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► **To cite this version:**

Virginie Rozée. The reproductive reality of Bolivian women: Interviews and observations within three public hospitals in La Paz and El Alto. International Seminar on interrelationship between contraception, unintended pregnancy and induced abortion, International Union for the Scientific Study of Population (IUSSP), Dec 2008, Addis Ababa, Ethiopia. halshs-00494296

HAL Id: halshs-00494296

<https://shs.hal.science/halshs-00494296>

Submitted on 22 Jun 2010

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The reproductive reality of Bolivian women

Virginie Rozée

Abstract

This paper is an account of the evidence collected and observations carried out within three public hospitals in La Paz and El Alto (Bolivia) in 2004. It aims to show the reproductive reality of the Bolivian women we met with, a revealing reality from the exercise relating to their reproductive and sexual rights, recently acknowledged as human rights by the International Community. In spite of many social and political efforts, the indicators of type and reproductive and sexual health of the country remain among the lowest in the region. Most of pregnancies was described as unplanned and were often proved to be unwanted. Those unintended pregnancies are connected with the knowledge and the use of contraception in the country, and lead us to look at the unsatisfied demand in matters relating to contraception among those patients questioned and Bolivian women in general, according to official statistics. All these realities described and observed are closely related to the illegal and insalubrious practice of the abortion, which is responsible for maternal deaths. The analysis we put forward to explain such a reality is that Bolivian women are subjected to various political, social, cultural and medical controls, which prevent them from making decisions about their own reproductive and sexual lives.

Biographical note

Social scientist, Virginie Rozée (virginie.rozee@ined.fr) works especially on issues of gender, health and sexuality. She has led a doctoral investigation on reproductive and sexual rights of women in Latin America, especially in Bolivia (2001-2006). She is currently a postdoctoral research fellow within the *Institut National d'Etudes Démographiques* (INED) in Paris investigating infertility care in France and in Europe.

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Reproductive and sexual rights make up a new generation of rights demanded and recently acknowledged as human rights by the International Community at the Conference on Population and Development in Cairo (1994) and the one on Women at Beijing (1995). For many authors and scientific feminists, they will be the key to women's liberation: "the liberation of women starts with the stomach" Simone de Beauvoir (De Beauvoir 1949) states. If it is a question of an old feminist demand, reproductive and sexual freedom, clearly defined from now in terms of rights, still constitutes a fundamental requirement for empowering other human rights for women.

Reproductive and sexual questions have long been taboo in Bolivian society. Following the film *Yawar Mallku* by Jorge Sanjines in 1968, which denounces compulsory sterilisation on Quechuas women in Bolivia by members of a United States organisation, contraception is fundamentally associated with a degree of American imperialism and reduction in the birth rate, and the government forbids all kinds of birth control. But thanks to the perseverance of medical workers, social actors and the international pressure, these questions have gained a political and normative boost since the 1990s. Since then, Bolivia has assumed new responsibilities and is committed to promoting and applying reproductive and sexual rights in all political and social spheres. It recognises "family planning" as a right, and abortion as a public health problem, thus granting it a very progressive position at the Cairo Conference (Rozée 2008).

Political and legal expression of reproductive and sexual rights relies nowadays on the formulation of specialist measures, on the introduction of these questions in the new Constitutional proposal and on the discussion of a specific ruling from Parliament. If in the 1970s Bolivia was the most backward country on the continent, if it is a question of it being the last country to introduce the subject of reproductive and sexual health and related rights,

today it relies on a legislative body which is very advanced compared to other Latin American countries or other regions of the world. Abortion remains an “*offence against life and corporal integrity*”, and therefore a punishable practice, but Bolivia is paradoxically one of the rare Latin American countries having national standards of care post-abortion, in the public health system.

Our research, which was spread over five years (2001-2006), consisted among other things of studying the social opinions of reproductive and sexual rights in the country. This study took place at three levels: the institutional level, the organised civil society, and finally the women population not mobilised. Within this environment we have carried out hundreds of qualitative interviews alongside responsible associations, medical and government services, along with people who manage matters relating to women and their reproductive and sexual health in Bolivia. Following this, we have then interviewed and observed women in inpatient and outpatient services in the gynaecological and obstetric departments of three public hospitals in La Paz, the capital, and its border city, El Alto. We chose La Paz and El Alto because the political decisions are taken and directly applied here, and the dates of the department of La Paz are similar with the dates of national level. To complete the information collected, we organised workshops on the theme of women and maternal health with groups of women from popular areas of La Paz and El Alto, about forty women.

In spite of many social and political efforts, the indicators of type and reproductive and sexual health of the country remain among the lowest in the region. In fact the social reality of the reproductive and sexual health of women revealed in the exercising of their rights, remains strongly characterised in Bolivia by an important demand to limit and spread out births, which remains unsatisfied, by a large number of unplanned and unwanted pregnancies, and by a significant impact of illegal abortions on maternal deaths. The evidence and observations, which we have collected and carried out within the hospitals at La Paz and El Alto and which we present here, accurately accounts for this reproductive reality of the Bolivian women we met with.

Interviews and observations within three public hospitals in La Paz and El Alto

As indicated in a working document of the Coordinadora de la Mujer, one of the principal Non-Governmental Organisations (NGO) defending the rights of women in the country, *“the rate of fertility relates to children who are wanted and conceived, and the use of methods to regulate fertility is the most important indicator with which to measure the exercising of their right to sexual and reproductive health”* (Coordinadora de la Mujer 2003, p.59). Contraception and abortion are two important components of sexual and reproductive rights, and consequently form the variables of the study. Unplanned and/or unwanted pregnancies are key indicators for evaluating the social reality of these rights, and are therefore the principle themes studied. In particular they allow observation of the autonomy of reproductive and sexual decisions and voluntary motherhood defined by groups of women as the right to decide, whether to reproduce or terminate an unwanted pregnancy, according to criteria set by the women themselves.

The results presented here follow a period of 3 weeks in 2004, in each of the three hospitals studied, in the gynaecology and obstetric departments, where we were immersed daily. We chose these establishments for various reasons: because they are public they directly apply government health measures, and the women who go there do not present any particular characteristics (1) and here they are shown how to exercise their reproductive and sexual rights. There we talked with more than 180 women to find out about their reproductive and sexual experiences. At the same time we carried out participant observations relating to medical care, to learn about the opportunities offered to women to exercise their rights in matters of reproduction and sexuality.

This regular presence allowed us to familiarise ourselves with the medical centre, to observe the medical care and to speak to patients. It also allowed patients and health staff to get used to our presence, to create an ambience of confidence, and so obtain the most relevant observations and discussions. Throughout the qualitative interviews and observations, we wanted to understand the medical and human attentions, whether political

practice was seen to be applied socially, and in particular, whether staff creates conditions favourable to the exercising of these reproductive and sexual rights; and to understand the perceptions, experiences and knowledge of patients relating to their sexual and reproductive lives.

The qualitative interviews with patients took place in waiting rooms of doctors' surgeries, mostly in patients' rooms, and occasionally in hospital corridors. For the discussions with the women, we decided and attempted to apply the methodology of dialogue of knowledge, developed in Bolivia by Susanna Rance, who is a famous figure in Bolivian sociology, specialist in themes of gender and social methodology and pioneer on questions of reproductive and sexual health in Bolivia.

The dialogue of knowledge is an aid and also a guide for qualitative social research in general, and more particularly when they are conducted in counties and communities where intercultural perspectives are primordial (such as in the case of Bolivia). This methodology proposes a new approach for socio-cultural research, and so emphasises an advancement in concepts and traditional methodological practices in social sciences. It sees interviews as a dialogue between the interviewer and the interviewee, as an exchange which goes beyond an instrumental benefit and confirmation of theory (Rance 2002).

Within the framework of the methodology, we consulted patients who were not tired, in pain, who were able and willing to talk for a while. Women, who were from outside, constituted the preferred population for interviewing. The first discussions were recorded. However the exchanges proved to be most useful after recording, and we decided not to record the next set of conversations. The discussions comprised a brief exchange which favoured the depth, that's to say the quality of the exchange more than the quantity. The interviews were therefore short. Some were shorter than others, sometimes with little information; others were on a daily basis, and allowed deeper and more detailed discussion. Some interviews were held with a group of patients in the same room. They proved a very

rich source of information, as the women, in a united confidence, shared their experiences, their knowledge and their opinions.

Generally we began the interview with *“I would like you to tell me the story of this baby, how this baby arrived, here, in the world...”*. This opening question showed specifically if the baby had been planned or not. After each talk, we gathered the main ideas broached in a work book (or notebook), in a quiet corner of the department. No notes were taken during the interviews as this could cause bias, distort the dialogue, and show a lack of respect to illiterate women (illiteracy being relatively important in Bolivia). The dialogue of knowledge methodology allows us to listen attentively, to be well accepted by the women interviewed, and so obtain many personal and relevant stories for the study.

Our discussions and observations are no doubt underlined with some political, social and medical realities, some indicators of reproductive and sexual health in Bolivia, but they cannot become widespread, given that the investigation was carried out in specific medical environments, and in a specific urban situation. The results presented are uniquely representative of the reality observed, from the sample studied.

Unplanned and unwanted pregnancies

When we asked the women we met within the maternity departments to relate the history of their newborn, some mothers explained that they had decided and planned to have a baby to be company for their last child or to fulfil themselves as women, and they sometimes had to persuade their partners:

“My husband didn’t want to, it was me [who persuaded him] (...) I have a baby .. 4 years old. And ... I wanted to have another daughter because she would suffer if an only one, she suffers, she hasn’t anyone to play with. That’s why I wanted to have a second... (...). Because my only child hasn’t anyone to talk to ... And the worst is that I have nephews... 8 boys and not one single girl. She can’t even play with them (...). And now, I have two little

girls... And I think she will be good company for my daughter. And ...so that's how my baby came to be born" (mother aged 26, 2 daughters, married);

"Good (...) my other baby is little, isn't he? (...) I wanted a companion for my baby because the others are big (...). And now my son... wanted someone to play with and no; but on her own at home, all the others are big... I said, 'no I am going to have one!'... And he was planned (...) he wasn't an accident (...)" (mother aged 34, 4 children, married);

[Her husband has custody of his two sons] "they miss me a lot, a lot... (perhaps that's why I decided to have a son because ... I cried a lot and I suffered a lot... [to her new partner] I kept saying to him... I would like to have someone... a son » I said to him (...) a son to feel fulfilled ... because time is passing and I am not going to be able to have a baby, so... "I want a son" I told him (...). 'Go on, I want a baby please'... And now no, no! Father's gaga" (mother aged 34, 3 sons, co-habiting);

"He really was planned (...) [With my husband], we planned it" (mother aged 33, 2 daughters, married).

If these pregnancies were described as wanted and planned, in the majority of cases, the pregnancies were noted in the clinical histories and related by the women as being totally unforeseen and unplanned, as a result of an accident (for example omission of pill), of negligence (as unprotected intercourse), of ignorance of the reproductive process and breastfeeding contraception method, or sometimes rape:

"This is my second baby. (...) but the first was planned (...). This one, he was the result of negligence on my part... (...)" (mother aged 33, 2 sons, co-habiting);

"(...) He hadn't been planned... It was an accident..." (mother aged 34, 2 sons, married);

“Otherwise if it had been ... if it had been ... and.. how do you say... planned (...). No, no it wasn't planned. And I took the contraceptive pill... And I stopped taking them and... I fell pregnant... and I became pregnant and I decided to have it that's all (...) ... and then he was born” (mother aged 22, 1 daughter, married).

Some women said that they regretted their pregnancies. An unplanned pregnancy is sometimes as a “dreadful” experience. But although it might not have been planned, it does not mean however that the baby wasn't awaited with love and desire:

“This was an accident... but he was really wanted, loved (...) he was really wanted, loved, we have been waiting for him to be born. It's my life” (mother aged 34, 2 sons, married);

“This baby was really wanted (...) Good... At the beginning, when she was in my belly, perhaps I didn't want her... But now I've seen her, when she was born... (...)” (mother aged 23, 1 daughter, co-habiting, single according to her medical records).

However, the observations and interviews with mothers or expectant mothers led us to suspect that some of the pregnancies were unwanted. Some women whose pregnancies were threatened refused treatment or wanted to go home no matter what, even if this meant the loss of the baby. Instead of being tended to they demanded to be signed out and discharged themselves from hospital against medical advice. Other women stated that, or were suspected by medical staff of having taken substances recognised as having active constituents to endanger pregnancy, those which could sometimes induce premature labour or the death of a newborn.

One woman with 9 children stated that she did not want “*so many*” children. One young mother of 23 explained that she would have preferred not to have had a child. “*Sometimes I regret...*”. One mother aged 25, with 2 children, and pregnant for the fourth time, hospitalised so many times with threatened miscarriages, stated “*going to lose the baby, but in one go*”. She refused on a daily basis to take her treatment (Corn flour diluted in water),

saying that it would make her sick, and she finished by throwing it in the bin. Another young woman of 15, whose pregnancy was the result of rape, confessed that she had wanted an abortion but her mother had prevented her.

A patient we met with, who was going to be a mother for the first time, asked if it was normal to lose blood during pregnancy, and seemed unaware of the risks and complications of pregnancy. But, in the group, the women seemed to know how to be careful during pregnancy, and what could cause an abortion, like taking infusions, walking too much, carrying or lifting heavy weights. We overheard a discussion between patients from the same room. One of them was trying to understand why the child of her room mate was born deformed (actually the baby was dead): “*Did you fall? Did you take something... an infusion... it isn't good to take an infusion or that kind of thing*” said the first one. “*Oh yes?*” interrupted the other. “*A painkiller, some pills?...*” insisted the first. “*Nothing at all*” replied the other.

At national level, a number of studies and research, such as the National Surveys on Demographics and Health (ENDSA) (2), revealed a large number of unplanned pregnancies. These unplanned pregnancies are intimately close to the use and the practice of contraception in the country, and bear witness to the failure of contraceptive practice and an unsatisfied demand in contraception.

The unsatisfied demand for contraception

Actual fertility and desired fertility

There is a specific demand to limit or space pregnancies (81% according to ENDSA 2003, the last national survey which results were published), a demand notably observed. If some families want a number of children (the perception prevails where the child is the main means of financial support within the family), in general women want less children, and to plan their future pregnancies. In the maternity departments, we asked mothers if their newborn would have any brothers or sisters. We became aware in making such a request,

that after a delivery, women generally do not want to repeat the experience in the immediate future. But this question and particularly the responses it brings, in fact evokes another request, to know what they hope to do, for example, to space out or limit future pregnancies, as we will eventually see.

Some women explained that they did not know, but that they would prefer to wait a while, to wait until this one is bigger: *“No... the only one. No, that’s it finished... perhaps in time... until then she will be an only one...; after a time, well we’ll see...”* (mother aged 23, 1 daughter, co-habiting); *“Not yet, not yet... I am going to wait... 3, 4 years...”* (mother aged 22, 1 daughter, married).

The women also mentioned economic difficulties as a sort of “Malthusianism of poverty” (Cosio, 1992), the need to work, and how hard it is to combine this with bringing up children, and their priorities and preferences regarding a good quality education for the children:

“No (...). Work and everything no (...). What use is it to bring him into the world and not give him any attention (...), with [an only son], you know what pleases him, what he needs, what he wants” (mother aged 22, 1 son, single);

“No... because...(…) After (...), he will want to study... And I won’t be able to ... So (...), me I’d like him ... to study, to have a profession. Something, something that he can (...) I will make him study... (...). With another child, I couldn’t” (mother aged 34, 3 sons, co-habiting);

“No, that’s it... I think I’ve finished... Two are enough because...there isn’t always enough money, there isn’t any work... And to have two, that would be difficult... I wouldn’t be able to work without neglecting him. With just one, at least I could work, eh (...). With her, I won’t be able to... With her no-one would take me on, a bit... (...). I will have to live on my husband’s pay, and that’s not much... he earns little enough... (...). Ditto the amount of

money you spend on food that's all... So no... these will be the only two in my life. There won't be any more" (mother aged 33, 2 sons, co-habiting);

"So we don't want to have another child because with the economic situation, and everything, today you have to think (...) to have more, more, more (...)" (mother aged 26, 2 daughters, married).

Other mothers explained that they thought they would have "enough" or even "too many" children, especially as to be a mother meant heavy responsibilities. One mother aged 33, with two daughters, explained that she did not want another child because as well as the pain, bringing up children was exhausting: "You must do the cooking, washing, cleaning...". Because of work the husband can't take on these responsibilities, she added, and "so that's what it's like for women, isn't it? Taking the children to school...".

These interviews were similar to the conclusions of the national official inquiries. According to ENDSA 2003, the fertility rate was calculated at 3.8 children per woman. In spite of a relative decline, this is still one of the highest rates in Latin America. This rate varied according to the place of residence and standard of education. A higher rate of urbanisation and a better standard of education correspond to a lower reproduction rate. This rate contrasts with the desired fertility rate of Bolivian women, estimated at 2.1 children per women. This difference between the observed and desired fertilities shows that many pregnancies were not planned, and that there is a demand for planning the family which is not being met.

Bolivia records the increase in the percentage of unsatisfied need for contraception. The concept of unsatisfied need in contraception comes from the fact that many women want to spread out births, whereas others do not want any more children. Yet they do not use any methods of contraception. According to ENDSA 2003, the estimated need for family planning at national level is unsatisfied for 22.7% of married women in union: 6.1% stated

they wanted to spread out their births and 16.6% stated they wanted to limit the number of children.

Estimates of the unsatisfied need for contraception in Bolivia show important differences relating to certain characteristics of women in a relationship, such living place, standard of education, and the age of the woman. Unsatisfied needs of contraception are more important, always according to ENDSA 2003, among youngest women, illiterate women (3 times highest) and women who live in the Altiplano and in rural area.

Knowledge of and the practice of contraception

When we asked the women in maternity units how they managed to avoid having a child or to wait until the time was right, many explained that they were going to be careful, eventually using a method of contraception, or to get some advice:

“Er... I think I can be careful with a condom” (mother aged 30, 2 daughters, married);

“I am thinking about injections [or the coil in two months]” (mother aged 22, 1 son, married, single according to medical records);

“I want to be careful with a method (...) the coil (...) There are so many things, aren't there? I will be careful that way...” (mother aged 25, 2 children, married);

“I am going to consult my doctor (...) or we will take care of it ourselves” (mother aged 33, 2 sons, co-habiting);

“I don't know... I've been told there is Family Planning here. I am going there... They will give me, I don't know, pills... I'll buy a coil, I don't know... but I will be careful, during a certain period, if ... Because... they say that you can get pregnant, no... during... breastfeeding. So I must be careful, that's all...” (mother aged 22, 1 daughter, married);

“... I am going to get... a coil... There are so many these days. (...). There’s a treatment, after a while, you can have ... a coil, a spiral... I don’t know what there is... I am going to see my gynaecologist...” (mother aged 34, 1 daughter, married).

Knowledge of and the use of both natural and modern contraceptive methods, allow pregnancies and births to be planned, thus avoiding unplanned pregnancies, and even unwanted ones. In spite of an interest and a demand from the population, contraception is essentially characterised by a significant gap between knowledge and practice.

In Bolivia the methods currently proposed by official standards bring together natural or traditional methods (the calendar or collar method, the periodic abstinence, the breastfeeding and amenorrhoea contraception method) and the so-called “modern”, artificial methods (the pill, injection, the coil, condoms, vaginal tablet, tying the fallopian tubes in women and vasectomy for men). In practice women use other methods to avoid pregnancy: washing themselves with coca-cola, vinegar, lemon, or salt water, inserting an aspirin or a match in the vagina, drinking herbal infusions, prolonging breastfeeding, etc.

In general, methods of contraception are known about in Bolivia. According to ENDSA 2003, 94% of women in union (15-49 years old) stated that they knew of some method or another, but only 58% of them used a method of contraception.

“Knowing” does not necessarily signify that the woman has precise information on the methods. In addition, having information on these methods does not determine use of them (even if it’s a conditional requirement). So if the majority of the population knows about some sort of contraceptive method the ENDSA inquiry does not take account of the quality of the information and how it is used.

During the study, if some of the patients we met did not understand what contraception was about when the subject was first broached, generally the patients from the different

hospitals knew or had heard about “family planning” or some methods. But, the majority stated that they did not use any methods of contraception, for various reasons. The death of a husband, negligence, or stopping the methods because of its inconvenience (the pill caused breast pain, injections gave rise to headaches, the coil can be uncomfortable and cause mood swings) were the reasons they came up with.

The practice of contraception is influenced by standard of education, place of residence, and social status. According to ENDSA 2003, women who use less contraceptive methods and therefore who are less likely to plan their pregnancies, are illiterate women (34% of women without education use a method), women living in rural area (48% of women living in rural area use a method), and poor women (42% of the poorest women use a method).

According to the same survey, 35% of women in union use a modern method (with a preference for the coil); and 23% of them use a traditional method (with a preference for the periodic abstinence). The use of one method doesn't guaranty the advent of unplanned pregnancy. Indeed, the efficiency of modern methods has to be put into perspective, by the lack of information, knowledge, supervision and follow-up in Bolivia. The pill, for example, is in theory obtained on medical prescription. But in practice, women obtain it without consultation, and without prescription. So there is not guarantee that they will receive information on how best to use the method, any secondary affects or contra-indications.

Traditional methods are not always effective, because of a lack of control and knowledge of the reproductive cycle. To use the safe period, to avoid unwanted pregnancies, it is important to know about and respect the menstrual cycle. According to ENDSA 2003, 50% of women use the periodic abstinence in an inappropriate way (because they don't know to identify the fertile period). A study published in February 2003 undertaken along with students from the public university of La Paz concluded that only 46% of male students and 26.4% of female students knew about the fertile period in women (Carrera de Sociología, Facultad de Ciencias Sociales and Population Concern 2003).

Resorting to abortion

Faced with an unplanned and unwanted pregnancy, women have two possible options: to go ahead with this pregnancy or resort to illegal abortion. The rising number of unplanned and unwanted pregnancies may explain therefore the prevalence of the practice in Bolivia.

Abortion is a punishable practice in Bolivia, although legal in the case of rape, abduction when marriage does not follow, incest, or when the pregnancy causes a risk to the mother's health. But these authorised exceptions are not applied. The legal restrictions on abortion however do not stop the women, and on the contrary, they resort to illegal services, inadequate and high risk, which put their health and life in danger.

An illegal, unhealthy and hidden social phenomenon

In the hospitals we studied, a significant proportion of women were hospitalised because of complications in pregnancy, risk of abortion, haemorrhages, or the danger of premature labour. Equally, we observed that in the gynaecology and obstetrics departments, the women had more pregnancies than live births. So, the majority of the women we met during the study had aborted at least once, but often in an undetermined fashion, that's to say intentionally or not. There are two types of abortion: spontaneous abortion, where there is a natural loss, and provoked or induced abortion, practiced voluntarily. It is difficult to identify the type of abortion given that the practice is illegal in Bolivia. In addition medical reports use the term "haemorrhages" for all failed pregnancies, without specification. The indicator of induced abortions in Bolivia is information which remains hidden in hospital records under the generic diagnosis of haemorrhages of the first semester, which does not allow us to identify if they were induced or not.

Studies show that abortion affects all social and cultural backgrounds, and all ages. The work study, due to lack of information, cannot prove any relationship between age, level of education, number of children, the practice of contraception and the probability of abortion.

The 12th Bolivian Congress for Gynaecology and Obstetrics, which took place 3rd August 1995, contradicts the hypotheses according to which, the lowest level of education corresponded to a higher probability of abortion, and confirms that abortion was not determined by standard of education, or by socio-economic statute. The Congress recognised however that abortion affected more women in a relationship than single women, and that the use of contraceptive methods among women who aborted was poor.

The most common methods in Bolivia for provoking an abortion are carrying heavy objects, strenuous physical exertion, punches in the stomach, intentional falls. It's also common to use the pill "Cytotec", an anti-ulcer medication known to trigger uterine contractions as an abortive pill. Bolivian women also used herbal infusions which have an effect on pregnancy and lead to abortion. These herbs are available from healers or freely available in shops known to sell curative and ritual herbs. The women have also resorted to injections, vaginal washes and above all to inserting various non-sterile objects into the vagina (Salinas 2000; Dibbits and Terrazas 1995).

Illegal abortions are practised in unsanitary conditions and can cause depressive behaviour, anxiety, fear, feelings of guilt, and others, even perforating the uterus, haemorrhages and serious infections which can cause infertility, and even death (Donlan and al. 2003). Earlier negative experience of abortion will not be enough to make women decide of their own volition, to use contraceptive measures to avoid future unwanted pregnancies.

Despite this censorship, many women have resorted to abortion. There is a large disparity between prohibitive laws and the real circumstances of abortion. Abortion in Bolivia is a real social fact by virtue of the extent of it, an extent particularly observed. However it is difficult to determine the number and nature of these abortions in the country because of their illegal and clandestine nature. Estimates, originating from investigations carried out by non-governmental and international organisations do however exist. A study, realized in 1999, stated that near 50% of beds in gynaecological units in the hospitals were occupied by patients admitted with complications following abortions (Friedman and al. 1999).

A resulting high level of maternal mortality

Illegal and clandestine abortion therefore maintains a high level of maternal mortality. In 1994, it was estimated at 390/100,000 live births (ENDSA 1994). It was responsible according to official, but not published, data from the National Health Secretariat in 1994, for 27 to 35% maternal deaths (Ministerio de Desarrollo Humano and al. 1996). According to the study realized in 1994 by Ineke Dibbits, the chief anthropologist at NGO TAHIPAMU (Taller de Historia y Participación de la Mujer), about 850 Bolivian women died each year from a badly executed abortion, this being the principal cause of maternal mortality (Dibbits 1994).

ENDSA 1998 did not produce any figures on maternal mortality, and the rates vary according to the source of information used. In Bolivia it is very difficult to evaluate the demographic reality because there is no proper access to the information, to indicators such as abortion for example. Moreover, the measures, and methods used change from one inquiry to another. It would then be a question, with some of the people consulted, of problems which are more political than scientific. According to the method used, the maternal death rate through haemorrhages is relative.

According to ENSA 2003, maternal mortality was 230 per 100,000 live births. In spite of a certain drop, despite the continued development and more and more specific government and non-governmental plans and programmes to reduce maternal mortality, despite extensive protection of pregnant women, the maternal mortality rate in Bolivia has not fallen significantly and remains one of the highest in Latin America.

ENDSA 2003 does not precise the principal reasons of the maternal mortality. According to some studies, and particularly a United Nations study realized in 2001 (Naciones Unidas Bolivia 2001), haemorrhage takes first place as a cause of maternal mortality. But there is a very narrow connection between haemorrhage and abortion, even a corollary relationship:

haemorrhages in the first half of pregnancy are mainly caused by clandestine abortions. But this relationship is difficult to prove.

Conclusion

There are connections between unplanned and unwanted pregnancies, unsatisfied demands for contraception and resorting to abortions. But these connections are relative. Indeed, as we demonstrated, unsatisfied demands of contraception are especially observed between poor, illiterate, indigenous and rural women. And abortion affects all social and cultural backgrounds. This proves that acting on contraception's knowledge and use, democratizing family planning and information related to, will have an effect on unwanted pregnancies, which conduce to abortion only for those women. It's so necessary to consider other variable.

Actually, we have observed that the women consulted who wanted to limit, space out or reject their pregnancies were subject to various political, socio-cultural and medical dominations, which inhibit their reproductive rights relating to reproduction and sexuality, and which prevents them from making decisions about their own reproductive and sexual lives: policies in place, subject to continuous financial and ideological pressures, do not tackle the theme completely, and are principally concerned with the binome "mother-child"; reproductive and sexual rights are linked to the socio-economic and educational conditions of the women, to a system of genre based on masculine dominance, and are open to cultural undervaluation; and finally, by imposing choices, in not respecting the expectations of patients, especially those who depend on cultural preference and freedom to make informed choices, those in charge medically reduce the independence and freedom of women regarding their sexuality and reproduction.

The women we met are not considered and do not consider themselves as having full rights and liberties in matters of reproduction, and even less in matters of sexuality. They have not the knowledge or sufficient opportunities to exercise their reproductive and sexual rights.

With the mobilisation of organised civil society, international pressure, inquiries which denounce a disturbing social reality, vis-à-vis the reproductive and sexual health of women, Bolivia has made advances in political statements relating to health in general and to reproductive and sexual health in particular. However, the normative advances were and are not accompanied by the political, economic, social and cultural conditions necessary for their application. There is some discrepancy between political demands and social necessity, between the demands of the population, and what opportunities it encounters.

Notes

(1) Nevertheless, women who go to public hospitals belong mostly to the middle and popular classes (women in the privileged classes usually turn to private medical care). We have, on the other hand, consulted and met with women of high ranking officials, for example diplomats.

(2) In Bolivia five National Survey on Demographics and Health Survey inquiries were carried out: ENDSA 1989, ENDSA 1994, ENDSA 1998 and ENDSA 2003.

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