

PUBLIC HEALTH AND CONTRACEPTION

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AUTHOR: MARGARET B. BROWN, Ph.D.

**REVIEWING COMMITTEE: PAUL KURTZ, Ph.D., STUART D. JORDAN,
Ph.D., DAVID KOEPESELL, J.D. Ph.D., RONALD A. LINDSAY, J.D., Ph.D.,
TONI VAN PELT**

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The Current Status of Contraception

Medical advances in contraception technology have been readily embraced, even by many adherents of religious faiths which prohibit their use. Some contraceptive method is used by almost nine of every 10 females in the U.S. at risk for unintended pregnancy; i.e., females who are sexually active, are not pregnant, and do not wish to be pregnant (Mosher et al., 2004).

The introduction of oral contraceptives in the early 60s, with an effectiveness rate of 99% with perfect use and 93% with typical use (improper or inconsistent use), was a major factor in enabling women to pursue higher levels of education and employment, attain economic independence, and enjoy sexual expression without the risk of an unwanted pregnancy. While there are some health risks from oral contraceptives, women have greater control over when and how often they face the greater risks of pregnancy (Trussel & Jordan, 2006).

Reliable birth control has helped couples plan both the size and spacing of their families and has contributed to slowing the population growth rate. The ability to control fertility affords individuals and couples greater economic opportunities and has the potential to enhance emotional and relational well-being by enabling couples to respond to normal sexual feelings without the consequence of an unwanted pregnancy.

After a period of virtually no innovation in contraceptives, pharmaceutical companies began in the late 1990s to introduce, and are continuing to develop, “long-term reversible and highly effective contraceptive products that move beyond the traditional oral contraceptives” (Sitruk-Ware, 2006, pg. 216-217). Recently introduced

products include new implants, medicated IUDs, vaginal rings, transdermal patches and several new combined oral contraceptives (COCs) (Johansson, 2000). Continuing research may lead to products which will both prevent pregnancy and protect against health problems such as sexually transmitted infections (STIs), particularly HIV, and reproductive cancers (Sitruk-Ware, 2006).

“When interviewed, women request affordable methods that are highly effective, reversible, easy to use and under their own control,” and men want simplicity and reversibility. Although research on male contraceptives continues, condoms and vasectomy are the only currently available methods (Sitruk-Ware, 2006, pg. 217).

Family Planning Is a Public Health Issue

In 2001, 49% of the 6.4 million pregnancies in the U. S. were unintended. Of those 3.1 million unintended pregnancies, 1.3 million ended in abortion. Fifty-four percent of women who had an abortion and 40% of women who had an unplanned birth had used contraception during the month in which an unintended pregnancy occurred (Finer & Henshaw, 2006). Contraceptive method effectiveness is measured both by perfect use and by typical use; i.e., improper or inconsistent use. The latter appears to play a significant role in unintended pregnancies.

Between the early 80s and the-mid 90s, publicly funded contraceptive care provided through Title X of the Public Health Services Act (42 U.S.C. §§ 300 et seq.) helped poor women attain contraceptive utilization rates close to those of more affluent women. However, the disparity in contraceptive use – and unintended pregnancy rate-- has increased for poor women since the mid-90s.

Between 1994 and 2001, the overall rate of unintended pregnancy did not change; but as the rate declined by 20% among women with incomes >200% of poverty and among adolescents, it increased by 29% among poor and less educated women (Finer & Henshaw, 2006). During this same period, many states cut funding for family planning and federal support declined when adjusted for inflation (Finer & Henshaw, 2006). Poor women are only half as likely to have health insurance as women overall (Gold & Sonfield, 2005).

Four states – Alabama, California, New York, and South Carolina—have improved access to health care and contraceptive services for low-income and poor women. Forrest & Samara (1996) calculated that for every \$1 invested in publicly funded family planning services, there was a \$3 saving in Medicaid costs for pregnancy-related and newborn care.

Data analyzed by the Guttmacher Institute, with support from the U. S. Department of Health and Human Services, underscore the increasing need for more – not less -- public funding for contraception supplies and services for poor women and adolescents (Guttmacher Institute, 2006, pg. 5).

- In 2004 there were 66.3 million women of reproductive age in the U.S.; of those, 34.4 million were in need of contraception because they were sexually active but did not want to become pregnant. About half of those women (17.4 million) needed publicly funded contraceptive services and supplies. Women needing publicly funded contraception either have incomes below 250% of poverty or are younger than 20 years of age.

- Since 2000, the number of women needing publicly funded contraceptive services has increased by one million, a 6% increase.
- Within that group, the number of poor adult women (incomes under 100% of poverty) increased by 15%, the number of low-income women (200-249% of poverty) increased by 3%, and the number of higher income women (at or above 250% of poverty) decreased by 3% between 2000 and 2004.
- The total number of women of reproductive age (66.3 million in 2004) and the total number of women needing contraceptive services increased by only 1% each – thus economic conditions, rather than population increase, was responsible for the increasing need for publicly funded contraception.

The Consequences of Unintended Pregnancies

About one-half of unintended pregnancies end in abortion (Henshaw, 1998). Of those that do not, some are accepted and do not place the child in jeopardy. For the remainder, there is a significant correlation with negative outcomes for the child and parent, beginning prenatally with smoking, drinking and poor health care, and after birth with an increased risk of abuse and neglect (Brown & Eisenberg, 1995).

Unintended pregnancies are disproportionately experienced by poor women, but even wanted children born into poverty face significant developmental risks. Poverty may interfere with cognitive and social development in children by reducing parental responsiveness, warmth, and supervision and by increasing maternal distress, inconsistent discipline practices and use of harsh punishments (Hanson, McLanahan, & Thomson, 1997; Forehand & Kotchick, 1996; Linver, Brooks-Gunn & Kohen, 2002). Recent research has shown that the negative experiences of growing up in poverty are likely to

have a far greater effect on academic achievement than a child's genetic endowment (Turkheimer et al., 2003).

While the rate of teen pregnancy has declined to its lowest level in 30 years, greater access to reproductive health services for adolescents and increased opportunities for youth development should be primary societal goals. Whether childbirth is planned or not, adolescent parents experience high levels of stress, which negatively impact mother-child interactions and subsequently hinder children's emotional and cognitive development (O'Callaghan et al., 1999). Similarities in developmental delays between children of adolescent parents and children who are known to be abused and/or neglected have been noted (Borkowski et al., (2002). Even when race, income, age of child, number of children, and maternal education are controlled, the age of the mother at the birth of her first child is predictive of child maltreatment (Connelly & Strauss, 1992).

The need for continuing research in contraceptive technology and public support for family planning is clear. Yet, there is a movement afoot to retreat from these advances and return to theological control of sexuality.¹

The “Contra-Contraception” Movement

Emboldened by success in imposing legislative and judicial restraints on access to legal and safe abortion, some conservative fundamentalists have quietly declared their intention to restrict the availability of contraception. Labeled “contra-contraception” in a *New York Times Magazine* article (Shorto, 2006), the movement is based primarily on

¹ We recognize that some oppose contraception on grounds other than religious ones. However, the focus of our paper will be on religiously-inspired concerns because the movement to limit contraception is almost entirely driven by religious objections. Note that we will not address the issue of abortion, as that issue lies outside the scope of this paper.

religiously-inspired concerns that access to contraception of any form promotes promiscuity and free sexual expression outside marriage. But among the more radical conservative Christians, contraception used by married couples is also regarded as an unacceptable separation of sex from procreation.

Efforts to impose this kind of thinking on society are neither new nor far in the past. It was only 41 years ago, in 1965, that the Supreme Court ruled in *Griswold v. Connecticut*, 381 U.S. 479, that the right to privacy within marriage freed married couples of prohibitions against obtaining counseling and medical treatment for the purpose of avoiding conception. Twenty-eight states had similar statutes.

While conservatives rail against government in our lives, some appear quite avid about having government in our bedrooms. Because a direct approach would likely set off a backlash, piece-by-piece efforts are being employed, reminiscent of the slow but steady progress in reducing access to abortion.

One approach is to make false claims about high rates of failure of condoms in preventing both pregnancy and STIs. This has been particularly blatant in abstinence-only education, in which contraception is discussed only in the context of failure. In Africa, where the AIDS rate is tragically high, the Bush Administration has channeled funds to abstinence instead of promoting condoms. However, the AIDS epidemic there is so alarming that even the Catholic Church appears to be considering a reversal on condom policy for disease prevention purposes only (Bruce, 2006).

Another approach is the claim that oral contraceptives place women at risk for serious illness or death. Although combined oral contraceptive use entails some risk, pregnancy imposes a far greater risk. Studies conducted in the U.S. and reviewed by

Trussel & Jordan (2006) show that the risk of death from pregnancy and delivery is higher than the risk of death from oral contraceptives for all women aged 15-44, the only exception being for women aged 35-44 who smoke. The risk of death from pregnancy is also higher than the risk of death from a spontaneous abortion, a medical abortion, or a surgical abortion, even at or later than 21 weeks of gestation. The risk of death from pregnancy-related complications and unsafe abortions for women in developing countries is considerably higher than in the U.S. (Trussel & Jordan, 2006).

In more than a dozen states, women are facing pharmacists' refusals to fill prescriptions for contraceptives. While the *Code of Ethics* of the American Pharmacists Association (APhA) mandates that patients' well-being and dignity must be foremost, another clause permits refusal to fill prescriptions based on personal beliefs if patients are directed to another pharmacist or pharmacy. In state legislatures, the number of bills introduced to support pharmacists' rights to refusal far outnumber the bills to require pharmacists to fill prescriptions or refer patients to those who will (Greenberger & Vogelstein, 2005).

Emergency Contraception

A blatant example of religious influence within government has been the Federal Drug Administration's 3-year delay in approving over-the-counter sales of emergency contraception (EC). Levonorgestrel, a hormonal medication similar to oral contraceptives, is highly effective in preventing pregnancy if taken within 72 hours following unprotected or under-protected intercourse; i.e., no use of contraception or possible failure of a contraceptive method. Also called "Plan B" or "the morning after

pill,” the medication is most effective if taken within 24 hours (ACOG - The American College of Obstetricians and Gynecologists, 2006).

In 1999, the Federal Drug Administration (FDA) approved Plan B for sale by prescription. Because of the time frame for effectiveness, it is crucial that women obtain the medication quickly. Obtaining and/or filling a prescription may be particularly difficult on evenings, weekends, and holidays. Even with prescriptions, women have experienced significant delays or failure in obtaining the medication because some pharmacies do not stock the medication or pharmacists refuse to fill prescriptions based on their personal beliefs.

Each year about 300,000 women in the U.S. are raped; approximately 25,000 will become pregnant as a result (Stewart & Trussell, 2000). Eighty-one percent of Americans believe, that despite religious objections, hospitals should not be permitted to deny assault victims access to emergency contraception (American Civil Liberties Union, 2002).

Although the need for EC for rape victims is self-evident, some medical personnel withhold information about the drug. Rape victims who know about EC may be denied access to it because hospitals do not stock the drug or emergency room physicians refuse to order the drug, again based on their personal beliefs. Although a Bishops Directive permits emergency room doctors in Catholic hospitals to provide EC for sexual assault victims who are not pregnant, a recent survey found, in states that require EC to be available for rape victims, 35% of Catholic hospitals reported that it is not available under any circumstances (Catholics for a Free Choice, 2006). The degree of control based on religious dogma in this country is particularly striking when compared to countries

like Brazil, Argentina, Chile and Peru, where EC is readily available to assault victims (Center for Reproductive Rights, 2004).

Opposition to Plan B stems from two beliefs: that EC is an abortifacient and that it will promote promiscuity. Groups which have been particularly vehement in their opposition to EC include Concerned Women for America, the Christian Medical Association, the Family Research Council, the American Association of Pro-Life Obstetricians and Gynecologists, and the American Life League (Ranney, Gee & Merchant, 2006).

Plan B is not an abortifacient. It “will not disrupt an established pregnancy” (ACOG, 2006). Depending on timing within a woman’s menstrual cycle, EC may prevent ovulation, fertilization of the egg, or implantation of the blastocyst (ACOG, 2004). (A blastocyst is a fertilized egg in which cell differentiation has begun.) Both ACOG and the Federal government define the beginning of pregnancy as the time of implantation of the egg in the uterine wall (ACOG Committee on Terminology, 1972; Department of Health and Human Services, 2005).

Promiscuity is a moral concept understood as casual sexual intercourse outside of marriage. Promiscuity is not a medical term. The public health community identifies risky sexual behaviors and strives to reduce their incidence to promote health but does not make judgments of consensual sexual behaviors as “moral” or “immoral.”

Three-year Struggle for Non-Prescription Plan B

As long as EC is available only by prescription, effective use is limited by time delays, the additional cost involved in obtaining and filling a prescription, access, and the ideology of pharmacists and pharmacies. ACOG estimated that over-the-counter

availability of EC could prevent at least half of the unintended pregnancies and half of the abortions in the U.S. (ACOG, 2004). Supporters of EC argued that nonprescription medication reduces the cost to the patient, a factor which may be particularly important to adolescents and poor women.

In April, 2003, the Women's Capital Corporation, the original producers of Plan B and now a subsidiary of Barr Laboratories, filed a petition with FDA for non-prescription status of the drug. Responding to that petition in December, 2003, members of two FDA advisory groups – by a vote of 24 to 3 -- recommended over-the-counter sale of Plan B. Despite the conclusion of the joint committee that the drug was safe for distribution to adolescents, in May, 2004, the petition was declined by Dr. Steven Galson, acting director of the FDA's Center for Drug Evaluation and Research, claiming that Barr Laboratories had not provided supporting evidence for this claim.

In July, 2004, Barr Laboratories reapplied for over-the-counter sale of Plan B for women over the age of 16. Although the decision was due in January, 2005, a further delay was announced, allegedly because of an “inability to review” all available information. On July 31, 2006, the eve of Senate confirmation hearings for Dr. Andrew von Eschenbach as director of the FDA, the FDA announced that it would reconsider its position and on August 24 announced its approval of non-prescription Plan B for women 18 years and older. Dr. von Eschenbach denied that ideology had been a factor in the delay or the proposed age limitation, claiming instead that insufficient evidence had been available about the safety of the drug for women under the age of 18.

In this 3-year period, more than 60 medical and citizen groups petitioned the FDA for approval, noting that all three factors for over-the-counter medications had been met

by EC: it is safe, it is efficacious, and it is easy to administer (AAP - American Academy of Pediatrics, 2005). Among these groups are the American Academy of Pediatrics and the Society for Adolescent Medicine (SAM), each of which has a policy statement supporting EC for all adolescents (AAP, 2005; SAM, 2004). Studies assigning adolescents randomly to either receive a supply of EC or to receive only counseling about EC have found that having a supply of EC available did not result in increased risky behaviors, such as having more frequent unprotected intercourse (AAP, 2005).

While the FDA withheld approval of non-prescription Plan B, six states made it available over-the-counter under certain conditions. In four of those states, pharmacists are permitted to dispense the drug under practice agreements with an authorized practitioner (Ranney, Gee & Merchant, 2006).

EC has been available on the global market for several decades. As of 2004, women in more than 30 countries had access to EC without a prescription, although cost sometimes precludes its widespread use for poorer women (Center for Reproductive Rights, 2004).

What Are The Implications?

The FDA is responsible for reviewing the evidence on effectiveness and safety of drugs, not making moral judgments about the use of drugs. Similar moral objections to contraception, per se, could result in other forms of safe and effective contraceptives being removed from the market. A former general counsel for the FDA, Peter Barton Hutt, in 45 years of observing agency action could remember no issue which has been given this kind of attention by an agency which has jurisdiction over a vast array of medication (*The New York Times*, 8/25/06).

The controversy over EC is simply one facet of a larger reproductive agenda pursued by some conservative and fundamentalist groups. While some states have passed legislation to require hospitals to provide EC or other services related to sexuality, there is a broad movement at the state level to “protect health workers who do not want to provide care that conflicts with their personal beliefs” (Stein, 2006). Some of these proposals focus specifically on pharmacists’ objections to EC or other forms of contraception, but other efforts are aimed at broader issues such as right-to-die, services to gays and lesbians, and AIDS prevention. Some bills would allow insurance companies to refuse coverage based on religious beliefs. Some employers, particularly religious institutions, refuse to provide coverage for contraceptive services in their health insurance plans.

Emergency room doctors and pharmacists operate under state licensing credentials which grant them authority withheld from others, but those credentials do not entitle them to interfere with anyone’s medical needs by imposing their personal religious beliefs upon others. The aggressive advocacy of dogmatic Catholics and evangelical Protestants apparent in both state and federal legislatures and some judicial settings threatens the rights of individuals to make their own decisions regarding sexuality. Under all the talk about preservation of the family, there is the dehumanizing wish to strip individuals and couples of autonomy and control of their lives and to deny women economic and sexual independence.

A Humanist Solution

Awakening the citizenry to the potential loss of individual freedom and control of one’s sexuality posed by mixing religion and government is a crucial step in addressing

these issues. Religious fundamentalists and others may choose to express their sexuality only within marriage and make each sexual event an opportunity for procreation. They may believe that sex with no expectation of procreation damages a relationship. Those who embrace the concept of sin may live by their rules.

But they must be prohibited from turning their narrow views on sexuality and individual freedom into the laws of the land. They must be prevented from raiding the U. S. Treasury to fund ideological indoctrination and enforcement, as they have done with abstinence-only education.

At the same time we are addressing the alarming situation in this country and taking steps to overcome the influence of religious dogma on public policy, we must work to support appropriate family planning policies and efforts worldwide. With irrefutable evidence of global warming and the threat of environmental degradation, slowing population growth is crucial for human survival. Expanding access to family planning services worldwide is the only logical response to the reality of limited resources on this planet and may be a means of reducing future conflicts based on competition for those resources. A slower rate of population growth has the potential to reduce pressure for immigration to the U.S.

Contraception should be considered a public health issue, not a moral issue. Everyone should have knowledge of, and access to, safe contraceptives to be protected from unwanted pregnancy and sexually transmitted infections. Government should support continuing research into contraceptive methods that are effective, easy to use, and reversible for women and men. Family planning services in this country should be publicly funded for those who cannot afford them, including adolescents. The United

States should provide its fair share of funding for family planning services worldwide through the United Nations and/or directly to countries requesting aid through organizations which have proven to be effective.

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