

## Parental experiences of barriers to pediatric surgery in Guatemala and policy recommendations to improve access

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**Background:** Morbidity and mortality from conditions amenable to surgery continue to rise in low- and middle-income countries. Children in Guatemala have difficulty accessing surgical care, although the precise barriers to care are not well-defined. Using a structured anthropologic approach, we sought to explore how parents or adult guardians (hereafter referred to as parents) experience barriers to pediatric surgery in Guatemala, suspecting that financial considerations were among the major obstacles to care.

**Methods:** We conducted interviews with 29 families of children receiving surgical care at two non-governmental organizations (NGOs) in Guatemala to examine perceptions of barriers to care. Inclusion criteria included being a parent or adult family member/caregiver of a child undergoing surgical care at an NGO providing free or low-cost care in Guatemala City or Antigua. Subjects were recruited by convenience sampling on the day of initial surgical evaluation. Transcripts were analyzed using a grounded theory approach; study enrollment was closed once thematic saturation was reached.

**Findings:** Parents identified financial costs, systems limitations, quality of care, and fear/mistrust as the primary barriers to care. It was common for parents to wait several years between when surgery had been recommended and pre-operative surgical evaluation. Transit time to the NGO often took hours. When asked if they would prefer to have a Guatemalan or foreign provider, over half of parents stated they would prefer the latter.

**Interpretation:** Surgery is an increasing priority in the global health arena. Understanding the barriers to care is critical for policy development to improve access to surgery for children. One unexpected finding of our study was the predominance of fear/mistrust, a theme which emerged more frequently than in previous studies. Despite financial obstacles, most parents cited a fear of the surgery as the single most important barrier to care. This may be due to the negative perceptions of public surgical care in Guatemala. Cooperation and collaboration between sectors, quality improvement, and health promotion may address some of these concerns and reduce barriers to care.

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## Exploring caesarean section decision-making in newcomer and Canadian-born women in Edmonton, Alberta

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**Background:** Caesarean section (C-section) deliveries are conducted when there is a failure to progress in labor, or compromised fetal status. However, they place women at higher risk for immediate complications

compared to vaginal deliveries. Mumtaz et al. (2014) showed that newcomer women in the prairie provinces experienced significantly higher C-section delivery rates compared to Canadian-born women, even though rates of recommendations by healthcare providers was equal. This on-going study aims to understand this trend, and explore how decisions regarding C-section deliveries are made within the experiences of newcomer and Canadian-born women.

**Methods:** A focused ethnography was conducted at a university-affiliated hospital in Edmonton, Alberta for an 8-month period in 2015. The study population comprised: 1) newcomer women who immigrated to Canada after 2004 (N=20) and 2) Canadian-born women (N=20). Both groups consisted of women who have a higher risk of undergoing a C-section. Data collection strategies included participant observation of prenatal appointments, labour and delivery along with in-depth interviews with the women. Written informed consent was obtained from all participants and ethics approval was received from the University of Alberta.

**Findings:** Preliminary findings indicate that decisions to have emergency C-sections were solely due to physician recommendations. Women stated the safety of the baby as the main reason for following physician recommendations. Both newcomer and Canadian-born women revealed deep-rooted trust in the recommendations, which was rarely questioned when the health of the baby could be compromised.

Conversely, when exploring decision-making of processes, which did not compromise the health of the baby, Canadian-born women were more likely to question the decisions of healthcare providers, and actively provide their opinions compared to newcomer women. Canadian-born women were more likely to recognize their patient rights, especially if they or their family members were part of the medical community.

**Interpretation:** The findings indicate a discrepancy in the role of the Canadian-born and newcomer women as patients, and further research is required to ensure newcomer women play an active, informed role in decision-making processes.

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## Drugs, docs, and delays: A qualitative analysis on barriers and facilitators to medical care engagement amongst people living with HIV in St. Petersburg, Russia

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**Background:** It is well-established that adherence to antiretroviral treatment (ART) and medical care engagement both improve personal health, and reduce infectivity and transmission in People Living with HIV (PLH), potentially leading to widespread reduction in HIV incidence. However, a high proportion of PLH worldwide are out of care. Russia's situation is even worse with lower medical