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Emergency contraception in Argentina: Grey areas of common sense and public policy

M. Pecheny*

Institute Gino Germani, University of Buenos Aires, Buenos Aires, Argentina

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This paper discusses specific obstacles to emergency contraception (EC) in Argentina, the 'grey areas' between contraception and abortion: potential users as well as health providers do not distinguish clearly between ordinary contraception, EC and abortion. Based on quantitative and qualitative findings, the study shows the need to intervene in providing the population and the health sector with information on EC, its mechanisms and accessibility, and the 'grey areas' that hinder an adequate distinction between regular contraception, EC and abortion.

Keywords: contraception; post-coital contraception; health services accessibility; reproductive rights; abortion

Introduction

In Argentina, the high number of induced abortions[1] reveals that contraceptives are not used systematically and/or fail in some cases. After unprotected sex or contraceptive failure, emergency contraception (EC) is the last chance to prevent an unwanted pregnancy. Unplanned pregnancies are a problem for public health as well as for the quality of life for both women and men, but EC is not widely used.[2] Although this is not a new practice, only since 2007 have there been public policies geared towards improving accessibility to EC, amid manifest opposition from the Catholic Church and conservative sectors (ISPM – MORI 2002, Portnoy 2006, Portnoy and Berkenwald 2006, Petracci and Pecheny 2007).

In this paper, we discuss accessibility to post-coital contraception, specifically hormonal EC.[3] We argue that the main obstacles to EC are not economic or related to the organisation of health services, but related to misinformation and biases: potential users as well as health providers do not distinguish clearly between ordinary contraception, EC and abortion. Hindrances to EC result in harms to individual and collective health and rights, affecting mostly women and in particular to those of fewer resources.[4]

This paper is based on a study conducted in 2007 in order to assess accessibility to EC in Argentina. Its objectives were to describe EC-related information and experiences of potential users and providers; to detect and describe the impact of the religious, ethical and political-ideological perceptions of EC accessibility; and to

*Email: mpecheny@retina.ar, mmpecheny@yahoo.com.ar

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describe institutional factors of accessibility. The study protocol went through a human subjects review and was approved by an independent ethics committee.

Using quantitative–qualitative methodology, we conducted a national survey and semi-structured interviews. The survey was administered to a random sample of 1219 women and men, 15–50 years of age, from urban centres having 300,000 inhabitants or more, stratified by sex, in similar proportions (standard error: 2.8%; 95% CI). Unlike most studies on contraception in Latin America, and following their recommendations (López and Pantelides 2003, 2007, Pantelides *et al*. 2007), we decided to include men in the sample. The interviews were conducted face-to-face at the residence of the respondent, with a rejection rate of 22% (this rate might not imply a significant bias in the results).

Semi-structured interviews were conducted in three metropolitan areas: Buenos Aires, Mendoza and San Juan. In these areas, public policies on reproductive health and cultural patterns differ. Buenos Aires is the main urban area of the country and includes the capital city, Mendoza has had a progressive policy on these issues for a decade, and its neighbour province, San Juan, is one the most conservative in Argentina (Petracci and Pecheny 2007). Respondents were recruited through employing a snowball sampling technique. Recruitment was carried out through health services and through informal contacts not related to health services. The intentional sample was composed of 54 women and men, as well as 15 health providers (see Table 1). The criteria used to identify eligible participants was as follows: women and men who were users, or potential users, of EC, were heterosexually active, at reproductive age, their socio-economic status and the final criteria was aimed at the inclusion of individuals with and without experience with EC (see Table 1).

Obstacles to EC

Specific barriers relate to how EC is used and functions, its legal status, the confusion between EC and abortion, which is illegal in Argentina[5] and where and how to get EC. Barriers are experienced differently according to gender, age, education and socio-economic status, but they cross all social segments studied. This paper summarises findings in connection to EC accessibility, particularly the 'grey areas' between post-coital contraception and abortion.

Knowledge and opinions about EC

According to our survey, 97.7% know at least one contraceptive method. To an open question about which contraceptive methods the respondents knew, 91.6% mentioned the male condom, 86.4% mentioned the birth-control pill and 60.8% mentioned the intra-uterine device (IUD) (Andía *et al*. 2008). In contrast, only 9.3% of respondents mentioned EC.

Later, the survey queried, 'If after intercourse, for some reason a concern or fear of a possible pregnancy should arise, regardless of your personal beliefs and according to your knowledge, do you believe that it is possible to do something to avoid it?' The 51.7% who responded affirmatively were asked the open-ended question: 'What can be done in such situation?' About 33.5% responded, 'taking the morning-after pill or EC'; 24.8% responded 'taking a pregnancy test and waiting'

Table 1. Qualitative sample (EC in Argentina study, 2007).

	Buenos Aires				Mendoza				San Juan			
	Low and lower-middle class		Middle class and up		Low and lower-middle class		Middle class and up		Low and lower-middle class		Middle class and up	
	Used EC	Never used	Used EC	Never used	Used EC	Never used	Used EC	Never used	Used EC	Never used	Used EC	Never used
Women	1	2	4	1	2	3	4	1	2	3	3	1
Men	2	1	1	2	2	3	1	4	0	3	3	5

and an equal percentage responded 'having an abortion'; 18.8% said 'taking a *Dosdías* pill'; 7.4% said 'taking a pregnancy test and taking the morning-after pill' (which is not indicated); and 4.0% responded 'taking birth-control pills in the usual doses'. *Dosdías* is habitually used to rule out pregnancy and, unlike hormonal EC, its administration is indicated when menstruation is already delayed. Responding *Dosdías* therefore suggests a misunderstanding about the purpose and timing of this drug. In focusing on the response 'taking the morning-after pill', we found differences according to sex: 40.7% of women as opposed to 26.4% of men mentioned that option.

We re-questioned those who responded 'No' (41.3%), or that they did not know (7.0%), whether anything could be done to prevent a pregnancy after unprotected intercourse, as well as those who had not mentioned EC in the open-ended question on 'What can be done', asking 'What is emergency contraception or the morning-after pill?' As a result, out of the total of 1219 men and women interviewed, 64.2% said they knew about EC. Women were aware of EC in a greater proportion than men (69.7% vs. 60.2%). Knowledge about EC progressed according to educational level (35.2% for incomplete elementary school studies to 87.5% for higher education) and socio-economic status (lower status 51.3% to upper status 84.8%).

These different percentages of affirmative answers in response to different ways of asking a question show that many have some knowledge about the existence of EC, although its spontaneous mention as a last resort after unprotected intercourse does not widely correlate with that extensive knowledge (see Table 2). Only 9.3% brought up EC spontaneously among contraceptive methods. In the more direct, but open-ended, question about 'scares', EC was mentioned by 33.5% of the subset who responded that one can do something to prevent pregnancy after sexual intercourse[6] – i.e., 17.3% of the total sample mentioned EC, almost twice as many as the entirely spontaneous mention. Finally, the explicit question on knowledge of EC resulted in 64.2% of the sample responding affirmatively.

Table 3 shows that the knowledge of appropriate uses and effects of EC were quite low, demonstrating inconsistency in general popular understanding of EC. The

Table 2. Mentions of emergency contraception according to gender (EC in Argentina study, 2007).

	Men % ($n=606$)	Women % ($n=613$)	Total % ($N=1219$)
Mention of EC, when asked about methods to prevent pregnancies ($N=1219$)	7.5	12.0	9.3
Mention of EC, when asked about methods to prevent pregnancies after sexual intercourse, among those who responded YES to the question: 'Can anything be done to prevent a pregnancy after unprotected sexual intercourse?' ($N=630$)	13.9	20.6	17.3
Affirmative answers to the question: 'Do you know what emergency contraception is?' ($N=1219$)	60.2	69.7	64.2

Table 3. People aware of emergency contraception[a] – knowledge and opinions about EC ($N = 782$) (EC in Argentina study, 2007).

	Opinion			
Statements on EC	Agree	Do not agree	Do not know/ Do not answer	Total
Morning-after pill or EC				
... works before intercourse.	5.2	88.2	6.5	100.0
... acts after intercourse.	91.7	3.7	4.6	100.0
... impedes fertilization (union of ovum and sperm cell).	58.3	23.3	18.4	100.0
... prevents fertilized ovule from implanting.	58.6	13.8	27.6	100.0
... may lead to malformations if woman is pregnant.	31.7	28.0	40.3	100.0
... is sold under prescription.	25.3	55.1	19.6	100.0
... is readily available at pharmacy.	73.9	10.5	15.6	100.0
... is readily available at hospitals or health centers.	45.4	19.9	34.7	100.0
... serves to terminate pregnancy.	57.8	30.2	12.0	100.0
... is illegal, but anyone can get it.	36.3	40.0	23.7	100.0
... is more convenient than using contraception every day.	15.5	72.0	12.5	100.0
... prevents AIDS.	1.8	93.1	5.1	100.0
N				782

[a]Sample includes all participants who answered 'yes' to the question 'Do you know what emergency contraception is?' (64.2% of the total sample).

percentages described below are based on 782 cases, 64.2% of the total sample, who affirmed they know what EC is.

Beyond the basics, namely, that EC is taken after and not before sexual intercourse, even the population 'who knows about EC' does not have adequate knowledge of how EC works (it prevents fertilisation and not implantation of a fertilised ovum). Misinformation about the timing, mechanisms and secondary effects of EC constitutes a specific barrier to access. Particularly, for the population, it is counter-intuitive to imagine contraception after intercourse. There is no accurate information on the stages and specificities of the fertilisation process (physiological, hormonal and its time sequence), which, because of the temporal characteristics of EC, in turn generates misinformation about it. Interestingly, people know that EC does not prevent AIDS (93.1%). Campaigns on condom use as a means of preventing HIV have managed to instill this message in our society, which corroborates the findings of other studies (Kornblit 2004).

The main sources of information about EC are non-medical: friends (39.5%), the media (36.2%), school or university (13.8%), relatives (9.6%) and partners (6.8%). Medical sources mentioned were gynaecologists (9.5%), public hospitals (6.5%), private hospitals (4.4%), health centres or clinics (4.2%), pharmacies (2.1%) and social work services (1.6%). Non-medical sources seem to be favoured over medical sources, as in the case of condoms, and in contrast to what happens with other

contraceptive methods such as the pill or IUDs (Pantelides *et al*. 2007, Andía *et al*. 2008). In the semi-structured interviews, some interviewees discussed the importance of friends as a key source of learning about EC. For example, a young man stated:

> I knew about it because of a friend of mine who went through the same thing and he was afraid of this and that, and ... another friend of his told him about this pill, it's like the information gets passed on ... (Male user, 23, Mendoza region)

Many chose non-medical sources of information mainly because '*it was easier*' to consult someone close, but also to avoid judgemental attitudes from doctors or pharmacists.[7]

Most people know that EC is available at the pharmacies, but are not sure if it is readily available at hospitals and health centres. At the same time, people do not know if a prescription from a physician is required or not. The norm in Argentina indicates that EC pills are sold like ordinary contraceptives, under simple prescription, which means in practice it is sold over the counter. However, one out of two people does not know that EC is accessible directly from a pharmacist without having to see a physician.

We observed a much higher level of knowledge about how to gain access to condoms (see Table 4). Pharmacies and kiosks were the places mentioned most often. This tells of a mode of access to birth control based on purchase, while raising questions as to the coverage of free access. When asking about birth-control pills, the degree of knowledge about how to obtain them is slightly lower than in the case of condoms, with a higher degree of knowledge in women, people of older age and higher education and socio-economic levels (data not shown here). For this method, focus is on two places: the pharmacy and public providers, as places of access. Much like in the previous case, the mode of access is based on purchasing.

When inquiring whether subjects would know where to obtain EC pills if they should need and/or want them, out of the total sample, 65.0% responded affirmatively,[8] 20.7% negatively and 14.4% did not respond or did not know. Women know where to get EC in a greater proportion than men (68% and 61.9%, respectively). In comparison with regular methods, the degree of knowledge on

Table 4. Knowledege on access to EC, condoms and birth-control pills (EC in Argentina study, 2007).

	EC	Condoms	Birth-control pills
Knows where to get it	Yes: 65.0% No: 20.7% na: 14.4%	Yes: 99.5% No: 0.5%	Yes: 97.6% No: 2.4%
Total (*N*)	1219	1219	1219
Where to get it (multiple answers)	Pharmacy: 84.8% Hospital, health centre or clinic: 24.9%	Pharmacy: 77% Kiosk: 57.8% Hospital, health centre or clinic: 32%	Pharmacy: 82.2% Hospital, health centre or clinic: 37.8%
Number of mentions (*N*)	943	2104	1543

obtaining EC is considerably lower than in the case of condoms and the pill (see Table 4).

Access to EC, even more than for condoms and the pill, comes about through the pharmacy. This demonstrates the scant visibility of mechanisms for its free distribution, and that people do not want to wait for the usual hour of consultation at health services (usually in the morning), and want to avoid the potentially long waiting period to obtain EC (longer at a health service than at a pharmacy) even more than the cost. In turn, access through pharmacies expresses that EC is given and obtained after the fact, and that no one had it at hand 'just in case'.

Experience of EC

We inquired whether people had been in a situation of being highly concerned or afraid of a possible pregnancy, if they had ever had a 'scare'. Out of 1127 heterosexually initiated cases, half admitted having found themselves in this situation (50.5%) and the other half had not (49.5%). Most scares occurred within a stable relationship (85.1%).

Regarding the course of action taken the last or only time it happened (open-ended question), out of 569 people who admitted being in such a situation, 37.5% did not do anything, 24.3% took a pregnancy test and waited, and 14.9% carried the pregnancy to term. Abortions accounted for 3.7% (21 cases), 4.4% took a *Dosdías* pill and 9.1% took EC pills (52 cases).

Out of the 52 cases that took EC pills, most obtained the method at a pharmacy (43 people), and two obtained it at a hospital or health centre; almost half did so in less than two hours, at the pharmacy; 48 purchased it, at a price ranging between 11 and 20 pesos for the most part (4–7 US dollars).

While, according to qualitative interviews, there were no difficulties that would ultimately impede access at pharmacies, embarrassment and other negative feelings could constitute a barrier in seeking EC, particularly for women:

> Because for both a man as well as for a woman ... having sex, making love ... they love it ... but at the same time, they feel embarrassed. The first time that you went to buy condoms at a drug store, at a kiosk ... you were embarrassed ... and a woman, when she goes into a pharmacy to buy contraceptives she's embarrassed, why? ... because the man ... that is, they know he's having sex ... and the woman, they going to know that she's having sex because she's taking precautions ... So, it's even more embarrassing ... for a man or a woman to buy the pill ... emergency contraceptive ... because the first thing you think is that ... the one that's selling it to you says: whoa, this guy had sex and didn't take any precautions ... So ... it is a little embarrassing. (Male user, 37, San Juan)

There is embarrassment in connection to sexuality and the violation of intimacy, but also in failing the 'birth-control norm', that is, the norm according to which every pregnancy should be sought after, and sought after at the 'right time' (Bajos and Ferrand 2002). Birth-control failure is experienced with embarrassment, not only in connection with sexuality, but with the fact (whether true or not) of not having taken precautions successfully: '*at this age, how could I have gotten pregnant without planning it?*'

Moreover, the attitudes of doctors and other professionals influence access. Women seen by primary and reproductive health care clinicians are not routinely

informed about EC before the need arises; very few gynaecologists and general practice physicians counsel women on EC in advance.

EC and the politics of abortion

In Argentina, as in other Latin American countries (Díaz *et al*. 2003, CLAE 2006, Dides 2006), the Catholic Church has made known the idea that EC is akin to a 'chemical abortion', deliberately failing to differentiate EC from Misoprostol and RU-486. Some Catholic NGOs presented objections before Justice and judges in some jurisdictions and prohibited EC distribution, until a higher court revoked those prohibitions (Clarín 2007, 2008, Petracci and Pecheny 2007). In such a context, however, the Ministry of Health has not conducted public campaigns to explain the distinctions between the mechanism and the effects of each of these products.

According to our survey and interviews, EC is associated with abortion regardless of individuals' personal opinions about abortion or regardless, after contemplation, of making the decision to have an abortion. When consulted whether EC 'serves to terminate a pregnancy' ('*si sirve para interrumpir el embarazo*'), 57.8% responded 'Yes'. This opinion was proportionately higher among men (63.6%) of older age, those who have completed their primary education (66.1%) and people of lower socio-economic levels (62.3%).

Whether EC could be defined as 'abortive', 39.5% agree, 36.2% disagree and 24.4% did not respond or did not know. This identification between EC and abortion also appears in the qualitative component. Associated to the word 'pill', EC loses its singularity when confused with other pills, like Misoprostol (Zamberlin and Gianni 2007). The abortive quality that a sector of society allotted to EC, and the fact that this idea was broadly made known without sufficient counter-information, allows its association with Misoprostol to operate unchecked. Because it is a pill that is taken after sexual intercourse, it is associated with abortion. As illustrated by the following quote, when inquired about their perceptions of the potential use of EC, some interviewees made a semantic association between EC and abortive mechanisms such as Misoprostol:

Q.: . . . perhaps in the future, do you think that you would take the morning-after pill? Do you think that's a valid option?
A.: Yes, but no. That's why I say 'never say never' . . . but supposing there is an extreme situation . . . um . . . [Cough]. I wouldn't take it.
Q.: You wouldn't . . .
A.: I don't know, I mean . . . what I went through . . . it was very hard . . . I went through it alone; I had to deal with it by myself. I mean, nobody knew about it at home . . . I . . . I . . . the contractions, the detaching . . . and all that . . . in my house . . . I couldn't sleep all night because of the contractions . . . because I was given an ovule to detach it . . . so, I cried and asked him to forgive me, you understand? . . . [Pretending to cry] Oh God, forgive me, forgive me . . . ! And I cried . . . you understand?
Q.: An ovule to detach it? Tell me about that.
A.: I think . . . he told me there's this ovule that helps it detach . . . all of it . . . the whole endometrium . . . the part where . . . where the placenta is . . .
Q.: Yes. And is that what you did?
A.: He put in an ovule and half an hour later . . . an hour later I began having contractions so bad I had to lie on the floor and cover my mouth, so I wouldn't wake anybody . . . to come see what I was going through. And at eleven in the

morning on a Saturday ... I went to get that done ... He told me to put it in when I went to bed ... it'll hurt, he said ... it might hurt, some girls felt no pain, but others did ... it can hurt real bad ... you know? He made that clear ... I was hoping it wouldn't hurt, poor me ... I felt bad ... because I wanted it ... I felt it ... and I did want it, you know what I mean?

Q.: Sure.

A.: And I felt very bad then, I rolled around, covering my mouth ... I dropped to the floor with pain ... I thought my spine would break in two ... I felt it all ... I don't know ... it felt as if something was being ripped out of me ... I don't know ... something was coming down and at 11 in the morning I left to ... to get a ... (Female non-user, 27, Mendoza)

We found similar words in the testimonies of other women and other men who had experienced abortions. Beyond the ambivalent description of the facts and the analysis that could be done of abortion narratives (Petracci *et al*. 2008), this testimony shows how EC is directly associated with abortion and that it may hinder the use of EC. The association, paradoxically, may lead to a (new) unwanted abortion.

EC is more associated with abortion than with regular contraception, because few presume that the union of the ovum and sperm cells may be blocked after intercourse. For some interviewees, any intervention in the process (whether that of fertilisation or implantation) goes against life and is therefore abortive. However, despite having different views on EC and abortion, when people decide to use EC, fear (or panic) of pregnancy seems to prevail over the thought that it is potentially abortive. Even when convinced, this does not constitute an impediment; at the very worst, it may cause personal conflicts and felt stigma in those who decide to use it:

Yes ... totally ... Totally, because I ... I am one hundred percent against abortion ... and I think ... it is abortive ... Because I think ... everybody tells you that it's not, because you have to wait three months ... or I don't know how many months ... it's not ... well, for me, from the moment of conception it's already a life ... That is my belief ... and in my opinion ... you are removing it somehow. So there's the conflict. And today I feel it too. Maybe there was nothing to remove, you know? Surely there was nothing to remove because it was never there ... whoa, the day I ovulated and ... but ... that will always be uncertain. That conflict yes ... that ... you're bringing me down (Laughs) I'm going to cry now ... (Female user, 26, Buenos Aires)

At the other extreme, yet stumbling over the same inaccuracies about the fertilisation process, are those who are convinced that EC is abortive, but use it all the same (*'sure it's abortive, so what?'*, a male interviewee with higher education from Buenos Aires said). The erroneous notion that EC is abortive affects accessibility to EC, in a context where abortion is criminalised. That is why we talk about 'grey areas'. A distorted perception of the legal status of EC represents an obstacle to its accessibility. When we asked about this matter, namely whether EC 'is illegal, but anyone can get it', 36.3% agreed, 40% were in disagreement and – just as in other questions concerning the grey areas – a high percentage, 23.7%, stated that they did not know, or did not respond. We cannot analyse this data in terms of correct or incorrect knowledge, because it includes one part information (whether it is legal or illegal) and another part personal opinion (that which refers to 'anyone can get it'). Yet it leads us to assume that, indeed, a great number of people hold both beliefs: EC is illegal, but its practice is widespread, similar to what occurs with induced abortion.

With uncertainty, several interviewees expressed the opinion that EC is *not* abortive. In these cases, the opinion was shaped by the idea, expressed vaguely, that

an abortion 'takes place later on', when pregnancy is advancing, implicitly endorsing the idea that having sex is not synonymous with being pregnant, or that abortion refers to a foetus which is already somewhat developed. The impression that EC does not constitute an abortion derives from the recognition of a lapse between the time of the sexual relationship and the time of the gestation.

The fact that EC operates by preventing fertilisation is definitely ambiguous, yet there is a grey area between the occurrence of sex and fertilisation, a grey area in which there may be intervention without having, so to speak, a proper abortion:

> An abortion is done when the baby is big ... (Female user, 29, San Juan)

> I don't have the information, but yeah ... I don't think that it has anything to do with abortion. I think that an abortion is a little more mature, it doesn't end up being ... a baby, or anything ... But I think that it prevents something that could end up happening ... in fact ... it keeps you from getting an abortion. (Female user, 20, Buenos Aires)

> For contraception, removing the word 'emergency', because that's before it is conceived, and abortion means once the baby is already formed, I feel there is a difference. (Female non-user, 22, Buenos Aires)

Some other users asserted that EC may or may not have abortive effects, but which does not represent a moral conflict for them:

> Q.: So did you know how it worked ...? Do you know how it works?
> A.: No.
> Q.: What can you remember?
> A.: That it's an abortion pill that you have to take the following day ... That's all ...
> Q.: Do you think it's abortive?
> A.: I think so ... Is it abortive? (Male user, 20, AMBA)

To recapitulate, for many people, the very possibility of contraception after sexual intercourse is counter-intuitive. In a context in which the Catholic Church and other sectors insist that EC is abortive, and in the absence of public campaigns of education about the mechanism of EC, the access to EC is still hindered by the association with abortion and illegality. In any case, EC has not yet been incorporated into the contraceptive practices of the Argentine population.

Discussion and conclusions

In Argentina, with the legal and policy advances in reproductive rights and sexual rights, research increasingly focuses on the factors that facilitate or hinder the conditions of enjoyment of rights and the access to sexual and reproductive health (Petracci and Ramos 2006, Petracci and Pecheny 2007). This research focused on the barriers that remain in the day-to-day practice and obstruction of the full enjoyment of reproductive rights and sexual rights for women and men. Our study revealed subjective practices and perceptions that impede accessibility to EC. Restricted access is connected to the public and political debate, which takes precedence over the medical and technical knowledge of professionals and the health sector. When reflecting on the issue of rights and reproductive health, such as in this case, the point of radical disagreement is the issue of abortion (Petracci 2004, Brown 2006, Petracci and Pecheny 2007). This issue over-determines accessibility to EC, as it

continues to be problematic to offering and using a contraceptive method whose boundaries with pregnancy termination are blurred. This phenomenon generates resistance, confusion and misinformation in users, potential users and the health sector.

A significant part of the population, as well as health professionals, do not distinguish clearly between regular contraception, EC, and methods which are (*ex profeso* or *de facto*) abortive. Thus are forged the first hurdles to the access of EC – the grey areas – given that the public and political debate has produced a very tight connection between EC and abortion. This is due to some particular characteristics that differentiate EC from regular birth-control methods. In particular, the fact that EC occurs post-intercourse tends to facilitate its association with abortion.

Factors blocking access to EC involve technical aspects related to policy implementation, assistance and information, and not being easily dissociated from political, ethical, cultural, legal, social and religious perspectives. These factors operate both in and out of the medical consultation.[9] However, this paper shows that institutional factors are crossed by political, moral and even confessional dimensions that generate invisible barriers to access. The absence of public education campaigns contributes to perpetuate the imprecise image that blurs the distinction between EC and other products that have abortive effects, such as Misoprostol, which appeared on the social scene simultaneously with the morning-after pill (Vázquez *et al*., 2004, Zamberlin and Gianni 2007).

The issue of access to EC places us in a scenario where it is necessary to break down the traditional barriers to achieve more health service coverage (Mazzáfero 1999), and barriers that operate within patient–doctor relationships (Luciani *et al*. 2007). However, most importantly, it is necessary to deal with a commonly held sense that does not recognise the idea of a contraceptive method that can be used after unprotected sex. Most of the population equates any intervention after sex with the interruption of the gestation process, an aspect reinforced by the perception mentioned above, and reinforced by ideological and religious values, which give moral weight to human attempts to maximise procreation.

Most people are able to identify situations that may be qualified as emergencies but do not take precautions against them (as they would, particularly in the mid- to upper-social sectors, in 'ordinary' situations to prevent unwanted pregnancies and STIs). Moreover, at health services centres, prevention for 'ordinary emergency situations' is not encouraged, for example, by counselling about EC or distributing EC during gynaecological checkups. The range of concepts regarding emergency situations is quite varied – a 'contraceptive emergency' is but one case. EC implicitly refers to a distinct meaning and timing of emergency: as occurring during or just after intercourse, due to contraceptive failure, etc. Measures are needed to explicitly determine the notion of emergency which calls for EC, and to clarify the specific cases for which EC is appropriate and those for which it is not. For this purpose, prior instruction on regular contraceptives and fertilisation control is also necessary. Often failing to use EC – or failing to ask for it – is not due simply to the lack of information on its availability, but also because the whole chain of prevention of unwanted pregnancies has failed.

Within the context of stigma and illegality associated with abortion, the semantic and practical association between EC and abortion should be countered by using evidence-based information, as well as framing the issue of accessibility within a

public health and human rights discourse. In such a framing, the perpetuation of 'grey areas', that function as barriers to EC use, serve as violations of rights to reproductive health information and services which would allow citizens to achieve maximal well-being in relation to their sexual lives.

Regarding EC accessibility, traditional barriers operate in the same way they do in relation to the use of regular contraceptive methods. These barriers are linked to quality of attention, friendliness at the health service centres, hours open, economic costs, unequal gender and social relationships, the type and moment of the relationship and sexual activity (initiation, whether with a steady partner or not), etc. Yet paying for EC has not been an obstacle for those who have used it. In contrast, subjective, social and cultural barriers have a high-priority regarding EC accessibility.

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Notes

1. In Argentina, recent estimations placed the number of abortions between 372,000 and 522,000 a year (Pantelides and Mario 2006).
2. Barriers to access also exist in many countries. As a result, EC use has not yet reduced the rates of unwanted pregnancies or abortions (Polis *et al.* 2007, Trussell and Raymond 2008).
3. EC, mistakenly known as 'the morning-after pill', is reserved for cases of true emergency: rape, unprotected sex, accidental or incorrect utilisation of regular contraceptives (von Hertzen *et al*. 2002, WHO 2007). Emergency hormonal contraceptives are simply different doses of the birth-control pills that have been used for decades. Products contain a progestin, levonorgestrel, and should be administered in the first five days after vaginal sexual intercourse. Several products, with different components and purposes, are sometimes mistakenly considered EC: *Dosdías*, Misoprostol and RU-486. *Dosdías:* with a similar composition to that of commonly used contraceptives, *Dosdías* is used to diagnose secondary amenorrhoea, ruling out pregnancy. *Misoprostol:* Sold under the name Oxaprost in Argentina, Misoprostol prevents gastric ulcers. It is widely used as an abortifacient. This last is off label use – *Mifepristone or RU-486:* an antiprogesterone used to terminate pregnancy within early weeks of gestation, is prohibited and not sold in Argentina.
4. Each year in Argentina, around 100 women die from complications due to unsafe abortions. These complications are the leading cause of maternal mortality. In 2006, the maternal mortality rate was 4.8 per 10,000 live births; 28% of those deaths were due to abortion-related complications (Ministry of Health 2007). In 2005, there were 68,869 hospitalisations due to abortions in public health institutions (Ministry of Health 2006).
5. The Penal Code criminalises abortion with some exceptions: in case of danger for the life or health of the pregnant woman; and when the pregnancy results from a rape, and from a rape 'committed to a woman legally declared insane or mentally retarded'.
6. The percentage who mentioned EC would be somewhat higher if we include those who responded '*taking a pregnancy test and then the morning-after pill*', that is 7.4% of the subset.
7. Health professionals are often reluctant to prescribe EC. Some professionals fear that EC may end up replacing the use of regular contraception. When inquiring about whether they consider EC to be 'more convenient than using contraception every day', a large percentage of our sample disagreed (72%). It would be worthwhile to examine to what extent these 'solutions' of last resort (including the use of Misoprostol) are actually prevailing over preventive practices, especially within the less educated. However, our data indicate that

beliefs about EC do not suggest that EC might compete with regular contraceptive use (also see: Polis *et al*. 2007, Trussell and Raymond 2008).

8. Answers of 0.8% were 'inconsistent' with their knowledge of EC, with the result that questions on this topic were answered by 65.0% of the sample and others by 64.2%.
9. From the point of view of professionals (Andía *et al*. 2008), obstacles are connected to the lack of EC awareness and its shortage of supply, as well as a shortage of qualified human resources. Besides, EC is difficult to find off hours (gynaecology departments usually see patients in the morning and gynaecologists at primary healthcare clinics do not attend it every day) while EC is not widely available in Emergency Rooms.

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