

## CHAPTER III: Contraception

A woman's right to decide whether and when to have children can be realized only if she has access to the full range of contraceptive methods in a setting that allows her to make an informed choice. Governments that fail to take the affirmative steps needed to put contraceptives into the hands of women seeking to plan their fertility breach governments' duties under international human rights law. Similarly, governments fail to uphold their duty when they limit women's contraceptive choices by, for example, strictly regulating or prohibiting a particular contraceptive method. At the same time, coercive practices relating to family planning, including forced sterilization, violate women's bodily integrity and autonomy.

This chapter addresses the duty of governments to ensure women's right to plan their fertility. It reviews the international legal foundations of this duty and identifies its three principal components: 1) guaranteeing all women access to contraceptives, 2) ensuring access to the full range of contraceptive methods, and 3) protecting women's right to give full, informed consent before accepting a contraceptive method. The chapter provides examples of recent national developments reflecting each of these governmental responsibilities.

### Contraception Facts

- Over 200 million women in low- and middle-income countries have an unmet need for effective contraceptives.<sup>1</sup>
- Every year, an estimated 76 million women in these countries have unplanned pregnancies.<sup>2</sup>
- Meeting women's need for contraceptives would drastically reduce the number of unintended pregnancies every year and prevent 142,000 pregnancy-related deaths—53,000 from unsafe abortion.<sup>3</sup>

### HUMAN RIGHTS FRAMEWORK

Women have a **right to reproductive self-determination**. This right is supported in international protections of physical integrity and privacy, which allow individuals and couples to make fundamental decisions about their intimate lives without government interference. In addition, the global community has repeatedly acknowledged the right to decide freely and responsibly the number and spacing of one's children. This right entitles women to have access to all safe, effective means of controlling their fertility. In order for women to enjoy these rights, they must have access to the full range of contraceptive methods, with an opportunity to give informed consent prior to selecting a method.

*For international legal foundations of the rights marked in bold, see Appendix B*

The right to access contraception has support in **guarantees of life and health**. For a woman who is denied that access and who lives in a country where abortion services are prohibited by law or inadequately funded by the state, a resulting unwanted pregnancy can pose a threat to her physical, mental, and social well-being. If she turns to an untrained provider or attempts to self-induce an abortion, she may undergo an unsafe procedure with devastating effects on her physical health. If she is forced to carry the pregnancy to term, she may suffer psychological harm or, where access to quality obstetric care is limited, serious physical harm.

Failure to ensure access to the full range of contraceptive methods violates women’s **right to freedom from discrimination**. Because women bear the primary effects of unwanted pregnancy—on their physical and mental health, as well as on their education and economic well-being—neglect of women’s contraceptive needs compromises their rights to health and autonomy.

Women also have the **right to enjoy the benefits of scientific progress**. Technological innovations can have a profound impact on people’s lives. Denying universal access to those innovations only reinforces social and economic inequalities. As the medical and scientific communities make advances in contraceptive technologies, governments must seek to facilitate all women’s enjoyment of those advances.

**These legal guarantees require governments to:**

- **Make sure all women have access to contraceptives.** Ensuring access to contraceptives means addressing economic barriers to contraceptive methods, adopting policies to promote family planning education, and legislating to prevent other barriers to women’s use of contraception, such as spousal authorization requirements imposed by health-care providers.
- **Ensure access to the full range of contraceptive methods.** Because not every contraceptive method will be acceptable or effective for every woman, promoting access to the full range of methods increases women’s likelihood of successfully planning their fertility. A full range of methods includes condoms, vaginal barrier methods, oral contraceptives, implants, injectables, intrauterine devices, male and female voluntary sterilization, and emergency contraception.
- **Protect women’s right to give their full, informed consent before accepting a contraceptive method.** Government policies that disregard women’s own wishes and life circumstances in order to meet demographic goals may give rise to coercive and violent practices. Subjecting women to surgical sterilization or administering contraceptive injections or implants without women’s informed consent, for example, are practices that violate women’s core reproductive rights.<sup>4</sup>

## 1. MEASURES TO ENSURE ACCESS TO CONTRACEPTION

Governments have an obligation to ensure that a woman’s right to plan her family is not violated because of her socioeconomic status. Necessary measures may include covering the cost of contraceptives, ensuring that private health plans cover contraceptives, or—as the government of **Guatemala** has committed itself to do—providing free contraceptive services to all women at public health-care facilities.

## A. Guatemala Guarantees Universal Access to Family Planning

*In April 2006, Guatemala adopted sweeping legislation to ensure universal access to all methods of family planning. The legislation met with fierce opposition from religious leaders and political conservatives, including the president of Guatemala himself.<sup>5</sup> The president vetoed the legislation, but the veto failed as the legislation was adopted by the national congress. However, before the law could enter into force, its legality was challenged in Guatemala's Constitutional Court.<sup>6</sup> The legislation had strong support among women's rights organizations.<sup>7</sup> In April 2006, having survived multiple court challenges, the law entered into force.<sup>8</sup>*

The Law on Universal and Equal Access to Family Planning Services has the following components.<sup>9</sup>

### *Goal of universal access*

The law has the goal of ensuring all persons access to family planning services, which it defines to include information, counseling, sexual and reproductive health education, and the provision of family planning methods.<sup>10</sup> The law is to be implemented nationally. Services are to be delivered at both public health facilities and private ones that offer basic health care (including those run by nongovernmental organizations); the formal education components apply to primary and secondary schools.<sup>11</sup> It is intended primarily to benefit rural populations who do not have access to basic health services.<sup>12</sup>

### *Strategies to address unmet need*

The law requires measures to ensure that public health facilities can provide universal access to all modern contraceptive methods. It calls for national surveys to identify unmet need for family planning in order to determine the best means of ensuring access for underserved populations.<sup>13</sup> It also calls for the Ministry of Public Health and Social Assistance to work with nongovernmental organizations (NGOs) to ensure that geographically isolated populations have access to family planning measures.<sup>14</sup> A special strategy is to be developed to ensure that adolescents are reached.<sup>15</sup>

### *Guidelines for service delivery*

The government must ensure that family planning services are offered by skilled providers and that these services are integrated into other reproductive health services, including prenatal, delivery, and postnatal care; uterine and breast cancer detection; testing for sexually transmissible infections (STIs); and prevention of osteoporosis.<sup>16</sup>

### *Educational reforms*

The legislation calls for the development of educational curricula in the areas of health and sexuality that address the effects of early and unwanted pregnancy on maternal and infant mortality.<sup>17</sup>

### *Assurance of service quality*

There are also provisions ensuring free and informed decision-making, provider training, adequate counseling, and the creation of measures for monitoring the provision of services and evaluating progress in the removal of barriers to access.<sup>18</sup>

## 2. ACCESS TO THE FULL RANGE OF CONTRACEPTIVES

While legal restrictions are rarely placed on most contraceptive methods, the two methods that are frequently subject to legal and regulatory barriers are surgical sterilization and emergency contraception (EC). For example, although surgical sterilization is the most commonly used contraceptive method in the world,<sup>19</sup> it is legally restricted in several countries and of unclear legal status in many others.<sup>20</sup> Where it is legal, often a woman may undergo sterilization only if her spouse has consented, she has attained an age well over the age of majority, or she has had a minimum number of children.<sup>21</sup> While the global trend has been toward liberalizing or clarifying laws on sterilization,<sup>22</sup> as recently occurred in **Costa Rica**, reproductive rights advocates in several countries continue to advocate for the removal of legal barriers to access.

EC is sometimes excluded from the range of available family planning services because of the mistaken belief that it acts as an abortifacient. It is vital that governments recognize that EC is a means of preventing, not terminating, pregnancy. Over 140 countries have made EC available for purchase.<sup>23</sup> Many governments are taking steps to put EC into women's hands by, for example, making it available without a prescription, as **Canada** recently did. Other nations, including **Mexico**, have added EC to the contraceptives listed in their official family planning norms, which are distributed to health-care providers all over the country. In addition, a number of countries, including **Kenya**, have taken action, through legislation and regulatory measures, to enable rape survivors to access EC without delay in public health-care settings.

### A. Costa Rica Issues Decree Endorsing Women's Right to Sterilization

*The decree, adopted by the Ministry of Health in 1999, was a victory for women's rights advocates who, for years, used activism as well as litigation to secure women's right to surgical sterilization as a contraceptive option. The law repealed a 1988 decree that made sterilization explicitly legal on therapeutic grounds, but was challenged in the nation's Constitutional Court when providers were found to be requiring women to obtain permission from their husbands prior to undergoing sterilization. (Prior to 1988, the law on sterilization was ambiguous. Sterilization was thought to be regulated by article 123 of the penal code, which assigned penalties for "injuries" that cause "loss of... the capacity to reproduce or to conceive."<sup>24</sup>) The challenge failed for lack of evidence that spousal consent was being required, but the court did affirm the principle that a woman seeking therapeutic sterilization should not be required to seek the consent of her husband in order to undergo the procedure.<sup>25</sup> With continued pressure from women's rights advocates and the national ombudsperson, the Ministry of Health adopted a new decree permitting sterilization without restriction as to reason.<sup>26</sup>*

The 1999 decree, issued by the Ministry of Health, makes surgical sterilization a contraceptive option for all women by repealing the 1988 decree.<sup>27</sup>

#### *Recognition of reproductive rights*

The decree notes in its preamble the state's duty to protect the population's "rights to sexual and reproductive health, and to respect and comply with the international commitments...that recognize the right of all people to control all aspects of their health and, in particular, their reproductive capacity...."<sup>28</sup>

*Counseling requirement*

The decree requires that all public and private facilities that offer services for reproductive and sexual health provide information and counseling to health-care users about the advantages, limitations, and contraindications of the various contraceptive methods. Users should be supported in selecting the methods that best meet their needs.<sup>29</sup>

*Process for informed consent for sterilization*

In addition, the decree establishes a process by which patients give informed consent prior to undergoing sterilization. A patient signs a document stating that 1) he or she consents to undergo the procedure; 2) he or she understands that the procedure is irreversible and knows about his or her right to informed consent; and 3) the treating doctor and institution are released from all legal responsibility.<sup>30</sup>

*Awareness of the needs of vulnerable groups*

Family planning counselors should take into account factors such as the patient's gender, age, socioeconomic status, and ethnic identity; providers also need to recognize the specific needs of minors and persons who are undocumented or lack insurance.<sup>31</sup>

**B. Canada Makes EC Available without a Doctor's Prescription**

*Before Canada's national health service, Health Canada, approved nonprescription EC at the national level, the provinces of British Columbia, Quebec, and Saskatchewan had already made legislative changes that allowed pharmacists to dispense EC.<sup>32</sup> In explaining its decision to make EC more accessible, Health Canada repeatedly referred to its own pilot projects, the experiences of other nations where EC is available without a doctor's prescription, and the wide body of scientific evidence demonstrating the safety and efficacy of EC in preventing unwanted pregnancy.<sup>33</sup> Health Canada also considered the fact that the World Health Organization supports the use of EC and its ready availability.<sup>34</sup> In response to concerns about the use of EC by adolescents, Health Canada pointed out that other forms of contraception are widely available to minors without the need for parental consent or notification.<sup>35</sup>*

On April 19, 2005, Health Canada approved the sale of levonorgestrel for use as EC without a doctor's prescription.<sup>36</sup>

*"Behind-the-counter" status recommended*

While EC's place of sale is determined by provincial and territorial pharmacy regulatory authorities, an advisory committee of the National Association of Pharmacy Regulatory Authorities recommended that EC be given "behind-the-counter" status. Individuals may purchase drugs in this category only after receiving counseling from a pharmacist. In a Regulatory Impact Analysis Statement accompanying the new regulation, Health Canada concluded that pharmacists were well positioned to create wider access to EC, noting that professional pharmacy organizations have developed guidelines and extensive training for pharmacists to ensure that women receive the appropriate screening and counseling before EC is dispensed.<sup>37</sup>

**C. Mexico Includes EC in Official Family Planning Regulations**

*An estimated 23% of all pregnancies in Mexico end in unwanted births and an additional 17% end in abortion.<sup>38</sup> The country's 2001–2006 Strategic Plan for Reproductive Health sets goals for providing the complete range of available contraceptive methods and for taking full advantage of recent advances in contraceptive technology.<sup>39</sup> In a move that brings national policy more in line with the Strategic Plan, the Ministry of Health added EC to the list of methods that are provided in government family planning programs. The list appears in national regulations that are distributed to all medical staff in Mexico's 31 states and Federal District.<sup>40</sup>*

On January 21, 2004, the federal government of Mexico amended its Official Family Planning Regulation NOM-005-SSA2-1993 to include EC in the roster of methods provided through government family planning programs.<sup>41</sup>

#### *Definition of EC*

The regulation refers to EC as “postcoital hormonal contraception,” which it defines as “a method that may be used by women within three days following unprotected sex in order to prevent an unplanned pregnancy.”<sup>42</sup> The definition specifies that postcoital methods should not be used regularly and are indicated solely under the circumstances outlined in the regulation.<sup>43</sup>

#### *Circumstances for use*

The regulation, which approves several postcoital contraceptive regimens, indicates that EC is appropriate for women of childbearing age, including adolescents, who wish to avoid an unplanned pregnancy under the following circumstances:

- after voluntary or forced sex without contraceptive protection;
- after a delay in the administration of injectable contraception; and
- after presumed contraceptive failure (e.g., broken condom, failed attempt to withdraw prior to ejaculation, suspended use of oral contraceptive pills for more than three days, expulsion of an IUD, or inaccurate calculation of “safe periods” when using the rhythm method or periodic abstinence).<sup>44</sup>

#### *Counseling required*

The regulation states that a prescription for EC must be accompanied by thorough guidance and counseling regarding its mode of action and possible side effects. In particular, providers should emphasize that EC cannot interrupt an established pregnancy and that when a pregnancy occurs despite use of EC, use of the product will have no harmful effects on the pregnant woman or the fetus. Counseling should also emphasize that EC is less effective than conventional oral contraception and that it does not protect against STIs, including HIV/AIDS. It further calls for counseling on regular family planning methods, as well as an assessment of the patient’s risk of contracting an STI.<sup>45</sup>

#### *No examination needed*

The regulation also states that gynecologic examinations or pregnancy tests are unnecessary prior to EC use.<sup>46</sup>

### **D. Kenya’s Ministry of Health Issues Guidelines on Making EC Available to Survivors of Sexual Violence**

*Statistics indicate that sexual violence is a serious blight on the lives of Kenyan women. According to police sources, 2,308 cases of rape were reported in 2003 and 2,908 were registered in 2004.<sup>47</sup> In a 2003 survey of 1,652 Kenyan women aged 17–77, 52% reported being sexually abused in their lifetime, while over 30% of the surveyed women reported an experience of forced sexual intercourse.<sup>48</sup> Although rape is widespread and the law that criminalizes abortion contains no exceptions for rape and incest, EC has not been readily available to rape survivors. The newly issued guidelines for the medical treatment of sexual violence survivors are a positive development toward ensuring that the needs of survivors are addressed.*

The National Guidelines for the Medical Management of Rape/Sexual Violence were issued by Kenya's Ministry of Health in 2004.<sup>49</sup>

*Components of care for survivors of sexual violence*

The guidelines outline the importance of providing survivors of sexual violence with counseling, EC, and postexposure prophylaxis for HIV.<sup>50</sup>

*EC access and information*

In recognition of the “psychological consequences of conceiving after being raped,” the guidelines state that EC should be offered to every nonpregnant woman or girl who has suffered sexual violence and is not protected by a long-term contraceptive method.<sup>51</sup>

*EC to be offered at no cost and outside of work hours*

According to the guidelines, EC should be available free of charge and outside of work hours in government health institutions where rape victims are likely to present.<sup>52</sup>

*Information to be provided on EC's mode of action*

The care provider should explain to the survivor that EC works by preventing pregnancy and is not a form of abortion.<sup>53</sup>

*Testing for pregnancy*

A baseline pregnancy test should be performed, but doing so should not delay the first dose of EC, since EC is known to not have any harmful effects on an early pregnancy. Women who return for follow up at six weeks should be offered another pregnancy test, regardless of whether they took EC after they were raped.<sup>54</sup>

### **3. INFORMED CONSENT AND THE RIGHT TO FREEDOM FROM COERCION IN ACCEPTING CONTRACEPTION**

To make appropriate decisions about their health, women must have access to reliable information and an opportunity to consider their health-care options. Governments must ensure that the necessary provisions are in place to protect the rights of all women to reproductive self-determination. Legislation and guidelines should detail medical providers' legal and ethical obligations to respect patients' dignity and rights, and to obtain their informed consent. **Slovakia** recently adopted legislation aimed at ending abuse in the provision of sterilization procedures.

#### **A. Slovakia Passes Legislation on Informed Consent, Access to Medical Records, and Sterilization**

*In late 2002 and early 2003, investigations in Slovakia uncovered clear and consistent patterns of health-care providers disregarding the need to obtain informed consent for sterilization.<sup>55</sup> Many providers failed to provide accurate and comprehensive reproductive health information to Roma patients, resulting in the violation of their human rights. In some cases, doctors and nurses provided misleading and threatening information to Roma women to coerce them into providing last-minute authorizations for sterilizations, or the women received no notice that they would be undergoing the procedure.<sup>56</sup> In a few cases, women under the age of 18 were forcibly sterilized without the authorization required by law from their legal guardians.<sup>57</sup> The Slovak government passed legislation in response to the public outcry stemming from these revelations.*

On October 21, 2004, Slovakia adopted Act No. 576 on Health Care and Services Related to the Provision of Health Care.<sup>58</sup> The law sets out requirements for ensuring informed consent, establishes patients' right to access their medical records, and specifies conditions under which sterilizations may be performed.

#### *Provisions on informed consent*

Providers must inform patients about the purpose, character, consequences, and risks of a medical procedure; the available alternatives; and the risks of rejecting treatment.<sup>59</sup> This information is to be provided in a manner that is noncoercive and understandable to the patient, and that allows sufficient time for the patient to decide whether to consent. A patient has the right to refuse medical information, as well as the right to withdraw consent for a procedure.<sup>60</sup>

#### *Exceptions to the informed consent requirement*

A court may override a patient's refusal to consent to treatment only when a patient is incompetent and treatment would be in the patient's best interest. Informed consent is not required in medical emergencies and when the patient's condition poses a threat to others or, in the case of a mental disorder, to the patient himself or herself.<sup>61</sup>

#### *Provisions on sterilization*

##### *Application and waiting period*

The law provides that sterilization may only be carried out 30 days after the receipt of a patient's written application and written informed consent.<sup>62</sup> Where a patient is not competent, a legal guardian may file the application and provide written consent.<sup>63</sup>

##### *Information to be provided*

The content of the information to be provided to the patient prior to his or her consent includes the following items:

- alternative methods of family planning other than sterilization;
- how the possibility of changes in a patient's life circumstances may affect the decision to undergo sterilization;
- the medical consequences and irreversible nature of sterilization; and
- the possible failure of sterilization.<sup>64</sup>

## CONCLUSION

In order to meet their international commitments, governments must improve access to high-quality family planning information and services that involve a wide range of contraceptive methods that men and women—and adolescents of both sexes—can freely choose from. Governments must ensure that neither ideological nor financial barriers impede contraceptive access. Legislation and health policies should ensure affordable access for low-income women. Finally, strict guidelines, enforced by the courts, must be put in place to protect individuals of any age from coercive contraceptive practices, especially forced sterilization.

## Endnotes

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