

Contraception and abortion

Monsignor Jacques Suaudeau, Scientific Director of the Pontifical Academy for Life, demonstrates how the various contraceptive techniques are in reality frequently abortive.

Interview conducted by the *Dialogue Dynamics* team

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The text below is a recasting, in question-answer format, of two well-documented presentations by Monsignor Jacques Suaudeau on various methods of contraception and the fact that they are frequently abortive in nature. The technical precision of the text is matched by its doctrinal accuracy, both valuable characteristics for any person of good will wishing to be accurately informed while enlightening their conscience in the light of the divine law inscribed in their heart.

Dialogue Dynamics considers it both useful and urgent to make this document available to educators, particularly in developing countries, where transnational lobbies exercise maximal pressure on populations and governments to implement “sexual and reproductive health” under the guise of implementing Millennium Development Goal five.

Although lengthy, this text is designed as a reference document to assist in training. It is also available in the form of a training seminar made up of teaching modules (short documents, considering one theme at a time).

Monsignor, let us begin with a definition: what is meant by “contraception”?

“Contraception” means any artificial method used, to a degree more or less temporary, to prevent (*contra*) conception (*ception*), i.e. the successful penetration of an ovum by a spermatozoa (fertilization) in the fallopian tubes. Contraception intentionally places an objective obstacle in the way of fertilization, in a way which is temporary, reversible. A distinction must be drawn between contraception and periodic abstinence, in which a couple places no obstacle in the way of procreation, which is a non-contraceptive method of “birth control”.

So contraceptives prevent the conception of a child?

This is not all they do. Alongside contraceptives proper, other technical methods now exist, generally distributed under the label of contraceptives, which act, not by preventing conception, but by preventing the initial development of the pregnancy in the days following fertilization: these methods are therefore abortive techniques which achieve an early abortion. Such techniques are known as *interceptives* if they “intercept” the embryo before its implantation in the uterus and *contragestives* if they cause the elimination of a newly-implanted embryo.

We perceive immediately the fundamental ambivalence of the term “contraception”, which may in fact mean an early type of “abortion”. Can you clarify which contraceptives can be categorized as “interceptives” and which are “contragestives”?

Interceptive techniques include pure progestogens, in the form of pills, injections or implants, intrauterine devices (coils or IUDs) and emergency and post-coital contraception. Contraceptives include *anti-chorionic gonadotropin* vaccines (anti-hCG vaccines), products acting as anti-progestogens (RU486 or *mifepristone*), and *prostaglandins*.

The invention and use of contraceptives is a phenomenon recent in the history of humanity, generating an anthropological revolution, the scale of which is still being measured. Can you remind us of the key landmarks?

Although use of the male condom dates from the XVII century, Wilhelm Mensinga developed a diaphragm which could be used as a pessary in 1880 and Ernest Gräfenberg invented the coil in 1928, it was the introduction in 1958 of the famous oestroprogestogenic pill by Gregory Pincus which marked the beginning of “modern” contraception. The pill was introduced for sale in 1960 in the United States under the brand name *Enovid*. In this compound, the world finally had the apparently ideal contraceptive method, long anticipated by feminist followers of Margaret Sanger, which would liberate women and solve all the problems of the third world - at least this was what people believed. This pill, modified in 1962 to make it more acceptable to patients (“ortho novum”), met with immediate success. By 1963 there were already more than a million users throughout the world.

The first oral contraceptives to be introduced to the market in 1960 were “oestroprogestogenics”, a combination of two synthetic hormones, one oestrogen and one progestogen, each producing an effect similar to that of hormones – oestrogen and progesterone respectively – naturally produced in the ovary. Another type of contraceptive, consisting of a progestogen product only – whose effect was similar to that of progesterone - , which could be administered in the form of pills, intramuscular injection or subcutaneous implants, was later developed. The progestogen most widely used in this type of contraception is levonorgestrel, found in “emergency contraception”.

Why do you think the pill was such a great success?

World opinion acclaimed its discovery as a major victory for science, which would put an end to the submission of women to nature and its rules. The discovery also seemed to come at the right time to help humanity curb “overpopulation”, the dangers of which were being dramatically emphasised.

One of the favourite arguments of the advocates of contraception was that the extension of its use would contribute to a reduction in the number of intentional abortions, in particular among adolescents. This argument was cited frequently in the debates that took place prior to, and which followed the publication of Pope Paul VI’s Encyclical *Humanae Vitae* (25 July 1968). The proponents of contraception heralded the pill as the ideal method of regulating births, offering numerous advantages over so-called “natural” methods of birth control, not least due its efficacy, and even advantageous from a moral standpoint, given that it allowed couples to experience their conjugal union in peace, without the sword of Damocles of an unwanted pregnancy hanging over their heads.

We notice that some of these arguments are still used today...

Of all the various arguments presented at that time in favour of contraception, it is the prevention of abortions which has most stood the test of time and which continues to be presented on a regular basis, in particular in European countries confronted with the increasingly worrying problem of juvenile promiscuity. But this argument is also regularly put forward by movements promoting population control throughout the world, spearheaded by the United Nations Fund for

Population (UNFPA). The argument runs that thousands of women would be dying in poor countries as a result of complications from illegal abortions and the Governments of these countries have a genuine moral obligation to promote different contraceptive methods in their populations to reduce the number of unwanted pregnancies, and hence abortions.

Propagation of the knowledge and use of contraceptives is therefore presented not merely as acceptable in moral and social terms – in spite of the negative demographic consequences – but as part of a true ethical imperative. The demand for contraception is ever-increasing, both in the young in wealthy nations and women of childbearing age in the developing nations.

But more and more young people are now using contraception in the developing nations. Have we not, for several years now, been witnessing a globalization of the western sexual revolution?

The UNFPA (*United Nations Fund for Population*) and WHO (*World Health Organisation*) had made it a priority to expand the use of contraception in the poorest countries, in order to limit population growth in those countries. According to this philosophy, the poor are not entitled to have children. The form of contraception offered was simple, veterinary: it consisted of either intrauterine devices or the administration of pure progestogens in the form of subcutaneous implants (Norplan). The two organisations concerned applied a reductive notion of “informed consent” with regard to contraception and treated women, in effect temporarily sterilized, in a cavalier fashion. The outcome in the populations concerned was a rejection of this form of contraception, seen as a remnant from the colonial error. However, what was driven out by the door is now coming back through the window, albeit in the more distinguished and elitist form of oral oestrogenic contraception. The result has been that young women in these countries, possessed with a degree of intellectual knowledge and appreciable income level, fascinated by the “liberal model” of the Western woman, are now adhering to the viewpoint of feminist “liberation” which has opened the world to the “sexual revolution”. What had initially been rejected on the basis of a healthy reaction of attachment to the values of the family and life, is now becoming accepted in the form of what must be termed voluntary and individualistic capitulation.

We are aware of the extent to which the Church’s position has been criticized since Humanae Vitae. But has the Church not been prophetic in its refusal of contraception?

The Church is in fact accused of insensitivity concerning the moral dilemmas of our time, and even encouraging abortion by its obstinate rejection of hormonal contraception, as recalled by Jean Paul II in *Evangelium Vitae*: “It is frequently asserted that contraception, if made safe and available to all, is the most effective remedy against abortion. The Catholic Church is then accused of actually promoting abortion, because she obstinately continues to teach the moral unlawfulness of contraception” (Ev.Vitae.13). However, in the light of the cumulative experience of the past 30 years in this area, population surveys and greater knowledge of the biological effects of contraceptives, we are entitled, in common with the Holy Father, to question the validity of this promotional argument.

Fifty years after the introduction of the first contraceptive pill, the reality is that, far from reducing the number of abortions, contraception has itself become increasingly abortive. Indeed, it is in the functioning itself of the “pill” that abortion gains an entry.

What do you mean by that?

At first the “pill” was presented purely as an “anti-ovulant” which suspended so to speak the functioning of the ovary in a way which was morally acceptable. It was claimed that, for the

good of humanity, what nature did spontaneously during pregnancy and lactation could certainly be imitated by the consumption of - naturally-occurring - hormones.

However, as early as the 1950s, it had been realized that the mechanism of the effective action of the combined oestroprogestogenic pill could not be defined as merely the prevention of ovulation. We know today that combined oral contraceptives have at least three points of impact on the organism, with reference to each of the three stages leading to the development of the child in the mother's womb:

- coagulation of the cervical mucus and hindrance – without total prevention – of the ascent of spermatozoa from the vagina to the uterus.
- blocking of ovulation: the egg doesn't form in the ovary. However, suppression is not total ("escape ovulation" takes place in 5% of cases) and fertilization remains possible (1.25% of cycles);
- prevention of the development of the mucous membrane in the endometrium, which becomes severely atrophied and incapable of receiving a fertilized egg. This leads to early abortion through the non-implantation of the embryo.

From what you are saying, the pill doesn't always prevent ovulation.

The first contraceptive pills introduced to the market in the 1960s contained high concentrations of oestrogens and progestogens and certainly acted by blocking ovulation. However, in view of the incidence of unpleasant side-effects and complications – in particular thromboembolic and hypertensive complications – generated by such high doses, the oestrogen and progestogen content of the combined contraceptive pill was progressively reduced. This reduction in dosage made the suppression of ovarian activity less complete. With the current pill, ovulation does in fact take place in spite of use of the contraceptive pill, at the rate of one in every 10 or 12 cycles surveyed. These "escape" ovulations make it possible for fertilization to take place while the pill is being taken if sexual relations occur within five days following ovulation.

The consumption of certain medications in conjunction with contraceptives (specifically psychotropics and antibiotics) and gastro-intestinal disorders (gastroenteritis, various forms of diarrhoea) may in addition interfere with the effectiveness of the anti-ovulation effects provided by the substances ingested. Hansen and Lundvall encountered such interference in 21 out of 70 women requesting an abortion despite the uninterrupted use of oral contraception.

Do the 5% of cases of ovulation you have mentioned as occurring despite the use of the contraceptive pill always result in a pregnancy?

The figure of 5% considerably exceeds the number of unwanted pregnancies occurring despite use of the oral oestroprogestogenic pill (one out of hundred women per year). It must therefore be acknowledged that the difference corresponds to early abortions, not detectable to the woman taking the contraceptive pill, yet caused by the pill. It is the action of the contraceptive on the mucous lining of the uterus (endometrium) which accounts for this difference, and hence these early abortions.

Does the pill have other effects in terms of ovulation?

Due to its progestogen component, the pill probably also acts on the fallopian tubes, slowing down the progression of the fertilized egg. The pill would therefore alter motility and secretions in the fallopian tubes, thereby placing an obstacle in the way of the spermatozoa, which is a contraceptive effect, and also the descent of the fertilized egg, which is an abortive effect. Given that its progress has been retarded, the egg will become too old to be capable of developing into

an embryo. The egg would not be implanted and would die. Delayed progression could also cause the embryo to be implanted in the tubal mucous membrane, causing an ectopic pregnancy. There does in fact appear to be an abnormal frequency of ectopic pregnancies among women taking low-dose pills.

And would the pill also have an effect on the endometrium?

The impact of oral oestroprogestogenic contraceptives on the endometrium has long been underestimated. An assessment now appears essential. It is the progestogen component of the pill which is the cause in this case. Its presence from the outset in contraceptive treatment in “combined” pills alters the ordinary development of the uterine endometrium, necessary for implantation of the fertilized egg, thereby inhibiting nidation. The pill here has an abortive role. The marked suppression of endometrial receptivity by oral oestroprogestogenic contraceptives certainly accounts in part for their efficacy in preventing the development of the embryo. It is this action on the endometrium which is known as the “interceptive” effect of the pill: embryos whose creation the contraceptive has been unable to prevent in the uterine tubes are “intercepted” in the uterus, which has been transformed into an environment hostile to life. These embryos are unable to “reach their goal”, i.e. nidate in the uterine mucous membrane of the uterus, in the same way as a ball confronted with a disappearing goal cage or a spacecraft unable to find the planet it is aiming for, which is then lost, its crew killed by cosmic radiation.

So the pill is abortifacient...

The pill’s marked suppression of endometrial receptivity – which accounts for its efficacy – is no longer in the domain of contraception, but in that of early abortion. In the absence of reliable user-friendly biological markers to detect the presence of the embryo before implantation, it is not possible to arrive at an objective assessment of the percentage of early abortions caused by the use of oestroprogestogenic contraception. An approximate assessment based on deduction would be that a woman taking the oestroprogestogenic contraceptive pill for 15 years would, in so doing, unknowingly destroy around two embryos. Even if halved to take account of the prevention of fertilization achieved by cervical mucus, the figure remains significant, having regard to the number of women taking oestroprogestogenic contraceptives (4 million in France alone).

Apart from oral oestroprogestogenic contraceptives such as the pill, what other types of contraceptives exist today?

Progestogen contraceptives occupy a growing position in the control of female fertility. The advantage of these pills is that they do not cause the disorders or complications associated with use of the oestroprogestogenic pill and can be taken during lactation without risk to the baby. The pills concerned are as follows:

- the minipill, or low-dose pill;
- contraceptives injectable every quarter (Depo-Provera);
- contraceptives in the form of subcutaneous implants (Norplant).

But are these products still true contraceptives? There is a serious problem of definition here. Contraception is in fact said to mean the prevention of fertilization of the ovum by the spermatozoa. But progestogens, whose action replicates that of the natural hormone progesterone, have little or no inhibitory effect on ovulation. They prevent the development of the embryo by acting elsewhere, primarily in the cervix and endometrium.

What are the operational mechanisms of these progestogens?

Progestogens act:

- by partially inhibiting ovulation mechanisms;

- by coagulating the cervical mucus: some sperm may still be able to pass through this barrier and rise from the vagina to the fallopian tubes. The high frequency of ectopic pregnancies obliges us to acknowledge that, in the context of progestogen “contraception”, fertilization continues to take place;
- by disturbing the motility of the fallopian tubes;
- by making the uterine mucus non-receptive to the embryo: this effect on the uterine endometrium is predominant. Progestogens interfere with the normal cyclical development of the endometrium, preventing nidation of the egg. Under the effects of progestogens, the uterus is to some extent “dormant” and hence incapable of receiving the embryo.

What is the minipill?

Progestogens administered orally, at low doses and as a continuous treatment, have become known as “micro-progestogens” or “mini-pills” due to their lower steroid content. The minipill is used where there are problems of dysovulation (anomaly of ovulation). The minipill involves fewer complications than the conventional pill, but is less effective. The drawbacks of the minipill are irregular cycles, bleeding, amenorrhoea, oedema and mastodynia. Its effectiveness in the prevention of pregnancy is linked to the dose of progestogens used, in turn restricted as a result of increases in vagina bleeding. Given that the minipill only prevents ovulation in a partial number of cases and its effect on the endometrium is predominant, it is in effect an abortifacient with interceptive effect. It allows fertilization in a significant number of cases, while rendering nidation of the embryo impossible. A woman taking the minipill could, without being aware of it, suffer one abortion a year.

Given that conception is not in fact prevented by the minipill and it is receptivity to the embryo which is impaired, the embryo, whose journey is itself modified through the effect of progesterone on tubal motility, may implant in areas other than the usual site. Tubal pregnancies always end in an abortion, leading to death of the embryo and posing a serious risk to the health of the mother.

A second type of progestogen contraceptive is the injectable contraceptive. How does this type of contraceptive work?

Progestogen-based preparations are administered every three months by injection. Their action is similar to that as the “minipill”: they are abortifacient by interception. The progestogen is released slowly from the injection point and has a contraceptive effect, rendering the mucus impervious to spermatozoa, but primarily abortifacient, radically impairing the uterine endometrium, making it unfit to receive the embryo. In addition, the embryo is transported into the fallopian tubes at abnormal speed. Ovulation may also be inhibited, but this is not a constant.

What are the most widely used injectable contraceptives?

The most well known and widely used are DMPA and NET-EN, which both contain a single hormone, a progestogen.

- DMPA (depot medroxyprogesterone acetate), synthesised in 1954, was first used as an injectable steroid for different therapies, including the treatment of cervical and kidney cancer, before it was noticed, in the 1960s that it had a powerful contraceptive effect. Dubbed “the shot” by its distributors, it was launched on the market under the brand name Depo-Provera in 1967. Injected intramuscularly at a dose of 250 mg, it is highly effective (100%) in preventing pregnancy for a duration of three months. It thus provides effective contraception for women who cannot, or do not wish to, take an oral contraceptive every day.

- The action, efficacy and side-effects of NET-EN (norethisterone enanthate) or Norigest are identical to those of DMPA.

What are the side-effects?

Depo-Provera has been in the news because it has been shown that its prolonged usage may cause a loss in bone density, a loss only partially reversible. It is therefore recommended that it should not be used for more than two consecutive years. It should in fact only be used if other methods of birth control do not suit the person concerned. The main drawback of injectable contraceptives is that they cause irregular unpredictable bleeding, an effect common to all progestogen-only contraceptives (such as Norplant and the mini-pill). In addition, it takes an average of 13 months for fertility to return to normal after the final injection of Depo-Provera. Finally, Depo-Provera causes an increased risk of cancer, in particular breast and cervical cancer, at least in animals. However, statistics in humans using this method of contraception do not appear to bear out this risk.

Have measures been taken to reduce these side-effects?

To remedy the disadvantage of haemorrhages, it has been proposed to modify these injectable contraceptives by combining an oestrogen with the progestogen. This has led to the development of HRP112, also known as CycloProvera or CycloFem and HRP102, also known as Mesigyna. These compounds have to be injected every three months. According to the WHO, these two products are highly effective, the side-effects are less and fertility returns to normal after usage has stopped sooner than in the case of DMPA and NET-EN. The two products have been extensively tested.

Injectable contraceptives are therefore used for the purposes of population control...

Depo-Provera has become a symbol of “population control policies” in discussions on family planning, some vaunting its efficacy as a contraceptive, in particular in the context of these “policies”, and others emphasizing the risks of a product specifically targeted at the poor in developing countries. The fact is that abuses, in the form of injection campaigns orchestrated by some Health Ministries, under conditions where the women undergoing injections are not adequately informed of their effects, are regularly reported.

Are there any more recent injectable contraceptives?

The most recent of the combined injectable contraceptives is Lunelle (Pharmacia Corp.), approved by the FDA (*U. S. Food and Drug Administration*) in October 2000. This product, administered by monthly intramuscular injections, contains oestrogen and progestin, and its action (and side-effects) are comparable to that of the combined oral pill. Its advantage is that it eliminates the need to take the pill daily.

Alongside the minipill and injectable contraceptives, you have also mentioned implants. What does this mean?

Proponents of population control policies in neo-malthusian circles were soon looking for a contraceptive which could be used in the developing countries on a large, organized and economic scale, without the need for repetition, in the context of “Government reproductive health programmes”. In other words, there was a need to develop a long-acting contraceptive, if possible effective over several years, which could be administered once only to persons informed to a greater or lesser extent, who, very probably, would not want the product if offered it a second time. It was the *World Population Council* who developed the notion of subcutaneous progestogen implants in 1966, demonstrating that a physiologically active material could permeate uniformly, constantly and slowly through the wall of a silicone capsule.

Can you describe the functioning mechanism of these implants?

Subcutaneous implants are capsules made of silastic, teflon or another polymer containing micro-crystals of a progestogen or oestrogen combined with a slow-release progestogen. The implant is biodegradable (although non-biodegradable implants are being researched). The hormones enter the circulation progressively as the capsules are absorbed by the organism. The release of hormones takes place at a constant rate, which is not the case with injectable contraceptives, where hormone release is high at the start, but diminishes progressively thereafter.

The action of subcutaneous implants is similar to that of injectable contraceptives: these also are abortifacients with an interceptive action, which operate by altering the structure and trophism of the endometrium so that the embryo is unable to implant and the pregnancy rapidly ends in abortion. Side effects include recurrent intermenstrual blood loss caused by the continuous release of small quantities of progestogen into the bloodstream.

When were progestogen implants first used?

Several types of progestogens, in capsule form and positioned intradermally, underwent clinical trials in the 1970s. But the side-effects of these progestogens (haemorrhage, ectopic pregnancies) were such that it was ultimately sub-dermal implants releasing *levonorgestrel* which were chosen. It was the Population Council which developed these implants under the brand name Norplant, for clinical trials to be carried out on the product before marketing.

Norplant began to undergo clinical trials in 1974, but it was some time later before it was first approved in any country. Finland, where Norplant had been produced, was the first country to approve it in 1983. It was subsequently approved by Sweden (1985), Indonesia, Ecuador, the Dominican Republic and Thailand (1987, before being registered and distributed in numerous countries (currently 60). The use of Norplant was approved in the United States in 1990. The product has been distributed in Great Britain since 1993.

Can you explain in greater detail how Norplant works and its degree of efficacy?

The Norplant system consists of 6 rods, each containing 36 mg of levonorgestrel, encapsulated in a flexible silicone casing. The rods are inserted in a fan-like shape beneath the skin on the inner surface of the arm, a minor procedure performed under local anaesthetic. The release of *levonorgestrel* is maximal in the first month of use, progressively diminishing thereafter. This product would continue to be effective even after five years. The rate of pregnancy in the first three years of use is less than 0.5%, rising to 1.6% in the fourth year. It becomes 3% in the sixth year and 4.3% in the seventh year. The *Population Council* and manufacturers recommend removal of the implant after five years of use.

Are implants in themselves abortifacient?

In Norplant we see the same method of action (abortion by interception) as with other pure-progestogen contraceptives (the minipill and injectable contraceptives). Norplant suppresses ovulation in a highly irregular manner: in the first year of use, 11.1% of cycles are in fact ovulatory and the incidence of these ovulatory cycles increases thereafter, as the release of *levonorgestrel* is progressively reduced until it reaches 45%. It is not therefore the action of inhibiting ovulation which explains the efficacy of Norplant. Little is known of its action on the cervical mucus. However, the effect of Norplant on the uterine endometrium is indubitable; histological disturbance has been observed in almost 90% of cases. After 3-12 months of exposure to Norplant, 50% of women present an endometrium too thin to undergo biopsy.

Norplant therefore acts as an abortifacient, preventing nidation of the embryo. Norplant also produces the same side effects (bleeding) as other non-combined progestogens.

Is Norplant widely used today?

There have been a number of difficulties in the distribution of Norplant, causing its use to be restricted to poor developing countries:

- 6 rods, 34 millimetres in length, must be positioned subcutaneously, a significant procedure which carries risk of infection and local intolerance.
- Norplant leads to significant vaginal bleeding, even actual haemorrhage, causing patient rejection. A significant proportion of users ask for it to be removed in the first two years following the implant, frequently as a result of haemorrhage caused by the progestogen.
- To restore fertility, it is necessary to remove the rods, necessitating surgical intervention. In theory, the implant could be removed within 5 minutes, but the reality is that the procedure takes an average of 20 minutes, and may last an hour if the person performing the procedure is inexperienced. Fertility is also slow to return.
- Due to its androgenic properties, Norplant causes acne and weight gain.
- Further unpleasant side-effects may be manifested, for sample headaches, mood changes, and abdominal pain. These side-effects are reduced in line with the duration of use.

Have improved forms of contraception by implant been developed, as in the case of injections?

A further form of Norplant, Norplant II, has been developed in parallel to improve the release of the active product and hence reduce the number of implants. *Levonorgestrel* is combined with silicone in the proportion of 1/1 and placed in a silicone capsule half as thick as that used in Norplant. Two rods only 4.4 cm long are implanted and are regarded as distributing the same quantity of *levonorgestrel* as Norplant over the same timescale. The failure rate of Norplant II is less than 1%. The implant is intended to be used over three years. The side-effects are the same as those of Norplant. Norplant II is easier to remove than Norplant.

Another implant, *Capronor*, has been developed more recently. It also contains *levonorgestrel*, but the capsule surrounding product is made of poly (*E-caprolactone*), which is biodegradable. Clinical trials on the product have shown that ovulation frequently occurs despite the contraceptive. All cycles are ovulatory in women using Capronor 2.5cm in length. However, the suppression of ovulation is 80% in women using Capronor 4cm long. The advantage of Capronor is that it is easier to remove than Norplant.

Another long-acting contraceptive implant, “*Implanon*”, has been developed by the Dutch firm Organon. It was introduced in Indonesia in 1998 and has recently been introduced on the European market. The product consists of a central core of *ethylene vinylacetate* (EVA), acting as a vehicle for a progestogen, *3-keto-desogestrel*, placed in a casing of EVA, on the model of Norplant 2. Given that *3-keto-desogestrel* is more powerful than *levonorgestrel*, the implant can be reduced to a single rod 4 cm in length and 2 mm in diameter, which maintains a sufficient concentration of active product to prevent pregnancy for at least two years. The insertion and removal of the rod are the same as for Norplant. Clinical trials have shown that the product has the same unpleasant side-effects as Norplant (bleeding), but appears to give rise to less acne and weight-gain because *3-keto-desogestrel* is less androgenic than *levonorgestrel*. It is said to be 100% effective the day after implantation and for three years thereafter. Normal reproductive functions will be restored within a week of removal of the implant.

Is the implant system also used in population control policies?

Norplant has been the focus of a major ethical debate, associated with the way it has been promoted by organisations campaigning for family planning to limit births in poor countries. The fact that Norplant has undergone clinical trials in developing countries only and that the true nature of the product has not always been disclosed to patients in whom the rods have been implanted has given the product a poor image from the outset. The fact that Norplant campaigns have frequently been coercive or involved abuse of trust, always in poor countries, combined with problems associated with implantation of the rods, haemorrhaging in patients and difficulties encountered by women wanting the rods removed, have served to exacerbate the poor image of this product.

And to what extent has it been used in the developed countries?

Hoeschst Marion Roussel, the Norplant distributor in Great Britain, withdrew the product from sale in this country in October 1999, due firstly to a slump in sales in this country, and secondly a recommendation from the *British Medical Association* to gynaecologists not to offer Norplant as a contraceptive. In fact, an initial wave of enthusiasm in this country in response to the official launch of the product has been succeeded by an increasingly vehement tide of criticism, as the number of user complaints has progressively increased. In the US, almost 4,000 legal actions have been instigated by users who have experienced various problems with this contraceptive.

The coil (IUD, intra uterine device) is the contraceptive method most widely used in the developing countries and family planning programmes organized by the WHO. 5% of British women between the ages of 16 and 49 were using a coil in 1999 (Office for National Statistics, 1999). The coil is used by 19% of couples throughout the world and 24% in the underdeveloped countries.

What is the history of the coil?

The idea of using a coil was suggested by the discovery of a phenomenon known since time immemorial: a foreign body placed in the uterus prevents the continuation of a pregnancy. It is said that Arabs and Turks placed pebbles in the uteruses of female camels to prevent them becoming pregnant during long desert crossings.

The first intrauterine device proper was designed in 1909 by a German physician, Richard Richter. It was made from the intestines of the silkworm and shaped like a ring. But the first major attempt at contraception using an intrauterine device was the work of a Berlin doctor, Ernest Gräfenberg. At first he used the intestines of the silkworm, joined together in a star-shape, to make his devices. Because these were too readily expelled, Gräfenberg later developed spiral rings made of silver or an alloy of copper, zinc and nickel. These “Gräfenberg rings” were used extensively in the 1930s. However the rings frequently caused pain and bleeding and were liable to be expelled or perforate the uterus. The main complication was the development of endometritis and salpingitis (inflammation of the Fallopian tubes), severe and recurrent, in numerous patients, followed by a number of fatalities. For this reason, Gräfenberg’s work was condemned by obstetricians and gynaecologists and the medical profession as a whole.

In 1937 the *American Medical Association Committee on Contraceptive Practices* expressed its total opposition to contraception using intrauterine methods. Intrauterine devices were condemned in Europe, but continued to be used in Japan. Development of the coil was halted until 1959, when the first reports testifying to their safety and effectiveness arrived from Israel and Japan and the Population Council in New York embarked on an intensive research programme resulting in the development of the modern coil, relatively well-anchored in the uterine cavity and well-tolerated.

The development of the modern coil owes much to the discovery of plastics, given that intrauterine devices made of these flexible and elastic materials could be folded and introduced through a tube into the uterus, expanding once in the uterus. “*Margulies coils*” (1964) and “*Lippes loops*” (1965) were the first polyethylene coils to be manufactured. In 1969 J.A. Zipper and his colleagues demonstrated that the addition of small quantities of copper to an inert intrauterine device greatly enhanced its contraceptive efficacy.

Can you describe a coil?

A whole range of intrauterine devices, made of plastic or silver, currently exists in various forms. They are inserted non-traumatically through the neck of the womb in the uterine cavity. There are various types on the market, differentiated by their shape and constituent materials. Some are made of plastic alone, in various shapes (T-shaped or crow’s foot); others are metallic (copper or other metals) in the form of a spiral surrounding a plastic frame. T-coils may contain a progestogen substance in their horizontal arm, released slowly into the uterine cavity. The progestogen, copper and other metals reinforce the action of the plastic coil. When the coil is introduced to the uterus, it is deployed in the cavity like an umbrella and anchors itself to the wall, remaining linked to the outside by a thin plastic wire, allowing for its removal two to five years after introduction.

Sometimes the coil fails to prevent the implantation of the embryo and a pregnancy develops: the coil can be removed under ultrasonic control by delicate traction on its “tail”, allowing the pregnancy to continue without risk to the baby. It is prudent under these circumstances to leave the coil in situ and not remove it until after delivery. Unfortunately, in both cases the risk of spontaneous abortion during pregnancy is far higher (around 50 %,.) than under normal conditions (around 12%).

How does the coil work?

- The coil does not prevent fertilization, given that it is criticized for being responsible for ectopic pregnancies.
- The coil acts through a mechanical effect, which is always present. Insertion of the coil triggers a foreign body reaction in the mucus membrane of the uterine cavity. The coil probably gives rise to uterine contractions and irritation of the endometrium, making the uterus unfit for nidation. It can be deduced that the coil prevents nidation of the embryo and hence acts as an abortifacient.
- The coil causes chronic endometritis. The inflammatory reaction in tissues in the area in contact with the coil releases the products of cellular decomposition of white corpuscles and endometrial cells, whose action is prejudicial to spermatozoa and the fertilized egg, which is unable to implant in an endometrium “in disorder”.
- The presence of the coil also causes the release of prostaglandin in the endometrium, increasing the contractile activity in the fallopian tubes and uterine body. This retards the ascent of spermatozoa and prevents implantation of the fertilized egg.
- The presence of copper in some coils has the additional effect of increasing secretion and fluidity in the endometrial mucus membrane. This fluidisation prevents implantation of the blastocyst (an early stage of embryo development), which then tends to wander along the uterine walls without being able to make stable contact. This leads to a reduction in the sensitivity of the endometrial cells to the action of oestrogens. Finally, copper exerts a toxic effect on spermatozoa.
- In coils containing progestogens, the mechanical effect is combined with a hormonal effect. 18 hours after insertion of a coil in the uterus, characteristic changes appear in the

uterine endothelium, accompanied by marked glandular atrophy and superficial decidual reaction, while the deep layers undergo the changes seen in a normal cycle. Superficial endometrial atrophy prevents implantation of the blastocyst. Here again, the abortive action of the intrauterine device is potentiated.

- An embryo unable to implant is expelled in the next menstruation. The woman will not realize she has been pregnant because the expulsion happens so early. A pregnancy test at this stage will be negative because there has been no placental development and hence no formation of Hcg (chorionic gonadotropin hormone, produced during pregnancy).

To sum up, can we say that all the contraceptive methods you have described are potentially abortifacient?

The contraceptives on offer today are becoming increasingly abortifacient, a finding which should provide food for reflection for those in the Church who have defended the use of contraceptives. The new developments in contraception have come not so much from new presentations of hormonal contraceptives (for example the famous “patch” or vaginal ring, currently widely publicized) than from the development of products, presented as contraceptives to legitimate their more or less unrestricted sale in chemists’ shops and avoid alerting public opinion, but which are in reality abortifacient. These are the so-called “emergency” or “post-coital” contraceptives. There is also *mifepristone*, or RU 486, usage of which is currently expanding, which results in an early “medical” abortion.

Turning to so-called “menstrual regulation” by mifepristone, the famous abortion pill RU 486: with this compound, already in wide use in France, the line between contraception and abortion, already blurred in the case of oral contraceptives, disappears altogether. The same chemical body can be used as a “contraceptive” or “abortifacient” to perform an early “medical” abortion. In fact, *mifepristone* always acts as an abortifacient because it is an “antiprogestone”. The product of the most recent research on oral contraception, RU486 provides objective evidence of the link between contraception and abortion. This link, already guessed at when the first pills came onto the market, has been confirmed after 30 years of distribution, promotion and usage of oral contraceptives.

Returning to our original question: has the generalized use of contraception allowed the practice of abortion to decline?

Contraception and abortion are in fact closely linked. They are linked in their biological reality. They are linked in the mentality which presupposes them. Abortion directly refuses and destroys the baby. Contraception also refuses the baby and uses any means at its disposal to counter the arrival of baby. In both cases, the baby is the enemy. He or she becomes the accidental product of genital activity reduced to mere pleasure or irresponsible futility based on a corrupt notion of human sexuality. “Sex” takes priority over the baby. If the baby arrives in spite of the use of contraception, it is no longer, as previously, accepted, but rejected and aborted. This is why it was logical for abortion to be liberalized once contraception had been made generally available, to remedy foreseeable failures of contraception.

The weakness and falsity of the argument “Prevention is better than abortion” have been demonstrated by the facts. Statistics show that the number of abortions has not fallen in proportion to advances in contraception and the corresponding fall in the birth-rate. The persistence of legal or illegal abortion is ascribed to irregular use of the oestroprogestogen pill or adherence to more traditional methods of contraception, fuelling demands for yet more contraception. There have been no qualms in some quarters in ascribing these abortions to those who dared to cast doubt on the benefits of oral contraception. The reality is that, once

contraception has been accepted and practiced, the person using that contraception has a tendency to believe herself protected against pregnancy, and hence to live a life of more intense sexual promiscuity, inevitably resulting, sooner or later, in an unwanted pregnancy.

Far from curbing abortion, contraception may even lead to it. It is always easy to proceed from one to the other.

Is this statement borne out by scientific research?

According to a survey carried out in Sweden, of a sample of 2,621 women in Göteborg, aged 19-24, monitored between 1981 and 1986, 89% of whom had used oral contraception on at least one occasion, 51% of whom had used this type of contraception continuously, and only 26% of whom had not used any contraception, 43% of these women fell pregnant during the period of the survey and 44% of these pregnancies ended in a legal abortion. Hence, in spite of easy access to and the practice of contraception, these women presented a high rate of abortion compared with the birth-rate.

The authors of a survey, carried out in Finland between 1976 and 1993 to verify the efficacy of the use of contraceptives in terms of the reduction in pregnancies and abortions among adolescents, found in this population group a parallel reduction in the number of pregnancies (9519 to 3168), abortions (4143 to 1513) and, to an even greater extent, the birth-rate (5376 to 1655). It was seen that abortions persisted in this population group in spite of the intensive use of contraception; while practicing contraception, these adolescents therefore continued to have recourse to abortion. The authors expressed astonishment at these figures: the abortion rate in fact rose in the late 1980s in all provinces and it was not until the 1990s that it fell again. The authors deduce that the initial effect of the use of contraceptives was to lead consumers to adopt a more negative attitude to preservation of any baby resulting from their sexual relations, hence leading to greater recourse to abortion.

K. Sidenius and N.K. Rasmussen observed that 90% of 110 adolescents admitted for abortion to Herlev Hospital, Copenhagen, Denmark, between 1977 and 1978 had been given information on contraception before their abortion and 60% of these adolescents were practicing a contraceptive method. The majority of these adolescents had their first sexual experience before the age of 15. There was no delay in the issue of information on contraception or the practice of contraception to distinguish this group from other adolescents. These abortions were therefore the outcome of failures of contraception.

The Allan Guttmacher Institute (the scientific arm of the *American Family Planning Federation*) published a survey, carried out in 1994-1995 on 10,000 women admitted for abortions, which showed that 57.5% of these women were using a contraceptive method in the month in which they fell pregnant.

A survey published in 1995 relating to 147 adolescents presenting with an unwanted pregnancy reported that 80% of these adolescents stated that they had used a contraceptive method during the period in which they had conceived. These somewhat surprising results are corroborated by E.S. Williams, who notes a proportionate correlation between the use of a contraceptive in early sexual relations and the incidence of pregnancy among adolescents. Given that this proportionate correlation cannot be solely ascribable to the failure of a contraceptive method, the authors suggest that the practice of contraception leads to increased sexual activity in young people, in turn responsible for this epidemic of pregnancies and abortions.

Let us repeat it: not only are the contraceptives in current use abortifacient, but the regular use of contraceptives does not lead to a reduction in the practice of abortion.

It is said that the use of contraceptive methods in the developed countries has been accompanied by a reduction in the absolute number of abortions. This optimistic statement must be tempered by the observation that, in countries in which oral contraception has been widely used, we have witnessed a rise in the number of abortions, both in absolute terms and in relation to the number of births and that, where there has been a reduction in the number of abortions, that reduction could be expected to have been far higher, having regard to the efficacy of the contraceptives used.

If abortions continue at a disturbing rate in spite of the fall in the birth-rate to a level considerably below the replacement threshold in countries in which contraceptives have been a part of everyday life for almost 30 years, it is because abortion has become commonplace and is used as an extension of contraception. The fact that the majority of abortions carried out in the developed countries are today seen in women who regularly use a method of contraception proves that there is no contradiction, indeed that there is coexistence, even continuity, between the two. There is now recourse to abortion as an “extraordinary” method of contraception when the first “ordinary” method fails. It is the same woman, with the same contraceptive mentality, who will one day practice chemical contraception and the next abortion. In California, 40% of the 300.000 to 500.000 annual abortions are carried out as a result of the failures of contraception.

And in Europe?

Let us take a precise and well-documented example: the French situation with regard to abortion. The number of “intentional terminations of pregnancy” has, over twenty years, fallen only slightly in France from 250.000 a year in 1976 (immediately after the liberalization of abortion) to 220.000 a year in 1994, the bulk of the reduction being observed between 1981 and 1988. Almost 70% of French women between the ages of 18 and 49 use a contraceptive method. In simplified terms, women having recourse to abortion can be divided into two categories: the first category contains women who only opt for abortion as a “last resort” once in their lifetime, whose numbers have effectively fallen as a result of the rigorous practice of contraception; the second category contains women who practice repeated abortions, perceiving abortion as merely “one of several birth control methods”, the numbers of which are responsible for the current plateau in the curve showing the evolution of the number of abortions. In 1976, 8% of women presenting for an abortion had previously had an abortion; in 1991 the figure rose to 24%; between these two figures, the increase was perfectly linear. Mme Blayo, from the French National Institute for Demographic Studies, stated, when questioned on this subject: *“The number of interventions has fallen, but the reduction is slow; this slowness is disturbing to those who believed that the propagation of highly effective medicalised contraceptive methods would rapidly remedy the phenomenon of abortion”*. She goes on to add: *“in a Malthusian society which exerts strong social pressure not to conceive, a pregnancy which is rejected is not necessarily the outcome of unintentional conception... When couples are urged to exercise increasing control over their reproduction, this clearly induces them not to accept failures”*. In plain language, the end result of the emphasis on contraception is increasing refusal of a baby which dares to present itself without having been invited. The contraceptive mentality is not therefore so remote from the abortive mentality.

What are the recent technical developments in contraception?

Current scientific research in the area of female contraception has not led to any great technical advancement; the aim of current research is to increase the intervals between the administration of abortive substances, administering them in injectable form or subcutaneously with the aim of

reducing the “fatigue” of daily consumption by the woman. In seeking to increase the efficacy and reduce the risks of contraceptives, pharmacological research has made contraception increasingly abortifacient; it is sufficient to cite the new forms of low-oestrogen oestrogen pills.

In his Encyclical *Evangelium Vitae*, no. 13, Pope John Paul II tells us: *“In order to facilitate the spread of abortion, enormous sums of money have been invested and continue to be invested in the production of pharmaceutical products which make it possible to kill the foetus in the mother's womb without recourse to medical assistance. On this point, scientific research itself seems to be almost exclusively preoccupied with developing products which are ever more simple and effective in suppressing life and which at the same time are capable of removing abortion from any kind of control or social responsibility.”*

In contrast, research in the area of male contraception is the exception and recent progress in this area already calls for ethical analytical study, even if the cultural and social implications of male contraception differ from those of female contraception. The focus in this area seems to be more on the study of physiological mechanisms (due to the possibility of “contraception” with a biochemical or bio-immunological basis) than on natural fertility, given that recourse to artificial insemination appears to have weakened physiopathological research.

As regards post-coital contraception, if its effectiveness in preventing the development of a pregnancy after sexual relations, presumed to be fertilizing, derives from the fact that it prevents implantation of the embryo, and hence has an abortive effect, should the various methods used in this context therefore be regarded as abortifacient?

Emergency or “post-coital” contraception can act in one of two ways to prevent the development of a pregnancy following potentially fertilizing sexual relations: it may have a simple contraceptive effect if ovulation has not already taken place and there are still living spermatozoa in the female genital tracts; but this simple contraceptive effect does not account for the efficacy of this product. It therefore has to be acknowledged that the product also acts by preventing uterine nidation of the pre-formed embryo, when ovulation has already taken place.

An embryo eliminated by post-coital contraception is an individual human being, who must be treated as a person. It is necessary to repeat at this point what biology has taught us for many years and which embryology, and in particular modern genetics, have only served to confirm: from the stage of the zygote, the human embryo presents all the characteristics of a new individual human being, developing its own properties in a wholly autonomous manner. At the moment of fertilization, that is penetration of the ovum by the “winning spermatozoa”, a new biological entity, the *zygote*, is formed. It is at this precise moment that the adventure of a new human life begins, as rightly emphasized in the Declaration on Procured Abortion issued by the Congregation for the Doctrine of the Faith on 25 November 1974: *“From the time that the ovum is fertilized, a life is begun which is neither that of the father nor of the mother, it is rather the life of a new human being with his own growth. It would never be made human if it were not human already...”*

This new programme, achieved by the union of gametes, is not an inert material: it is a new project, which constitutes itself by itself and which is the author and actor of itself. This is qualified by the term “*individuation*” (a new being created by the fusion of gametes), and “*autonomy*” (its development is by no means conditioned by extrinsic factors; it has in itself the key to its own development).

This shows that the embryo is already a human being.

If a human embryo, before its implantation into the uterus, presents itself, in biological terms, as animated by an individual human life, organized as an organism endowed with the capacities of autonomy, self-direction, self-repair and homeostasis, this human embryo cannot be judged other than as a human individual, a man. This was the message conveyed in ancient Christian times and there is little today to add to what has been said by “our fathers in the faith” in the light of human reason. This message condemns abortion in these terms: “*To prevent birth is anticipated murder; it makes little difference whether one destroys a life already born or does away with it in its nascent stage. The one who will be a man is already one; the fruit is already in the germ*” (*Homo est et qui est futurus; etiam fructus omnis iam in semine est*) (Tertullien, *Apologeticum*, vol. 1, IX, 8)

It is at the moment of fertilization that this new human being has begun his/her individual life, embarking on a vital cycle which will lead him/her to become a foetus, a new-born, a child and adult until the moment of natural death: “*To this perpetual evidence ... modern genetic science brings valuable confirmation. It has demonstrated that, from the first instant, there is established the program of what this living being will be: a man, this individual man with his distinguishing aspects already well-determined. From the moment of fertilization, the adventure of a human life has begun, each of whose major capacities takes time to find its place and to be in a position to act.*” (Congregation for the Doctrine of the Faith, *Declaration on Procured Abortion*, no. 13, AAS 66 (1974) 738.)

This is why the human embryo, from the moment of fertilization and formation of the zygote, and before its implantation into the uterus, deserves the full respect accorded to the embryo in general, and more specifically the embryo after implantation. As reason dictates and the Church forcefully underlines: “*From the moment of conception, the life of every human being is to be respected in an absolute way because man is the only creature on earth that God has “wished for himself” and the spiritual soul of each man is “immediately created” by God; his whole being bears the image of the Creator. Human life is sacred because from its beginning it involves “the creative action of God” ... God alone is the Lord of life from its beginning until its end: no one can, in any circumstance, claim for himself the right to destroy directly an innocent human being*”. (*Donum Vitae*, Introduction, 5).

Because that which will be the adult is already included in the foetus, ready to express itself objectively when the programme-project of the foetus gives it this instruction, it is reason which prompts the conclusion that the embryo in general, and therefore the pre-implantation embryo, has the value of a human person. This is why the respect due to the pre-implantation embryo means treating it as a human person, acknowledging in it the rights of the person, and primarily the right to life: “*Thus the fruit of human generation, from the first moment of its existence, that is to say from the moment the zygote has formed, demands the unconditional respect that is morally due to the human being in his bodily and spiritual totality. The human being is to be respected and treated as a person from the moment of conception; and therefore from that same moment his rights as a person must be recognized, among which in the first place is the inviolable right of every innocent human being to life.*” (*Donum Vitae*, I,1).

Does this mean that any contraception which prevents implantation of the embryo is unacceptable from a moral standpoint?

Prevention of the implantation of the embryo in its earliest days and the fact of emergency contraception are tantamount to intentionally giving rise to the elimination of that embryo, and hence its abortion. There is no place here for mitigating casuistry, or the “double effect”

argument, because emergency contraception has a single purpose only: not to allow a pregnancy already begun to develop. It is clear that, in post-coital contraception, the intention and the act itself (that is, the taking of the pill) are abortifacient.

What is the Church's position on this matter?

Post-coital contraception is a grave act, condemned with the same force with which any form of abortion is condemned. Emergency contraception must therefore suffer the same negative judgement applied to any other form of abortion: it is an “abominable” crime, in the terms of the second Vatican Council (“God, the Lord of life, has entrusted to men the noble mission of safeguarding life, and men must carry it out in a manner worthy of themselves. Life must be protected with the utmost care from the moment of conception: abortion and infanticide are abominable crimes.”). The Holy Father solemnly condemned abortion in his Encyclical *Evangelium vitae* (24 March 1995) as a “grave moral disorder”. We can add that this was the strongest pontifical declaration, pronounced with the highest possible degree of authority: this condemnation also applies to post-coital contraception: “... *in accordance with the Magisterium of my predecessors and in communion with the Bishops of the Catholic Church- I declare that euthanasia is a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person. This doctrine is based upon the natural law and upon the written word of God, is transmitted by the Church's tradition and taught by the ordinary and universal Magisterium*” (EV no. 62).

The elimination of the embryo before implantation, in the form of intentional abortion, is therefore a crime against the person, in actual fact a homicide. It is not the degree of development of the embryo which determines this judgement, but the fact of intentionally terminating a human life – otherwise one could also justify infanticide because the newborn has not yet completed its intellectual development. The degree of development achieved by an embryo at a given moment can have no influence on the objective negativity of the ethical judgement pronounced on its elimination. It is not because an embryo finds itself at the stage of four or eight cells or a blastocyst that it is “worth” less than a morphologically “complete” embryo, in the third month of pregnancy, for example. In anthropological, philosophical, moral and theological terms, the value of the human being is the same, irrespective of the phase of the vital cycle at which it finds itself, and there are two reasons for this:

- in biological terms, given that the development of the embryo is programmed, continuous and intrinsically autonomous, there is no substantial difference, merely a difference in terms of development between the zygote, created as the immediate result of conception, and the newborn baby.
- in philosophical and axiological terms, the whole value of the human person as an individual is ontologically present in the embryo from the moment of conception. The fact that the manifestation of the ontological and existential reality takes place gradually and continuously throughout the lifetime of the individual does not make it permissible to believe that the “after” is not rooted and caused in the “already”; between the “already” realized and the “not yet” developed, there is the entire span of gestation and life, but there is no qualitative, or indeed ontological, leap between the two: it is the same existential act which underlies development, and it is the same “I” which is truly present and which acts, even when there is as yet no auto- conscience or social recognition.

Even if there were any subjective doubt concerning the link between the fertilized egg and the personal being deriving from that egg, conscience is obliged to refrain from any attack on the human embryo, in the same way as one should refrain from firing a gun into a bush if one

believes, even without certainty, that there may be a person in the bush, rather than a hunting prey.

What arguments are used to justify the use of the post-coital pill?

To justify the use of “post-coital contraception” in moral terms, some doctors invoke the absence of direct scientific knowledge of its mechanism of action. There is no evidence, they say, of the prevention of implantation of the embryo for which emergency contraception techniques are criticized. What is certain, they continue, is that these methods have a “contraceptive” effect when used before sexual relations. Considering that the pregnancy prevention effect of these compounds is very brief, is not absolute, and occurs only within 48 hours after sexual relations, why not, they say, allow that it is the contraceptive action which is operative in the prevention of pregnancy? It is known in effect that fertilization is not an immediate phenomenon, that it may occur several hours after sexual relations, either because of the rupture of a follicle during or immediately after relations or because of residual spermatozoa which later pass through the neck of the womb and reach the ovocyte in the hours following sexual relations.

These doctors add that, if post-coital contraception techniques are not abortive, but purely contraceptive, and even if doubt remains in this regard, it would surely be uncharitable and unreasonable to deprive people of this assistance. When one thinks of the economic and human costs of an unwanted pregnancy in an adolescent still at school and entirely financially dependent on his parents, use of the “morning-after pill” does not seem disproportionate. What would be disproportionate, continue these doctors, would be not to use this pill, at the risk of having to manage a pregnancy in an adolescent incapable of looking after a baby once it is born, or the more probable risk of driving the adolescent to the solution of surgical abortion, legal or otherwise, perhaps at the cost of her health, if not her life.

How can these statements be answered?

No survey carried out to date has been able to provide objective evidence of the purely contraceptive action of the “morning-after pill”, whereas a number of different surveys have demonstrated a link between the ingestion of emergency contraception and the consecutive appearance of symptoms of hormonal imbalance and disorders in the uterine endometrium, predictive of an incapacity in the endometrium to be receptive to an embryo. If there is any room for uncertainty as regards the exact action of emergency contraception methods, this doubt veers towards an abortive action through the prevention of implantation. If this is the case, the rule in the area of morality demands that one refrains from using this pill, because what is at stake is not a simple economic problem or the difficulties associated with the occurrence of pregnancy in an teenager: what is at stake is the value of a human life, which surpasses any other value.

In addition, we are not here confronted with a case of confused conscience, because there can be no doubt as to the value of the planned action, as claimed by some advocates of the “morning-after pill”. As stated above, a woman requesting emergency contraception does so because she has had, possibly fertilizing, sexual relations and does not want the potential pregnancy to develop. Her intention is not, at that moment, contraceptive, as implied by the advocates of post-coital contraception: her intention is abortive. A doctor who prescribes the “morning-after pill” to such a person is not prescribing the pill as a “contraceptive” (to prevent fertilization), but as an abortifacient (to prevent the development of a possible pregnancy). It is true that a woman who takes “emergency contraception” may do so in the absence of an incipient pregnancy, but this possibility does not alter the moral quality of recourse to this practice.

Are women who resort to “emergency contraception” fully aware of the gravity of their act?

The lack of appreciation of the gravity of this act, decided and realized in this way, is primarily attributable to the misleading presentation of “post-coital contraception” offered to public opinion in the media and also in the medical world. To justify recourse to “emergency contraception”, it is in fact maintained that, not only does it have no abortive mechanism, but actually makes it possible to reduce the number of abortions. Such an affirmation has been facilitated by a redefinition of the key terms of reproduction, in the wake of artificial insemination techniques and the resolution of the legal problems thereby posed. The term “pre-embryo” has thus been increasingly propagated in the language of centres “of reproduction”: conception, and hence the beginning of pregnancy, has been dissociated from fertilization, associating these terms with implantation of the embryo in the uterus. A judgement is therefore being made that the prevention of implantation of the embryo is not an abortion, but still part of contraception.

The attempt to define as a “pre-embryo” an embryo in the stages preceding implantation, thereby relegating it as something undifferentiated, runs counter to the objective truth of the individuality and autonomy of the pre-implantation embryo, demonstrated in genetics.

What can we do in the face of this semantic manipulation, whose consequences are so serious for the person?

It is clearly the duty of physicians, moralists, confessors and educators to enlighten the opinion of the faithful and the public in general, denouncing the semantic dupery which has led to acceptance of the “morning-after pill” in national parliaments. This dupery has unfortunately frequently neutralized the reactions of those with a responsibility for legislative and moral direction in our society. While there is a duty to underline the moral gravity of the act of post-coital “contraception”, confessors are confronted with the problem of enlightening consciences in this regard, taking account of the intractable ignorance which may be encountered in this regard in some penitents.

A further argument often advanced is that of rape: could this be regarded as a specific indication for “emergency contraception”?

It is often claimed that, in view of the sad circumstances under which a pregnancy may arise in rape cases, post-coital contraception would be an ideal method of preventing a pregnancy which is not only unwanted, but will be experienced as the material and organic prolongation of the evil of rape, for the woman who has been the victim of the attack and those close to her, if a foetus develops as a result of that attack. This is why there are many who would hesitate routinely to recommend the use of post-coital contraception, but who approve of it when the person in question is a rape victim.

It is clear that, if employed within 48 hours following a rape and successful in preventing a possible pregnancy, post-coital contraception offers a considerable objective and material benefit to the patient, the attending doctor and society as a whole: this “contraception” in effect eliminates the problem of the development of a pregnancy under such conditions, with the implied obligation of either acceding to a request for abortion from the victim or finding a solution for the child, once born, if the victim has agreed to keep it.

However, even in the painful “borderline” case of rape, the possibility of choice does not truly exist in moral terms because human life has a fundamental value, which surpasses any other value and any baby who develops as a consequence of rape is innocent. To use emergency contraception under these circumstances is to seek to eliminate this possible child at the start of his or her life, adding a further evil to the evil of rape already perpetrated.

A rape victim has to take a decision, as soon as possible, concerning the possible use of post-coital contraception. Persons who have a responsibility for welcoming, comforting, monitoring and helping victims of sexual violence and spiritual pastors who find themselves (for example in refugee camps) in contact with such victims, cannot make that decision in their stead. But they must help the victim make that decision in a way that will be as mature and responsible as possible. They must not conceal the truth of the value of the child from the conscience of the person they are assisting and neither must they minimize or silence the potentially abortive effect of the morning after pill. It is however always necessary to present the truth, the moral duty (to keep the child where there is a pregnancy) in conjunction with an offer of concrete help and support, irrespective of the decision taken by the victim.

The multiple arguments employed by international organisations to expand the use of contraception in the developing countries include that of poverty: population growth is said to be one of the causes of poverty in the South and population stabilization is said to be a factor in the enrichment of the North. What is your response to this argument?

The reduction in the birth-rate triggered by the regular use of contraception would, in effect, appear initially to facilitate the economic expansion of the country by cutting public and private expenditure on education. This would prevent the arrival in the world of human individuals who would be “useless mouths” as long as they were not put to work. By the same token, one would for a time solve the problem of youth employment, given that there would be less young people. The short-term perspective of such arguments is evident. The wealth of countries in the North does not come from their low birth-rate, but from their streamlined economic system, well-established industries, the benefit of expertise on tap in the population and the ability of those countries to call upon foreign manpower to fill the gap caused by the low birth-rate. Without wishing to spread doom and gloom, ageing populations will sooner or later pose a threat to this well-being and the lack of a youthful population will deprive these countries of their dynamism, unless they rely increasingly on immigration to meet the needs of industrial production in a country lacking in manpower, a policy which poses a risk to social peace. Conversely, the attribution of poverty in certain countries to a birth-rate regarded as excessive and the belief that, by reducing that birth-rate, one will promote the economic expansion of the country, is a naïve assumption: it is not children who damage economic expansion, but the lack of an industrial infrastructure, the lack of skilled manpower, the lack of an education system providing the expert training of which industry stands in need, political instability and wars. Rather than receiving contraceptives, these countries need trainers and educators to transform a body, apparently excessive, of children, into the human capital without which long-term development is inconceivable.

What can we conclude from all this?

In conclusion, the overview we have provided regarding the contraceptives available today and their abortifacient properties prompts the following observations:

- 1) Far from reducing the number of abortions, contraception to some extent finds in abortion a natural unfolding. Given that the contraceptive mentality is in fact close to the abortive mentality, large-scale use of contraception in the developed nations has contributed to the routine use of abortion.
- 2) Scientific research today is oriented towards the development of increasingly “effective” contraceptive techniques to prevent conception and the continuation of pregnancy, with increasingly less risk to the woman, resulting in increasingly abortifacient contraception. This is a further demonstration of the close link, not only cultural but also scientific, between the use of contraception and the demand for abortion.

- 3) To avoid uttering the word “abortion”, people talk about the pharmacological “prevention” of implantation, “interception” or “contragestion”. It is also asserted that the embryo is not an embryo as long as it is not implanted in the lining of the uterus, but simply a “pre-embryo”, a mass of cells which does not call for any particular respect. However, a play on words cannot change the reality of the facts.
- 4) Those tempted to take the easy path of post-coital contraception in the form of oral hormones frequently do so for reasons of personal convenience, refusing a child no longer regarded as a gift, but as a nuisance, an obstacle to personal happiness, as damaging. These persons must be helped to become aware of the distortion of their conscience and hence their moral life, to which they are agreeing.
- 5) It is necessary for persons who consider themselves entitled to have recourse to contraception for medical, psychological, social or economic reasons justifiable before a third party and before God, to do so with full knowledge of the facts, that is in the knowledge that they will be destroying an embryo at one moment or another in their contraceptive life. Their action will be objectively the same as an abortion termed “surgical”, with the difference that they will not realize this and will not see the results of their abortion. No “right to ignorance” exists in this area. By the same token, pastors, theologians and spiritual advisers who, verbally or in writing, endorse the use of contraception, must know that, in so doing, they are endorsing all the abortions thereby caused and to be caused, which will amount to millions of individuals.
- 6) Today there is nothing heroic, exceptional or disingenuous in resorting, within the framework of responsible parenthood, to “natural” methods of controlling female fertility, whose scientific basis, efficacy and benefits to couples in terms of deeper conjugal communion, are known. This is why it is necessary for a husband and wife to exercise their responsibility in this area by acquiring training in these methods. Persons advising these couples – doctors, social workers, priests, and male and female religious – should consider it their moral duty to promote and facilitate access to these natural methods .

This reflection on the increasingly definite links which currently exist between the practice of contraception and abortion can only, in conclusion, lead us back to the words of the Holy Father on this subject in paragraph 13 of the Encyclical *Evangelium Vitae*: “*Certainly, from the moral point of view, contraception and abortion are specifically different evils: the former contradicts the full truth of the sexual act as the proper expression of conjugal love, while the latter destroys the life of a human being; the former is opposed to the virtue of chastity in marriage, the latter is opposed to the virtue of justice and directly violates the divine commandment "You shall not kill". But despite their differences of nature and moral gravity, contraception and abortion are often closely connected, as fruits of the same tree*”.

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 Contact:admin@dialoguedynamics.com
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