Findings: United Nations human rights treaties, in particular the *1979 Convention on the Elimination of All Forms of Discrimination Against Women*, *1989 Convention on the Rights of the Child*, *1948 Universal Declaration of Human Rights* and *1976 International Covenant on Economic, Social and Cultural Rights* oblige Member States to adopt policies and practices that protect children's right to healthy development and women's rights to health, appropriate pregnancy services, and education to support the health of herself and her children. We find a large variation between practice guidelines in terms of how closely recommendations on e-cigarette use in pregnancy align with these human rights obligations.

Interpretation: In clinical practice, a higher degree of vigilance is needed to ensure that both providers and patients are given clear, accurate messages about the known and unknown risks associated with e-cigarette use. Clinical practice guidelines should consider both scientific evidence and global human rights principles. Within a human rights framework, health providers have an ethical obligation to ensure that pregnant patients can make informed decisions on all matters related to their pregnancy, including e-cigarette use in pregnancy.

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Abstract #: *2.027_WOM*

Social Factors Influencing Family Planning Knowledge, Attitudes, and Practices in the Ngäbe Population in Bocas del Toro, Panama

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Background: According to Panama's 2009 National Sexual and Reproductive Health Survey, only 19% of indigenous women in Panama use modern family planning (FP) methods. Despite the Ngäbe representing 62% of the indigenous population, there is limited research on their use of FP.

Methods: 14 Ngäbe communities in Bocas del Toro served by Floating Doctors were surveyed. Women between the ages of 18 and 50, who had >2 children were invited to be interviewed about FP knowledge, attitudes, and practices.

Findings: A total of 148 women were enrolled, mean age 32.18 (SD = 8), and mean number of pregnancies 4.9 (SD = 2.5). On average, first sexual encounter occurred at age 14.7 (SD = 1.9), with first pregnancy occurring at age 16.3 (SD = 2.5), and mean spacing between first and second pregnancy was 2.8 years (SD = 2.1). Only 7% of women could not name any family planning method. Women reported ideal age to begin having children as 21.5 (SD = 4), and reported ideal birth spacing as 4.8 years (SD = 2.4). 78% did not want to have more children but only 32% were currently using FP. 40% of women currently not using FP had used a form of FP in the past. 41% of women used any FP methods. Respondents with unmet need for FP reported concerns about side effects (48%) and lack of access (32%) as main barriers to using FP. Women practicing indigenous religions were less likely than all other religious groups to use FP ($X^2 = 19.0$, $p<0.001$). FP use was higher for women who received information on FP during prenatal visits ($X^2 = 8.5$, $p = .003$), from health care providers ($X^2 = 7.5$, $p = .006$), and who talked with a health care provider about FP during the last year ($X^2 = 4.8$, $p = .029$). There was no significant association between age, location, education level, marital status, number of pregnancies, and FP use.

Interpretation: Ngäbe women believe it is important to delay first birth, increase birth spacing, and have fewer children. However, misconceptions about FP and concerns about side effects are widespread and deter FP use. Receiving accurate FP information from health care providers increases use. Qualitative research is needed to more fully understand how indigenous beliefs and traditional practices influence FP use.

Source of Funding: University of Connecticut School of Medicine.

Abstract #: *2.029_WOM*

Saving Mothers Project-Distribution of Birth Kits with Misoprostol in Two Rural Districts of Mara Region Tanzania: The challenges with survey data

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Program/Project Purpose: The "Saving Mothers Project" in Bunda and Tarime Districts of Mara Region, was conducted from October 2015 to early 2017. Pregnant women were provided with clean delivery kits with misoprostol to prevent infection and postpartum hemorrhage. The kits were distributed through community health workers (CHWs) and nurses. The women were instructed to seek a health facility for birth, but the kits could be used for home births, delivery on route, and at the facility as supplies were often lacking. Also, CHWs were given mobile phones equipped with an m-health application to register the pregnant women, send them reminders to attend antenatal clinic, warn them about danger signs, and track their delivery outcomes.

Structure/Method/Design: We randomized all the pregnant women who were registered by the CHWs using the m-health application. We then interviewed 20 percent of the group using a structured interview on tablet computers in order to evaluate the success of the project. We will report on the first 12 months of data collected.

Outcome & Evaluation: We surveyed approximately 2,323 women in Bunda District (1,485) and Tarime District (838). The facility birth rates for the participating women was high at 83%, all attended by a skilled health provider. Only 4% of women had no provider available (either alone or with family or friends only) and a further 12% had a TBA. The reported facility birth rate with the m-health data and from the District Health Offices showed improvement in facility births, but not to the extent of our data. It appears women falsify their delivery location if they have a non-facility birth as they are aware that home births are not approved of by the government.