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Emergency Contraception under Attack in Latin America: Response of the Medical Establishment and Civil Society

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Abstract: *The concept that it is possible to prevent a pregnancy after coitus is not new, but has gained prominence over the last 10–15 years. It provides a second chance to women who do not want to get pregnant and who, voluntarily or not, have had unprotected intercourse. Emergency contraception has been under strong attack by the Catholic church and anti-choice organisations in Latin America, who claim that the interference with implantation of the fertilised ovum is equivalent to an early abortion. The accumulation of evidence, however, is that the mechanism of action of emergency contraception is to prevent ovulation and that it does not interfere with implantation. This has been ignored by the anti-choice movement. The pattern of opposition to emergency contraception has been the same all over the Latin America region. The medical establishment and civil society, including the International Consortium for Emergency Contraception, have played a key role in defending access to emergency contraception throughout the region. A positive consequence of the public opposition of the Catholic church is that the concept and the method have become better known, and emergency contraception has become widely used. The cases of Peru, Brazil and Chile are described as examples.* ©2007 Reproductive Health Matters. All rights reserved.

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THE concept that the administration of sex hormones could prevent pregnancy when administered after coitus is far from new. In the first attempts to develop emergency contraception, relatively large amounts of oestrogen were administered to cause withdrawal bleeding after suspension of treatment. The effect of oestrogen is to cause the endometrium, the membrane that lines the interior of the uterus, to grow. The fall in the concentration of oestrogen in the blood then causes the endometrial lining to be sloughed off, with consequent bleeding.[1,2] The intended mechanism of action of such high doses of oestrogen was to cause endometrial changes that would be incompatible with implantation, as had been shown to occur in non-human primates.[3] Increasing levels of progesterone, produced by the ovary after ovulation, transform the endometrium, making it receptive to the fertilised egg. This progesterone-induced effect was to be countered by the administration of a large amount of oestrogen, thus preventing implantation. However, the high amount of oestrogen that was used caused nausea and vomiting in almost every subject, leading to the abandonment of the idea.[1,2]

This early research was the origin of the concept that any post-coital pill for pregnancy

prevention that is taken after sexual intercourse acts by preventing implantation. The fact is, however, that the current dedicated emergency contraception pill is a progestogen, a hormone that induces changes in the endometrium necessary for the maintenance of pregnancy. This fact has not changed the popular belief that the mechanism of action of all emergency contraceptive pills is to block implantation. That mistaken belief is coupled with the lack of understanding that the female oocyte is not fertilised immediately after intercourse; fertilisation may occur from 24 hours to five days later, giving time to interfere with the process before fertilisation. This misconception may be irrelevant in most of the world, but it has been a key element on which a concerted attack against free access to emergency contraception pills in Latin America has been based. The lack of awareness of the political implications of the belief that emergency contraception prevents implantation may be the reason why so little care has been taken to correct this misconception.

Emergency contraceptive pill and its mechanism of action

Widespread knowledge of emergency contraception is relatively new, but the first clinical trials showing it was possible to control human fertility by the administration of steroidal hormones after coitus were published 40 years ago.[1] Several options were tried, from high doses of oestrogen alone, as described above, to high doses of combined oral pills containing ethinyloestradiol and levonorgestrel, known as the Yuzpe regime.[4–6] In 1974, these authors gave the name ''morning-after pill' to this method, intended to be used following rape or unexpected and unprotected sexual intercourse.

One year earlier Kesseru et al had proposed the use of levonorgestrel alone as a post-coital pill, to be taken after every sexual intercourse during the cycle, a scheme with the theoretical advantage of not requiring a daily pill.[7] The effectiveness of this method was much lower than that of the combined pill, so its use was discouraged. In fact, there is an almost total lack of reference to it even in some of the most comprehensive books on contraception published before the mid-1990s. It was not until 1993 that a single study, conducted in Hong Kong, demonstrated that the use of levonorgestrel alone was as effective as the Yuzpe regimen in preventing pregnancy, with a reduced frequency of adverse events.[8]

In April 1995, the International Planned Parenthood Federation (IPPF), Family Health International (FHI), Population Council and World Health Organization met at Bellagio for a meeting hosted by South-to-South Cooperation in Reproductive Health, supported by the Rockefeller Foundation. This meeting developed a consensus statement calling for the need to make access to emergency contraception a practical reality.[9] Shortly afterwards, the Consortium for Emergency Contraception, an international collaboration of seven organisations, was created. The promotion of the concept of emergency contraception by this Consortium gave a totally new life to this method.

Initially, efforts to make emergency contraception accessible to women were focused on the Yuzpe regimen, since it used four tablets of the standard contraceptive pill, which contained 250 mcg of levonorgestrel and 50 mcg of ethinyl oestradiol, which was readily available in many countries. The woman had to take two of these pills as soon as possible and no later than 72 hours after unprotected sexual intercourse, and another two pills 12 hours later. In theory, access to the Yuzpe regimen was relatively easy. In practice, its use was minimal because knowledge of it was limited among both the public and gynaecologists.[10,11]

Promotion of the Yuzpe method became more complicated when the pharmaceutical companies launched a new, lower-dose generation of pills, which meant that the number of pills to be taken to obtain the right dose increased to eight, four as soon as possible and four 12 hours later. As the general public were not aware of the different doses of hormones in different brands of pills, they had difficulty in knowing how many pills to take post-coitally. In the absence of a dedicated product, that became an obstacle to more widespread use of this kind of contraception.

Greater attention to emergency contraception was raised by a large, comparative clinical study coordinated by the World Health Organization, which showed that levonorgestrel alone was significantly more effective than the Yuzpe regimen and was associated with fewer side effects.[12] It was the broad dissemination