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# Relationships between contraception and abortion: the problematic issue of prevention in Latin America

*Agnès Guillaume\* and Susana Lerner‡*

## **Abstract**

In Latin America, in spite of a high contraceptive prevalence among married women, many unintended pregnancies and unsafe abortion occur. This statement questions the issue of prevention of pregnancy and mainly this of an absence of a preventive culture for men and women. First, these difficulties are analyzed considering the individual barriers to prevention: - the contraceptive practice around an unwanted pregnancy is analyzed through different studies to explain unexpected pregnancies and abortion - the awareness of pregnancy risk pending on social level and the condition of sexuality- and men involvement as actor or barrier in this prevention according to their relationships are considered.

In the second place, institutional barriers are considered: barriers coming from conservative or religious groups, health systems or society.

Results presented come from the review of the literature on abortion in Latin America and the Caribbean realized from 1990 to 2005 and from some recent publications.

## **Keywords**

Prevention – abortion – contraception – men – barriers of access – Latin America

## **Résumé**

En Amérique Latine, malgré une prévalence contraceptive élevée parmi les femmes mariées, beaucoup de grossesses non désirées et d'avortements se produisent chaque année. Cet article interroge la question de la prévention des grossesses et principalement celle d'une absence d'une « culture de prévention » chez les hommes et les femmes. Tout d'abord, ces difficultés sont analysées en considérant les différentes barrières à la prévention : - la pratique contraceptive au moment d'une grossesse non désirée est étudiée sur la base des résultats de différentes études pour expliquer la survenue des ces grossesses, et des avortements - la conscience du risque de grossesse - et la participation d'hommes comme acteur ou obstacle à cette prévention selon le type de relation entretenue. En second lieu, l'accent est mis sur les barrières institutionnelles provenant des groupes conservateurs ou religieux, des institutions de santé ou de la société.

Les résultats présentés proviennent d'une revue de la littérature sur l'avortement en Amérique Latine et dans les Caraïbes réalisée pour les années 1990 à 2005 et de quelques publications récentes.

## **Mots-clés**

Prévention – avortement – contraception – homme – barrière d'accès - Amérique Latine

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## Introduction

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According to WHO (2003), 26.5 million unplanned pregnancies occurred in the world. Some of these pregnancies lead to legal or illegal abortion. Six millions of them would happen even with perfect (correct and consistent) contraceptive use (Grimes *et al.*, 2006) In Latin America and the Caribbean, 52% of the 18 million pregnancies occurring each year are unplanned, and 23% end in abortion even if in this region 71% of married women use contraception (Glasier *et al.*, 2006). In this region, most of these abortions are unsafe due to the prevalent restrictive laws and account around 17% of maternal deaths (Grimes *et al.*, 2006). Some studies shown that a high proportion of pregnancies terminated by an abortion occur among women using contraception (Moreau *et al.*, 2005) due to misused of the method (forgetting discontinuation...) or to the own limit of effectiveness of the method.

These high rates of unplanned pregnancies and in succession of unsafe abortions have led to the question of preventing a pregnancy risk. The adoption of a preventive behaviour needs that women and men be aware of pregnancy risk at the time of sexual intercourse and that they could access to prevention (Moreau *et al.*, 2005). If most governments have adopted public policies implementing family planning programs (FPP), only a few have adopted legislation that authorized the practice of abortion or have implemented effective services to perform the ones legally permitted. Nevertheless, in most countries the two options coexist and occasionally play complementary roles, one being abortion practice clandestine and unsafe in the majority of the less developed ones, where it is illegal and/or very restricted and the other being contraception. The general pattern observed suggests that improvement on contraceptive practice and FP services will reduce unplanned pregnancies and abortions, although it will never entirely eliminate them, as a perfect and totally effective contraceptive coverage is never achieved (Bongaarts and Westoff, 2000; Marston and Cleland, 2003; Mundigo, 1993; Singh *et al.*, 2006). While reproductive health needs defined by women are not being considered, mainly needs for contraception, unintended pregnancies may occur and abortion could take place as the only or ultimate option in the absence, failure or ineffective use of contraception.

These high rates of unplanned pregnancies and abortion have led to consider the complexity of social, political, cultural and subjective factors that intervene in the link between abortion and contraceptive prevalence and in the case of Latin America to suggest the relevance of the absence of a “preventive culture” in both components of this interrelationship (Guillaume and Lerner, 2007). Therefore, the aim of this paper is to illustrate the various circumstances and factors which have prevailed in prevention of pregnancy risk in Latin America addressing some relevant questions: Why do such high unintended pregnancies occur in a context where contraceptive practice is frequent, extended and with high prevalence levels? Why do women resort to abortion in place of using contraception, in a context of high risk abortion? How is prevention of pregnancy risk perceived among men and women? Our analysis will be centred in the social, institutional and individual or subjective prevention barrier, considering also the role of men, which it is also essential in preventive practices.

The arguments, empirical evidences and results presented in this paper come mainly from the review of the literature (1990-2005) on abortion in Latin America and the Caribbean (Guillaume and Lerner, 2007), a publication where the situation surrounding induced abortion is analyzed according to different themes (legislation, political and social debate, health and social consequences, abortion and contraception, males participation, among others) and from some recent published studies. It is important to note that legal access to abortion is very restrictive in most Latin American countries, being its practice therefore highly clandestine.

## **Reasons of unintended pregnancies**

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As many authors have stated the analyses of the reasons for seeking abortion as a result of an unintended and unwanted pregnancy is an alternative way to understand the context and strategies of prevention adopted by women or couple.

The available literature clearly shows that these reasons are often complex, interrelated, determined by a variety of factors and neither universal nor common to all women... They vary according to age, the stage in a woman's life cycle, her parity, her socioeconomic living conditions, her access to reproductive health and family planning services and her degree of religiousness. They also depend on the woman's social and personal values or those of her partner, the relationship between her and her partner, the value she gives to motherhood, as well as the social acceptance of pregnancies out of wedlock, and to women's expectations and life projects. Other reasons respond to the social, cultural, economic or religious circumstances prevalent in each country, fear of rejection by the partner or parents due to an unmarried women's pregnancy.

In addition, abortion as a result of an unplanned pregnancy is a problem that is determined by the difference of power relations between genders, insufficient sexual and reproductive education, particularly for young people, as well as the impossibility of obtaining access to basic health and family planning services (Center for Reproductive Rights, 2003). The political and health institutional context, and barriers of access could explain the absence or effectiveness of services: the quality of health services to diminish fears, failures, negative side effects, gossips... regarding contraceptive use; the lack of a wide range of methods in order to select the ones better fitted to women's physical and social conditions (for example, contraceptive methods for adolescents). Barriers and reasons expressed by women that are not considered or very seldom considered in the design and implementation of FPP.

According to Bankole (1998) in their comparative study of abortion reasons in the world, the most common reasons in Latin America for interrupting unplanned pregnancy are socioeconomic problems with one's partner or reasons linked to the women's age or due to the high frequency of consensual unions. Espinoza and López Carillo (1994) argue in the same sense "It has been documented that certain women decide to interrupt a pregnancy due to the need not to procreate any more, either temporarily or permanently or because of the economic difficulties associated with the need to maintain a household, hold down a job, continue with an education program or because of their partner's or family's negative attitude towards the pregnancy".

For Langer (2002) the four main reasons for the increased in the levels of abortion in the Latin American region are:

- 1) People's growing desire to reduce the size of their families.
- 2) The lack of access to family planning methods.
- 3) The degree of reliability of contraceptive methods and their possible failure.
- 4) Involuntary sexual relations.

In a more comprehensive and integral approach, as Lamas (2003) points out, for defenders of women's rights, the three main category of causes underlying an unwanted pregnancy are firstly, those that have to do with the "human condition": forgetfulness, irresponsibility and unconscious desires. In this respect, sexual violence and individual neglect play a key role. A second category of causes is linked to social wants, particularly the lack of broad sex education programs, which translates into widespread sexual and reproductive ignorance. Finally, there are causes related to

contraceptive failure. According to Lamas, the first type of cause is the most complex and difficult one to deal with, since it involves transgressions of the human condition, in which neglect, mistakes and forgetfulness are part of its essential nature.

The context regarding the exercise of sexuality is a central element and in order to understand the preventive strategies to be adopted. Studies analyzing the context of Aids prevention have shown that individuals construct their own definition of risk taking into account contextual elements as well as material elements (Moreau *et al.*, 2005). The adoption of preventive behaviour needs that women and men be aware of pregnancy risk at the time of sexual intercourse. When the decision to have sexual relation is reached jointly by the couple, women aware of being at risk of pregnancy are more likely to have the possibility to use/or negotiate a preventive measure. However, in most cases, women do not have the possibility to exercise their sexuality in a risk-free manner and to prevent it from unintended pregnancies, as frequently men impose their sexual decisions; therefore most of unintended pregnancies and abortion occur due to an absence of prevention. Likewise, in many Latin American countries, the risk of unintended pregnancy is also closely linked to the widespread context of intimate partner violence, placing women in a situation of vulnerability and, therefore, with limited preventive and contraceptive behaviours.

## **Limitations and barriers for prevention**

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To prevent a pregnancy women need to become aware that they are exposed to a pregnancy risk and that they have the economic and social capacities as well as access to conditions, – that is social capital and access to means and services – for prevention, without or at least less limitations and barriers. The individual or subjective capacities and the external conditions, Institutional barriers are closely linked as the latter are material or ideological influences being internalized by women, guiding their perceptions, values, attitudes, capacities and practices or in other words they contribute to mould their preventive behaviour to avoid unintended pregnancies and abortions.

### ***Individual barriers: limits of methods or perception of prevention?***

#### **Contraceptive lack or failure: an explanation for unplanned pregnancies**

Diverse studies, with different survey samples, conducted with women who aborted in Latin America show some evidences of contraceptive practice before an abortion. As it is described in Table 1 some simplistic and well known facts are observed:

- a) Many abortions occur frequently due to contraception absence: between one third and 78% of women did not use contraception before their unplanned pregnancy.
- b) A high rate of contraceptive failure seems to be due to their incorrect or irregular use or to their ineffectiveness, mainly in the case of natural methods or barriers methods. Mundigo (1993) underlines that women using natural methods know very little about their fertile period, which further reduces these methods' effectiveness. In Colombia more than 2/3 of unplanned pregnancies are due to a contraceptive failure with barriers methods or traditional ones, and in Puerto Rico half of the failures are due to natural methods (abstinence or withdrawal), but the same results could be also a consequences of the limited access and/or inadequate quality of FP services; Ali and Cleland (2005) in their study about sexual and reproductive behaviour among single young women in Latin America underline that they use contraception for relatively short

periods of time and some of them stopped their use, because of dissatisfaction with the method (health concerns, side-effects, inconvenience and so on).

- c) Reject of some modern methods is related to incorrect or irregular use, or due to wrong knowledge of the conditions to use them (Glasier *et al.*, 2005). It may also be due to bad experiences or fear of using them often based on false beliefs or side negative effects (Villarreal Mejía, 1992).
- d) The high failure rates of these methods are related to “human condition” as Lamas has mentioned (2003) (see *infra*) or the presence of erratic behaviours in women’s contraceptive experience as argue by Zamudio Cárdenas *et al.* (1999). The experience of an abortion does not really involve women in a contraceptive practice, as the data from Zamudio Cárdenas study in urban areas in Colombia shows that among those women having their first abortion, 21% had used a contraceptive method, among those having second and third abortions, this proportion rose to 28%, while among women with subsequent abortions, it fell to 17.8%.
- e) Contraceptive practice is tightly linked to the personal life of women and their sexual life. In some cases, its use may appear unjustified for women that have sex rarely or irregularly, such as young women, widows and non-married. The barriers methods may seem to be useful in this situation, but in case of condom women need to negotiate male participation in this prevention, a difficult situation in case of male domination or in case of sexual abuse. A study by the Population Council conducted at the Mexico City General Hospital (Lara *et al.*, 2003) found that of 231 women who had become pregnant as a result of rape, over two thirds (66%) were adolescents with a very low contraceptive practice (2%) at the time of the sexual assault.

**Table 1:** Contraceptive use before induced abortion

Country	Interviewed women	Year of survey	Contraceptive use before abortion
Argentina	404 lower class women	1992 - 1993 (López and Masautis, 1994)	40% of contraceptive failure using pills, condoms, injections, IUDs and the rhythm method, in descending order
Colombia	301 women in a clinic in Bogota	1991 (Mora Téllez <i>et al.</i> , 1999)	33%: no contraceptive use - 67% : failure of traditional or barrier method
Colombia	602 urban women (16 to 48), admitted for treatment of incomplete abortions	1991 (Villarreal Mejía and Mora Téllez, 1992)	43% : no contraceptive use - 57% : contraceptive failure : 12% using modern methods, 36% incorrect use
Colombia	Women in urban areas (around 30000 women)	1992 (Zamudio Cárdenas <i>et al.</i> , 1999)	78% : no contraceptive use 22% : contraceptive failure or misuse
Dominican Republic	352 women in hospitals for abortion complications	1992 (Paiewonsky, 1999)	25% : contraceptive failure: 1/5 periodic abstinence, around 1/3 withdrawal, 16% pill, 10% condom - 45% no currently using - 25% never used
Nicaragua	445 Maternal deaths related to pregnancy	2000-2002 (Padilla and McNaughton, 2003)	65% : no contraceptive use - 22% : contraceptive failure
Puerto Rico	Women in <i>ProMujeres</i> organization	1991 (Azize Vargas <i>et al.</i> , 1993)	59% contraceptive failure: 50% failure with abstinence or withdrawal, 32% stopped other method because of side effects
Southern Cone country	808 women in a clandestine urban abortion facility	1995 (Strickler <i>et al.</i> , 2001).	3/5 : no contraceptive use
Colombia, Peru, Mexico, Ecuador	49 women resorting to medical abortion	2003 (Lafaurie <i>et al.</i> , 2005)	34/49 : no contraceptive use - 12/49 : contraceptive failure - 3/49 : victim of sexual violence (no use)

Source: Data obtained from different studies documented in Guillaume and Lerner (2007)



## Access barrier to prevention: what perception of risk?

The access barrier to prevention and in particular to contraception could be due to women's perception of pregnancy risk but also to their perception, value and attitudes toward the means and practices for prevention. As Lamas (2003) has mentioned, the difficulties of preventing pregnancies are mainly due to causes related to the "human condition", elements related to human nature that are strongly determined by social and cultural context.

In this line, some authors have stressed the need to consider the meaning and scope of what could be named as the "culture of prevention" and planning, as part of a more comprehensive conceptual frame to analyze the link between contraception and abortion (Zamudio Cárdenas *et al.*, 1999; Rostagnol, 2003; Langer, 2003). This approach is shaped within a much larger space than socio-demographic conditions, technical-institutional aspects (availability and access of contraceptives, information, costs...), medical aspects (effects of contraception on the body) and a wide range of socio-cultural dimensions, which – as social constructions – define preventive behaviour. But most important, it refers to the conditions and structural possibilities in developing countries, which are too precarious to consolidate a culture of prevention, and which are reflected in the lack of clear, stable working conditions, strong organizational structures, foreseeable rules of the game, strong, broad social security structures, and fair mechanisms of access and social participation. Given these circumstances, it is assumed that the population finds it difficult to develop a culture of planning, within which prevention is regarded as an everyday way of acting. Thus, in conditions of unemployment, poorly paid jobs, and everyday structural inequity, the population develops a sense of opportunism, a sense of the moment and a taste for chance, and this skill enables them to deal with everyday unforeseen conditions and cope with its risks.

The ability of prevention is link to the awareness of risk. The notion of moment or of temporality as part of the cultural context in which an individual's life is lived is frequently characterized by a "need for immediacy", (Zamudio Cárdenas *et al.*, 1999; Rostagnol, 2003) that is, living the moment and a certain inability to think in linear time that would allow for future projects or simply planning in different areas of life, including reproductive decisions. This vision seems to be more common in men than in women because men are not accustomed to taking measures to prevent pregnancy.

Additionally, the absence of a preventive and planning culture and behaviour can largely be explained by other dimensions such as:

- a) the conditions of inequality and power relations between genders, male control or domination of women, the limitations of inter-gender communication, women and men's different perceptions of the link between sexuality and reproduction;
- b) the social representations of the health consequences of modern contraceptive use ;
- c) women's relationships with their own bodies and their self-esteem, their autonomy, which leads them to resort to abortion out of fear of using safe contraceptives and the troublesome side-effects they attribute to them.

The fact that certain women prefer to resort to abortion rather than use contraceptive methods have led some authors to analyze the advantages abortion could have in relation to family planning and conversely, the advantages of the latter over abortion. Effective, preventing pregnancy required a high degree of shared responsibility in sexual behaviour, which implies having sufficient information and education about contraception, as well as a greater awareness of the measures to be taken before having sex. Conversely, resorting to an abortion requires less education as regards sexual and reproductive health (David and Pick de Weiss, 1992). A late period and the anxiety caused by the

possibility of an unwanted pregnancy are often enough issues to make a woman seek an abortion. Unlike most contraceptive methods, abortion is 100% effective – if performed properly, it is performed once, regardless of the time of intercourse, and it provides a guarantee, not just a probability of preventing pregnancy. Abortion does not interfere with sexual activity – except in the event of complications – nor does it entail the health risks that, according to some women, are entailed by modern contraceptive methods. Moreover, when remorse is associated with abortion, the guilty feelings are similar to those related to the repeated use of contraceptives. Conversely, they add, abortion constitutes only a single violation of a woman's value system. A similar behaviour is documented in some countries in Africa as certain women prefer to resort to abortion rather than use a modern contraceptive method (Guillaume, 2004) because of their fear of the side effects of contraception and of infertility and also the possible advantages of abortion over contraception in young women is that it enables them to test their fertility.

### **Male involvement: actors or barriers in prevention?**

Since the Cairo Conference's Action Program emphasis on the male role in reproduction, including family planning and sexual health has been highly placed. The array of modalities and possibilities for male participation varies according to the particularities of the social and temporal context, as well as the prevailing social norms in each context (Tolbert *et al.*, 1994). The presence of men in general and especially women's partner (named "*los otros significativos*") "can be active or passive, and the degree of involvement can vary according to the socio-cultural context, the familial organization, and the moment in the women's life cycle" (Llovet and Ramos, 2001). The influence they exert on their partner's prevention of pregnancy, or even their own experiences with contraception, are largely made up and moulded by power relationships, and masculine and feminine roles and identities that are constructed socially and culturally in terms of the meanings and appraisals of sexuality and reproduction. The paradox to which the majority of studies refer lies in the perception that sexuality is a predominantly male ambit in which he exerts control and power over feminine sexuality and the confines of reproduction and its regulation, as well as are unwanted pregnancies are considered a feminine space for which the woman is responsible. Nonetheless, the male is seen frequently as the key actor in terms of the power he exercises in the decision-making processes within such confines: in most of cases, men impose their sexual decisions on their female partners.

For some authors, the idea that has socially and culturally predominated is that reproduction is mainly a female act so women are responsible for the consequences of employing or eschewing contraceptive methods (Zamberlin, 2000; Mora Téllez and Villarreal, 2000; Langer and Espinoza, 2002; Guevara Ruiseñor, 1998; AEPA *et al.*, 2002). Nevertheless, it is important to be aware that this situation contrasts with diverse studies based on fertility surveys carried out during the 1970s in Latin America, which presented evidence that the male (women's partners) tends to be in opposition to and constitutes the main obstacle to utilizing these methods. A barrier in contraceptive use depends also in the type of communication between man and woman concerning the practice of contraception as unwanted pregnancies and unsafe abortions are more likely to occur when, within the couple, there is ignorance and a lack of dialogue concerning their desires regarding the number of offspring and their opinions and preferences in the practice of contraception. On the other hand, when the couple openly discusses the topic effective contraceptive practice is observed (Mora Téllez and Villarreal, 2000).

There are not polarized or unequivocal patterns on the meanings and attitudes of males concerning the practice of contraception, but instead there are differentiated attitudes, values responses, and behaviours among distinct social groups, cultural contexts, and above all, different generations.

According to Faúndes and Barzelatto (2005) the existing evidence leaves little doubt about the frequent male dominance in the decision to have sexual relations, that it is usually being accompanied by the lack of male responsibility concerning pregnancy risk. Sexual abuse in or out of wedlock reduces opportunities of prevention. In their study carried out in Brazil, they found that nearly 35% of women consulted had had sexual relations against their will because they believed that they were obliged to satisfy the desires of their partners.

In some studies they argue the responsibility of women in contraceptive behaviour. For example in Buenos Aires, men did not think about pregnancy risk assuming that the woman was responsible for taking care of herself (Zamberlin, 2000). Younger men in the same study explained the non-use of condom by these same reasons but also because a greater sexual desire overcomes the fear of pregnancy and the fact that the sexual encounter was unplanned.

In a qualitative study in Mexico City with 52 men who had experienced an abortion Guevara Ruiseñor (1998) pointed out that near to half of them failed to assume any responsibility for preventing an eventual pregnancy, delegating the responsibility to the women "...I thought she was taking care of it"; that which reflects the prevailing idea "...I didn't think she'd get pregnant", and the final type, present at a lower percentage and related to contraceptive failure, "...she used the IUD" or "...the condom broke".

Another aspect concerning men participation in contraception practice is related to the availability of methods for men: with the exception of condom, withdrawal, periodic abstinence and vasectomy, most contraceptive methods are feminine as in the field of biomedical research, priority has been given to inhibiting fertility and greater resources have been oriented toward the development of feminine methods, creating a gender inequality (Castro Morales, 1998) and reducing men's role in fertility regulation. Moreover, as Zamberlin (2000) has pointed out masculine participation in contraception has been substantially reduced because the oldest methods, such as *coitus interruptus*, periodic abstinence, and condom have come to be regarded as inefficient and underestimated by FPP. Condom knowledge and use is now widespread, mainly among young population, due in part to HIV prevention programs, although it is also one of the most frequently rejected methods has been usually associated with feelings of discomfort, difficulties in putting them on, and as a method interfering in sexual pleasure, although it was one of the most frequently used methods, mainly in casual relationship to protect them also against HIV/AIDS. Men are not perceived as contraception protagonists in FPP, and they consequently confer the responsibility for and control of the prevention behaviour to women, while they are excluded from its practice or at best, assume a secondary role.

Most of the above mentioned barriers and consequences related to contraceptive practice underlie the abortion practice. Male involvement in the decision process to interrupt a pregnancy is narrowly linked to the type of affective and stability relationship between partners. There have been also significant findings that reveal the importance of the couple's emotional bond and living arrangements during their engagement period, or another type of relationship, in the decision whether or not to use contraceptive methods or end a pregnancy rather than allow it to continue. The greatest responsibility and support is found among stable couples and in those who maintain affective relationships, a situation generally not found in parallel or sporadic relationships or in relationships in which there are no sentimental ties. On the other hand, the degree of consensus or conflict in the couple determines the way in which men as well as women process the decision on abortion (Guevara Ruiseñor, 1998; Aliaga Bruch and Machicao Barberly, 1995) This behaviour is also related to gender inequality: it seems that couples whose relationship is more equal, have a greater tendency to negotiate on whether or not to resort to an abortion and the conditions under which it is practiced.

## **Institutional barrier**

Access to family planning, counselling and a wide range of contraceptive methods is often hampered or even prevented by a wide range of barriers. These include the geographical and social circumstances that deny or limit access to health services by specific population groups such as adolescents: economic barriers (such as the cost to reach health facilities or the cost of contraceptive methods), socio-cultural ones (religious or cultural disapproval, opposition from or difficulty negotiating with one's partner) as well as a range of prejudices (fear of side effects or infidelity on the part of one's partner) (Center for Reproductive Rights, 2003). In Guatemala, Kestler *et al.*, (2009) underline the role of cultural factors such as "a very conservative religious establishment and a male-dominated society" as barriers to spread of modern contraceptive knowledge of women.

One of the main conclusions of the Researchers' Meeting on Abortion in Latin America and the Caribbean (Encuentro de Investigadores sobre Aborto Inducido en América Latina y el Caribe, 1994) is that in the region, "the supply of contraceptive assistance is scarce and incomplete, with very little diversification of available methods and a lack of knowledge of cultural barriers."

As mentioned Faúndes and Barzelatto (Faúndes and Barzelatto, 2005), barriers to prevention are also due to the arguments of some conservatives groups whose "the paradox between declaring oneself against abortion and opposing the prevention of unwanted pregnancies" referring to their arguments: opposition to the use of modern contraceptive methods, calling them artificial or attributing an abortive effect to some of them, as well as opposition to sex education, on the grounds that this encourages earlier sexual initiation. These are arguments that eventually encourage abortion with all the adverse consequences seen in countries with restrictive legislation. The same reticence is developed with emergency contraception wrongly considered as an early abortion (Faundes *et al.*, 2007).

Difficulties of prevention access are also due to the role of medical staff: in their reproductive behaviour women decision depends on their partners attitude but also of doctors that in many cases could dictate to women their own biomedical norms to regulate their fertility (choice of contraceptive method or opposition to abortion) (Lerner and Quesnel, 2003).

In countries where contraception practice is largely socialized and somehow institutionalized as it forms part of government reproductive health and family planning programs, the incidence of abortion is closely linked, among other things, to the shortcomings of these programs. Some of these refer to the lack of administrative units place on family planning and reproductive health programs at different geographical level; existing health and family planning services; the range of methods offered; the effectiveness and safety of the methods used or offered; the information given to women and the voluntary acceptance (and not imposed) of various means of preventing pregnancy (Cochrane and Sai, 1993).

A state's inability to offer quality family planning services or make them available to the entire population constitutes another barrier. This is compounded by the rejection of certain population groups of contraceptive methods, for religious or other reasons; the authorities' denial of this service to minors, parents' opposition to their children being informed or receiving contraceptive services and the reluctance of husbands or sexual partners to let their partners use contraceptives (Bankole *et al.*, 1998). Young women faced to difficulties to obtain contraception because of the reluctance of providers and also to their own perception of these methods: fears of side effects inconvenience, malaise and the hope of not to be pregnant, as part of their difficulties to perceive sexual risk.

In the case of Peru, for example, some of the major institutional barriers mentioned in different studies include: the difficulties to obtain a sterilization as the local legislation regards this procedure as equivalent to abortion, even though the two are quite different (Huaman, 1994); the priority given in the reproductive health programs to curative aspects to the detriment of prevention and that they fail to prioritize sex education. These situations are partly due to the fact that the Catholic Church obstructs the development of programs related to these issues (Aramburú *et al.*, 1991). The lack of geographical access to health services, personal attitudes, cultural patterns and the lack of information on the correct use of methods and their side effects explains why 56% of Peruvian women of reproductive age and 31% living with their partners either do not use any family planning method or fail to do so correctly (Lafaurie *et al.*, 2005).

In La Paz, (Bolivia), a qualitative study on unwanted fertility and the barriers to using family planning services showed that, contrary to popular belief, certain cultural norms of the Aymara Indians living in urban centres are compatible with fertility regulation, while other norms prevent access to such regulation. It is common for members of this community to discourage the discussion of sexual issues and contraceptives among family members, friends or health providers; rumours and stories are spread about the supposedly harmful effects of modern family planning methods; and there is deeply-rooted suspicion, distrust or fear of modern medicine and medical professionals, as well as taboos about medicalized abortions (Population Council, 1994; Schuler *et al.*, 1994).

## **Final considerations**

The prevention of pregnancy risk is a very complex issue in Latin America. Preventive behaviour remains difficult due to institutional barriers and limitations, life conditions, as well as to individual options and capacities. In situation of economic or social difficulties, low social and cultural capital, the access to prevention and the development of a culture of prevention remains difficult as it is not seen as a priority of day-life. Women are not totally free in their preventive access because of the influence of male partner, medical staff and institutions such as community or family members and political and religious institution on their own decisions (Lerner and Quesnel, 2003; Faúndes and Barzelatto, 2005).

If the culture of prevention varies according to social classes, it is also differential between genders. Women are more frequently aware of prevention than men because of their significance role in the reproductive events (antenatal follow-up, postnatal care and children health-care...). Also the meaning and practices of sexual life among genders and generations are different, and male domination seems to play an important role. In addition, the preventive behaviour depends on the experiences of life, the type of couple relationships (stable or casual), the future life-project, aspects that determine the preventive process, and the decision to abort in case of unplanned pregnancies.

The question of abortion is a problematic issue: In most countries, legal access to abortion is very restrictive or totally prohibited. But this prohibition does not dissuade women from their practice in cases of unplanned and unwanted pregnancies. Abortion has been practiced in all places and societies and “will always continue to do so irrespective of restrictive laws, religious proscriptions or social norms” (Grimes *et al.*, 2006). But women need to deal with the high risk associated to unsafe abortion; risk which is much higher for young, less educated and low social class women who cannot resort to safe abortion.

Finally, it seems important to underlie that for multiple reasons, the medical institutional or the individual logic and action can also compete with other social logics, such as the logic of conservative groups, that shape and structure sexual, contraceptive and preventive practices. Therefore, the need

for prevention policies is to focus more on specific circumstances or situations at risk; conditions linked to particular social contexts and relational contexts than to the notion of individual at risk or groups at risk (Beltzer and Bajos, 2008).

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