruption and the threatened loss of security that the birth seemed to entail.

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ABOUT THE AUTHOR Carole Browner is an assistant professor of anthropology at Wayne State University, Detroit, Michigan.

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