CONTRACEPTION AND ABORTION TODAY: THE PERSONAL IS POLITICAL

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Need to control fertility found throughout history

Modern method use 1st half of 20th century consisted mainly of condoms and diaphragms

- **1640 1st condom found England**
- **1844 rubber condoms**
- **1860s/80s womb veil (diaphragm)**
- **1899 vasectomy**
- **1909 first IUD**
- **1950s Lippes loop/vac aspiration**
- **1960s oral contraception/implant**
- **1980s medical abortion**

Museum of Contraception & Abortion, Vienna

What has been happening on the ground: last 100 years?

Global total fertility rate = almost 2

- Population growth rate has been falling globally for the past 50-60 years.
- Global total fertility rate dropped from 4.5 (1970) to 2.6 (2005). Today = almost 2.
- World has been having great success in reducing fertility for a long time – we need to start thinking about "population" issues differently.

(Prof. Hans Rosling, Karolinska Institute, Sweden)

… and the trend is still downward

- 42% of world's population already below replacement fertility.
- 40% above replacement level but not high.
- 18% still have high fertility, almost all in the poorest, least developed countries.
- Much more is changing too…

Menarche to menopause

- Average age of menarche falling, average age in UK at 13, but as low as 8 (Mexico).
- Menopause happening later, average age in UK is 52. Means a woman has ± 40 fertile years = ± 520 cycles.
- Women having only two children or fewer need protection against pregnancy very long time.
- Contraceptive use, e.g. in UK, very high. Only one in three sexually active women has an abortion in her lifetime and only a third of those will have more than one abortion (Stone/Ingham) = very low failure rate.
- On the other hand, in poorest countries, far fewer women using modern contraception, e.g. Somalia, only 1%.

Women's main reasons for non-use of contraception

- Level of unmet need for contraception (estimated 222 million women in developing world, 2012) declined only slightly in recent decades.

- Reasons – 51 surveys married women 2006-2013 in Africa, Asia, and Latin America & Caribbean:
  - infrequent sex,
  - concerns regarding side effects or health risks, mainly menstrual disruption and fears of infertility.

(Williamson et al. 2009; Sedgh G & Hussain R, 2014)

Married women, reasons for unmet need, by region: Africa/Asia/Latin America & Caribbean 2006-2013

% married women aged 15-49	Africa (24%)	Asia (ex. East Asia) (15%)	Lat Am+ Carib (13%)
Infrequent or no sex	19	31	34
Side effects/health risks	28	23	24
Opposition from others	24	27	11
Post-partum amenorrhea/breastfeeding	19	18	14
Sub-fecundity	3	3	11
Lack of access	8	6	4
Lack of knowledge	8	6	4

(Sedgh G & Hussain R, 2014)

Young, unmarried women's main reasons

- A review of studies among young women, primarily unmarried, in sub-Saharan Africa found mainly these reasons:
  - lack of access to family planning education and information,
  - unwillingness to risk the social disapproval associated with seeking services.
- These reasons are as likely to be true elsewhere too.

(Williamson et al. 2009; Sedgh G & Hussain R, 2014)

Is it all (young) women's fault? No!

Policy, legal and political reasons for non-use

- Failure of health systems to make all methods available
- Experience of negative side effects that is reasonable, not stupid
- Litigation due to damages – Dalkon Shield
- Campaigns against methods due to abuse of informed consent – Depo Provera
- Anti-abortion movement promulgation of lies, distortions of facts and fearmongering
- Refusal by providers to provide – conscientious objection or due to single status or absence of husband consent
- Criminal laws against – contraception in past; abortion then and now.

Emergency contraception: disappointment

- Use of emergency contraception (EC) has increased markedly in countries where a product is available over the counter, but barriers to availability and use remain.
- Although effective in clinical trials, it has not yet been possible to show a public health benefit in terms of reduction of unintended pregnancy rates.
- Ullapristone-based emergency contraceptive (Ella One) offers better effectiveness than levonorgestrel.
- But it is still less effective than ongoing, regular contraception.

(ESHRE Capri Workshop Group, 2015)

Evidence from research findings/guidance not acted on

- Six randomized, controlled trials 1977–1995 on safety and effectiveness of task-shifting for the delivery of long-acting contraceptives:
  - IUD insertion by nurses compared to doctors (2 studies)
  - IUD insertion by auxiliary nurse-midwives compared to doctors (2 studies)
  - Tubal ligation by midwives compared to doctors (1 study)
  - Vasectomy by medical students compared to doctors (1 study).

- Findings
  - Little or no difference in contraceptive outcomes between cadres.
  - Task shifting for the delivery of long-term contraceptives may be a safe and effective approach to increasing access to contraception.

- Similarly, re abortion, failure of many countries to approve mifepristone, replace hospital abortion clinics with primary care and gynaecologists with mid-level providers, or avoid delays in treating complications.

(Polus S, et al. 2015; WHO Safe Abortion Guidance 2012)

Global policy input mixed: "FP vs. abortion"

- ICPD 1994 – a wider definition and concept of SRHR was agreed, positive emphasis on family planning, but right to abortion almost fatally compromised.
- Anti-abortion movement, Vatican led, adopted by right-wing political and religious groups, began a backlash that is getting stronger by the year.
- MDGs 2000 omitted any reference to both family planning and abortion; access to reproductive health inserted late, never promoted. And SDGs???
- Donors' positive SRHR policies overshadowed by Gates' style of funding for FP and refusing to touch abortion.
- Anti-abortion movement begins to take anti-contraception and anti-assisted reproductive technology stance, beginning with EC and IVF and expanding – also Vatican led.

What's missing: crossing the line between contraception and abortion

- Family planning methods that act when administered after fertilisation that:
  - could be used for more days after unprotected sex than current emergency contraceptives, and
  - could be used only on the relatively rare occasions when menstrual period is delayed.

(Raymond EG, et al, 2013)

- Availability of and improvements in abortion methods, especially very early methods that woman can obtain from a pharmacy or other provider and use at home, for example, early medical abortion.

Risk of regression to a narrow "FP" agenda

- The much needed re-focus on giving more people the means to control fertility is being threatened by a narrow agenda:
  - focus on increasing new contraceptive users only, ignoring existing users and problems leading to discontinuation
  - emphasising long-acting reversible methods (LARCs) over all others
  - ignoring methods for men (vasectomy)
  - ignoring male and female condoms (and HIV/STIs too??)
  - setting targets and/or paying providers for performance… even while claiming to embrace a rights-based approach,
  - less tolerance for failure to use a method or a decision to choose a less effective method
  - seeking to reduce “unmet need” *only* for contraception
  - not committed to integrating FP services with other reproductive and sexual health services, and
  - excluding safe abortion.

More complaints

- The improvement in current methods of contraception, abortion and sterilisation, compared to 50 years ago, is enormous, and new research is creating new methods such as vaginal rings and multipurpose technologies. So why are so few methods available in most countries today?

- In spite of the WHO *Safe Abortion Guidance* recommending medical abortion with mifepristone and misoprostol and vacuum aspiration as the main abortion methods since 2003, D&C is still widely practised.

- Recent deaths at a sterilisation camp in India are an extreme example of failure of quality of care in service delivery. But how good are most services?

What do women need?

- Most of the time, those having sex with a man want to avoid getting pregnant, and when necessary, terminate unwanted pregnancies.
- This includes most adolescents and young people, those who don’t want any children, and those who have already had the children they want.
- Having babies is occupying only a few of women's fertile years (if at all). More women and men are remaining childless.
- People need good information, access to a range of affordable methods, good quality services and help with any problems to avoid method failure and discontinuation.
- Family and partner support, school and social support, government policy and programme support.

Adolescents and young people

- Adolescents and young people experience the most unwanted pregnancies, STIs and HIV – have the most sex and least access to services.

- Among the 21.6 million women each year with unsafe abortions, adolescents suffer the most from complications and have the highest unmet need for contraception – still not perceived as eligible for “family planning” many countries.

- Lack access to knowledge about sex, bodies and fertility, how to negotiate safe, wanted sex and refuse unwanted sex, how to talk to partners about sex and using protection. Adolescent girls in particular experience widespread pressure and coercion to have sex. Boys too.. No one makes sure young people have someone to talk to or know where to get help.

Most people believe in the right to manage fertility

- The demand for fertility control is growing – not just because the youth population is growing, which it is, but also because most people now believe it is their right to decide whether and when to have children and they want the means to do so.

- International Campaign for Women's Right to Safe Abortion says: "Abortion should not be restricted, prohibited or criminalised." And no woman who has had an abortion and no safe abortion provider should be "stigmatised, harassed, discriminated against, or prosecuted".

- Just think how much will have to change before these simple-sounding goals can be achieved.

Reproductive and sexual rights

- The need to control fertility is part of a much broader set of needs related to reproduction and sexuality, including being able to:
  - have sex without fear of negative outcomes,
  - have sex if and only if we want to and only when and with whom we want to,
  - get pregnant,
  - have only the children we want,
  - survive pregnancy in good health with a healthy baby, and
  - have a safe abortion without legal restrictions, fear of morbidity and death, or condemnation when pregnancy is unwanted.

Abortion is not a problem, it's a solution

- **Stop use of stigmatising language about abortion**
  - We are all against abortion, even if we know it’s necessary.
  - No woman should have to die giving life.
  - We must reduce problems like STIs and abortions.

- **Use language supportive of women’s right to decide**
  - Contraception, abortion and sterilisation are all safe and legitimate methods of controlling fertility.
  - Abortion is as much a part of women’s experience as pregnancy.
  - Preventing unwanted pregnancy and providing safe abortions are equally important ways of meeting women’s reproductive health needs.
  - Abortion is the keystone of women’s liberation.

Demonstration against anti-abortion bill, Spain February 2014

The future

- Having fewer children and being able to decide whether and when to have them has opened up new worlds for women, in terms of being able to participate more fully as citizens in their countries' affairs and to seek education and employment, even if not yet on an equal par with men.

- It has changed everyone's lives in fact.

- This is a revolution that has taken place within only a few generations.

- We should ensure it continues and reaches everyone, remembering that every new generation of young people needs to learn it all from scratch.

THANK YOU VERY MUCH!!!

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