CENTER FOR REPRODUCTIVE RIGHTS

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FACT SHEET

Setting the Record Straight on Contraceptives

Women exploring the use of contraceptives[1] are often faced with misleading information about their safety and effectiveness, as well as women's right to access them. This misinformation can prevent women from realizing their reproductive rights, including the right to decide freely and responsibly the number and spacing of their children; the right to receive and impart the information and means to; the right to attain the highest standard of sexual and reproductive health; and the right to make decisions concerning reproduction free of discrimination, coercion, and violence.[2] This factsheet sets the record straight on oral contraceptives and governments' obligation to provide family planning services.

True or False: Oral contraceptives do not effectively reduce unwanted pregnancies.

False: Contraceptives are very effective as they significantly decrease the number of unintended pregnancies. The United Nations Population Fund (UNFPA) estimates that 50 percent of all pregnancies are unplanned and 25 percent are unwanted.[3] Unwanted pregnancies occur disproportionately among young, unmarried girls who often lack access to contraception.[4] According to the World Health Organization (WHO), for every 100 women using oral contraceptive pills,[5] only 8 will become pregnant in the first year. If oral contraceptives are taken properly without mistake, the rate is less than 1 pregnancy per 100 women over the first year (3 per 1,000 women).[6] With progestin-only contraceptive pills,[7] the rate is less than 1 pregnancy per 100 breastfeeding women and 3 to 10 pregnancies per 100 non-breastfeeding women over the first year.[8] If pills are taken every day at the same time, the rate is less than 1 pregnancy per 100 non-breastfeeding women over the first year.[9]

True or False: Contraceptives effectively reduce induced abortions.

True: It is widely held that universal access to a wide range of affordable contraceptive methods reduces the rates of unwanted pregnancies and induced abortion.[10] Worldwide, about one-fifth of all pregnancies end in induced abortion. Satisfying the unmet need for contraception would further reduce women's need to resort to abortion. The effect of national contraception programs on reducing the rate of abortion is well-documented. In seven countries (Bulgaria, Kazakhstan, Kyrgyzstan, Switzerland, Tunisia, Turkey, and Uzbekistan), abortion rates fell as use of modern contraceptives rose.[11] Additionally, contraceptive use contributes to lower rates of maternal mortality and morbidity by reducing unintended and unwanted pregnancies and unsafe abortions. UNFPA estimates that "one in three deaths related to pregnancy and childbirth could be avoided if all women had access to contraceptive services."[12] This would save the lives of 175,000 women annually, in addition to preventing numerous childbirth-related injuries.[13]

Nevertheless, while access to safe, effective contraception can substantially reduce the need for abortion, it will never fully eliminate it.[14] Even with widespread contraceptive use, unintended pregnancies still occur. No contraceptive method is 100 percent effective and many people still confront significant obstacles to obtaining contraception. Thus, the need for safe, legal abortion will continue despite contraceptive use. Moreover, access to safe, legal abortion is a fundamental right of women.

True or False: Oral contraceptives cause cancer and have severe side effects.

False: The use of combined oral contraceptives is actually proven to *decrease* the risk of two cancers (ovarian and endometrial); this protection continues for 15 or more years after stopping use.[15] Studies show that women who have used combined oral contraceptives[16] more than 10 years ago face the same risk of breast cancer as women who have never used combined oral contraceptives. Most side effects experienced by women using oral contraceptives are minor (such as headaches or changes in menstruation patterns) and many will subside after a few

months of use.[17] There are, however, numerous known health benefits related to combined oral contraceptive use. In addition to reducing the risk of pregnancy and protecting against certain cancers, oral contraceptives can help protect against ovarian cysts and iron deficiency anemia, as well as reduce menstrual cramps and bleeding problems, ovulation pain, excess body hair, and symptoms of other conditions affecting the ovaries and uterus.[18]

True or False: Oral contraceptives, including emergency contraception, are abortifacients and have severe side effects on women's health and well being.

False: Oral contraceptives do not cause abortion or disrupt an existing pregnancy.[19] Rather, oral contraceptives work by suppressing ovulation and thickening the cervical mucus, thus blocking sperm penetration.[20] If a woman becomes pregnant while taking oral contraceptives, evidence confirms that the contraceptives will not cause birth defects or otherwise harm the fetus.[21]

Similar to standard oral contraception, emergency contraception does not cause abortion. Emergency contraception prevents pregnancy and consists of the same hormones found in ordinary oral contraceptive pills.[22] Depending on when in a woman's cycle emergency contraception is taken, it may act by delaying or inhibiting ovulation, inhibiting fertilization, or inhibiting implantation of a fertilized egg, which in medical terms is considered to mark the beginning of pregnancy.[23] Emergency contraception does not work if a woman is already pregnant[24] and evidence shows that it will not otherwise harm an existing fetus.[25] Moreover, emergency contraception does not make women infertile and side effects are generally mild.[26] Emergency contraception is also safe for adolescents: The WHO reports that contraception use among girls 13 to 16 years-old is safe and that adolescent girls are capable of using emergency contraception correctly.[27]

Emergency contraception has been estimated to have an effectiveness rate of 75 percent when it is used within 72 hours of unprotected intercourse; thus, for each pregnancy that occurs after use of emergency contraception, three are prevented.[28] The WHO's handbook for family planning providers recommends giving all women who want emergency contraception a supply in advance, finding that women who have emergency contraception on hand are more likely to use it when needed and to take it as soon as possible after unprotected sex.[29]

True or False: Inaccessibility of contraception for women is a form of discrimination.

True: According to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), discrimination against women is "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."[30] Limited access to and high costs of oral contraception disproportionately affect women and girls, particularly those with fewer financial resources, and thus constitute discrimination. Access to affordable contraceptives increases reproductive autonomy and the ability of women to enjoy equal social, economic, civil, and political rights. The Committee on the Elimination of Discrimination against Women (CEDAW Committee) has stated that "[m]easures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women."[31] The Human Rights Committee has also noted that obstacles to women's access to contraception — including high costs[32] — are violations of the Covenant on Civil and Political Rights' Article 3 non-discrimination provisions, which guarantee the equal right of men and women to the enjoyment of all civil and political rights.[33]

True or False: The government has an obligation to provide funding for contraceptives.

True: As a matter of international law, governments are required to ensure women's access to quality sexual and reproductive health services, including family planning services.[34] In particular, access to contraception for marginalized groups such as adolescents, rural women, and low-income women is of great concern because members of these groups face significant social and economic barriers to accessing family planning services and thus require greater government assistance to do so. Several UN human rights bodies have addressed the need for governments to improve access to contraception and address all obstacles, including high costs.[35] The CEDAW Committee has called for special efforts to accommodate vulnerable population groups and their need for contraceptive and family planning services, particularly women and girls in rural or resource-poor areas.[36] The CEDAW Committee has specifically recommended Slovakia to take measures to increase women's and adolescent girls' access to affordable health care services, including reproductive health care, and affordable means of family planning as a way of addressing the country's high abortion rate.[37]

WHO has also called for government assistance to improve affordability of contraception. For example,

following a comprehensive assessment[38] undertaken by WHO and regional NGOs on abortion and contraception in Romania, a final report recommended offering free or subsidized contraceptives along with reliable information on the benefits of modern contraception.[39] As a result, Romania's Ministry of Health and Family earmarked considerable funds to provide free contraceptives to eligible women.[40] Oral contraceptives were also included on the list of drugs subsidized (by 65 percent) by the National Health Insurance House.[41]

True or False: Adolescents do not have a right to access contraception.

False: The Convention on the Rights of the Child (Children's Rights Convention), the main treaty granting special protections to minors, recognizes the importance of adolescent autonomy and acknowledges that minors have "evolving capacities" to make decisions affecting their lives.[42] Adolescents' rights to life, health, and privacy entitle them to access sexual and reproductive health services,[43] including contraceptives and family planning services. The Committee that monitors the Children's Rights Convention (CRC Committee) has voiced concern regarding the lack of sufficient health services for adolescents[44] and high rates of teenage pregnancy,[45] as well as concern that "contraceptives are not within financial reach of all, thus limiting their use."[46] In particular, the CRC Committee has recommended that States Parties, including Slovakia, provide family planning information, services, and contraception to address teen pregnancy.[47]

True or False: If health care providers and pharmacists claim a "conscientious objection" to contraception and family planning, they have no obligation to provide services.

False: The right to the highest attainable standard of health is a fundamental human right and the government should ensure that the practice of conscientious objection does not impede the effective realization of this right.[48] Because a conflict of conscience can only be experienced by human beings, conscientious objection cannot be exercised on behalf of an institution.[49] With respect to individuals, the International Federation of Gynecology and Obstetrics (FIGO) (which includes a member organization from Slovakia) acknowledges that practitioners have a right to respect for their conscientious convictions, but that their duty is to provide their patients with accurate information on reproductive health services and not to "mischaracterize them on the basis of personal beliefs."[50] International standards clearly establish that providers must give notice of the services they decline to provide, appropriately refer patients who request such services, provide timely care when referral is not possible and delay would jeopardize patients' health and well-being, and provide care regardless of personal objections in emergency situations.[51]

With respect to pharmacists, the European Court of Human Rights established in the case of *Pichon and Sajous v France* that the refusal to sell contraceptives by two pharmacists amounted to the imposition of personal beliefs on the public. The Court held that "as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products."[52] At a minimum, States should ensure that there are enough non-objecting pharmacists that would ensure the provision of contraceptives for women, within a reasonable distance from where they live.

Finally, the CEDAW Committee recently recommended that Slovakia adequately regulate the exercise of conscientious objection by health professionals so as to ensure women's access to sexual and reproductive health services.[53] The CEDAW Committee noted that state refusal to legalize the performance of certain reproductive health services for women is discriminatory and that if health service providers invoke "conscientious objection" as grounds for refusal, measures should be introduced to ensure that women are referred to alternative health service providers.[54]

ENDNOTES

1 While women have the right to choose from the full range of modern methods of contraception, this factsheet is focused primarily on correcting misinformation surrounding the use of oral contraception.

2 *Programme of Action of the International Conference on Population and Development,* Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc. A/CONF.171/13/Rev.1 (1995), ¶ 7.3, *available at* http://www.unfpa.org/icpd/icpd-programme.cfm (last visited July 17, 2009) [hereinafter *ICPD Programme of Action*].

3 United Nations Population Fund (UNFPA), *Safe Motherhood: Reducing Risks by Offering Contraceptive Services*, *available* http://www.unfpa.org/mothers/contraceptive.htm (last visited July 16, 2009) [hereinafter UNFPA Safe Motherhood].

4 *Id.*

5 Combined oral contraceptive pills contain low doses of two hormones—a progestin and an estrogen—like the natural hormones progesterone and estrogen in a woman's body. World Health Organization Department of Reproductive Health and

Research, et al., Family Planning: A Global Handbook for Providers: Evidence-based Guidance Developed Through Worldwide Collaboration 1 (2007), *available at* http://www.infoforhealth.org/globalhandbook/handbook.pdf (last visited August 24, 2009) [hereinafter WHO Handbook].

6 *Id.* at 2.

7 Progestin-only pills contain very low doses of a progestin like the natural hormone progesterone in a woman's body. WHO Handbook, *supra* note 5, at 25.

8 WHO Handbook, *supra* note 5, at 26. Breastfeeding women have the additional protection from pregnancy that breastfeeding provides. *Id.* at 43.

9 *Id.* at 26.

10 Gilda Sedgh, Stanley Henshaw, Sunheela Singh, Elisabeth Ahman & Iqbal H. Shah, *Induced abortion: estimated rates and trends worldwide*, 370 The Lancet 1338, 1342 (October 2007).

11 Cicely Marston & John Cleland, *Relationships Between Contraception and Abortion: A Review of the Evidence*, 29 Int'l. Family Planning Perspectives, March 2003, at 6–13. Several of the UN treaty-monitoring bodies have also discussed the link between lack of access to contraception and increased rates of abortion. *See, e.g.,* Equatorial Guinea, ¶ 9, U.N. Doc. CCPR/CO/79/GNQ (2004); Georgia, ¶ 12, U.N. Doc. CCPR/C/79/Add.75 (1997); Armenia, ¶ 15, U.N. Doc. E/C.12/1/Add.39 (1999); Poland, ¶ 12, U.N. Doc. E/C.12/1/Add.26, (1998).

12 UNFPA Safe Motherhood, *supra* note 3, at ¶2.

13 *Id.*

14 David A Grimes, Janie Benson, Susheela Singh, Mariana Romero, Bela Ganatra, Friday E Okonofua & Iqbal H Shah, *Unsafe abortion: the preventable pandemic.* 368 The Lancet 1908, 1915 (November 2006).

15 INFO Project, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, Contraceptive Myths and Counseling Messages, 5-6 (International Planned Parenthood Federation 2007), *available at*: http://www.ippf.org/MythsData/Myths_Injectables.pdf (last visited Aug. 24, 2009) [hereinafter INFO Project].

16 WHO Handbook, *supra* note 5, at 4.

17 *Id.* at 17. Side effects can include changes in menstruation patterns, headaches, dizziness, nausea, breast tenderness, acne (usually improves), mood changes, enlarged ovarian follicles, weight change (rarely), and occasionally increased blood pressure. Blood pressure can increase a few points with use of combined oral contraceptives and, in very rare cases, users can develop blood clots in deep veins of legs or lungs. In extremely rare cases, a combined oral contraceptive user can experience a heart attack or stroke. Progestin-only pills have no such known health risks. *Id.* at 2, 3, & 27.

18 *Id.* at 3.

19 *Id.* at 22 & 42.

20 Info Project, *supra* note 15, at 24.

21 WHO Handbook, *supra* note 5, at 22 & 42.

22 Guttmacher Institute, *Emergency Contraception*, http://www.guttmacher.org/media/supp/ec121702.html (last visited Aug. 24, 2009). [hereinafter *Emergency Contraception*].

23 *Id.* at ¶1. *See also* Family Health International, *Emergency contraceptive pills: Information for policy-makers and providers*, http://www.fhi.org/en/RH/Pubs/Briefs/ECPs/ECPbrief.htm (last visited August 24, 2009).

24 WHO Handbook, *supra* note 5, at 45.

25 *Id.* at 54.

26 *Id.* at 48. Some emergency contraception users have reported the following side effects: slight irregular bleeding or changed monthly bleeding pattern, abdominal pain, fatigue, headaches, breast tenderness, dizziness, nausea, and vomiting. However, women using progestin-only emergency contraception are much less likely to experience nausea and vomiting. *Id.* at 47 & 53.

27 *Id.* at 55.

28 *Emergency Contraception*, *supra* note 22.

29 WHO Handbook, *supra* note 5, at 49.

30 Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/189, UN GAOR, 34th Sess., Supp. No. 46, art. 1, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].

31 Committee for the Elimination of Discrimination Against Women, *General Recommendation No. 24: Women and health,* 20th Sess., ¶11, U.N. Doc. A/54/38 (1999).

32 *See, e.g.*, Poland, ¶ 9, U.N. Doc. CCPR/CO/82/POL (2004).

33 *See, e.g.*, Georgia, ¶ 12, U.N. Doc. CCPR/C/79/Add.75 (1997); Poland, ¶ 11, U.N. Doc. CCPR/C/79/Add.110 (1999).

34 For more information *see* Center for Reproductive Rights, Pro Choice Slovakia and Citizen and Democracy, *International Standards on Subsidizing Contraceptives* (September 2009).

35 *See e.g*. Belarus, ¶ 374, U.N. Doc. A/55/38 (2000) ("In particular, the Committee urges the Government to increase affordable contraceptive choices for women and men so as to increase the use of contraception."); Estonia, ¶ 112, U.N. Doc. A/57/38 (2002); Croatia, ¶ 117, U.N. Doc. A/53/38 (1998); Hungary, ¶ 260, U.N. Doc. A/51/38 (1996); Poland, ¶ 9, U.N. Doc. CCPR/CO/82/POL (2004); Poland, ¶ 28, U.N. Doc. E/C.12/1/Add.82 (2002).

36 *See, e.g.,* Lithuania, ¶ 159, U.N. Doc. A/55/38 (2000); Ukraine, ¶ 287, U.N. Doc. A/51/38 (1996).

37 U.N. Committee for the Elimination of Discrimination Against Women, *Report of the Committee on the Elimination of Discrimination against Women, Fortieth and Forty-first Sessions*, 98, ¶ 42 & 43, U.N. Doc. A/63/38, (2008) *available at*: http://www2.ohchr.org/english/bodies/cedaw/docs/CEDAW.C.SVK.CO.4.pdf. [hereinafter Report of the CEDAW Committee]. The Committee is particularly concerned with difficulties faced by women in vulnerable communities. *Id.*; *see also* Slovakia, ¶ 92, U.N. Doc. A/53/38/Rev.1 (1998).

38 World Health Organization (WHO), et al., Abortion and Contraception in Romania: A Strategic Assessment of Policy, Programme and Research Issues (World Health Organization 2004), *available at*: http://whqlibdoc.who.int/

publications/2004/9739953166.pdf (last visited Aug. 24, 2009) [hereinafter WHO Assessment in Romania].

39 *Id.* at 42.

40 *Id*. at 43. Categories of eligible women would include: unemployed, pupils and students, women in families that receive social assistance and/or have no income, women with permanent residence in rural areas, and women who undergo elective abortion in a public health facility.

41 *Id.* at 43.

42 Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, UN GAOR, 44th Sess., Supp. No. 49, art. 12(1), U.N. Doc. A/44/49 (1989) *reprinted in* 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990).

43 *Id.* at arts. 6 & 24; *See also* International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), UN GAOR, 21st Sess., Supp. No. 16, art. 6, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976). *See generally* R. J. Cook et al., *Respecting Adolescents' Confidentiality and Reproductive and Sexual Choices*, 98 Int'l Journal of Obstet. & Gyn. 182-187 (2007).

44 Paraguay, ¶ 23, 33 & 45, U.N. Doc. CRC/C/15/Add.75 (1997); *see also* Hungary, ¶ 36, U.N. Doc. CRC/C/15/Add.87 (1998).

45 Poland, ¶ 42, U.N. Doc. CRC/C/15/Add.194 (2002); Lithuania, ¶50, U.N. Doc. CRC/C/LTU/CO/2 (2006).

46 Russian Federation, ¶ 55, U.N. Doc. CRC/C/RUS/CO/3 (2005).

47 Slovakia, ¶ 38, U.N. Doc. CRC/C/15/Add.140 (2000). *See also* Russian Federation, ¶ 48, U.N. Doc. CRC/C/15/Add.110 (1999); Latvia, ¶ 45, U.N. Doc. CRC/C/LVA/CO/2 (28/06/2006). Other committees (CEDAW, Human Rights Committee, Committee on Economic, Social and Cultural Rights) have expressed similar concerns and recommendations. *See e.g*. Bosnia and Herzegovina, ¶ 35, U.N. Doc. CEDAW/C/BIH/CO/3 (2006); Ecuador, ¶ 11, U.N. Doc. CCPR/C/79/Add.92 (1998); Jamaica, ¶ 30, U.N. Doc. E/C.12/1/Add.75 (2001).

48 The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Commission on Human Rights Resolution 2003/28, Preamble and ¶ 8 (Apr. 22, 2003), *available at* http://www.dhsantementale.net/cd/biblio/pdf/SM-DH_063.pdf (last visited Aug. 24, 2009). *See also* Judith Bueno de Mesquita and Louise Finer, Conscientious Objection: Protecting Sexual and Reproductive Health Rights 9 (University of Essex 2008) *available at* http://www2.essex.ac.uk/human_rights_centre/rth/docs/conscientious%20objection%20final.pdf (last visited Aug, 24, 2009).

49 Croatia, ¶ 109, U.N. Doc. A/53/38 (1998). *See also* Decision 2001-446 DC of 27 June 2001, Voluntary Interruption of Pregnancy (Abortion) and Contraception Act (Fr.); Decision T-209 of 2008 (Constitutional Court of Colombia).

50 International Federation of Gynecology and Obstetrics (FIGO), *Resolution on "Conscientious Objection*," adopted by the FIGO General Assembly on Nov. 7, 2006, *available at* http://www.figo.org/projects/conscientious (last visited Aug. 24, 2009). The Slovak Society of Gynecology and Obstetrics headquartered at Comenius University is a member of FIGO.

51 *Id. See also* CEDAW General Rec. No. 24, supra note 31 at ¶11 and E.U. Network of Independent Experts on Fundamental Rights, *The right to conscientious objection and the conclusion by EU Member States of concordats with the Holy See*, Opinion No. 4-2005: (14 December 2005).

52 Pichon and Sajous v. France (Inadmissibility Decision), App. No. 49853/99, Eur. Ct. H.R., (2001).

53 Report of the CEDAW Committee, *supra* note 37, at ¶42 & 43.

54 *Id.* at 43. *See also* CEDAW General Rec. No. 24, *supra* note 31, at ¶11.