

## International Trends Reveal Increased Use of Abortion-Inducing Contraceptives

by Arland K. Nichols (Originally published on ZENIT.org, January 19, 2012)

Recent controversies in the United States surrounding the “morning after pill” point to international trends making such potentially abortifacient drugs increasingly accessible to men and women of all ages. While the Catholic Church’s consistent teaching about the intrinsic evil of contraception (cf *Humanae vitae*) seems to be increasingly validated by the sciences as a destructive social and physical phenomenon in society, many still have the mistaken impression that it is to be avoided only for “religious” reasons. In fact, what we are seeing is widespread acceptance of drugs that not only prevent pregnancy, but actually cause abortions, making their labeling as “contraceptives” somewhat misleading.

In the late 1990’s the Rockefeller Foundation formed the International Consortium for Emergency Contraception (ICEC), whose charter was to spread the use of “emergency contraception” throughout the world.<sup>1</sup> Among the original member organizations are International Planned Parenthood Federation, Population Council, and Population Services International, and their initial campaign targeted nations long in the crosshairs of “population control” organizations: Sri Lanka, Kenya, Mexico, and Indonesia.

The campaign has been “successful” as emergency contraception is now available in over 140 countries today.<sup>2</sup> It is available from a pharmacist (which allows for consultation with the patient) without a prescription in 58 nations and enjoys full “over the counter” status in six nations - India, Norway, Netherlands, Sweden, most provinces in Canada,

and for women as young as 17 in the United States. The widespread and growing acceptance of emergency contraception is a troubling trend for Catholics that deserves our attention, so in order that our concern may be properly informed, let’s briefly make some distinctions among the drugs in question.

The primary emergency contraception promoted all these years by the ICEC is the synthetic hormone levonorgestrel, which is marketed under numerous names: in English speaking countries these include Plan B, Next Choice, Levonelle and Pregnon. Levonorgestrel is approved for use up to 72 hours after sexual intercourse, but is commonly used up to five days later to prevent pregnancy. Studies indicate that levonorgestrel does not kill an embryonic human being who has already implanted in the uterus; nonetheless, it may still act as an abortifacient.

Levonorgestrel is often confused with what is popularly known as “the abortion pill” or “RU-486.” RU-486 is the synthetic steroid, Mifepristone. Mifepristone (marketed as Mifeprex in the United States) is FDA approved to chemically abort a child who has reached seven weeks of age in the womb. Mifepristone terminates established pregnancies.

Another “emergency contraceptive” was added to the market when the European Medicines Agency approved ulipristal acetate in 2009, while the Federal Drug Administration (FDA) approved its use for the United States in 2010. It is marketed as Ellaone and Ella, respectively, and is available in thirty countries. Its method of action is summarized well by the European

Medicines Agency: “Ulipristal acetate prevents progesterone from occupying its receptor...progesterone is blocked, and the proteins necessary to begin and maintain pregnancy are not synthesized.”<sup>3</sup> That is, it can prevent a newly conceived child from implanting, *and* can disrupt the child that has already implanted, killing him.

Because levonorgestrel is the most common emergency contraceptive, here we will focus on two common and flawed claims that have led to its acceptance in the international community. The first claim is that science has proven that levonorgestrel never causes an early abortion, so women may take it without fear of ending the life of their child.

Levonorgestrel primarily functions so as to prevent a woman from ovulating. As has been noted, it does not kill a child that has already implanted. Many studies indicate that Plan B may also have a secondary method of action if a woman ovulates even though she took levonorgestrel.<sup>4</sup> If fertilization occurs (bringing a new human being into existence) following a “breakthrough ovulation” the drug may prevent this embryonic human being from implanting on his mother’s uterus. Patrick Yeung Jr. and his coauthors explain that levonorgestrel “interferes with the normal development and function of the corpus luteum; a dysfunctional corpus luteum then leads to an impaired endometrium [wall of the uterus] that interferes with embryonic implantation.”<sup>5</sup> They argue that “no evidence exists to contradict this interceptive effect” and suggest that “levonorgestrel is estimated to act as an abortifacient 3-13% of the time” when taken immediately prior to ovulation.

This abortion-inducing effect is acknowledged by the FDA which states that levonorgestrel “is believed to act as an emergency contraceptive principally by preventing ovulation or fertilization . . . In addition, it may inhibit implantation (by altering the endometrium).”<sup>6</sup>

The Catholic Church, noting that levonorgestrel may at times act as an abortifacient by preventing the child conceived from implanting in his mother’s womb, says in *Dignitas personae* that use of such a drug when it prevents implantation “fall[s] within the *sin of abortion* and [is] gravely immoral” (n. 23).

The second claim that is often used to gain public acceptance of Plan B is that easy access to it will reduce unintended pregnancies and, thus, abortions. For example, Doctor Andre Lalonde of Canada’s Society of Obstetricians and Gynaecologists has stated “[b]etter access and greater knowledge and use of emergency contraception could significantly reduce the incidence of unintended pregnancy in Canada.”<sup>7</sup> This claim was echoed by the Institute of Medicine’s (IOM) recent recommendation that led the United States Department of Health and Human Services to require all insurance plans to cover levonorgestrel free of charge. The IOM stated “that greater use of contraception within the population produces lower unintended pregnancy and abortion rates nationally.”<sup>8</sup> Such assertions are specious, as numerous studies show that greater access to emergency contraception reduces neither unintended pregnancies nor abortion.

A 2010 study of eleven randomized control trials by Chelsea Polis of the Johns Hopkins Bloomberg School of Public Health concluded: “Our review suggests that strategies for advance provision of emergency contraception which have been tested to date do not appear to reduce unintended pregnancy at the population level.”<sup>9</sup> Further, a 2007 study published in *Obstetrics and Gynecology* arrived

at the same conclusion: “increased access to emergency contraceptive pills enhances use but has not been shown to reduce unintended pregnancy rates.”<sup>10</sup> And a November 2006 study in the same journal concluded that increased access to emergency contraception “did not show benefit in decreasing pregnancy rates.”<sup>11</sup> Similarly, levonorgestrel does not reduce rates of abortion, as indicated in a 2004 study published in *Contraception*.<sup>12</sup> In spite of free provision of emergency contraception to 18,000 women, “no impact on abortion rates was measurable. While advanced provision of EC probably prevents some pregnancies for some women some of the time, the strategy did not produce the public health breakthrough hoped for.”

All told, the studies reveal that, contrary to the many “professional and editorial opinions and projections” that emergency contraception reduces unintended pregnancies and abortion, I am unaware of a single population-based study indicating that it is actually effective in doing so.

Yet the international trend toward greater and easier access to levonorgestrel continues, and over time, drugs that are more likely to cause the death of the embryonic human beings (such as “Ella” and “EllaOne”) are likely to replace levonorgestrel. While this article has not focused on the immoral use of contraception within marriage, it has identified the pervasive and life-threatening results of the contraceptive mentality in society. We cannot ignore these troubling trends which are clear manifestations of the culture of death. Our knowledge and principle-based action can stem the tide as seen in Honduras which, in 2009, banned the sale of emergency contraception.

Massive and influential organizations with deep pockets are actively promoting abortion-inducing contraceptives throughout the international community, misleading many who would oppose their use if they were aware of their potential abortifacient effects and

non-effectiveness in reducing abortion rates. To date, such organizations have faced little effective opposition. One way for the Catholic pro life community to stem the tide is to shed light upon the false claims made about emergency contraception. Against those who claim that “science” requires the adoption of ever more life-changing and life-ending medications, we must be ready to reply with the scientific facts that show their claims for what they really are – anti-life.

(Endnotes)

- 1 <http://www.cecinfo.org/>
- 2 <http://ec.princeton.edu/questions/dedicated.html>
- 3 [http://www.ema.europa.eu/docs/en\\_GB/document\\_library/EPAR\\_-\\_Product\\_Information/human/001027/WC500023670.pdf](http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Product_Information/human/001027/WC500023670.pdf)
- 4 The author notes that there are some, including within the Catholic scholarly community, who suggest that an abortifacient effect is extremely unlikely. Perhaps most notable is Rev. Nicanor Pier Giorgio Austriaco, O.P. See “Is Plan B an Abortifacient?,” *National Catholic Bioethics Quarterly*, (V7 N4), 703-707.
- 5 Yeung et al., “Argument Against the Use of Levonorgestrel in Cases of Sexual Assault,” *Catholic Health Care Ethics: A Manual for Practitioners*, Ed. Edward J. Furton, (Philadelphia: 2009), 144.
- 6 [http://www.accessdata.fda.gov/drugsatfda\\_docs/label/2009/021998lbl.pdf](http://www.accessdata.fda.gov/drugsatfda_docs/label/2009/021998lbl.pdf)
- 7 <http://www.cwhn.ca/resources/cwhn/ec.html>
- 8 <http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx>
- 9 <http://www.medicalnewstoday.com/releases/182584.php>
- 10 [http://journals.lww.com/greenjournal/Abstract/2007/01000/Population\\_Effect\\_of\\_Increased\\_Access\\_to\\_Emergency.25.aspx](http://journals.lww.com/greenjournal/Abstract/2007/01000/Population_Effect_of_Increased_Access_to_Emergency.25.aspx)
- 11 [http://journals.lww.com/greenjournal/Fulltext/2006/11000/Impact\\_of\\_Increased\\_Access\\_to\\_Emergency.9.aspx](http://journals.lww.com/greenjournal/Fulltext/2006/11000/Impact_of_Increased_Access_to_Emergency.9.aspx)
- 12 <http://www.cwfa.org/images/content/scotland0905.pdf>

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