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Indigenous Women of Latin America: Unintended Pregnancy, Unsafe Abortion, and Reproductive Health Outcomes

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Abstract

Indigenous women in Latin America have poorer reproductive health outcomes than the general population and face considerable barriers in accessing adequate health services. Indigenous women have high rates of adolescent fertility and unintended pregnancy and may face increased risks for morbidity and mortality related to unsafe abortion. However, research among this population, particularly focusing on social and cultural implications of unwanted pregnancy and unsafe abortion, is significantly limited. This article reviews the literature on unsafe abortion in Latin America and describes successful interventions to ameliorate reproductive health outcomes within Indigenous communities. It also explores important implications for future research. Shedding light on the circumstances, perspectives, and lived realities of Indigenous women of childbearing age, could encourage further qualitative investigation and mitigate negative outcomes through improved understanding of the topic, targeted culturally appropriate interventions, and recommendations for future policy and programming reformations.

Keywords

Latin America; unintended pregnancy; unsafe abortion; social exclusion; social determinants; community based participatory research

Introduction

In many parts of Latin America, Indigenous women are disproportionately affected by adverse reproductive and sexual health outcomes. They commonly live in rural, poor, marginalized areas with limited access to health care and family planning services. Rates of unintended pregnancy and adolescent fertility are high in Indigenous populations, and women face greater risks of abortion related complications and death than the general public. These health disparities mark systemic patterns of inequality linked to gender, ethnicity, and socioeconomic status. Despite official policies and religious and public discourse that oppose abortion as a moral and legal offense, unsafe induced abortion is widespread and commonly practiced at dangerously high rates in Latin American countries (as well as throughout much of the developing world), with poor, young, and ethnic minority women bearing the brunt of physical and social costs. To grasp the on-the-ground situation and effectively identify possible solutions, women's experiences and beliefs regarding abortion, and the circumstances that shape their decisions, must be evaluated within the socio-cultural context and in light of greater political, economic, and historical processes. This article presents a review of the literature on unsafe induced abortion in Latin America, with a particular focus on first hand accounts of Indigenous women. Current methods to reduce abortion rates will be explored, as well as implications for future reproductive health research and practical intervention among Indigenous populations.

Global Overview

Unsafe abortion has been described as “one of the most neglected sexual and reproductive health problems in the world today” (Grimes et al., 2006) and is a major public health crisis throughout many developing countries. The World Health Organization (1993) defines unsafe abortion as a procedure to terminate pregnancy that results in complications or death due to inadequate skills of the provider, harmful techniques, and/or unsanitary conditions. In 2008, 43.8 million abortions occurred worldwide; nearly half of all abortions were unsafe and 98% of all unsafe abortions occurred in developing countries (Guttmacher Institute, 2012).

Abortion procedures, when carried out by trained professionals in appropriate settings, carry very low risks of complications and death (Grimes et al., 2006). In countries where abortion is criminalized and must, therefore, occur in clandestine and often unsafe conditions, abortion is a leading cause of maternal death. The majority of Latin American countries maintain highly restrictive abortion laws. Cuba, Guyana, and Puerto Rico are the only countries in Latin America that allow abortion without any restrictions; 7 of the 34 countries and territories in Latin America do not permit abortion for any reason. Abortion is allowed in 8 countries to save the mother’s life and, in some countries, in the case of rape, rape of a mentally disabled woman, and fetal malformations (Guttmacher Institute, 2012).

In countries that do not legally permit abortion, women resort to the services of untrained or inadequately trained professionals in precarious conditions, or attempt to self-induce an abortion. Due to these circumstances, unsafe abortion mortality rates are up to 100 times higher in Latin America than in industrialized nations (Paxman et al., 1993). Rates of unsafe induced abortion throughout Latin America and the Caribbean (32/1,000 women) are only higher in East and Middle Africa, and the percentage of maternal deaths due to unsafe abortion in Latin American and the Caribbean (12%) is only surpassed by East Africa and sub-Saharan Africa (WHO, 2011). Rates are particularly high in South American countries with large Indigenous populations; between 1995–2000, it was estimated that 18% of maternal mortality in Ecuador, 16% in Peru, and 28% in Colombia were attributed to unsafe abortion complications (Lafaurier et al., 2005).

Current reported rates of unsafe abortion likely reflect low estimates due to underreporting and challenges to data collection. Research is often hindered by the illegal status of abortion throughout most of Latin America, as well as social, religious, and political constraints.[1] In addition, incidence rates are often determined by urban hospital admissions data, which only account for women who are able and willing to seek hospitalized care for induced abortion complications. Not counted are women who successfully complete an induced abortion, are unable to seek hospitalized care due to geographic and financial barriers, or do not seek care fearing legal or social repercussions.

A common method of induced abortion outside of a medical facility is the use of abortifacients. This may include herbals, teas, and poisonous plants, as well as modern pharmaceuticals, such as Cytotec, Metrigen, or Quinine. The latter is commonly used for malaria prevention or treatment, but when taken at doses high enough to induce an abortion, can also cause death (Mundigo, 2006). Other methods may include the insertion of a rubber catheter, sticks, or other foreign bodies into the uterus in order to rupture the amniotic sac and produce uterine contractions. Women may also resort to physical harm — falling down

[1]Abortion research was delayed for nearly a decade as a result of USAID funding policies (i.e., Mexico City Policy, or “global gag rule”). In addition, women may be reluctant to speak with researchers for fear of social stigmatization, religious condemnation, and legal repercussions, impeding data collection and accurate reporting.

the stairs, repeated punches to the abdomen, consumption of toxins, such as laundry bleach or turpentine, or the insertion of toxic substances into the vagina.

In addition to mortality, unsafe abortion can cause a spectrum of harmful complications such as pelvic infections; sepsis; hemorrhage; cervical and vaginal perforations; damage to urethra, bladder, and bowels; and infertility. Women may also suffer from feelings of guilt, hopelessness, and social stigmatization. In a Chilean study, 76% of participants reported that the psychological distress caused by an undesired pregnancy outweighed fear and personal conflict related to abortion (Weisner, 1988). Unsafe abortion creates economic costs for the healthcare system,[2] as well as indirect costs, such as the effect on child health and education related to the loss of a mother; it is estimated that world-wide 220,000 children lose their mothers due to abortion complications each year (Grimes et al., 2006).

Social Determinants

Across Latin America, studies have revealed myriad determinants for unintended pregnancies and unsafe abortion, including poverty, lower education levels, high fertility rates, younger age at first intercourse, adolescent pregnancy, rural areas of residence, sexual violence and insubordination, and cultural and language barriers in health care facilities (Encuestra Nacional de Demografia y Salud, 2005; Terborgh et al., 1995; Goicolea et al., 2009; Eggleston, 1999). According to the work of Palma et al. (2006), areas without effective family planning programs left women with low education, older women, poor women, and women with several children at the greatest risk for induced abortion. Self-induced abortion was found to be more common among women living in rural areas where abortion services are unavailable or limited. Research conducted by Bernabe-Ortiz et al. (2009) across 20 cities in Peru found that the prevalence of induced abortion in the jungle region was nearly twice as high as that in the coastal and highland regions. Other risk factors for induced abortion identified in this study included lower age at first intercourse, multiple sexual partners, and older age at time of interview (Bernabe-Ortiz et al., 2009).

Many studies have shown that Indigenous origin is a significant risk factor for unsafe abortion and unwanted pregnancy. In Mexico, Indigenous women are five times more likely to abort unsafely than non-Indigenous women (Sousa et al., 2010). Indigenous women generally have lower resources and less opportunity than more affluent middle and upper class women to access safe, clandestine abortions conducted by trained professionals and in sanitary conditions (Elgar, 2011; Morgan and Roberts, 2012). High quality services and major hospitals are generally located in urban centres, which are sometimes geographically and financially inaccessible to Indigenous women living in poor, rural areas (Singh et al., 2006). In an investigation on induced abortion among women in Guatemala, 49–63% of Indigenous women obtained abortions from traditional birth attendants and less than 15% were attended by highly trained professionals (compared to two thirds of well-off women in urban centres) (Singh et al., 2006).

In Ecuador, studies conducted by Eggleston (1999), Goicolea (2009), and the Ecuador National Demographic and Maternal Health Survey (ENDEMAIN, 2004), have found that rates of unintended pregnancy are much higher in regions with large Indigenous populations. However, according to Bremner et al. (2009), of the 369 Indigenous women interviewed, the majority knew how many children they desired and over half of the sample (51%) did not want another birth. Undesired pregnancy is a key determinant in a woman's decision to seek an abortion (Paxman et al., 1993). Goicolea's (2010) extensive research in Orellana, one of

[2]Treatment of unsafe abortion accounts for up to 50% of hospital budgets for obstetrics and gynecology in some low and middle income countries (Guttmacher Institute, 1999).

the poorest regions in the Ecuadorian Amazon, revealed that 72.3% of Indigenous women in this region had experienced an unwanted pregnancy, with adolescent fertility rates far exceeding the national average. In another study by Goicolea (2001), community members and medical practitioners identified unsafe abortion as a critical issue in women's reproductive and sexual health. According to the Ministry of Health Statistics from 1999, abortion complications (most likely due to unsafe induced abortions) were the second most frequent cause of hospital admission in Orellana among women of childbearing age, accounting for 13.5% of all admissions (Goicolea, 2001).

In many rural regions in Latin America, family planning services and resources have been slow to reach marginalized, Indigenous populations (Terborgh et al., 1995). When services are provided they often lack appropriate counseling and patient education, as well as other aspects of high quality care (Bremner et al., 2009; Palma et al., 2006). Even when contraceptives are widely available, access can be impeded by ineffective family planning programs that do not respond to community needs and fail to provide accessible and suitable contraceptive methods and services (Ross and Frankenberg, 1993; Mundigo and Indriso, 1999).

Patient perspectives of the safety and effectiveness of various contraceptive methods, the use of nonmedical or nonpharmacological methods (withdrawal, rhythm method, herbals), and partner opposition or partner preference for certain methods may also influence the use or nonuse of contraception and fertility regulation. Indigenous husbands often play a primary role in decisions about family planning and may oppose methods that are under the woman's control for fear of infidelity, for religious reasons, or due to social disapproval (Terborgh et al., 1995). Indigenous women sometimes have lower levels of education, which has been associated with low contraceptive use. The average education of Indigenous women in Ecuador, for example, is two years and nearly half of women are illiterate (Planned Parenthood, 2012).

Decision Making

The examination of women's perspectives and experiences of induced abortion is imperative to understand the complicated and multivariate nature of the circumstances and conditions in which she decides to terminate the pregnancy. Women's decisions are shaped by social, cultural, political, and economic factors that are often entangled with complex social dynamics and structural constraints. Far from a simple story, women's decisions are fraught with ambivalence and uncertainty; women often must reevaluate religious ideologies and moral convictions that may not be compatible or pragmatic within the limitations of their social and economic realities. Women's testimonies, situated in place and time, reveal the socially embedded roots of pervasive inequalities — local human consequences of broader societal and political disjunctures.

> Reproductive 'choices' are far more than individual, or psychological. Broad demographic, sexual, reproductive … patterns are ultimately *social* patterns, contextualized by the rationalities of class, race, ethnicity, sex, religious background, family and reproductive history, and not simply by individual 'risks and benefits.' (Rapp, 1991, p. 385)

A woman's decision to induce abortion is often a response to situational conditions and circumstances, despite conflicting moral or religious ideology. Even if a woman views abortion as immoral, the disadvantages of inducing abortion may outweigh the perceived risks of supporting a child in an impoverished household or with an abusive partner. In these cases, meanings of "choice" and "consent" must be critically questioned and contextualized (Lock and Kaufert, 1998; Abu-Lughod, 2002). The decision to abort as a response to the

conditions surrounding the abortion (Petchesky, 1990, p. xvi) may be particularly true for women in many Indigenous communities where poverty, domestic violence, inadequate health care access and services, and geographic isolation continuously threaten the social fabric of health.

In studies of lower class and Indigenous women in South America, poverty and an abusive partner or the absence of a partner were cited as central causes of reproductive health problems. Past or current gender-based violence is associated with unwanted pregnancy and induced abortion (Bant and Girard, 2008). Intimate and sexual violence against women is pervasive in many Indigenous communities in Latin America. Nearly all of the Ecuadorian women participants in the study by Schoenfeld and Juarbe (2005) had been abused or had witnessed abuse by a domestic partner. Domestic violence (*maltratamiento*) was identified as the second greatest threat to women's health after extreme poverty (*falta de plata*). According to a survey completed in several Peruvian Quechua communities, 44% of women interviewed reported at least once incident of rape (Yon, 2000). In the qualitative study done by Lafaurie et al. (2005), several participants from Ecuador and Peru who induced abortion had been victims of intimate partner violence. Sexual abuse and rape are additional determinants of Indigenous adolescent pregnancy and unsafe abortion (Goicolea et al., 2009; Palma et al., 2006). Even where abortion is legally permitted in the case of rape, women are rarely familiar with abortion laws and policies and unable to navigate the convoluted legal system for aid and reparation.

In another study in Peru, Indigenous women described "many children" as a cause of health problems and poverty. Rather than linking this to a lack of contraceptives, however, women attributed gender inequality, unequal decision-making, and domestic violence (Bant and Girard, 2008). In Woodson's (2011) study on Indigenous Colombian women, participants commonly described economic deprivation and partner instability as primary reasons they induced abortion. One woman stated:

> I was having a lot of problems with my spouse. Yes, we were having a lot of problems at the time. He turned to drugs and alcohol and I felt alone. I wanted to do something; anything … so I fell [in an attempt to abort]. And now I am here [hospital]. It is a very sad situation. (Woodson, 2011, p. 36)

Other reviews have identified additional determinants: lack of emotional and economic support from the woman's partner (Llovet and Ramos, 1998; Browner, 2001), fears of rejection by society or family, and desires to attain personal satisfaction prior to motherhood (Palma et al., 2006).

Some studies indicate that in many communities in South America, fertility regulation may primarily be conceptualized and practiced in terms of postconception methods (Newman, 1985; Hammer, 1996; Nations et al., 1997). Nearly half of the women interviewed in the study by Lafaurie et al. (2005) described abortion as a way to regulate menstruation. According to a young Peruvian domestic worker:

> What I did was regulate my period. I'm not going to accept that I've had an abortion because if I had been three or four months along, then I would have felt bad.… But, I don't feel that way because I was barely a month pregnant. What I did was simply regulate my period, nothing more. (Lafaurie et al., 2005, p. 80)

In Hammer's research among Quechua women in Bolivia, most conventional contraceptive options conflicted with women's ethnophysiological understandings and were perceived to threaten their fertility. For fear of the risks of childbirth and the strains of poverty, women welcomed natural early term abortions and sometimes tried to induce them. Women in this community do not perform naming rituals for fetuses less than six months, which are viewed

as watery, expelled substances (*yakulla*) and are, therefore, unceremoniously discarded (Hammer, 1996, p. 7). Morgan (1997) similarly found that Ecuadorian women demonstrate considerable ambivalence towards the personhood of the fetus and do not generally attribute personhood to early, "unformed fetuses." One of the study's participants illustrated the common acceptance of early pregnancy termination by stating:

> Of course earlier is better [to abort]. Preferred, for example, in the case of unmarried women who find themselves pregnant, to do it at one month.… That's like 'bringing down the period' (*bajado la regla*). There is not yet any fetus (*feto*), no one, nothing. (Morgan, 1997, p. 342)

This perspective sharply contrasts with US antiabortion rhetoric and Catholic discourse that emphasize the individualization, personification, and inherent "rights" of the fetus.

Successful Interventions

Community Development and Family Planning

In rural, Indigenous communities, women are not often involved in the planning and implementation of health-based interventions (Schoenfeld and Juarbe, 2005). Interventions are much more likely to succeed and endure if women's experiences, perceptions, and self-identified needs, as well as local knowledge and existing community networks are assessed and integrated into programs and policies. The most successful programs to improve reproductive health outcomes within Indigenous communities offer a holistic approach focusing on the dissemination of information, education, the provision or improvement of family planning services and outreach projects, and advocacy for gender equity and community development. They value women's agency, active participation, and roles in their families and communities, integrating women's skills and knowledge, rather than casting women as passive recipients of biomedical intervention (Rathgeber, 1995). Through the evaluation of the community's challenges and unmet needs, and through partnership and participation of community members (particularly Indigenous women) programs are more likely to be well-received by communities and offer sustainable solutions over time. Two successful and sustainable models, which have achieved significant improvements in women's reproductive health over several years, are described below.

Some successful interventions implemented among Indigenous communities focused on expanding effective family planning services and education through the participation of, training, and partnership with Indigenous community members. In Peru, organizations such as the Amazonian People's Resource Initiative (APRI) in conjunction with MINGA-Peru, as well as Movimiento Manuela Ramos (MMR), have initiated programs in Indigenous communities based on the community health promoter or *promotora* model. In the initial stages of these programs, extensive interviews (*autodiagnosticos*) were conducted with Indigenous women to identify perceived challenges and experiences with health care providers and services. Language and cultural barriers have been shown in numerous studies to be prominent deterrents for Indigenous community members in seeking care (Thaddeus and Maine 1994; Ishida et al., 2012). By working with *parteras* (traditional midwives) and community members, organizations established intercultural programs and agendas incorporating cultural practices and Indigenous languages into medical facilities and health care services. Integration and active involvement of the community improved the acceptance of health care facilities as a legitimate source of care and increased women's utilization of available family planning services.

Another key aspect of the *promotora* model is women's empowerment and self-esteem building. The *promotora* model creates networks of female community members who, following initial training sessions, meet regularly to convene workshops on a range of

reproductive and sexual health issues, as well as issues having to do with women's rights, such as intimate violence. *Promotoras* often report improvement in their relationships with their husbands and increased self-confidence (Dean et al., 2000). These organizations include other interventions aimed at improving women's health and enhancing community development, such as income generating activities (which help women gain economic independence and improved gender equity in the home), information dissemination through radio broadcast, and community education (such as the Indigenous Teachers Training Program in Iquitos).

In Ecuador, the organization *Centro Médico de Orientación y Planificación Familiar* (CEMOPLAF) has achieved substantial strides through the engagement of community volunteers and the establishment of clinics and outreach projects throughout the country. Today, CEMOPLAF provides reproductive health care and education at 26 clinics in 11 provinces in Ecuador. The organization focuses on education, counseling, the distribution of contraceptives, family planning and clinical services, the orchestration of workshops for parents and peer educators, and outreach programs targeted towards rural, Indigenous communities (Schweninger, 2011).

Like Movimiento Manuela Ramos, CEMOPLAF has succeeded in reaching Indigenous communities by partnering with community members in identifying key priorities and concerns. Agendas are based on the community's needs, rather than predetermined generic models. For example, after evaluating one community's needs and learning that agricultural development was a greater priority for the community than the program's health initiatives, CEMOPLAF aided the community with agricultural projects. Once the projects were established, the organization was able to implement a health education component (Schweninger, 2011). Today, CEMOPLAF, in addition to direct patient services, trains government health care workers on reproductive and sexual health care and counseling, has established a research and evaluation department, and provides reproductive and sexual health education for adolescents.

Community based programs can be effective in reducing rates of unsafe abortion mortality and morbidity by targeting other important dimensions of health and wellbeing, such as poverty and domestic violence, and by improving accessibility and availability of contraceptives and family planning services. Unsafe abortion is inextricably linked with other key public health issues and women's rights. Appropriate interventions to prevent unwanted pregnancies and unsafe abortions must address broader goals of poverty reduction; improved status of women in society; gender equality; and women's basic rights to safety, education, and health care resources.

In addition to identifying priorities and providing education, resources, and services, community based organizations can play a central role in facilitating visibility of Indigenous women's health issues and in promoting the organization and collective activity of women within Indigenous movements. Development planners and policy makers too commonly assume that the desire to control one's sexuality is primarily a middle class, urban priority. Nowhere, for example, in the United Nations' *Declaration on the Rights of Indigenous People* (2008) is the reproductive and sexual health of Indigenous women mentioned. Women are significantly underrepresented in Indigenous movement leadership and have little opportunity to voice their needs and demands in the political arena (Bant and Girard, 2008). This has also been the case, historically, in Latin American feminist movements, which have largely been headed by middle and upper class, educated elites. However, changes in the political participation and activism of Indigenous women may be on the rise, following the lead of the Bolivian Indigenous women's movement.[3] Through the formation and mobilization of new organizations, Bolivian Indigenous women were able to influence

the content of the new Bolivian state constitution by asserting gender-specific demands pertinent to their communities and according to Indigenous world-views (Rousseau, 2011). Sharing experiences in an organized capacity and identifying key issues and priorities among women can lead to empowerment, collective action, and collaborative partnerships that facilitate enhanced social status and better health outcomes.

Postabortion Care Services

In addition to reproductive and sexual health projects and preventative services, adequate postabortion care is imperative to reduce maternal mortality and morbidity associated with unsafe abortion and to prevent repeat abortions. According to a review of results of ten major postabortion care research projects over nine years in seven Latin American countries (Billings and Benson, 2005), as well as additional studies (Paxman et al., 1993; Langer et al., 1997), postabortion care can significantly improve with the following interventions:

- Treatment with Manual Vacuum Aspiration — this method is safer than the conventional method used in Latin America, sharp curettage, and requires less heavy anesthesia. In addition, this procedure can be performed in an ambulatory setting, which reduces overall costs and length of hospital stay.
- Integration of counseling services into clinical treatment — by incorporating contraceptive counseling and the provision of methods, a significantly greater percentage of patients was informed of options and left the hospital with some method of contraceptive. For example, in Peru-Callao in 1998, after implementing the intervention, women accepting a contraceptive rose from 2% to 59%. In a follow-up assessment in 2000, 90% of women obtained some method of contraception.
- Training of health professionals and social workers — in some research sites training health professionals and social workers increased interpersonal communication with patients, improved negative attitudes of health care workers towards patients, and increased the number of patients that received important information prior to and following their procedures. However, the results of this intervention were weak in the majority of studies, suggesting the need for further training.

Adequate and accessible postabortion care is an essential element in reducing maternal mortality and morbidity associated with unsafe abortion. As demonstrated in the above review, simply providing services for abortion complications, without guidelines or further interventions, will not suffice; services must include appropriate technologies and a woman-centred approach (which includes counseling, comprehensive information, and the provision of contraceptives) in order to reach the greatest number of women possible and prevent further incidents of unsafe abortion. In addition, providers must continue to be educated and trained to demonstrate compassion and integrate cultural respect and culturally congruent practices into their care. For example, if providers do not speak the Indigenous language of the patient, a translator must be available for adequate education and counseling.

Decriminalization of Abortion and Access to Safe Abortion Services

Abortion is not yet decriminalized in most Latin American countries despite clear indications that the provision of available and accessible safe abortion services is the most effective method of reducing maternal mortality and morbidity associated with unsafe

[3]In 2011, the “International Meeting of Indigenous Women’s Voices” brought together 130 Indigenous activists in Bolivia. The meeting culminated in a formal declaration on the sexual and reproductive rights of Indigenous women, including the right to safe and legal abortion.

abortion complications. In developed countries where abortion is legal, rates of unsafe abortion are extremely low (1/1,000 women) (WHO, 2011). In recent years in Latin America, overall maternal mortality has decreased as a result of improved obstetric emergency care; however, mortality rates due to unsafe abortion have remained stagnant and now disproportionately account for a larger percentage of overall maternal mortality rates. Until abortion policies in Latin American countries can be evaluated apart from the influences of political and religious agendas, easily preventable mortalities and morbidities due to unsafe abortion will undoubtedly persist.

Implications for Future Research

Limited research exists on women's experiences and the social and cultural implications of unsafe abortion in Latin American Indigenous communities. Although quantitative studies illuminate important data on mortality and morbidity, women's viewpoints, the nuances of the decision-making processes, and the underlying forces and circumstances surrounding a woman's decision are necessary for a comprehensive overview and a more intimate understanding of the issue. How women define pregnancy and abortion may vary considerably across cultures and communities. For example, among Quechua women in southern Bolivia, only after four months of gestation will a woman acknowledge a pregnancy with certainty (Hammer, 1996). Other studies conducted among Indigenous women reveal that methods used to induce an abortion in early gestation were not viewed by women as abortifacients but, rather, as ways to restore a delayed period (Newman, 1985). Researchers need to identify how women decide to manage their fertility, if at all, and what resources are utilized in doing so. What method of contraception or family planning, if any, do women employ and why? What role does the partner and/or other family members play in the regulation of her fertility?

Other important considerations for conducting research among Indigenous women include inquiry into how women make reproductive decisions, especially regarding abortion, despite contradictory societal, political, religious, and even personal beliefs. Do women reconcile ideological compromises for the sake of pragmatism? Do Indigenous women act surreptitiously in implementing reproductive health decisions? If not, do they confide in social networks, partner support, practitioners, etc.? Are women familiar with the legal and medical risks of induced abortion, and to what extent?

Adolescent Indigenous women are particularly at risk. Generational shifts, gender dynamics, the effects of modernization and emigration have scarcely been explored in relation to unsafe abortion, even though such factors have been shown in studies to affect young Indigenous women's perceived identity and behaviour (Muratoria, 1998; Miles, 2000). Do any of these factors contribute to sexual vulnerability or influence life objectives, reproductive health priorities, or abortion decisions?

There is an indication for further qualitative, on-the-ground research on unsafe abortion and reproductive and sexual health in Indigenous communities. However, thoughtful consideration and close examination of appropriate and desired methodological approaches is clearly warranted. Culturally appropriate and community based research questions, methodologies, models of analysis, and deployment of findings are critical to positive and productive research endeavours and beneficial outcomes for the community.

> The way researchers acquire knowledge in Indigenous communities may be as critical for eliminating health disparities than the actual knowledge that is gained about a particular health problem. (Cochran et al., 2008)

Several studies have demonstrated that community based participatory research methodology may be an appropriate and effective approach to health research with and within Indigenous populations (Cochran et al., 2008; Minkler, 2005; Pain, 2004; Wallerstein and Duran, 2006). According to this methodology, Indigenous community members participate in all stages of the research process. Community members define the needs and priorities and set the research agenda. They may also determine research guidelines that adhere to culturally congruent ideology and practice and reflect the community's own "unique knowledge systems" (Louis, 2007). By incorporating Indigenous etiological theories, integrating community insight, and equalizing power differentials, community based participatory research has the potential to facilitate sustainable solutions, decrease health disparities and instigate long-term social change (Wallerstein and Duran, 2006).

Community based health organizations, like those previously described, are in a key position to conduct community based participatory research that assesses women's and men's perspectives, experiences, and current challenges related to unsafe abortion and how abortion needs are situated among other health and economic priorities. These organizations have operated within Indigenous communities over extensive time and understand important community relations and social dynamics — an intimate knowledge of everyday life practices and events that is essential to meaningful research and effective interventions. The integration of abortion into existing frameworks of health research, services, and advocacy, will draw upon personnel, resources, and facilities that are already in place to improve the reproductive and sexual health of the community and will help to reify unsafe abortion as a real priority and pressing concern.

A feasible starting point and a practical model for Indigenous communities interested in researching and addressing unsafe abortion may lie in a collaborative project that identifies and assesses discursive and material sources of abortion stigma in the community. Stigma is a common dimension of women's experiences of abortion across cultures, produced through a series of highly contextualized and localized social processes that may contribute to and exacerbate negative health outcomes. Kumar et al. (2009) note that abortion stigma is articulated and reinforced through a variety of mechanisms on several levels of society: mass culture, structural, organizational, community, and individual. Through a series of focus groups, in-depth interviews, and archival and observational analyses of media, law, and public discourse, community researchers can engage Kumar et al.'s (2009) recommended course of action to empirically measure and deconstruct abortion stigma. The community can then use this knowledge to formulate interventions that address and dismantle causes of abortion stigma and the mechanisms through which it is expressed and perpetuated.

Conclusion

Evidence indicates that Indigenous women in Latin America may be affected more severely by the consequences of unwanted pregnancy and unsafe abortion than the general population. Unsafe abortion constitutes a public health crisis throughout the majority of Latin American countries with highly restrictive abortion laws, with the most vulnerable and marginalized populations bearing the greatest burden. Institutional and legal barriers to safe abortion procedures, inadequate postabortion care, deficient or substandard family planning services and provisions, as well as other critical issues affecting maternal health (poverty, low education, and absence of health care services) contribute to the persistent challenges women face in achieving positive health outcomes. There is a pressing need to develop further research that explores unsafe abortion among disadvantaged subgroups and to evaluate currently successful interventions to aid in the creation of programs and policies targeted towards these populations. Reproductive and sexual health and wellbeing, as well

as availability and accessibility to the conditions and services needed to maintain and restore reproductive and sexual health, are inherent human rights. Laws, policies, and inequalities that hinder these rights and ignore the needs of vulnerable populations are failures of society and governments to uphold the respect and value of human life to which we are all entitled.

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