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Past Due: Emergency Contraception In U.S. Reproductive Health Programs Overseas

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Two months after the Food and Drug Administration (FDA) officially announced that certain regimens of combined oral contraceptives were safe and effective for postcoital contraception, the Office of Population Affairs (OPA) in the Department of Health and Human Services sent a guidance letter to its regional program offices about what had conventionally come to be known as emergency contraception. The letter noted matter-of-factly the FDA's announcement and provided instruction for use of the method in Title X family planning programs. In considering the range of methods to be offered, it explained that "grantees should consider the availability of emergency contraception the same as any other method."

The OPA guidance was issued in 1997. Since that time, emergency contraception has been made available under Title X as a matter of course. More recently, the Department of Defense also included the back-up birth control method in its formulary of medications at all of the department's medical treatment facilities, clinics and pharmacies worldwide. Yet, more than 13 years after supplies of emergency contraception became available in domestic family planning programs, the U.S. Agency for International Development (USAID) has not acted to add emergency contraception to its official commodities list and, accordingly, is still not offering emergency contraceptive pills in its family planning programs abroad. Such action is long overdue.

Fighting the Science

Ever since it was developed, the "morning-after pill" has been politicized and attacked as an abortifacient by ultraconservative organizations and policymakers. More so than other forms of contraception, this method has faced unusual opposition both in the United States and internationally.

In certain developing countries, emergency contraception has become the battleground for proponents and opponents of reproductive rights, and this is most evident in the region of Latin America, where the Catholic Church maintains a strong influence. Legislatures or courts in countries such as Peru, Honduras, Chile and Ecuador have banned or restricted access to emergency contraception in recent years, although not without a fight. For example, in 1998, Chile's Constitutional Court outlawed the free distribution of emergency contraception for poor women in its public health clinics, basing its decision on the assertion that emergency contraceptive pills are "abortive." But earlier this year, President Michelle Bachelet succeeded in restoring access for poor women when she signed a new law to resume free distribution of the pills, after a prior attempt to do so through executive order had failed. Chile's Minister of Health pointed out the inequality and "hateful discrimination" that the judicial ruling had inflicted on the poorest members of society, compared with those women with more resources who could go to the private sector for the drug.

The assertion that emergency contraception is or can act as an abortifacient derives from a definition of pregnancy embraced by the Catholic Church and many antiabortion advocates but flatly rejected by the medical profession. Under this definition, pregnancy begins with the "moment of fertilization"—the union of an egg and sperm. Major medical organizations, on the

other hand, as well as U.S. government policy, consider a pregnancy to have begun only when the entire process of conception is complete, which is to say after the fertilized egg has implanted in the lining of the uterus.

Studies on the mechanism of action of emergency contraception show that it works primarily by interfering with ovulation. In cases when ovulation has already occurred, the method may inhibit fertilization or, in cases when fertilization has already occurred, it could, in theory, prevent implantation—although current evidence does not support this latter mechanism of action. In theory, all hormonal contraceptive methods could work through all of these modes, although prevention of ovulation is the primary demonstrated mode for all of them. The major point, of course, is that if pregnancy were synonymous with the act of fertilization, all of the most effective reversible contraceptive methods—including oral contraceptive pills, injectables and IUDs—could be considered, at least theoretically, to be possible abortifacients.

In describing emergency contraception's mechanisms of action, the FDA has stated that emergency contraception "works like other birth control pills to prevent pregnancy." The World Health Organization states unambiguously in its guidelines that "[emergency contraceptive pills] are not effective once the process of implantation has begun, and will not cause abortion." Similarly, the American Medical Association, the American College of Obstetricians and Gynecologists, the International Federation of Gynecology and Obstetrics, and a host of other medical institutions have unequivocally stated that emergency contraception does not terminate an established pregnancy.

Cutting Through the Confusion on Effectiveness

Emergency contraception is effective at preventing pregnancy after unprotected sex—with greater effectiveness the sooner it is taken after intercourse. However, because the method only protects against pregnancy after a single act of intercourse, if a woman does not use it after every time she has unprotected sex, she is not fully protecting herself against unintended pregnancy. Estimates of the effectiveness of emergency contraception range between 59–94%.

A 2010 Cochrane review of studies that tested the impact of advance provision of emergency contraception to women concluded that such interventions designed to improve access to the drug did not translate into reduced pregnancy or abortion rates at the population level. These studies have created confusion about the efficacy of the method itself. However, the studies reviewed focused on advance provision of the method, not actual use of the method. The failure to see changes in pregnancy and abortion rates at the population level from interventions to supply emergency contraception in advance does not undercut the essential argument about the effectiveness, necessity and value of the method. Because evidence does show that emergency contraception cuts the risk of unintended pregnancy for individual women and because it is the only postcoital method available, provision of emergency contraception remains an important option in helping women lower their risk of facing an unplanned pregnancy.

Although the medical community has uniformly agreed that emergency contraception is, in fact, contraception, there has been some confusion about its effectiveness, especially in light of research indicating that advance provision of the method has not had a demonstrable impact on reducing pregnancy and abortion rates at the population level. That research, however, does not contradict earlier clinical research showing emergency contraception's effectiveness in reducing an individual's pregnancy risk (see box).

The Contribution of Emergency Contraception

The number of unintended pregnancies in the developing world is shockingly high: some 75 million every year. There is, obviously, an urgent need for more and better contraceptive use on the part of sexually active women and couples. Provision of emergency contraceptive supplies by USAID would be an important aspect of meeting the need for contraceptive services in poor countries.

LOW AWARENESS, LOWER USE

In developing countries, most of the population has never heard of emergency contraception, and almost no one in some countries has ever used it.

Country	% aware of emergency contraception	% ever used emergency contraception
Ghana (2007)	35	3
Kenya (2003)*	24	1
South Africa (2003)	20	<1
Pakistan (2006–2007)	18	<1
Nigeria (2008)	15	3
Democratic Rep. of the Congo (2007)	11	1
Philippines (2003)*	10	<1
Egypt (2007)*	7	<1
Indonesia (2007)*	6	<1

*Currently married women. *Note:* Data are for reproductive-aged women. *Source:* Most recent available data from the Demographic and Health Surveys, compiled by the International Consortium for Emergency Contraception.

However, uptake of emergency contraception may be particularly challenging in much of the developing world, in part because of the pervasively low rates of even basic awareness of the method (see table). In the absence of such awareness, the demand for the method is low and its use is even lower. (In a country like France, by contrast, 89% of reproductive-aged women know of the method, and 17% have used it.) Thus, USAID has a key role to play in addressing this problem. USAID procurement of emergency contraception would bring more access and better knowledge of the method to countries that face a large unmet need for family planning services. In turn, this visibility would generate more demand for the product. Supplies of emergency contraception, along with more training and education about the method by USAID, would be especially important in countries that are encountering their own legislative and political battles around its mechanism of action, legality and accessibility. USAID's public support and procurement of emergency contraception would send a powerful symbolic message to these countries that it is a safe, effective and legitimate form of contraception.

It is worth noting that the need for emergency contraception exists throughout societies where prevalence of unintended pregnancies remains high, but the case for this particular form of contraception is especially acute in countries where there are widespread incidents of gender-based violence, conflict, humanitarian disasters, refugee and displacement situations, and other emergencies. For women caught in these situations, emergency contraception represents perhaps the only chance to prevent a pregnancy that is not wanted.

Putting History Behind

It is not difficult to understand how USAID's desire to avoid controversy may have inhibited it in the past from treating emergency contraception the same as all other newly approved contraceptive methods for purposes of its commodities distribution program. Less easy to understand is how that stance can be justified now, given the overwhelming consensus from the medical community about the drug's mechanism of action and that 12 years after FDA approval, there is growing interest in and demand for the product.

Still, the agency's past experiences with anticontraception and antiabortion activists at home and abroad—including from within Congress—have been highly contentious. Interference from these actors clearly played a role when USAID declined to move ahead with a process to include emergency contraception in its commodities program, after the FDA approved the first dedicated product in 1998. The agency endured withering and long-term assaults on its field programs, especially in countries such as Peru, where conservatives falsely accused the USAID mission of engaging in coercive practices and practicing abortion. Rep. Chris Smith (R-NJ), in particular, was vehement in his opposition and exerted considerable pressure on the mission during a trip to Peru to withhold support for emergency contraception. USAID grantees in Peru, however, were instructed by the agency through a 2005 communiqué to maintain a "policy of neutrality" on emergency contraception and to refrain from using USAID funding to express any policy position on emergency contraception.

The State Department faced similar opposition when Smith and his allies predictably objected in 1998 to the inclusion of emergency contraception in an interagency field manual, which outlined the reproductive health services that should be available during emergency situations. In particular, they protested the availability of the contraceptive method for victims of sexual violence in refugee camps. In that case, however, the field manual in the end did include a recommendation of emergency contraception's availability for rape victims.

Since that time, the policy climate around emergency contraception has notably shifted, and USAID's failure to include emergency contraception in its contraceptive service delivery mix stands in contrast to other U.S.-funded family planning programs. This posture seems particularly incongruous now, when congressional leaders are strongly pro–family planning, as is the Obama administration. Indeed, a leading champion of emergency contraception is Secretary of State Hillary Rodham Clinton herself. While in the Senate, Clinton was a driving force behind a campaign to force the Bush administration to purge politics from the FDA's consideration of over-the-counter status for emergency contraception. She pushed hard for a review, based solely on scientific evidence, which led eventually to FDA's switching the morning-after pill to over-the-counter status in the United States. In light of the secretary's personal history with the issue and her continuing commitment to promoting and advancing women's reproductive health through U.S. foreign assistance programs, it is odd that action has not been taken more quickly to rectify the omission in U.S. foreign aid programs. At the same time, with an administrator of USAID finally in place to sign off on a policy change, any further delay in reversing USAID's stance is clearly unwarranted.

Finishing the Job

All of this is not to say USAID is doing nothing with respect to emergency contraception. On the contrary, albeit in a quiet and limited fashion, the agency covers emergency contraception in its trainings and educational materials, and allows counseling about this option with family planning clients. And USAID itself reaffirms in its materials that emergency contraception cannot cause an abortion, but rather reduces the need for abortion by preventing an unintended pregnancy.

However, the agency needs to take the plunge and demonstrate its full support for this method of birth control. Emergency contraceptive pills should be included in USAID's commodity distribution program, and the agency should actively follow up with guidelines, trainings and education for its field operations. The latter step is particularly important given the misinformation about emergency contraception that is promulgated by conservative groups and the lack of access to the commodity for so long in USAID's overseas programs. Because the United States is prohibited by law from funding abortion, the mere fact that USAID would be distributing emergency contraception sends a clear message that emergency contraception is just that—contraception. This simple action, in and of itself, may be useful in helping to limit the effect of misinformation and disinformation campaigns that portray the morning-after pill falsely as an abortifacient.

At the end of the day, emergency contraception adds another option to the limited recourses available to women to regulate their fertility. USAID's assistance in supplying it would help expand access to a crucial contraceptive method for women in poor countries and would offer them the only method available that can be used postcoitally, making it a unique and necessary tool in any donor efforts to avert unintended pregnancies. www.guttmacher.org

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